

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.

ALISTAIR MUNRO is Professor Emeritus of Psychiatry at Dalhousie University, Halifax, Nova Scotia, and an internationally recognized authority on delusional disorder.

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

ALISTAIR MUNRO

Dalhousie University, Halifax, Nova Scotia



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To my wife Mary, who 'not only tolerated, but encouraged'

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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 DSMIII-R 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 disinfect 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 DSMIII-R (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.

1

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 (DSMIII-R) 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 synonymy. 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 Ärzte*) 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-

priate to the delusional content, and Kraepelin steadfastly maintained that paranoia was not secondary to a disorder of mood.

The illness he described was largely one of middle and older age, the most common onset being between 30 and 40. In his series (of only 19 cases) men outnumbered women. In his description he emphasized that the premorbid personality was frequently abnormal, with lifelong eccentricities and strange attitudes in more than half of his cases. He believed these features caused stresses, setting up a vicious circle which helped to precipitate the illness.

For many years he considered paranoia to be invariably unremitting and incurable. However, in his textbook's eighth edition he did allow for a better prognosis in some cases. While still believing that most cases were unrelenting, he said that milder cases might develop their delusions temporarily as a result of stress and that some of these might be related to manic-depressive illness. In these 'reactive' cases he believed that the paranoia was 'understandable' (see p.15) as an outcome of interaction between environmental stress and a predisposed personality: otherwise he regarded paranoia as an 'endogenous' illness. It is possible that 'reactive' paranoia is the condition now known as 'brief psychotic disorder' (DSMIV) or 'acute and transient psychotic disorder' (ICD), which is described in Chapter 11.

Kraepelin's views on paraphrenia

In the eighth edition of his textbook, Kraepelin introduced a new diagnosis, that of paraphrenia. He described paraphrenia as similar to paranoid schizophrenia, having fantastic delusions and hallucinations, but with relatively slight thought disorder and much better preservation of affect. Compared with schizophrenia, personality deterioration was considerably less and there was little loss of volition. The behaviour of paraphrenic patients was much less disturbed than that of schizophrenics, and even when their delusions were severe they appeared reasonable in manner. Their ability to communicate and to convey affective warmth remained good.

Now that he had described paraphrenia as an illness lying between paranoid schizophrenia and paranoia, Kraepelin was encouraged to say that paranoia did not have hallucinations. So, henceforth a paranoia-like illness with hallucinations would be considered to be paraphrenia. As will be indicated later, this is perhaps the only serious diagnostic mis-step made by Kraepelin in the whole area of paranoid/delusional disorders.

Kraepelin's views on paranoid schizophrenia

While he was defining paranoia and paraphrenia, Kraepelin was pursuing his major task of refining his other diagnoses, especially dementia praecox and manic-depressive insanity.

As has been already noted, he introduced the term 'dementia paranoides' in 1896 to describe a small group of patients with profound and bizarre persecutory and grandiose delusions who showed fairly rapid personality deterioration, marked thought disorder and severe affective symptoms.

As also previously described, in 1899 (op cit) he began to employ 'dementia praecox' to describe much of what is now called schizophrenia, distinguishing three subtypes: hebephrenic, catatonic and paranoid. (Bleuler later added a fourth: simple schizophrenia.) In the paranoid variety he included the severely disturbed dementia paranoides cases as well as patients whose delusions were more systematized and stable and whose general deterioration was slower. In 1903–04, in the textbook's seventh edition, he mentioned that some of the latter did not deteriorate severely at all and did not have the profound incoherence and mood disturbance typical of dementia praecox; some of these cases were later transferred to the paraphrenia category.

His core group of paranoid schizophrenics is essentially the one we recognize today. Their illness comes on relatively late, they deteriorate less than other schizophrenics, but they still show features characteristic of schizophrenia, with generalised thought disorder, affective involvement, and disorder of volition as well as florid delusions and hallucinations.

Other contributions to the conceptualization of the delusional disorders

In 1911, Eugen Bleuler (1857–1939) introduced the term 'schizophrenia' to avoid the twin misconceptions inherent in the name 'dementia praecox', that it was necessarily a deteriorative illness and that it could only occur in the young (Bleuler, 1950). As Kendler and Tsuang (1981) note, Bleuler gave more latitude than Kraepelin in the diagnosis of schizophrenia and he included many of the paranoid illnesses in this category. Nevertheless, he did recognize paranoia as a separate disorder and, in fact, allowed the presence of hallucinations in the diagnosis. At first he recognized paraphrenia but subsequently saw it as a variant of paranoid schizophrenia. In general, his influence led to an over-recognition of schizophrenia for many years, especially in the United States.

Karl Jaspers (1883–1969) struggled to differentiate symptoms such as delusions which were the result of a ‘psychic process’, a hypothetical mechanism to explain enduring psychological symptoms which could not be ‘understood’ from other symptoms which could be recognized as a ‘development’ from the previous personality. In his concept of ‘Verstehende’ psychology, schizophrenic symptoms were not understandable, in contrast to many paranoid symptoms which could be comprehended as an outcome of environmental stress impinging on an abnormal personality. His views have been very influential although they continue to generate debate (Huber, 1992), but in our context at least they did seem to support Kraepelin’s contention that schizophrenia and paranoid disorders were separate, and also emphasized the frequency of premorbid personality abnormalities in paranoid/delusional disorders.

Ernst Kretschmer (1888–1964) suggested that paranoid symptoms tended to occur in abnormally sensitive individuals who experienced life-long conflict between strong feelings of inadequacy and an unrequited sense of self-importance (Kretschmer, 1927). Under the influence of a ‘key experience’, an ‘understandable’ psychosis emerges, with delusions of reference and persecution. Fish (1974) believed that this might explain some delusional contents, but failed to elucidate the paranoid mechanism.

Psychoanalysts believe that the contribution of Sigmund Freud (1856–1939) to the understanding of the paranoid/delusional disorders is basic. Certainly, his descriptions (1958a, b) of the putative mental mechanisms involved in paranoia are useful as metaphors, but his diagnostic approach was loose and his nomenclatures confusing. However, he did say that paranoia and dementia praecox should be seen as distinct disorders.

While the Kraepelinian view of paranoid disorder has proved the most enduring one, it has not necessarily been accepted everywhere. As Fish pointed out, many European psychiatrists did not accept paranoid disorders as separate illnesses but instead regarded paranoid conditions as expressions of other mental illnesses such as schizophrenia, affective disorder, organic brain disorder or as psychogenic reactions secondary to environmental stress acting upon an abnormal personality. It should be appreciated that this viewpoint is still prevalent in parts of Europe (Berner, 1965; Retterstøl, 1966), and is radically different from present-day practice in the English-speaking world. In DSMIV and ICD10, delusional disorder is essentially and specifically Kraepelinian paranoia and not a group of illnesses.

Subsequent developments

Paranoia

In 1931, after Kraepelin's death, Kollé reported his study of primary paranoia, describing the detailed follow-up of 66 cases seen in Kraepelin's former clinic in Munich. Despite the fact that a proportion of the cases of paranoia retained these original features, he emphasized those which had not, and concluded that paranoia was really a rare form of schizophrenia.

In the United Kingdom, the term 'paranoia', in its technical sense, had almost fallen into disuse by mid-century. Mayer-Gross, Slater and Roth, in the second edition of *Clinical Psychiatry* (1960), wrote off the condition as of 'merely historic interest'. These authors' views proved influential and in the United States in 1977 we find Gregory and Smeltzer echoing them. Later, in the United Kingdom, the *British Medical Journal* (1980) said that 'paranoia is no longer a fashionable term'. Yet the third edition of *Clinical Psychiatry* (Slater and Roth, 1969) had taken a very different line and endorsed the concept of paranoia with its encapsulated delusions and also of paraphrenia.

In *The International Statistical Classification of Diseases*, eighth edition (ICD8, 1968), paranoia was an *extremely* rare condition, while in ICD9 it had become simply rare. In the meantime, in DSMI (1952) paranoia was described in traditional terms and 'paranoid state' approximated to paraphrenia. In DSMII paranoid disorders (except paranoid schizophrenia) were grouped as 'paranoid states' (a loose amalgam of paranoia and paraphrenia) but it was questioned whether they were distinct from schizophrenia. DSMIII added confusion by describing paranoid disorders as characterized only by persistent delusions of persecution or delusional jealousy while still providing a rather half-hearted description of Kraepelinian paranoia. It also presented an unconvincing subgroup of illnesses named 'shared paranoid disorder' (an attempt to describe *folie à deux*), 'acute paranoid disorder' (see Chapter 11) and 'atypical paranoid disorder'.

Lewis (1970) wrote a seemingly authoritative article on paranoia and paranoid which nevertheless tails off in inconclusiveness. Similar perplexity is displayed in another standard British work, Henderson and Gillespie's *A Textbook of Psychiatry for Students and Practitioners*, whose sixth edition (1944) endorses the paranoid psychotic disorders as entities and even includes paranoid schizophrenia with them. Yet by its ninth edition (Henderson and Batchelor, 1962) it rejects the 'cumbersome' Kraepelinian nosological grouping of paranoia, paraphrenia and paranoid schizophrenia.

Prior to DSMIII, Winokur (1977) had re-described paranoia under the name ‘delusional disorder’, basing his findings on a strict nosological approach of Kraepelinian type and the observation of case types. In 1980, Kendler somewhat elaborated Winokur’s criteria and suggested a division into simple delusional disorder (without hallucinations) and hallucinatory delusional disorder – a distinction currently regarded as redundant. Soon after, the present author (Munro, 1982a) separately evolved a description of paranoia remarkably like that of Kraepelin and the above two authors, based on a study of a series of patients with monodelusional hypochondriasis (see Chapter 2). Like Winokur’s, this contribution emphasized subtypes of paranoia based on specific delusional contents.

Thus, by 1982, Winokur, Kendler and this writer had separately concluded that, despite all the intervening confusion since Kraepelin’s death, paranoia existed, was much less rare than had been believed, and was readily diagnosable on empirically derived criteria. In addition, the present author presented evidence for treatability (see Chapter 13).

DSMIIIR agreed and its description of ‘delusional (paranoid) disorder’ was largely that of Kraepelinian paranoia except that ‘nonprominent’ hallucinations were allowed. The illness is distinct from affective and schizophrenic disorders. ICD10 (1992–93) has a very similar description and DSMIV differs only slightly from DSMIIIR.

So, despite its vicissitudes, paranoia, delusional (paranoid) disorder or simply delusional disorder, is now officially recognized and is increasingly being diagnosed. A more optimistic approach to treatment is giving an added incentive to seek out and carefully diagnose cases.

The clinical subtypes of paranoia

While paranoia was struggling to re-establish its credentials, its subtypes, especially erotomania and pathological jealousy, were enjoying a somewhat spurious independent existence, and these two entities will now be considered briefly.

Erotomania. As Enoch and Trethowan (1979) have shown, cases of apparent erotomania have been described since classical times. Kraepelin (1921) revived attention to it by designating erotomania as a subtype of paranoia. His typical patient was a middle-aged female disappointed in love, a description similar to that of Bianchi (1906). Kretschmer (1927) developed this stereotype of old maids developing a psychosis due to unrequited love and Hart (1921) actually referred to ‘old maid’s insanity’.

The psychiatrist most identified with the description of erotomania was de Clérambault, whose work was published posthumously in 1942. Despite his own insistence to the contrary, his 'pure' variety of erotomania is now regarded as synonymous with the Kraepelinian subtype of paranoia as accepted by DSMIV and ICD10. De Clérambault's secondary type of erotomania is best regarded as a complicating feature of another disorder such as schizophrenia (Segal, 1989).

In recent years, it has been demonstrated that erotomaniac delusions can occur in men (Taylor, Mahendra and Gunn, 1983), who are more likely to act out their delusions (Goldstein, 1987). Also, cases of homosexual erotomania have been reported (Dunlop, 1988; Signer, 1989).

Pathological jealousy. Jealousy is as old as mankind but as Mullen (1991) points out, what was, in Western society at least, a socially acceptable reaction to infidelity has, at least in a proportion of cases, come to be regarded as evidence of psychopathology. While there has, for a very long time, been an appreciation of the difference between 'normal' or 'understandable' jealousy and the pathological variety, much of the literature on the subject is unclear as to the nature of that pathology.

Kraepelin (1899) clearly described cases of paranoid/delusional disorder in which jealousy was the predominant theme and he noted that this picture could arise in individuals addicted to drugs such as cocaine, as well as in alcoholics. An association between alcohol abuse and morbid jealousy was described as early as 1847 by Marcel and has been recorded by others, for example Langfeldt (1961) and Shepherd (1961) who also found an association with cocaine and amphetamine addictions.

Brierly (1932) and East (1936) confirmed the long-held impression of the dangerousness of pathological jealousy by showing that up to a quarter of *sane* murderers killed out of jealousy; and Mowat (1966), studying murderers who had been found criminally insane, estimated that 12 per cent of the males and 15 per cent of the females were motivated by jealousy. Indeed, the forensic aspects of morbid jealousy are a highly important aspect of the subject.

Freud (1958a) theorised that unconscious homosexual feelings were the basis for delusions of jealousy but subsequent workers, for example Langfeldt (1961), Shepherd (1961) and Vauhkonen (1968), found no support for this in their studies, although the last-named did report that a considerable number of his patients had other types of sexual dysfunction.

Retterstøl (1967) has provided one of the very few follow-up studies of pathological jealousy, involving 18 patients with 'jealousy-paranoiac psy-

chosis', who were interviewed from 2½ to 18 years after the initial diagnosis was made. His results suggest a more benign course than is usually reported: 11 out of 18 patients were delusion-free at review, but since the majority were classed as 'reactive psychosis, paranoid', one has to speculate whether they would now be regarded as true delusional disorder cases.

In 1987, DSMIIIR included a monodelusional jealousy presentation as one of the subtypes of paranoia. Now, as 'delusional disorder, jealous subtype', this concept is enshrined in DSMIV and ICD10. The term 'Othello syndrome' (Schmeideberg, 1953; Enoch and Trethowan, 1979), often used as a synonym for pathological, especially delusional, jealousy, is confusing and should be avoided in clinical descriptions.

Paraphrenia

This disorder remained in ICD9, where it was said to be a 'paranoid psychosis in which there are conspicuous hallucinations, often in several modalities. Affective symptoms and disordered thinking, if present, do not dominate the clinical picture and the personality is well preserved.' (The category also subsumed involitional paranoid state and late paraphrenia.) This indicated that some psychiatrists in Europe and the United Kingdom still used the diagnosis, but it is rarely mentioned nowadays in the United States. It was not included in DSMIII, DSMIIIR or DSMIV, and in fact its last official recognition in the USA was in the 1945 *Statistical Manual for the Use of Hospitals for Mental Diseases* (American Psychiatric Association), tenth edition. Now, it has also disappeared from ICD10.

In 1960, Jackson commented that the diagnosis of paraphrenia was still commonly used in Britain and, in 1988, Black, Yates and Andreasen (1988) made the same comment, although they may have been referring specifically to 'late' paraphrenia. Yet, in 1970, Lewis said that paraphrenia was an uncommon diagnosis in Britain.

Much of the literature on paraphrenia is as contradictory as this indicates and it would be easy to conclude (if we did not have the example of paranoia to compare with) that paraphrenia must be something of a chimera to cause such uncertainty. Yet, as a practising clinician, this writer sees cases which closely agree with Kraepelin's description of paraphrenia and there are not a few fellow psychiatrists who feel the same way. Until ICD9 there was at least an official recognition of this viewpoint and Kendler and Tsuang (1981) stated, 'The followup results in general support Kraepelin's division of the paranoid psychotic disorders into three groups . . . Of these paranoid psychotic patients with bizarre delusions and/or

hallucinations, about half go on to develop symptoms of thought disorder and personality deterioration (i.e. Kraepelin's paranoid dementia praecox) and half never develop such symptoms (i.e. Kraepelin's paraphrenia).'

If experts in the field believe the condition exists, why is it so widely ignored? There is no doubt that Kraepelin himself found paraphrenia more difficult to defend than paranoia and even before his death, Mayer (1921) had published a follow-up study of 78 cases of paraphrenia diagnosed in Kraepelin's own clinic. More than half the cases had deteriorated to other psychiatric diagnoses, but 28 of them had remained apparently paraphrenic. Subsequent writers have tended to stress the deteriorated cases and since then paraphrenia has often been regarded as a stage on the way to schizophrenia. A serious problem is that there has been no extensive case-series study on paraphrenia (except for 'late' paraphrenia – see Chapter 8) in the past half century.

The jury may still be out in the case of paraphrenia, but in the present era when diagnostic issues are much more alive than for a very long time, there is no question that its validity will be tested in many more scientific ways than ever before. There are those of us who believe that its existence will be vindicated just as paranoia's was. To this end, the writer and two of his colleagues, A. Ravindran and L. Yatham (personal communication, 1997), have undertaken a case-finding study which, in our view, vindicates our opinion that paraphrenia is a separate and recognisable disorder (see Chapter 7).

Late paraphrenia

In the sixth edition of his textbook (1899), Kraepelin introduced another delusional psychosis – presenile delusional insanity – which (despite the 'presenile') did not occur until the age of 55 or over and was not related to an organic aetiology. Bleuler (1950) later grouped these with schizophrenia (as he also grouped paraphrenia).

In the United States, presenile delusional insanity was accepted as an official diagnosis by the American Psychiatric Association until the emergence of DSMI in 1952, when it was combined with involuntional melancholia to form 'involuntional psychotic reaction' (presumably a mixture of severe affective and paranoid/delusional cases). In DSMII (1968), 'involuntional paranoid state' was a return to the more Kraepelinian description of presenile delusional insanity and emphasized lack of marked schizophrenic thought disorder.

DSMIII refers to involuntional melancholia and involuntional paranoid

disorder in its index, but they are not described in the text so are presumably regarded as *passé*. ‘Atypical paranoid disorder’ covers any case not described in the rest of its (unsatisfactory) paranoid disorder section. DSMIII-R’s index mentions involuntional melancholia but not involuntional paranoid disorder, but there was a category of psychotic disorder not otherwise specified (NOS) which could, for some clinicians, allow some consideration of delusional disorders in the elderly.

ICD8 had a category of ‘involuntional paranoid state’ but this is also called ‘involuntional paraphrenia’ and is described as a paranoid variety of involuntional psychotic reaction, without the conspicuous thought disorders typical of schizophrenia. ICD9 had paraphrenia, which also included ‘involuntional paranoid state’/‘late paraphrenia’. ICD10 has ‘other persistent delusional disorders’, a residual category which can be used for all chronic delusional disorders not meeting the criteria for paranoid/delusional disorder, which could include paraphrenia.

In the meantime, in England in the 1950s, Roth and his colleagues (Roth, 1955) had introduced the concept of ‘late paraphrenia’, an illness beginning in the sixties, seventies or even later and characterized by highly systematized delusions, while hallucinations in clear consciousness were also common.

This diagnosis continues to be used widely in Britain (and may be why Black, Yates and Andreasen (1988) thought that paraphrenia was a common term there), but argument about its separate diagnostic status continues. Post (1966) and Holden (1987) argue against it, Grahame (1984) argues for it but says there is a considerable overlap with schizophrenia, and Soni and colleagues (1988) see similarities with schizophrenia but argue for its separateness. Late paraphrenia is discussed further in Chapter 8.

Schizophrenia and paraphrenia are, in this author’s belief, separate disorders, but in advanced old age their presentations become so similar that it is probably no longer worthwhile arguing for a diagnostic differentiation on noninvestigative clinical findings alone. This aspect is considered elsewhere (see Chapter 9).

Late onset schizophrenia

As noted, Kraepelin did not exclude late onset cases of schizophrenia from his category of dementia praecox, but after his time many psychiatrists were unwilling to label a case schizophrenic if a psychotic illness began after the age of 45. This has led to tortuous attempts to diagnose late onset functional psychoses without actually calling them schizophrenic.

Nowadays, there is an increasing acceptance of late onset schizophrenia but it is still not altogether clearly defined. Most authorities agree that it is more likely to be paranoid schizophrenia with bizarre delusions and hallucinations but relatively little disturbance of thought form. It is much more common in females, and a family history of schizophrenia is often absent. Response to neuroleptic medication is frequently good.

It will save a great deal of semantic manoeuvring if this category becomes widely accepted and, if it is, it could be that, as suggested previously, no real differentiation can be made between first onset schizophrenia and paraphrenia in the very elderly, except possibly by neuroinvestigative means.

Delusional misidentification syndromes – background aspects

While the conditions discussed until now have been regarded at various times as belonging to a group of paranoid or delusional disorders, it is now time to introduce a relative stranger which presently has no categorical status.

In 1923, Capgras and Reboul-Lachaux presented the case of a middle-aged woman who believed that her close relatives had been replaced by identical doubles as part of a plot to steal her property. Their description has become the prototype for the concept of the delusional misidentification syndromes, of which a number of varieties has been enumerated (Christodoulou, 1978). These will be considered later in Chapter 9.

As time has gone on, purely psychological theories of aetiology have gradually given way to increasing evidence of organic brain factors in aetiology (Cummings, 1985), including organically determined problems in facial recognition (Ellis and Young, 1990), although Fleminger (1992) adduces evidence for a combination of psychological and organic brain factors as causation.

Some authors, for example de Pauw, Szulecka and Poltock (1987), have noted parallels between the delusional misidentification syndromes and paranoid/delusional disorder, and this is discussed further in Chapter 10. Interestingly, in the more recent literature there have been a small number of reports of successful treatment of Capgras or Frégoli phenomena with pimozide (de Pauw, Szulecka and Poltock, 1987; Passer and Warnock, 1991; Tueth and Cheong, 1992), which provides further tentative evidence for features in common (see Chapter 13). Later, it will be argued that the group of delusional misidentification syndromes warrants a niche in the official diagnostic category of delusional disorders.

Reactive and periodic psychoses

Alongside the discussions and arguments about schizophrenia and paranoid/delusional disorders there is a parallel controversy as to whether there is yet another mixed group of psychotic disorders, characterized on the one hand by periodicity and on the other by brief duration and the presence of precipitating stress factors. As will be seen in Chapter 11, there is a good deal of uncertainty and authors often use the concepts of periodicity and reactivity synonymously, which is not always appropriate. It is necessary to provide a very brief background to these two types of disorder so that subsequent discussion of their characteristics may be more intelligible.

Periodic psychoses

Cycloid psychosis is the archetype of the periodic psychosis. Leonhard (1961) has provided the most comprehensive description of the illness and proposes three subtypes (which are mentioned in Chapter 11). Fish (1974) took a more simplistic approach and described cycloid psychosis as an illness with schizophrenic symptoms and a manic–depressive course. Some episodes may be precipitated by stressors but most seem to arise spontaneously (Cutting, 1990). Most authors agree that the prognosis for an individual episode is usually good.

Some authors (e.g. Cutting, 1990) have proposed that cycloid psychosis is an atypical form of bipolar disorder, while others (e.g. Perris, 1988; Fish, 1974) see it as a separate disorder. What is important in our context is that an episode of cycloid psychosis may be very difficult to separate from schizophrenia (Leonhard, 1961; Fish, 1974), schizoaffective disorder (Perris, 1988) or paranoid disorder (Crammer, 1959). At present, cycloid psychosis is not included in DSMIV or ICD10 and therefore, as Perris (1988) points out, is often misdiagnosed as schizophrenia or schizoaffective disorder for want of awareness of its existence.

Reactive psychoses

Here we have a category of illness in which an episode of psychosis is precipitated by stress and then tends to clear up once the stress is removed. The acute picture is often mistaken for schizophrenia or for delusional disorder (DSMIII had a separate category of acute paranoid disorder) but rapid resolution of symptoms usually makes the differentiation clear. DSMIV (1994) describes ‘brief psychotic disorder’ and ICD10 (1992–93)

has 'acute and transient psychotic disorders', both of which essentially capture the essence of the brief reactive psychosis but, as will be discussed in Chapter 11, show evidence of misunderstandings in both cases.

The ancestors of the reactive psychoses are, on the one hand, 'hysterical psychosis' (Hirsch and Hollander, 1969; Cavenar, Sullivan and Maltbie, 1979) and, on the other, '*bouffée délirante*' (Pichot, 1986), but the picture has been complicated by the addition of the Scandinavian concept of reactive or 'psychogenic' psychosis, an illness described (Retterstøl, 1978) as occurring in constitutionally predisposed personalities as the result of stress and tending to clear up over time (in some cases as much as two years). Unfortunately there is controversy about the latter (Dahl, 1987) and a substantial proportion of cases has been shown to deteriorate to schizophrenia or bipolar disorder (Jauch and Carpenter, 1988). The implications of some of these controversial concepts are further discussed in Chapter 11.

Paranoid personality disorder

Many German psychiatrists regard the presence of a foregoing personality disorder, especially of the paranoid or 'sensitive' type, to be a frequent antecedent of paranoid/delusional disorder, thereby making the latter more 'understandable'. There seems little doubt that many patients with established paranoid/delusional disorder did have odd or eccentric premorbid personalities, but this has never been shown to 'explain' the psychotic illness.

DSMIV (1994) and ICD10 (1992–93) take an atheoretical approach and describe this personality disorder in terms of identifiable features rather than postulated causation and mental mechanisms. It is included in the 'cluster A' personality disorders (along with schizoid and schizotypal personality disorders), recognising that it is often difficult to diagnose a specific personality disorder when it is more a question of recognising in a given individual a predominance of particular traits which are shared in differing proportion by several personality disorders.

If delusions appear, the diagnosis is then superseded by that of a psychotic disorder. Certain authors (e.g. Kretschmer, 1927; Akhtar, 1990) suggest that paranoid personality disorder is genetically and phenomenologically related to the paranoid/delusional disorders. There is little scientific evidence for this, although the impression is a persistent one. A study by Kendler and Gruenberg (1982) is the nearest approach to an empirical confirmation, although it seems to show a link between paranoid

personality disorder and ‘schizophrenia and related disorders’, rather than just paranoid/delusional disorders alone.

Conclusions regarding the delusional disorders

To sum up and, in the process, to oversimplify, the following are suggested as relevant to the illnesses which have been discussed:

- (1) Paranoia/delusional disorder is a disorder in its own right whose description is still, to some extent, clouded by archaic concepts. It is considerably more common than usually thought.
- (2) Paraphrenia is well delineated in the older literature and, if given a modern description (see Chapter 7), is probably as distinguishable from schizophrenia as is delusional disorder.
- (3) Paranoid schizophrenia is a well-established diagnosis but, instead of retaining it as a subtype of schizophrenia, serious consideration should be given to returning it to the category of delusional disorders, as Kraepelin originally proposed.
- (4) Late paraphrenia may well be a continuation into old age of paraphrenia.
- (5) Late onset schizophrenia is simply schizophrenia beginning in an older individual. The more advanced the age, the more difficult it is to differentiate late paraphrenia from it, and at that age this clinical differentiation may no longer be useful.
- (6) Cycloid and reactive psychoses should be distinguished clearly from each other (see Chapter 11) and should never be confused with delusional disorder.
- (7) Delusional misidentification syndromes are currently an orphan group of disorders which, in this author’s view, should be included among the delusional disorders. At this time they are of great interest because they show considerable promise of providing significant neuropathological evidence about the genesis of certain delusions.
- (8) Paranoid personality disorder, despite its name, has no place among the paranoid/delusional disorders, although some cases (along with other group A personality disorders) may develop psychotic symptoms under certain conditions, at which point the disorder may enter into the paranoid spectrum (see Chapter 7).

Despite the apparent ‘separateness’ of the above diagnoses, a recurring theme in the literature is that a proportion of cases from virtually any of

them may change rapidly or gradually to schizophrenia. We must therefore be aware that these disorders can either be illnesses in their own right or, less commonly, may be a temporary stage in a deteriorative pathological process.

Notes on phenomena associated with delusions

Introduction

Delusional disorder is so called because a delusional system is the most prominent feature of its symptomatology. Of course, delusions are not the only feature of the illness, and delusional disorder is only one of many psychiatric conditions associated with delusions. However, a relatively unique feature of this particular condition is that, because of the encapsulated nature of the false beliefs, delusional and nondelusional aspects of mental function appear to coexist in the same individual, thereby giving a golden opportunity to compare and contrast them. Sadly, until now, little or no systematic research has been carried out on this or other aspects of delusions in delusional disorders.

Delusions are regarded as one of the most characteristic elements of all the psychotic illnesses and in both the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSMIV) and the *International Statistical Classification of Diseases*, tenth edition (ICD10) they are among the symptoms cited as most essential to the diagnosis of schizophrenia and delusional disorder.

It is a widely held view that delusions are qualitatively different from normal ideas or beliefs and have an all-or-nothing quality. The DSMIV definition appears to confirm this viewpoint. It states that a delusion is

A false belief based on an incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture (e.g. it is not an article of religious faith). When a false belief involves a value judgment, it is regarded as a delusion only when the judgment is so extreme as to defy credibility. Delusional conviction occurs on a continuum and can sometimes be inferred from an individual's behaviour.

The definition goes on to say that 'It is often difficult to distinguish between a delusion and an overvalued idea (in which case the individual has an unreasonable belief or idea but does not hold it as firmly as is the case with a delusion).' This now seems to imply a somewhat less than

black-and-white view of delusion. Also, the phrase 'delusional conviction occurs on a continuum' suggests that there is no clear division between delusional and nondelusional thinking.

This inconsistency of definition is not unique to DSMIV but pervades the whole topic, and the clinician has to use what knowledge is at hand, but should be aware that even 'official' descriptions, as in DSMIV and ICD10, are very unsatisfactory. Experts in the field frequently express their frustration by making comments like: 'Delusions remain enigmatic even after many years of research' (Butler and Braff, 1991) and 'A review such as this is limited by the heterogeneity of the data surveyed. Studies span several decades and have widely differing methodologies' (Flint, 1991). As yet, we even continue to have problems at times in distinguishing between delusions and overvalued ideas (McKenna, 1984).

This task has become increasingly difficult as traditional systems of nosology and diagnostics have been challenged and subsequently altered, and it is unfortunately true that the working clinician still does not have a more reliable yardstick than the DSM/ICD definitions of delusion (Sedler, 1995).

A very great problem in interpreting the findings of studies on delusions in psychiatric illness is that diagnostic criteria for cases under investigation are frequently imprecise or outdated and diagnostic categories are mixed. As has been remarked for delusional disorder, systematic studies are few, case series are always brief and the quality of the diagnosis is very often in doubt, especially in reports prepared prior to the late 1980s. There have been a number of excellent reviews on delusions in recent years, including Arthur (1964), Winters and Neale (1983), Butler and Braff (1991), Maher (1992), and Garety and Hemsley (1994), but despite their perceptive approach and the distinguished work done by many of these authors, the conclusions still usually contain a caveat similar to that of Butler and Braff (1991): 'A reliable and valid method of quantifying and characterizing delusions is needed so that the impact of changes in diagnostic nomenclature can be empirically validated.'

Phenomenology and psychopathology of delusions

Phenomenology in the field of medicine at large is the study of phenomena pertaining to health and disease. A prime aim of that study is to allow us to cluster such phenomena into characteristic and recurring patterns to provide us with a description of syndromes or illnesses. When these descriptions appear to have both validity and reliability, we can then utilize the

methods of pathological investigation to enquire into causation, to establish prognosis and, by extension, to determine the effectiveness of a specific treatment on a discrete illness. This approach has been the mainstay of scientific progress in the field of physical disease since the mid-nineteenth century, and nowadays is subserved by many sophisticated investigative disciplines representing a wide biological spectrum.

Phenomenology and pathology in the physical domain aim to be empirical and atheoretical. However, like any branch of science they are open to speculation, hypothesis and argument and, also like science in general, their data will change as new facts become available. The living brain has been so inaccessible until recently and our methods for studying it have been so crude and at such a distance from the actual pathology, that we have had to rely on conjecture which all too often becomes dogma.

Many modern psychiatrists loosely think of phenomenology in the field of psychiatry as being directly analogous to phenomenology elsewhere in medicine, but this is rarely the case. One can make direct measurements of temperature or blood pressure, study the constituents of blood or urine, interpret the appearances of a radiograph or examine a tissue sample under the electron microscope. One cannot make observations like this on thought disorder, hallucinations or delusions: we cannot even, at this stage, agree with any degree of exactness just what these epiphenomena are.

A traditional approach in the phenomenological study of the psychiatric patient has therefore been to use *empathy* (Gruhle, 1915; Jaspers, 1963) as a way in which to understand how a patient thinks or feels at a given time and how, for example, a delusional idea may affect him or her. This does not mean that we actually understand the delusion or the illness to which it belongs: instead, we have 'felt' ourselves into the patient's mind and can recognize something different from our own 'normal' experience, and can therefore appreciate both this abnormal phenomenon and the individual's response to it.

There is no question that this method has enabled us, over many years, to build up a useable descriptive phenomenology in psychiatry but it is easy to see how subjective the approach is, how open it may be to the observer's bias and theoretical approach, and how difficult it will be for different observers to agree on what they have observed and what to call it. And this is exactly what has happened, with different schools of psychiatry using their own exclusive jargons and deriving their own particular inferences.

When DSMIII appeared in 1980, it avowed to be as dogma-free as

possible and it and its successors have been at pains to adopt a rather bleakly reductionistic approach to the description of psychiatric phenomena and psychiatric illness. This seems to have coincided with a growing trend in many centres outside as well as inside the USA, and ICD10 has largely followed the DSM lead. The result, for many psychiatric phenomenologists, is an abrupt split in ideology between the discipline's past and its present. This has *not* occurred in the classificatory aspect of psychiatric illnesses, especially for the major psychiatric disorders, since it has gone back largely to Kraepelinian principles.

In psychiatry, our traditional concepts of delusion largely stem from the work of Karl Jaspers (1883–1969), whose writings have been enormously influential in the areas of phenomenology and psychopathology (Jaspers, 1963).

Jaspers' definition of delusion consisted of the following criteria:

- (1) That the belief is held with extraordinary conviction and with profound subjective certainty.
- (2) That it is maintained against the effect of other experiences and of convincing counter-argument.
- (3) That it is impossible with regards to its content.

He insisted that delusions were incapable of being modified, and proposed that the incorrigibility of the delusional belief was the individual's outstanding protection against internal mental collapse (i.e. the pit prop, despite being bent and cracked, might still prevent the mine roof from falling). The primary delusion, in Jaspers' view, was caused by a hypothetical disease process in the brain: it was therefore not susceptible to *psychological* enquiry. The characteristics of the premorbid personality might provide the material for the delusional content, but again could not explain the delusion itself.

These views remain extremely influential in psychiatry and still form the basis of teaching about delusions in many textbooks. A more recent author (Mullen, 1979) adopts a similar definition and is widely cited in the modern psychiatric literature when delusions are described. He characterized delusions as follows:

- (1) They are held with absolute conviction.
- (2) The individual experiences the delusional belief as self-evident and regards it as of great personal significance.
- (3) The delusion cannot be changed by an appeal to reason or by contrary experience.

- (4) The content of delusions is unlikely and often fantastic.
- (5) The false belief is not shared by others from a similar socio-economic group.

This is very similar to the definitions subsequently adopted by DSMIV (1994) and ICD10 (1992–93), both of which emphasize the profound dichotomy between delusion and normal belief. But, as will be seen a little later, recent investigations challenge all of the criteria mentioned above.

Jaspers described several types of delusions and although these descriptions are used much less nowadays, they are briefly presented here so that the reader who is not familiar with them will have some experience with the terms if he or she comes across them in reading. Also, we tend to throw such terms around quite carelessly in discussion and it is as well to have an accurate grasp of their original intentions (Sims, 1988). Jaspers divided delusions into *primary* and *secondary* forms. The *primary delusion* is seen by Jaspers as arising from an abnormality of brain and is not understandable (by the standards of current knowledge). Primary delusions were further divided into four types, thus:

- (1) Autochthonous delusion (or ‘delusional intuition’), which is phenomenologically similar to the sudden appearance of a normal idea, especially an inspirational idea. The idea appears fully-formed (‘autochthonous’ means ‘sprung from the soil’) with strong intuitive certainty. This process occurs in a single step.
- (2) Delusional percept is a normal perception imbued with delusional meaning. Although the belief is false, it has tremendous significance for the individual, and the perception remains unaltered even though it now has a profound new interpretation for the patient. A distinction is made here from the ‘delusional misinterpretation’, which is an adaptation of a percept to fit in with other delusional beliefs. The process of developing a delusional percept is said to occur in two stages, the first in which a belief is perceived as especially meaningful and the second in which it becomes invested with delusional significance.
- (3) Delusional atmosphere (also known as delusional mood or *Wahnstimmung*) is the phenomenon where the person senses the world to be subtly changed in a significant way. This may be allied with ‘delusional awareness’ in which there is a heightened appreciation of atmosphere. There is a feeling of anticipation often associated with perplexity and apprehension and this, not uncommonly, is relieved when the delusion crystallizes out.

- (4) Delusional memory (or ‘retrospective delusion’): this resembles an autochthonous delusion or a delusional percept but it presents as a false memory. The individual claims to remember something which did not happen and will attest to this with conviction. Oddly, this (apparently the least of Jaspers’ four types of primary delusion) has become rather important as a concept of late. Current controversies about ‘recovered memories’ and the ‘false memory syndrome’ have raised a spectre for mental health professionals and for patients’ relatives of being unjustly accused of sexual and other misdemeanours long after the acts have allegedly been done. Most such cases are not related to delusions or to delusional disorders, but when an accusatory paranoid individual makes persistent and fanatically pursued charges, it might be very difficult in some cases for the accused person to prove his or her innocence.

Secondary delusion is said to be understandable in the patient’s present mood or circumstances, in relation to peer group beliefs or as a long-term outgrowth of personality factors or cumulative life experiences. It is suggested as being an unconscious manoeuvre on the part of the patient to ‘explain’ his or her other symptoms and thereby to gain psychological relief. While this may be the commonsense explanation, in practice it is often difficult to separate primary and secondary delusions and, at most, the delusional content may appear to be explained, but not the delusional mechanism.

In academic and clinical discussion, the primary–secondary distinction often comes to the fore but it has largely been abandoned in recent clinical classificatory systems, especially DSMIV and ICD10.

Delusions and nosology

Attempts have been made to classify psychotic disorders according to the content of their delusions (Sinha and Chaturvedi, 1989). This has only limited usefulness (Maher, 1992). There is, for example, some evidence that delusions in schizophrenia may have certain distinguishing qualities (Schneider, 1959) and, of course, once the diagnosis of delusional disorder has been made, the specific delusional theme can then usefully distinguish the different subtypes (e.g. jealousy, erotomania, somatic, etc.) (Munro, 1995). Also, in major depression with delusions, the mood-congruent quality of the delusions, with themes of poverty, self-deprecation and nihilism, may be very characteristic (Cutting, 1985). But, in general, one

gets only limited help in diagnosing illness by relying solely upon the delusional content: it is rare to be able to identify the illness unmistakably by this alone.

Recent experimental work on delusions

Recent work on delusions is cautionary, since many of our dearly held beliefs do not hold up to detailed examination. For example, it now appears that:

- (1) Delusions are not rigidly fixed but can fluctuate in intensity over time, even in the absence of treatment (Alloy, 1988).
- (2) Delusional incorrigibility does not appear to be absolute (Garety and Hemsley, 1994) and evidence is growing that, under certain circumstances, delusional thinking can be modified (e.g. by cognitive therapy) (Kingdon, Turkington and John, 1994). Also, it has come to be realised that maintaining a strong belief against opposing evidence is not by itself abnormal but is instead a common normal human trait (Ross and Anderson, 1982).
- (3) Some clinicians continue to maintain that delusions are relatively impervious to medications but there is little *bona fide* research in this area and common sense observation seems to indicate that, with an increasing repertoire of new treatments this is less and less so. That is not to say that we necessarily *cure* delusions, but certainly effective treatment in major mood disorder or delusional disorder can allay them to the point where they are either no longer evident or interfere minimally with normal functioning.
- (4) Delusions are not, as we often believe, absolute yes/no entities. Instead there is growing evidence that they are complex, multidimensional phenomena (Kendler, Glazer and Morgenstern, 1983). To some extent these dimensional elements are independent of each other and can either co-vary or vary independently.
- (5) A delusion is not necessarily a blind belief and some delusional individuals can think about them and even collaborate with investigators in measuring them (David, 1990).
- (6) Bizarreness of a delusion is rapidly losing its credibility as a distinguishing feature (Flaum, Arndt and Andreasen, 1991; Mojtabai and Nicholson, 1995). In delusional disorder, where the delusions are usually tightly structured and defended with, at times, exquisite pseudo-logic, the premise may still be quite bizarre despite what

DSMIV and ICD10 say. (For example, one of the author's patients who was unhappy with the outcome of a cosmetic operation on his nose was convinced that his future well-being depended on his having a second operation to shorten his neck.)

Any clinician working with delusional patients must be aware of the many challenges to his or her traditional understanding and definition of delusion. It is not the purpose of this book to discuss the complex experimental and theoretical situation which exists in relation to delusions but we should be aware of the uncertainty of our understanding of delusions and the implications this may have in our diagnosis of the disorders with which they are associated. In the meantime, until more scientifically validated and clinically applicable definitions appear, we are mostly left with the clearly unsatisfactory descriptions of delusions in DSMIV and ICD10.

No widespread agreement about the origin of delusions exists and many theoretical positions are under exploration (Maher, 1988; Harper, 1992; Garety and Hemsley, 1994). Interestingly, while so much uncertainty remains, a slowly increasing and clinically relevant literature on the behavioural-cognitive treatment of delusions is emerging (Kingdon, Turkington and John, 1994; Fowler and Morley, 1989). And, from the psychiatrist's viewpoint, an exciting recent development is the collaboration between psychologists, psychiatrists and brain scientists in studying the delusional misidentification syndromes (see Chapter 9), where findings particularly pertinent to clinical practice are beginning to emerge.

Some idea of the complex interweaving of historical and current concepts of delusions can be obtained from a number of excellent recent publications (Garety and Hemsley, 1994; Manschrek, 1995; Roberts, 1992; Schifferdecker and Peters, 1995; Spitzer, 1990, 1992). The psychoanalytic approach has been advanced lately by writers such as Aronson (1989) and Freeman (1990) but the influence of this school on the medical approach to patients with delusions is very small at the present time.

Sociodemographic theories of the origin of delusions were once influential, but recent evidence has suggested that societal influences are mainly on the content of delusions rather than on their form, and cannot explain their aetiology. Studies on the phenomena of koro (Ang and Weller, 1984), amok (Gelder and colleagues, 1996) and delusional hypochondriasis (Munro, 1982b) appear to demonstrate this. Considerations of delusions as atavistic phenomena and as misapplications of normal mental mechanisms in unfamiliar modern situations (Schlager, 1995) are beguiling, but as yet almost entirely hypothetical.

At this time we are beginning to see very early indications of possible effects of brain pathology on psychopathology, including the generation of delusions (Cummings, 1985; McAllister, 1992) and this is an area of exciting new potential because of the variety of new investigative tools becoming available.

Delusions in clinical practice: a practical approach

When reading the literature on delusions, one is aware that a great deal of it was written before any of the therapeutic advances in psychiatry that began in the mid-1950s. These advances have revolutionised our approach to psychiatric illness and to the patient, have introduced the necessity for scientific methodology in the study and treatment of such illness, and incidentally have taken away the leisure to study cases *in extenso*.

It is only in the past generation that real experimentation has begun in the field of phenomenology, including the study of delusions. In psychiatric texts, there are still confident descriptions of what delusions are, the phenomena related to them, and how they appear. Unfortunately the confidence is not always allied to consistency, so that definitions, nomenclature and descriptions overlap, vary subtly and become embroiled in the philosophies to which their protagonists adhere, even when they claim to be eclectic. Much of this, as already noted, has still not been applied to psychiatric practice.

In the clinical world, where there is now an imperative to treat as efficiently and effectively as possible, we must have a practical working approach which allows us to recognize a delusion, place it in a diagnostic context, and treat it along with the other phenomena that make up the particular illness in an individual patient. Sims (1988) makes an interesting and rather bold observation when he says, 'there is usually very little difficulty for the observer in deciding whether a false belief is a misinterpretation of the facts based on false reasoning, or a delusion'. That statement is difficult to prove and, at the very least, requires the word 'skilled' to be interpolated before the word 'observer'. However, it does seem to be true that the experienced and insightful clinician develops some sense of when a belief is likely to be false and is held with delusional intensity, and this has to be the starting point of the clinical observation that the patient is deluded.

Of course, the patient does not make this observation, because his belief to him is a self-evident truth. What is it then that alerts the psychiatrist to the likelihood that he is dealing with a delusion and therefore a delusional

illness? It is rarely one factor, but rather an accumulation of nuances which leads him to these conclusions. The following are suggested as indicators, no one of which is pathognomonic, but an accumulation of which is increasingly suggestive.

- (1) The patient expresses an idea or belief with unusual persistence or force.
- (2) That idea appears to exert an undue influence on his or her life, and the way of life is often altered to an inexplicable extent.
- (3) Despite his profound conviction, there is often a quality of secretiveness or suspicion when the patient is questioned about it.
- (4) The individual tends to be humourless and oversensitive, especially about the belief.
- (5) There is a quality of *centrality*: no matter how unlikely it is that these strange things are happening to him, the patient accepts them relatively unquestioningly.
- (6) An attempt to contradict the belief is likely to arouse an inappropriately strong emotional reaction, often with irritability and hostility.
- (7) The belief is, at the least, unlikely.
- (8) The patient is emotionally overinvested in the idea and it overwhelms other elements of his psyche.
- (9) The delusion, if acted out, often leads to behaviours which are abnormal and/or out of character, although perhaps understandable in the light of the delusional beliefs.
- (10) Individuals who know the patient will observe that his belief and behaviour are uncharacteristic and alien. (The exception is when a *folie à deux* is occurring – see Chapter 10.)
- (11) There may be associated features such as suspicion, hauteur, grandiosity, evasiveness, threatening behaviour or eccentricity, as well as hallucinations, thought disorder, mood change, etc. Acting out of the delusion (Buchanan, 1993) and violent behaviours associated with delusions (de Pauw and Szulecka, 1988) may also occur.
- (12) Perhaps most important, the delusion will occur in the setting of a psychiatric disorder whose other features are characteristic: the delusion and its content will be strongly coloured by the specific nature of that disorder. Also, the delusion will usually respond to the treatment appropriate to the disorder.

When the clinician has observed an accumulation of several of the above elements in a particular patient, he or she must be highly suspicious that delusions are present.

Conclusions

We may be thankful that DSMIV and ICD10 both recognize delusional disorder, since that illness (in its previous incarnation as paranoia) was in almost total eclipse until its reacceptance in 1987 by DSMIII. Nevertheless, the official diagnostic systems remain niggardly in restricting the category to only one illness. In Part II we shall look at paranoia/delusional disorder in detail, but then in Part III a case will be made for a 'paranoid spectrum' which includes several illnesses in addition to delusional disorder.

The history of paranoia, and especially of its exclusion from the standard diagnostic canons of the mid-twentieth century, makes salutary reading. Careless diagnostic practice allowed it to be overshadowed by other illnesses, especially schizophrenia. Despite recent advances in our recognition of psychiatric disorders, similar things still happen today. Paraphrenia, once equally accepted as a separate diagnosis alongside paranoia, is still under the shadow of schizophrenia. Delusional misidentification syndrome (DMS), which has many similarities to delusional disorder, is simply in limbo, with no classificatory recognition whatsoever.

Adequate definition of illness is essential before worthwhile research can be carried out on it, and lack of good clinical research ultimately means poor patient care. There also needs to be much more applied research in the field of delusions and related phenomena so that we can become more skilled at recognising the phenomena, and eliciting the psychopathology of the paranoid spectrum disorders.

The rest of this book will attempt to define the features and the boundaries of these illnesses and will differentiate them from other conditions with superficial similarities which do not form part of the same group.

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