Delusional Disorder

Paranoia and Related Illnesses

Alistair Munro

CAMBRIDGE

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DELUSIONAL DISORDER
Paranoia and Related Illnesses

Delusional disorder, once termed paranoia, was an important diagnosis in the late nineteenth and early twentieth centuries. Subsequently it was subsumed with schizophrenia, and only in 1987 was it reintroduced into modern psychiatric diagnosis. This book aims to reconcile recent knowledge with older ideas about the condition, and thereby to provide a contemporary perspective to the concept of delusional disorder and to integrate the scattered literature on the topic.

The illness has a characteristic form, but the content of the delusional system can vary widely. Sufferers may deny mental illness and refuse psychiatric help, so that mental health professionals, who should be at the forefront in dealing with delusional disorder, are often the last to see it. Psychiatrists and other clinicians will therefore appreciate this review of a disorder once considered untreatable but in fact, as the author shows, responsive to appropriate management. The text deals with the emergence of the concept of delusional disorder, and goes on to detail its manifold presentations, differential diagnosis and treatment. Many instructive case histories are provided, illustrating manifestations of delusional disorder including the persecutory and somatic subtypes, and variants including dysmorphic and infestation delusion, erotomania, and related conditions in the paranoid spectrum such as paraphrenia, *folie à deux* and paranoid personality disorder.

This is the most wide ranging and authoritative text on the subject to have appeared for many years, and the first to suggest, based on the author's extensive experience, that the category of delusional disorder should contain not one but several conditions. It also emphasizes that, contrary to traditional belief, delusional disorder is a treatable illness.

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Publisher's Note

The Publishers acknowledge their debt to the late George Winokur, MD, who, in the last years of his life, worked with them to develop this book, and three further volumes, as the first titles in a new series under his editorship, to be called *Concepts in Clinical Psychiatry*. Dr Winokur was not, unfortunately, able to read any of these works in their final form.

Dr Winokur's contribution to contemporary psychiatry, and in particular his dedication to a medical model for psychiatric disorder, was distinctive, and his editorial style was inimitable. These four volumes are a tribute to his vision for psychiatry as a clinical discipline founded on the principles of scientific evidence and clinical judgement.

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Paranoia and Related Illnesses

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To my wife Mary, who ‘not only tolerated, but encouraged’

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Case descriptions

Preface

Paranoia and its related disorders were regarded as an important group of psychiatric illnesses until the early part of the twentieth century. Then, because of prevalent classification practices – particularly the tendency to overdiagnose schizophrenia – the diagnoses of paranoia and paraphrenia virtually died out. In 1987, paranoia was revived by DSMIIIR and was renamed 'delusional disorder': as such, it currently is the only officially recognized member of the old paranoid disorder clustering.

Although the diagnosis disappeared, the illness and its sufferers did not. The result was both an inappropriate 'lumping' of cases of delusional disorder into other categories, most usually schizophrenia, and an extraordinary 'splitting', in which cases of paranoia/delusional disorders were recognized for some secondary feature, but their true diagnosis was ignored. The latter especially has meant a profoundly scattered literature and a great deal of confusion as to what is delusional illness and what is not.

This book is an attempt to define more clearly the concept of paranoia/delusional disorder and to gather the shards of the current body of knowledge into a more coherent whole. It also tries to define the limits of delusional disorders and to dispel some of the confusion which still exists when trying to exclude vaguely similar illnesses. At the same time, a strong effort is made to point out that paranoia/delusional disorder is not the only 'delusional disorder': for example, paraphrenia and delusional misidentification syndromes (DMS) are strong candidates for inclusion in an expanded category.

Although written primarily for psychiatrists, this volume should be of considerable interest to many other specialties and professions. For example, general physicians, plastic surgeons, dermatologists and gastroenterologists, among others, all become involved with individuals who have somatic delusions, and neurologists increasingly see cases of DMS.

Lawyers and law enforcement personnel are frequently involved with individuals who offend because of jealous or erotomanic delusions and who may stalk or assault their victims. Social workers and others in the community field deal with many deluded clients, and even pest control officers have an interest since they are not infrequently called in to disinfest houses by individuals who believe they are assailed by parasitic organisms.

The contents of the book are technical but, so far as possible, the style has been kept jargon-free and eschews unnecessary speculation. It is designed to be a practical guide to professionals, whether medical or not, who are curious about these fascinating illnesses and who may require some apposite and up-to-date knowledge to recognize and deal with them in their particular settings. Frequent case-examples are provided to emphasize what are, and what are not, features of the various subtypes.

Throughout the book, unless the sex of an individual is specifically indicated, the words 'he' and 'she' should be regarded as interchangeable.

I wish to express my gratitude to Sharon C. Munro, Reference/Collections Librarian, Leddy Library, the University of Windsor, Ontario, Canada for her great help in tracing the less accessible references I needed for this book. I would also like to thank Mr. Robert Lennie for his considered comments on the contents of the manuscript, and Marilyn Harper for its meticulous preparation.

As always, my particular thanks go to my wife and family for their tolerance while I struggled (not always amiably) with this project.

Unless otherwise stated, all literary quotations throughout the book are taken from *Bartlett's Familiar Quotations*, 15th edition, published in 1980 by Little, Brown and Co.

A.M.

Part I

Delusional disorders and delusions: introductory aspects

He who would distinguish the true from the false must have an adequate idea of what is true and false.
Benedict Spinoza (1632–1677)

Delusional disorder, under its former soubriquet of paranoia, is a venerable diagnosis. Unfortunately both the concept and the diagnosis fell into abeyance in the early part of the twentieth century and have only come back into prominence since 1987, when paranoia – renamed delusional disorder – was revived in DSMIIIR (the revised third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*). It has subsequently been confirmed in the tenth revision of the World Health Association's *International Statistical Classification of Diseases* (ICD10, 1992–93) and in DSMIV (1994) and, as will unfold in the course of this book, a considerable world-wide and cross-disciplinary literature on the subject has grown up in recent years.

To many mental health professionals, delusional disorder remains a shadowy concept and it is quite possible for a psychiatrist to have a busy practice and either not see, or not recognize, cases of the illness. This arises from a combination of lack of knowledge about it and of relative rarity in the psychiatrist's office of patients with the disorder: the reasons for the latter will be explored later.

In this section, an introduction to the disorder is undertaken and we will consider why the disorder appears to have such an elusive quality. A cursory knowledge of the evolution of paranoia/delusional disorder is essential as a background to the consideration of this elusiveness and, as will become apparent, this process has been extraordinarily complex and its sources extremely fragmented.

Finally, we shall consider briefly several aspects of the phenomena associated with delusions, the principal feature on which the diagnosis of

delusional disorder depends. Here, the literature is much more coherent but it will emerge that many of our preconceptions about delusions are highly debatable and that even the best experimental work in the field may not always translate into applications which are useful in the clinical field.

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Outline and introduction: a brief perspective on the delusional disorders

This chapter will be divided into three sections: (*a*) an introduction to the delusional disorders; (*b*) a concise description of the derivation of current concepts regarding delusional disorders; and (*c*) some notes on phenomena associated with delusions.

An introduction to the delusional disorders

Delusional disorder is an accepted diagnosis nowadays but many aspects of its description still stem from writings of the late nineteenth and early twentieth centuries, and modern descriptions are still only a few years old.

In writing about paranoia/delusional disorder (these terms will be discussed in detail later) there are two misconceptions which must be countered. The first is that it is rare. Certainly, cases do not appear in profusion in the average psychiatrist's office but, as will be shown in Chapters 2 and 3, there are many references to different manifestations of the illness in several literatures, of which the psychiatric is but one. Cumulatively, these create an impression of a disorder that is far from unusual. In addition, because many cases remain unrecognized in the community (see p.51) it is possible that delusional disorder in its various degrees of severity is really quite common. But this is guesswork and all that we are justified in saying at present is that it is not nearly so rare as psychiatrists believe and that, rather oddly, psychiatrists are often the last professional people to see such cases.

The second misconception is that the illness is untreatable. It is not so long ago that virtually all psychiatric disorders were inaccessible to therapy, but we take it for granted now that many of them respond to treatment, whether it is pharmacological or psychological or, very often, a combination of both. As will be described, delusional disorder as a distinct diagnosis faded from view at a time of therapeutic hopelessness in psychiatry and only returned to our awareness in the 1970s and 1980s.

For many physicians not familiar with the modern literature, the illness is still saddled with an extremely gloomy outlook. In fact, Chapter 13 underlines the new attitude of optimism we can adopt with an illness which, if allowed to go untreated, is certainly both severe and disabling, but which, adequately treated, may have one of the more hopeful prognoses of the severe psychiatric disorders.

A note on terminology

In the late nineteenth century the paranoid illnesses were a well-recognized group of disorders and, of these, paranoia was the most notable with the addition, in the early twentieth century, of paraphrenia as a relatively close second. Thereafter, as will be described, these terms increasingly lost favour while paranoid schizophrenia and paranoid personality disorder became well-established diagnostic concepts.

As well as this, 'paranoia' and 'paranoid' became common laymen's terms, usually implying habitual attitudes of distrust, suspiciousness and irritability in an individual rather than any specific psychiatric illness.

With the appearance of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, third edition, revised (DSMIIIR) in 1987, paranoia was revived as a distinct disorder but was renamed 'delusional (paranoid) disorder' and given its own separate category. Currently, the term 'delusional disorder' represents both a category of psychiatric illness and the only disorder which that category subsumes. Subtypes of delusional disorder are distinguished by the predominant content of the delusional system, for example persecutory, grandiose, somatic, etc. Paraphrenia at this time has no recognized diagnostic status in our official diagnostic systems, but a case will be made later in the book for its reinstatement.

In the 1970s, the present author wrote extensively on a delusional illness characterized by somatic complaints and referred to at the time as 'monosymptomatic hypochondriacal psychosis' (or MHP), a name derived from the German and Scandinavian psychiatric literatures. It has since become apparent that this is a subtype of delusional disorder, as now described in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSMIV) and in the *International Statistical Classification of Diseases*, tenth edition (ICD10), and in recent years it has seemed best to give up the use of the term 'monosymptomatic hypochondriacal psychosis' and refer instead to 'delusional disorder, somatic subtype'.

In the present volume, paranoia and delusional disorder are regarded as

one and the same thing and the names are used synonymously or, at times, in conjunction as 'paranoia/delusional disorder' to underline that synonymity. As has been explained above, 'delusional disorder, somatic subtype' and 'monosymptomatic hypochondriacal psychosis' are also interchangeable with each other, but the former will invariably be used except to make some special point. Both DSMIV and ICD10 utilize the term 'delusional disorder' and it has rapidly gained precedence over older terminologies: it makes good sense, therefore, to employ it preferentially and to refer to its different subtypes to ensure uniformity. Where older terms are introduced from time to time, an attempt will always be made to explain how these relate to modern usages.

However, conventional classifications and jargon are rarely infallible and an argument will be put forward for necessary changes to the current views of DSMIV and ICD10 on delusional disorders.

For a variety of reasons which will be considered later, the concept of paranoia had 'fallen into abatement and low price' by the mid-twentieth century. It had gradually come to be described in the textbooks in the most perfunctory way, if it was mentioned at all. Indeed, one standard British text of the time went so far as to say it probably did not exist at all (Mayer-Gross, Slater and Roth, 1960).

Now that paranoia has returned to respectability under its new title of delusional disorder, however, and cases are being recognized with increasing commonness, does it not seem odd that a whole illness category could simply vanish for several decades? In Chapter 2 this situation will be examined in rather more detail with an attempt to explain how it could happen.

Of course, it is obvious that the cases did not disappear. Instead they were viewed differently and were usually placed under the (then) catch-all rubric of schizophrenia. Because paranoia really does not resemble schizophrenia very closely, cases would be diagnosed as aberrant forms of the latter: but schizophrenia was seen as having so many aberrant presentations that another one seemed to make little difference. For many years, therefore, psychiatrists of this author's generation saw cases of paranoia but did not have the knowledge to appreciate that this was an illness in its own right.

The recognition of cases of delusional disorder

There has been a considerable renaissance regarding paranoia/delusional disorder since the early 1980s, at first concentrating to a considerable

extent on the somatic subtype (i.e. MHP) but latterly looking at the other subtypes and at the illness in general. Unfortunately, much of the current literature is anecdotal and based on a large number of very small case samples, and it is scattered across many journals in several disciplines. There is a growing number of knowledgeable contributors in the area but the awareness of delusional disorder among psychiatrists in general is still somewhat restricted. This is one reason why the present volume has been written, as an attempt to gather together some very disparate material, to provide an overview, and to inform clinicians about an important, though still imperfectly appreciated, psychiatric disorder.

Another factor as to why delusional disorders still sometimes seem obscure is that many of their sufferers continue to be quite high-functioning and survive to a greater or lesser degree in the community. Also, as part of their delusional belief system they flatly reject any suggestion that they are mentally ill, so they deliberately and often angrily avoid being referred to psychiatrists. This means that many mental health specialists are still unfamiliar with such cases and remain uncomfortable in making a diagnosis. Psychiatric consultants still see too many individuals with delusional disorder wrongly labelled schizoaffective, called an atypical psychosis or given a similar nondescript label. At least we much less often lump the cases with schizophrenia, but psychiatrists and others in the mental health realm still have much to learn about modern concepts of delusional disorder and about how to treat these patients.

Paranoia does not have a good reputation, being associated in most people's minds with anger, suspiciousness, ideas of reference, accusations of persecution and rejection of psychiatric help. These are certainly features of many cases and may make it difficult to engage the individual in treatment. On the other hand, many patients who are viewed as 'paranoid' are actually suffering from severe personality disorder or paranoid schizophrenia and in some ways these are perhaps even more difficult to engage in therapy.

Many anecdotal treatment results, and a small number of double-blind drug trials, appear to show a consensus that delusional disorder, despite its traditional resistance to treatment, can now be regarded as an eminently treatable illness. Munro and Mok (1995) reviewed the world literature (much of which is regrettably incomplete) and found that pimozide tends to be the most widely used drug in different forms of delusional disorder and that it appears to give very good results, but it is pointed out that the evidence is still insufficient to know whether it is inherently superior to other neuroleptics in treating delusional disorder. What is most important,

however, is not to urge a particular treatment but rather to underline the treatability of the illness.

The gap of nearly 60 years between the disappearance of paranoia and its reappearance as delusional disorder is a dreadful indictment of the diagnostic standards of the mid-twentieth century. How could we ever have confused paranoia with schizophrenia? Yet we did and, as will be pointed out later, we are still apparently making similar errors in relation to other diagnoses.

This book will attempt to describe the clinical aspects of delusional disorder in an understandable way (using case descriptions as illustrations), to look at delusional disorders in their wider nosological context and, finally, to suggest some ideas for the future. As new investigative methods become available to the clinical neurosciences, that future promises to be an extremely fruitful one; it will be even more fruitful if our diagnostic practices can become more precise *now*, thereby permitting research to concentrate on increasingly homogeneous illness categories.

If the reader is an experienced clinician, the present volume should provide him or her with useful information to help with the more refined diagnosis and treatment of the delusional disorders which occur in his or her clinical work. If, on the other hand, the reader is unfamiliar with the delusional disorders, perhaps what has been written will provide the knowledge that allows for ready recognition when the first case comes along. Nowadays we have much readier access to the older literature as well as to the rapidly growing number of new publications on delusional disorder. We are therefore no longer mapping almost totally unfamiliar territory as was the case only 20 years ago.

Until now, work on delusional disorder has remained largely at the descriptive level and very little that is experimental has as yet emerged. That is a great pity, because it is a condition which could very well reward scientific study. It has certain features which suggest that it may be the outcome of quite circumscribed brain pathology: not least among these suggestions is the rapid return to relatively normal mental function in patients who respond well to a neuroleptic, even when the illness has been of very long duration.

Neurobiological research on this illness might well give us profound insights into important aspects of the psychopathology of psychotic illnesses and of their brain correlates. In addition, since effective treatment is available, we are potentially able to follow the disorder from the wholly untreated to the fully treated stage, making observations each step of the way.

Delusional disorder or disorders?

There is a grey area between the important groupings of the major mood disorders and 'the schizophrenias' (schizophrenia being not a single illness but – more likely – a conglomerate of related disorders). Paranoia/delusional disorder partly fills this in and has some overlap of clinical features with both types of illness. But there are other illnesses in this ill-defined area, not all of them officially recognized by DSMIV and ICD10.

It will be contended that paraphrenia is the most notable of these 'unofficial' disorders, but there are some more which have a more or less accepted existence, and these include cycloid psychosis, brief reactive psychosis (brief psychotic episode) and the delusional misidentification syndromes. Later, an argument will be put forward for the inclusion of paraphrenia in a 'paranoid spectrum' and as a worthy candidate to be a second delusional disorder. Cycloid psychosis and brief psychotic episode are often confused with each other and with delusional disorder, and it has been found necessary to try to disentangle a confusing literature on both in order to clarify their respective features and to demonstrate that each differs markedly from delusional disorder, while being part of its differential diagnosis.

The delusional misidentification syndromes share some important features in common with paranoia/delusional disorder and, on that ground alone, may qualify to be regarded as a further 'delusional disorder'. In addition, fascinating evidence about specific brain abnormalities in these syndromes is accruing and throws potential light on the aetiology of delusional disorder itself. This has been considered in some detail in Chapter 9.

It may seem to some purists that it is inappropriate to give space to these various disorders in a book on delusional disorder, but the literature on delusional disorder has been, until recently, unhelpful in separating it from other illnesses, including schizophrenia, paraphrenia and the other conditions just mentioned. We must be more conversant with all of these in order to be sure when we are, or are not, dealing with a case of delusional disorder *per se*.

The derivation of current concepts regarding delusional disorders

While discussing schizophrenia, Stengel (1957) said, 'There are many indications that differences of theoretical concepts, however vaguely held, are frequently responsible for diagnostic disagreements'. His observation could apply equally to the paranoid/delusional disorders, where psychia-

trists have often diagnosed according to preconceived belief rather than by unbiased observation. The career of the paranoid/delusional disorders since the death of Kraepelin is a sad commentary on psychiatry's unhappy tradition of confusing hypothesis with explanation, and its all-too-frequent lack of respect for scientific methodology.

At present, DSMIV (1994) and the international statistical classification of diseases, tenth edition (ICD10) describe only one delusional disorder. In 1981, Kendler and Tsuang, citing respectable authority, listed four illnesses in this category, as follows:

(1) Paranoid schizophrenia.
(2) Paranoid state (which approximates to paraphrenia).
(3) Paranoia (now known as delusional disorder).
(4) Paranoid psychoses of late life (often called 'late paraphrenia').

They excluded paranoid personality disorder since it is not a psychotic condition and it is not associated with delusions. Elsewhere in this book (see Chapter 12) this disorder will be mentioned briefly, mainly to emphasize that differentiation.

Paranoid schizophrenia is not usually included with the paranoid/delusional disorders, though Emil Kraepelin (1909–1913) thought that there were good arguments why it might be. Although this section deals mostly with paranoia and paraphrenia, later in this chapter and elsewhere, some background information on paranoid schizophrenia, late paraphrenia, late onset schizophrenia, brief reactive psychosis, cycloid psychosis, and delusional misidentification syndromes will also be presented, since these illnesses hover uncertainly on the edge of the paranoid/delusional group.

Problems concerning nomenclature

The delusional disorders have often been overshadowed by schizophrenia and, at times, by the mood disorders. The borderlines are admittedly shadowy, yet paranoid/delusional disorders were quite well defined nearly a century ago. Unfortunately, terminology has been a major stumbling block and words like 'paranoia', 'paraphrenia' and 'paranoid' have been used so loosely that even professionals find difficulty in defining them satisfactorily. This situation still gives rise to major problems in discussing this group of illnesses.

Fish (1974) noted that English-speaking psychiatrists customarily use 'paranoid' to mean 'persecutory', whereas strictly speaking it should mean

'delusional'. Kendler and Tsuang (1981) emphasized the need for definitions, as well as inclusion/exclusion criteria for paranoid/delusional disorder, but careful use of definitions concerning these illnesses is still the exception rather than the rule, although DSMIV and ICD10 certainly have taken several steps in the right direction.

We speak about paranoid disorders but specifically exclude paranoid personality disorder. When we talk about paranoid personality disorder we have to say, 'This is not a paranoid (i.e. delusional) condition'. This is confusing and logic suggests that, as a minimum, the personality disorder be given a new name. However, in the preparation of DSMIIIR (1987) it was considered that psychiatrists would be particularly reluctant to give up the term, 'paranoid personality disorder'. So, instead, 'paranoid disorders' lost their name and became 'delusional (paranoid) disorders' in DSMIIIR.

DSMIIIR was very restrictive and DSMIV and ICD10 have remained so; therefore this new category contains only one disorder, which corresponds largely to the traditional definition of paranoia. Like Kendler and Tsuang (1981), the present author firmly believes there are several delusional disorders, and it is hoped that new interest in this area will lead to recognition of some or all of them and provide adequate up-to-date descriptions of them.

Paranoia until the late nineteenth century

Kraepelin (whom we shall soon mention in more detail) was just beginning his pioneering work on the reformation of psychiatric classification at this time and paranoia was only one of many diagnoses whose description varied widely from one centre to another. Nevertheless, based on the descriptions already extant in the 1890s, a psychiatrist of that time might have been able to say the following about paranoia:

(1) It is a stable disorder characterized by the presence of delusions.
(2) It is a primary disorder, not secondary to another psychiatric diagnosis.
(3) It is a chronic disorder: in many cases it appears to persist unaltered until death.
(4) The delusions are logically constructed and are internally consistent.
(5) The disorder is a monomania: that is, the delusions have a single and consistent theme.
(6) Despite the monodelusional quality, different patients' illnesses have

differing contents, including ideas of influence, persecution and grandiosity.

(7) The individual experiences an exaggerated sense of self-reference.

(8) It is apparently a disorder of the highest aspects of the intellect and, although affective symptoms may be present, paranoia is not secondary to depressed mood.

(9) Hallucinations can occur, and in some cases may exacerbate the delusional ideas.

(10) The presence of delusions does not interfere with the individual's general logical reasoning (although within the delusional system the logic is perverted) and there is no general disturbance of behaviour.

(11) Many cases appear to arise in the setting of a markedly abnormal personality.

(12) The frequency of the illness is unknown but it occurs often enough to make it of some note.

(13) There are many theories of causation, but the aetiology of the disorder is in dispute.

As will be seen in Chapter 2, this is not at all a bad description of paranoia as perceived at the present time, but unfortunately in 1890 the situation was like a jigsaw puzzle with many psychiatrists holding separate pieces, and with no-one quite able to see the overall picture.

It was left to Emil Kraepelin to articulate the principles which go to make up not only paranoia, but the paranoid/delusional disorders in general, and to make some kind of coherent construct out of them.

The influence of Kraepelin

Emil Kraepelin is widely considered to be the originator of modern classificatory methods in psychiatry. Following the example of Kahlbaum (1863) he studied illnesses not only according to their appearances at a given time, but also according to their characteristic courses over periods of time. His work on schizophrenia, manic–depressive illness and paranoid/delusional disorders remains seminal. His famous textbook (*Psychiatrie, Ein Lehrbuch für Studierende und Ärtze*) first appeared in 1883 and eventually ran to nine editions. It has had an enormous influence on psychiatry, and many of his views are still widely respected today.

In the 1896 edition of the *Lehrbuch* he described three apparently separate disorders, dementia praecox (a term he inherited from earlier

workers), catatonia and dementia paranoides, whose ultimate courses appeared to be mental degeneration. He regarded paranoia as a distinct condition with its own course and outcome.

In the next edition (1899) he revised his views on dementia praecox, catatonia and dementia paranoides and proposed that they were different aspects of one illness, to which he gave the overall label, 'dementia praecox', the illness Bleuler (1950) later called 'schizophrenia'. Dementia paranoides included those cases which appeared to meet the criteria of paranoia, except that they thereafter deteriorated rapidly. Paranoia continued to be seen as a separate illness with well-systematized delusions which were not bizarre, with a chronic but nondegenerative course, and with relatively slight involvement of affect and volition.

From then until his death in 1926, Kraepelin maintained his general view of paranoia, although he gradually introduced detailed modifications. Because of opposition from some quarters, he doubted its validity at times and on occasion he considered dropping the diagnosis, but always found it too useful to do so.

He differentiated paranoia distinctly from dementia praecox at all times by insisting that delusions in paranoia were systematized and relatively consistent, nonbizarre, and often related – though pathologically – to real-life events. He believed that persecutory delusions were the most common, followed by delusions of jealousy, grandeur and eroticism. Nowadays, hypochondriacal delusions are also well recognized: Kraepelin observed such delusions but never himself saw a case which he felt was characterized by them. At first, he allowed auditory hallucinations and auditory misinterpretations to be included in the description of paranoia, but in the eighth edition of his textbook (1909–1913) he specifically excluded these.

According to Kraepelin, patients with paranoia had no disturbance of the form of thought, as opposed to the abnormal (delusional) content, and the main defect was considered to be in their judgment. The personality was well-preserved, even though the illness might last several decades and the only behavioural changes were those related to the delusional beliefs. For example, an individual who felt he was persecuted might attack his 'persecutor' but would behave acceptably in every other circumstance. This was in marked distinction to the generally disturbed behaviour of the schizophrenic.

The mood in paranoia can be fairly normal when the patient is not thinking about his delusional ideas, but becomes very intense when he is preoccupied with them. Nevertheless, the mood essentially remains appro-