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A reconceptualization of paranoia: Applications for research, classification, and intervention

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University of Hawaii, 1992
A RECONCEPTUALIZATION OF PARANOIA:
APPLICATIONS
FOR RESEARCH, CLASSIFICATION, AND INTERVENTION

A DISSERTATION SUBMITTED TO THE GRADUATE DIVISION OF THE UNIVERSITY OF HAWAII IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF
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To those who suffer from paranoia
or from the paranoia of others
As Lao-Tsze said in the 6th century B.C., the journey of a thousand miles begins with one step. The thousand-mile journey to a Ph.D. in an APA-approved clinical psychology program began, for me, with a step toward understanding paranoia.

While I had been very much interested in psychopathology as an undergraduate—in fact, I wrote my English honors thesis on Hamlet's breakdown, and decided to go to medical school and specialize in psychiatry—I abandoned these dark concerns to marry, move to sunny Hawaii from Harvard, study the literature of the Pacific, teach English to undergraduates at the University of Hawaii, and bring up a lively family of four.

However, no paradise is secure from threat and harm; and by the time my youngest child was out of elementary school, I had become a church and community volunteer, a peace activist, and a person acutely aware of the devastating effects of paranoia on every level of society, from the individual to the international, implicated as it has been in abuse, traffic fatalities, racism, assassinations, and punitive political policies. I wanted to learn more about paranoia, and I wanted to be able to do something about it; so I enrolled in a course on abnormal
psychology. The rest is my academic history—including the perhaps inevitable choice of paranoia as the topic for my dissertation.

Now at the end of my graduate journey, I must express my deepest gratitude to several people: To my husband, Paul, and my children, Elizabeth, Deborah, David, and Jonathan, who unfailingly supported and cheered me on the way, despite their own loss of much of my attention; to Dr. Ian Evans, my first professor of psychology and since my friend, who set me on the road to becoming a clinical psychologist; and to Dr. Anthony Marsella, my adviser, who, more than anyone else, shaped my thinking about psychopathology—and who, having done so, gave me the time, space, and trust to pursue my own particular notions about paranoia. I would also like to thank the other members of my dissertation committee, Drs. Daniel Blaine, Richard Dubanoski, Ronald Johnson, and Thomas Hilgers, for their helpful discussions about my topic—and for improving the quality of academic life in all they do.
ABSTRACT

The need for a reconceptualization of paranoia may be seen in DSM-III-R, from which the historical concept has been essentially eliminated, while paranoid schizophrenia and paranoid personality have been retained. This need is also evident elsewhere in the literature: most empirical studies are on paranoid schizophrenia, but most of these do not provide consensually derived criteria for the diagnosis, and are therefore of limited validity. Furthermore, recent developments in theoretical psychology call for the reconceptualization of psychological phenomena in general; paranoid phenomena are included.

This dissertation first examines the history and present status of the concept of paranoia, including major models of the disorder and issues found in the literature. It then discusses problems in regard to the classification of delusional (paranoid) disorders in DSM-III-R, proposing a reconceptualization of paranoid disorders as a third class of major disorders, distinct from schizophrenia and depression, with serious impact on society. Arguments are presented for a return to the use of the terms "paranoia" and "paranoid disorders" in preference to "delusional disorder," including the facts that delusions are only one feature of these disorders and are salient features of other disorders.
Specific problems in classification and approaches to solutions are then discussed, including the parameters of the paranoid spectrum, and the definitions, nomenclature, inclusion, or exclusion of types and subtypes of paranoid disorders. In addition, it is proposed that the concerted ideation and actions of large groups of people may be identified as paranoid, and that therefore a new diagnostic category should be created, that of societal paranoia.

Paranoia is then further reconceptualized in terms of a holistic model of behavior. This reconceptualization integrates various models of paranoia which identify environmental, cultural, biological, and psychological factors that predispose persons to paranoid disorders. The holistic model also suggests the nature of events or situations which prompt covert and overt paranoid behaviors; these are seen as the paranoid persons' maladaptive attempts to cope with perceived stressors.

Finally, recommendations are offered for specific research problems to address issues in the literature and the reconceptualization of paranoia in this dissertation, particularly in regard to intervention.
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Because all knowledge is in our estimation a thing of beauty and worth, and because this is more particularly true of those types of knowledge which are more exact in themselves or which refer to more excellent or more remarkable objects; on both these grounds we are justified in ranking psychology, or a study of the soul (psyche), among the first of our interests.... To arrive at any trustworthy conviction about the soul is one of the hardest tasks with which we are ever confronted.

--Aristotle

Psychology

(4th century B.C.)
I. INTRODUCTION

The Need for Theoretical Studies in Psychology

The dedication of behaviorally oriented psychologists to obtaining and applying data-based facts has produced a massive literature and significant advances in our knowledge of the human mind and both normal and abnormal behavior. However, it has often led to the dismissal of theoretical studies as groundless and inconsequential, and to the practice not of science but of "scientism"--an exclusionary approach to psychological investigation (Mahoney, 1989).

There have been indications during the past few years, however, that the tendency may be reversing and that there is a growing concern with theoretical studies (e.g., Kukla, 1989; Sarason, 1989). Although Dollard and Miller's (1950) attempt to reconcile psychoanalytic and behavioral principles was remarkable for its uniqueness, and Mahrer's (1970) editing of a volume of alternative theoretical approaches to personality classification went largely unnoticed, the late 1980s have witnessed the founding of
such organizations as the International Society for Theoretical Psychology, the Society for Studying Unity Issues in Psychology, and the AABT Special Interest Group for Theoretical and Philosophical Issues. Increasing numbers of psychologists are attending the meetings of these organizations and publishing in their journals.

Several reasons may be cited for this growing trend toward theoretical studies. One is the disunity of psychology (Staats, 1983) and the consequent difficulties in communication among psychologists. Other reasons for the rising interest in theoretical studies go beyond the need for theoretical unification of the psychological literature as it exists, and involve the reliability and validity of findings in that literature. Opposing orientations have long challenged each other's "facts" and the methodologies used in obtaining them; the appropriateness of the use of the null hypothesis and of various other statistical procedures in psychology has been challenged; and cross-cultural psychologists in recent years have observed that non-Western cultures use models of personality and psychopathology to which Western terms and findings do not apply (e.g., Marsella, 1979). But even beyond these multiplying theoretical problems in need of solution, with those involving ethnocultural values becoming ever more urgent, a general theoretical problem has been formulated which presents a challenge to virtually
all data-based psychological literature: It challenges the assumptions of the scientific method itself as it has been developed and used in modern times.

Lincoln and Guba (1985), in writing of the concept of "naturalistic inquiry," declared that while scientific investigation tends to present "reality" as simple, tangible, and fragmented, our experience of it is in fact multiple, constructed, and holistic; while investigators consider themselves to be detached and objective, it is in fact impossible to separate the knower and the known, and all investigations necessarily value-bound; and, further, causality is not unidirectional but multidirectional and simultaneous. This theoretical position itself can be challenged, but it cannot be ignored.

Overall, it appears that at this juncture in the history of modern psychology, we may be witnessing the beginnings of a major paradigmatic shift in the discipline, characterized by a growing recognition of the need for theoretical studies is the herald. As Thomas Kuhn (1962) observed in his analysis of the structure of scientific revolutions, the advancement of science proceeds as a dialectical process between bodies of facts and theories to account for them, theories being "distinct views of nature" or "paradigms." Even if we are not at such a point in the history of modern psychology and psychiatry, and if we accept Kuhn's theory, it seems evident that data-based and
theoretical studies are inseparably linked and equally necessary to the advancement of our discipline.

The interdependence of theory and empirical research has been made explicit, in fact, in a description of the functions of theories by Hans J. Eysenck (1954), a psychologist known for his insistence on data collection and analysis. According to Eysenck, a scientific theory serves to (a) "organize and structure a variety of apparently unrelated facts," and (b) "lead to the discovery of new and hitherto unknown facts...which may...support or disprove the original theory." Even an emphasis on facts, therefore, does not negate a basic need for theoretical studies.

The Need for Theoretical Studies on Paranoia

If the theoretical unification of the psychological literature is to proceed, the component parts of the literature must be distinctlyconceptualized and internally organized. And it is necessary to venture no further into the psychological literature than the Diagnostic and Statistical Manuals of the American Psychiatric Association to see that no topic in the psychological literature could be in greater need of theoretical reconceptualization and reorganization at this time than that pertaining to paranoia. For example, all four editions of the DSM series list different types of paranoid disorders, with few or no
references to deleted types necessary for the interpretation of other literature on the topic; and the latest edition in the series, DSM-III-R, citing a desire to avoid confusion, has renamed paranoia "delusional (paranoid) disorder," while retaining paranoid schizophrenia and paranoid personality as the names of presumably related disorders--from the latter of which delusions are pointedly excluded (see Appendices).

This confusion in the DSM-III-R use of the term "paranoid" is compounded by the avoidance of the use of the noun from which the adjective is derived, and hence by the lack of a definition of paranoia--although the term is widely used in both psychological and lay literature. Nevertheless, a definition of paranoia can be derived from the literature, including the DSM-III-R description of delusional disorder: Paranoia is a mental disorder characterized by the presence of persistent nonbizarre delusions of persecutory, grandiose, or other self-referential content, which are not due to other mental or organic disorders. Social and marital functioning may be impaired, while nondelusional intellectual and occupational functioning may be satisfactory. Excessively self-defensive or aggressive and violent behaviors related to the delusions may occur.

This definition of paranoia can then be used as a reference point for implicit definitions of paranoid
schizophrenia and paranoid personality disorder: Paranoid schizophrenia is a disorder in which paranoid delusions are prominent in a person primarily diagnosed as schizophrenic. Paranoid personality disorder is one in which tendencies toward paranoid thinking and behavior are long-term dominant and disabling characteristics of a person.

These implicit definitions are less than satisfactory, however, not only because they are implicit rather than explicit in DSM-III-R, but because, like the sections in the manual from which they are derived, they appear to avoid reference to what have historically been perceived to be salient emotional features of paranoid disorders, such as hostility, suspiciousness, hypersensitivity, and anger.

Further ventures into the literature on paranoia reveal other unresolved basic problems, including whether paranoia is (1) a third major psychosis, after schizophrenia and depression, or (2) a subtype of either or both of the other major psychoses, or (3) merely a diagnostic construct. Obviously, the classification and description of paranoid and delusional disorders is fraught with problems, and a firm—but not inflexible—theoretical framework is needed to which researchers and clinicians can attach data, diagnoses, and treatment. Ideally, given the continued use of the DSM series as a basic reference in the field of psychopathology, such a framework should appear in DSM-IV;
and this would require extensive revision of DSM-III-R. Proposals for revision will be discussed in Chapter III.

The pragmatic need for a firm, inclusive, and well-articulated theoretical framework for paranoia and related disorders becomes clear when one reviews the data-based studies in the field. Most of these studies are on paranoid schizophrenia, using hospitalized patients as subjects; and yet diagnostic specifications for the classification of the patients as paranoid schizophrenics—who made the diagnosis, when, and using what criteria—have not been reported in a major proportion of cases (Ritzler & Smith, 1976).

The instability and fragmentation of the DSM classification and description of paranoia and related disorders, and consequent problems in their use, misuse, or non-use, have necessarily contributed to data unreliability and invalidity. Far more important are the implications of such a system for the possible misdiagnosis, permanent labeling, and inappropriate medication of patients (Munro, 1988).

It follows, then, that theoretical studies on paranoia, including a reconceptualization of the disorder and related disorders, particularly in the DSM series, are needed to help resolve problems in classification, research, and treatment. Beyond this, however, there is a need for a further reconceptualization of paranoia which is consonant
with the emerging scientific paradigm of naturalistic inquiry. A model of behavior, both normal and abnormal, which provides for such reconceptualization and indeed for the reconceptualization of psychopathology in general, has been developed by A. J. Marsella (1982, 1984); called an "interactional model," it diagrams the multiple and holistic nature of experience and the multidirectional and simultaneous nature of causality. It will be discussed in detail later and be used as a basis for an extended reconceptualization of paranoia.

In regard to the perceived needs which prompted the undertaking of this study, it remains to be pointed out that studies of psychopathology, both theoretical and data-based, in addition to being of both academic and clinical interest and value, may also serve societal needs. An issue only tangentially addressed in DSM-III-R, for example, concerns the impact of individual cases of psychopathology on society; larger related issues include the possibility that segments of a society or a whole society can be classified as psychopathological. While such issues are rarely addressed in the psychological literature, they can obviously be of great significance.

This appears to be particularly true in regard to paranoia. The two most obvious examples of this in the 20th century may be seen in the rise of the Third Reich and the forty years of the "cold war"—provided one agrees
that the word paranoia, whatever else it may mean or not mean, refers to persistent delusions of persecution or grandeur. It was Adolf Hitler's and, through his influence, the Nazi party's delusion that Jews, social democrats and communists, conscientious objectors, homosexuals, and members of other minority groups threatened the existence of the Third Reich; and this, along with other factors, including their conviction that they represented the "master race" of the world, led to the Holocaust, World War II, and ultimately to the defeat of Germany and its ally Japan, with the development and use of the atomic bomb. Following World War II, it was the persistent fear of attack and takeover by each other that led the United States and the Soviet Union to stockpile more nuclear weapons than would be required to kill everyone and everything on earth several times over. This is irrational and dangerous behavior, and more particularly it appears to be paranoia on a global scale.

There are other notable if not global examples of what may be called, to coin a phrase, societal psychopathology and, particularly, paranoia on a societal level. Some of these have been documented by Hofstadter (1965), who identified and analyzed what he called The Paranoid Style in American Politics, tracing "heated exaggeration, suspiciousness, and conspiratorial fantasy" back to the 18th century. He also observed that "notions about an
all-embracing conspiracy...are familiar phenomena in many countries throughout modern history." One might add that such notions are not limited to modern times but may be seen in the long earlier history of witch-hunts, wars, and other vicious and violent societal behaviors throughout the world; many of these were recognized as mad and catalogued, in fact, in 1841 by Charles Mackay, in his Extraordinary Popular Delusions and the Madness of Crowds.

Neither Hofstadter nor Mackay were writing as psychologists, however, and the societal dimensions of psychopathology have not worked their way very far into the psychological literature in general or into the present diagnostic system, which was designed for the treatment of individuals.

However, whether or not societal psychopathology is classified among the psychological or psychiatric disorders, its relationship to disordered individuals is clearly significant. This has been intimated by the inclusion of post-traumatic stress disorder among the anxiety disorders in DSM-III-R; however, although the disorder was first identified in veterans of the Vietnam war, the war itself was not identified as pathological behavior on a societal level, and the prevention of PTSD by the prevention of war was not considered.

The psychological literature does contain case histories which document the impact of paranoid individuals
In reading the history of nations, we find that, like individuals, they have their whims and their peculiarities; their seasons of excitement and recklessness, when they care not what they do. We find that whole communities suddenly fix their minds upon one object, and go mad in its pursuit; that millions of people become simultaneously impressed with one delusion, and run after it, till their attention is caught by some new folly more captivating than the first. We see one nation suddenly seized, from its highest to its lowest members, with a fierce desire of military glory; another as suddenly becoming crazed upon a religious scruple; and neither of them recovering its senses until it has shed rivers of blood and sowed a harvest of groans and tears, to be reaped by its posterity.

--Charles Mackay

Extraordinary Popular Delusions and the Madness of Crowds (1841)
on segments of society, however—for example, a study of Jim Jones and his massacre of his followers in Jamestown (Lasaga, 1980), and a study of a private citizen who murdered three people as the first step in his program to massacre mankind (Arleti & Schreiber, 1981). Studies of psychiatric groups made in Germany (Baker & Hafner, 1982) and France (Benezech, 1984) also provide examples. Most notably, a large proportion of assassinations and attempts on the lives of public figures, including President Kennedy, have been committed by persons diagnosed as paranoid (Swanson, Bohert, & Smith, 1970; Clarke, 1990). And as an example of a common impact of paranoia on society, 52 per cent of the drivers with a history of alcoholism and psychopathology who were responsible for fatal traffic accidents during a 3-year period in a Michigan county had been diagnosed as paranoid (Selzer & Weiss, 1966).

Examples of paranoid thinking and its consequences may currently be found, in fact, in the daily newspapers. Readers may expect stories about domestic violence springing from excessive jealousy and/or involving the scapegoating of children, about gang rapes and murders of persons perceived as threats because of their ethno-identity, and about military action proceeding from grandiose claims made by various national leaders. Meanwhile, the threat of nuclear destruction hangs over
The time in which we live was once called the "Age of Anxiety" by Leonard Bernstein; now it appears to have developed into an "Age of Paranoia" (Marsella & Scheuer, 1989).

All this is not to say, of course, that every paranoid person is a threat to society; on the contrary, paranoid persons tend to withdraw from society. Furthermore, paranoid persons may be seen as victims of society rather than victimizers: powerless social positions and threatening social conditions have been found to be factors in the development of paranoia (e.g., Yeh, 1972; Mirowsky & Ross, 1983).

But even if the suffering due to paranoia were limited to only the mental anguish experienced by affected persons and their families and immediate associates, there would still be a need for studies which would foster increased understanding of and concern about the disorder and related disorders, and which would lead to their identification, treatment, and prevention.

In fact, it may well be that the suffering of paranoid individuals is not limited to mental anguish: studies reported in the medical psychology literature (e.g., Barefoot, Dahlstrom, & Williams, 1983; Suarez & Williams, 1989) have recognized hostility and anger as risk factors in cardiovascular disease. Combining research on both disorders might benefit sufferers of each.
The investigation of paranoia and related disorders, as the comparatively small and discrepant literature indicates, has not been commensurate with their intensity and impact. However, relatively recent important contributions have included an edition of the *Schizophrenia Bulletin* (1981) with articles by P.A. Magaro and K. S. Kendler among others; comments on DSM classifications by A. Munro (1982, 1987, 1988); a theoretical behavioral model of paranoia by S. N. Haynes (1986); and a theoretical developmental-psychobiological model by N. Marinello (1989). These will be discussed in detail later.

Overall, basic studies which are needed are theoretical ones which will address classification problems to be found in DSM-III-R and provide a more integrated conceptualization of paranoia and related disorders. There is also a need for the further reconceptualization of paranoia which will indicate factors in the development and maintenance of the disorder and related disorders, their various effects on the person and his life, and the bidirectional nature of the relationship of the paranoid person and society.

**Purpose and Procedures of Dissertation**

The overall purpose of this dissertation is to provide a needed reconceptualization of paranoia, and to demonstrate its applications for classification, research,
and intervention, in accordance with the needs for such a reconceptualization.

This purpose will be pursued in the following four chapters.

Chapter II. The second chapter will provide an overview of the history and present status of the concept of paranoia. Discussing issues in their historical context and in light of later developments, it will trace the history of the concept and its definition from the invention of the term by the ancient Greeks, and will note contrasting and comparable concepts in Biblical literature and the virtual disappearance of the term during the Dark and Middle Ages; then it will trace the reemergence of the concept during the Renaissance, and finally describe its metamorphoses in modern psychopathology. References to paranoia in popular literature and common communication, and their relationship to the psychological concept, will be included.

Major models or conceptualizations and theories of paranoia to be found in the psychological literature will then be reviewed. These include psychiatric, psychodynamic, behavioral, cognitive, psychobiologic, sociological, and cross-cultural models, most of which include developmental perspectives.

Finally, unresolved issues pertaining to paranoia and related disorders will be discussed. These will include
theoretical and research issues in regard to classification, involving nomenclature, types, and subtypes; diagnosis and assessment; epidemiology; etiology, course and prognosis, and treatment and prevention.

Chapter III. The third chapter of the dissertation will address issues in regard to the DSM classification of paranoia and related disorders as noted above, and suggest possible resolutions, based on references in the psychological literature and a reconceptualization of paranoia compatible with the DSM format.

Specific problems with possible solutions to be considered include the following: (a) the place of paranoia and other paranoid disorders among all the disorders, particularly in regard to schizophrenia and mood disorders; and the parameters and organization of the paranoid spectrum, with reference to definitions and differential diagnoses; (b) use of the term delusional disorder versus paranoia and paranoid disorders; and (c) type and subtype problems including the following: the nomenclature of erotomania, the inclusion of somatic delusions as a subtype, the deletion of shared and acute paranoid disorders as subtypes, the lack of references to types dropped from the DSM series but still found in the literature, notably paraphrenia, and the non-recognition of paranoia on a societal level. The separate classification
of paranoid personality disorder and paranoid schizophrenia will also be discussed.

Chapter IV. The fourth chapter of the dissertation will extend the reconceptualization of paranoia by developing a model of the disorder which will indicate its development, maintenance, and appropriate treatment. This model will be based on the interactional model of both normal and abnormal behavior developed by Marsella (1982), which will be integrated with the stress-coping continuum model of Marsella and Scheuer (1988) to provide a dimension for behavioral change over time and to indicate the role of motivation in the behavioral scheme. The resultant interactional stress-coping model of behavior, like the basic Marsella interactional model, as noted earlier, will be consonant with the paradigm of naturalistic inquiry (Lincoln & Guba, 1985) and will be applied to paranoia and related disorders; it will indicate paranoid experiences as being both multiple and holistic and their causality as multidirectional and simultaneous. Other models of paranoia, discussed in Chapter II, will be integrated insofar as possible into the new model of paranoia. This integrative model of paranoia will then be modified for application to other paranoid disorders. It will also be discussed in regard to the dictum of naturalistic inquiry that all investigation is value-bound.
Chapter V. The fifth chapter of the dissertation will summarize and discuss the preceding chapters, and suggest specific problems for future research. These problems will address the issues presented in Chapter II in terms of the reconceptualization of paranoia and the classification of paranoid disorders described in Chapters III and IV; they will also test the proposed reconceptualization and classification.

The specific problems suggested to generate hypotheses for research will be clustered in groups according to their common concerns: the validity of the DSM-III-R nomenclature and description of delusional (paranoid) disorder; the overlap of this disorder with related disorders; the presence and nature of delusions in nonparanoid disorders; the prevalence of paranoid disorders, and other demographic information and correlations; possible factors in the etiology of these disorders, and implications for treatment and prevention; the presence and nature of paranoid disorders in other cultures; and the validity and usefulness of the category of societal paranoia, as proposed in this dissertation for inclusion in the official classification system. The need for the development of instruments for the assessment of paranoid disorders, not only for diagnosis but to provide data for research, will be emphasized.
Throughout the following chapters, there will be an attempt to bring together existing findings and theory about paranoia and related disorders, to organize disparate information about them into a new comprehension of them, to recognize that paranoia—and, by implication, other psychopathology—exists on a societal as well as an individual level, and to lay the groundwork for further investigation and intervention.
II. OVERVIEW OF THE CONCEPT OF PARANOIA

History and Present Status of the Concept of Paranoia

The Greeks

The concept of madness has existed in Western civilization from the beginning; the Greeks had words for it, and one of the words was paranoia. Paranoia is a compound of two other Greek words, para, meaning "beside," and noia, meaning "the mind." A paranoid person, then, was considered to be someone who was "beside himself"--as we also say in English when a person appears to have lost the ability to perceive, think, and behave normally.

It has been customary in histories of psychopathology to dismiss the derivation of paranoia by saying that it was used as a non-specific term for madness in ancient Greece, and that only in modern times has it been assigned to a specific disorder. However, the verbal form of the word, parano-so, means "to think amiss, misconceive, misunderstand, be deranged or senseless, lose one's wits" (Liddell & Scott, 1843/1966); and the Greeks commonly used two other words to refer to madness of nonphysical origin:
Mania, meaning frenzy such as that experienced by the prophetess at Delphi, the priestesses at Dodona, and poets inspired by the Muses; and moria, meaning folly or senselessness, derived from the same verb from which the English verb "moron" was derived, although it did not necessarily refer to mental retardation. It seems, therefore, that from the beginning the word paranoia connoted what two millennia later Kraepelin (1896/1921, p. 208) referred to as "a primary disease of the intellect placed over against mania and melancholia, in which were seen the standard disorders of the emotional life." On the other hand, it was when the word paranoia was revived from the ancient Greek in the 18th century that it was used as a general term for mental disorders, including amentia as well as dementia. The more specific use of the word, consonant with the Greek connotations, came about in the 19th century, as we shall see later.

Paranoia, however, was not among the major mental disorders referred to by Hippocrates (c. 400 B.C./1939), who may be considered the first Western psychiatrist--although Sumerians and Egyptians had recognized melancholia and hysteria more than 2,000 years earlier (Menninger, 1963). In addition to melancholia as caused by an excess of "black bile," and hysteria as caused by a "wandering womb," Hippocrates referred to epilepsy as resulting from hereditary brain malfunctioning, and
phrenitis as mental disturbance occurring with fever—in contrast to mania which occurred without fever. However, the descriptions of these disorders corresponded only roughly to modern descriptions, and the category of melancholia came to be used for all chronic mental disturbances; it therefore included what only in modern times were separately categorized as depressive and paranoid symptomatology.

It is in the writings of the great Greek philosophers and playwrights that we find specific use of the term paranoia. For example, Plato (5th century B.C./1986) refers to both mania and paranoia in the same passage of his Phaedrus, a dialogue in which Socrates and Phaedrus discuss the struggle of the psyche, or the soul or rational mind, to control both irrational appetites and spiritual drives. Mania is described as the madness which makes prophecy or poetry possible when gifted people are inspired by the gods, or which is experienced by people destined to be lovers by the will of the gods (particularly Aphrodite and Eros, known as Venus and Cupid in Roman mythology). Paranoia, on the other hand, is described as the madness which makes atonement possible after families have evoked the wrath of the gods.

It is very interesting indeed that modern theories and research on paranoia, developed for the most part, it seems safe to assume, by people who are unfamiliar with the
Phaedrus, associate the disorder with irrational appetites (erotomania, grandiosity), and guilt and punishment (jealousy, persecution), as well as with anger and earlier family behavior. This makes the concept of paranoia seem less of a construct and more of a discovery about a complex variation of human nature and human behavior; and it surely supports the contention that more than the simple presence of delusions is essential to the understanding of this disorder.

Among the great Greek playwrights, it was the tragedians, and particularly Euripides, whose plays reveal a strong social conscience and subtle psychological insights, who not only used the term paranoia but portrayed the problems of protagonists, notably Orestes, as springing from fatal flaws of character or personality, particularly hubris or pride and a desire for revenge (Aeschylus, Sophocles, Euripides, Aristophanes, & Aristotle, 5th-4th centuries B.C./1943). Again, the Greek and the modern concepts of paranoia seem to correspond.

It must be noted that while Hippocrates and other early Greek physicians, up to and including Galen in the 2nd century A.D., associated madness with physical conditions and causes, the philosophers and playwrights associated madness with religion and ethics. In fact, even in his Psychology, which may be considered the first textbook in the field, Aristotle (330 B.C./1935) showed no concern with
psychopathology but only with normal processes of sensation and rational thinking; however, he did discuss evil or aberrant behavior in his treatise on ethics, and declared that it is, like good behavior, entirely voluntary.

These divergent views of mental disorders as mental illness or as problems in behavior, to be investigated differentially as diseases or contextually as bound to value systems, are still basic divergent views held today. In fact, despite their frequent crossing and recrossing in the history of psychopathology, and the contributions that each has made to the other, in a very general way these divergent viewpoints are what distinguish psychiatry from psychology--the tradition of Hippocrates from the tradition of Socrates, Plato, and Aristotle.

The problems addressed in this dissertation, particularly in regard to the classification of delusional disorder/paranoia in the official manual of the American Psychiatric Association, may serve as a micro example of the macro problem of bringing these viewpoints together.

The Bible

The other main source of Western thought about the nature of the mind and madness, in addition to the Greek as elaborated and disseminated by the Romans, was the Hebrew source. In the body of writings which have come down to us as standard editions of the Bible, and which span thousands
of years and include books of mythology, history, law, poetry, proverbs, prophecy, biography, and letters to associates, one predominant theme can be traced: the bidirectional relationship of the Creator and the created of God and human beings, with implications for the relationship of human beings to each other and to the rest of creation. It is not surprising, then, that there is little in the Bible about the nature of the mind and madness which considers them apart from religious or ethical values.

There is inevitably much concern in the Bible with illness and anguish, but whereas Greek physicians were mainly concerned with physiological explanations and treatment for mental as well as physical problems, the Hebrews saw much suffering as the consequence of vicious emotions or actions (e.g., The Song of Solomon, 8:16; 1st Chronicles, 21:7-14), or as a testing of one's moral fiber (e.g., Job 2:1-10), and regularly relied on divine help for overcoming physical and mental problems (e.g., Acts 8:4-8).

These divergent viewpoints may be seen as persisting in our time; but they need not be seen as contradictory. Although contemporary medicine follows the Greek tradition, psychotherapy assumes the value of treatment other than physiological even for organic disorders; anyone who has ever been ill realizes that illness tests the stability of
Set me as a seal upon thine heart,
as a seal upon thine arm:
for love is strong as death;
jealousy is cruel as the grave:
the coals thereof are coals of fire,
which hath a most vehement flame.

--The Song of Solomon, 8:6
(c. 1000 B.C.)
one's positive personality traits; and behavioral medicine views much illness as the result of irresponsible behavior. In fact, Hebrew dietary and hygenic laws (e.g., Leviticus, 11-15) may be seen as early preventive medicine in Western culture, although they were presented as divine dicta. The absence of a Hebrew Hippocratic viewpoint does not imply rejection but only cross-cultural difference.

There is correspondence between the philosophical Greek view and the religious Hebrew view of the mind or soul and madness, in that both assigned critical importance to the will, and held people responsible for wrong thinking or wrong behavior. However, while the Greeks had a word for extremes of such behavior as a particular kind of madness, or paranoia, the Hebrews did not identify such behavior as madness. On the other hand, madness which implied possession (mania in Greek) was recognized in both cultures, and in neither were the persons who experienced it held responsible; the difference, however, was that the Greeks tended to look upon it as inspired by the gods or the Muses and therefore good (Plato, 5th century B.C./1986), while the monotheistic Hebrews tended to look at it as inspired by demons and therefore bad (e.g., Luke 4:33-35).

The Romans. The Romans inherited the Greek views of the mind and madness, along with Greek philosophy, religion, drama, and medicine, and invented Latin words to
distinguish among what were presumably the kinds of madness of most interest to them—amentia, dementia, furor, and rabies. The strong and persistent influence of Roman culture on ours is indicated by the fact that these words are still in use today in their original forms and with essentially the same meanings (Lewis & Short, 1907). Perhaps most importantly, however, the Romans invented a general term for madness, insania, which we have inherited as the general English term, insanity. The Latin root of the word, sanitas, may be seen as reflecting the Roman genius for pragmatic thought and action, and the Roman ideal of a sound mind in a sound body: it may mean either soundness of body or health, or soundness of mind, including right reason, good sense, and discretion. An implication is that the person is not simply an object of physical forces but, as the Greeks and the Hebrews also believed, the person is an agent, for better or worse, in determining the state of his physical and mental health.

Nevertheless, like the Greeks and the Hebrews, the Romans believed that in some cases a person could be driven mad. An example of this may be found in The Acts of the Apostles; it is especially interesting in contrast to the Hebrew notion of causality, an example of which may be found in the Gospel According to John. In the latter passage (John, 10:14-21), Jesus is described as just having healed a blind man, and as preaching about bringing "other
sheep" into the "fold" of Israel. Some of the listeners ask the others why they are listening to Jesus, when he has "a devil and is mad"; some of the others respond by asking rhetorically, "Can a devil open the eyes of the blind?"

In the passage which illustrates the Roman viewpoint (Acts 26:22-24), Paul has been beaten by a crowd in Jerusalem for preaching the gospel and for having brought gentiles into the temple; and he is then arrested by Roman soldiers for having created a disturbance. However, after he addresses the commandant in Greek and makes known his status as a Roman citizen by birth, the commandant provides protection for him and eventually sends him on to be heard by Porcius Festus, the new Roman governor of Palestine. While Paul is telling the story of his conversion, he is interrupted by Festus, who shouts, "Paul, thou art beside thyself; much learning doth make thee mad!"

Nevertheless, since his original appeal was to Caesar, Paul was sent on to Rome; and there he preached openly and laid the foundation for the church, which spread the teachings of the Bible throughout Europe, over the roads of the Roman empire, using Latin as the common language. Along with these teachings went value-laden views of the mind and madness, including notions of demonic possession and personal responsibility for wrong thinking, while much of the Hippocratic search for physiological explanations and treatments appears to have been left behind—along with
I am the good shepherd, and know my sheep, and am known of mine. As the Father knoweth me, even so know I the Father: and I lay down my life for the sheep. And other sheep I have, which are not of this fold: them also I must bring, and they shall hear my voice; and there shall be one fold, and one shepherd....

There was a division therefore again among the Jews for these sayings. And many of them said, He hath a devil, and is mad; why hear ye him? Others said, These are not the words of him that hath a devil. Can a devil open the eyes of the blind?

--The Gospel of St. John, 10:14-21
(1st century A.D.)

Having therefore obtained help of God, I continue unto this day, witnessing both to small and great, saying none other things than those which the prophets and Moses did say should come: That Christ should suffer, and that he should be the first that should rise from the dead, and shew light to the people, and to the Gentiles.

And as he thus spake for himself, Festus [the Roman governor] said with a loud voice, Paul, thou art beside thyself; much learning doth make thee mad.

(1st century A.D.)
the distinctions made by the Greek philosophers between "good" and "bad" possession, and mania and paranoia.

Although this chapter, up to this point, has been primarily concerned with the history of the concept of paranoia, and this concept cannot be found in the Bible, a question may still be raised as to whether the disorder can be identified in the Bible, using the minimal definition of delusional (paranoid) disorder in DSM-III-R: It is a disorder characterized by persistent nonbizarre delusions of persecutory, grandiose, or other specific content, which are not due to other mental or organic disorders.

Questions about rationality or irrationality in the Bible are exceedingly thorny ones for theologians, interested lay persons, and psychologists alike. Addressing them fully from the psychological viewpoint would require preliminary consideration of a host of other questions, including the following: What is the difference between convictions and delusions? Between visions and hallucinations? Are there any differences other than those of terminology? Should common sense or scientific questioning be applied or not to religious faith?

Equivocal answers to the first and last questions would be that yes, the Bible is crowded from Genesis to Revelation with reports of convictions/delusions and even visions/hallucinations, in which the commonest themes
include persecution, grandeur, jealousy, and a conviction of being loved from afar by a powerful personage with whom one seeks spiritual union. And, yes, articles of faith, like any other hypotheses, should be able to survive both common sense and scientific questioning, even if positive proof is not obtained.

Are adequate answers obtainable to the other questions? Perhaps they are, if one extends the definition of paranoia to include overt as well as covert behaviors, and requires that the overt behaviors as well as the delusions be identified as pathological. In the terms of the verse quoted earlier (John 10:21), for example, the question then becomes whether a "devil" can "open the eyes of the blind."

The Dark and Middle Ages

Although the Hippocratic or physiological approach to mental disorders may not have greatly affected the continental and British cultures encompassed by the Roman empire, this approach continued to be used by physicians in the Mediterranean area for several centuries, as Menninger (1963) has noted in detail.

Among these physicians was Celsus, who lived in the first century A.D. and who listed all known diseases as they affected the person from head to heels. Among the diseases of the head, he listed melancholia and "a third
kind of disease" with two subgroups, with and without hallucinations. It is interesting that even today the absence of hallucinations in delusional (paranoid) disorder is considered significant, as is the presence of hallucinations in paranoid schizophrenia. However, the "third kind of disease" may have been mania.

Other physicians in the first century who continued to differentiate among mental disorders included Aretaeus of Cappadocia, who recognized senile dementia, which appears to be related to what has been called in this century paranoid state, involutional paranoid state, or paraphrenia. And Galen (129-199 A.D.), whose works became a model for physicians for centuries, referred to anoia as a pathological mental condition, distinct from moria and melancholia.

Later physicians included the fifth century Caelius Aurelianus, who listed animosity and suspiciousness among features of melancholia; the sixth century Alexander of Tralles, who described an angry subtype of melancholia; and the seventh century Paul of Aegina, who seems to have merged classical with Christian views of madness, and among his categories included demonomania, or possession by evil spirits.

In these early classification systems, paranoid features were most often associated with melancholia; however, it is important to remember that melancholia was a
category that included virtually all chronic disorders, and was not simply equivalent to depression. Nevertheless, even recent arguments have been made for viewing paranoid disorders as variants of depression. For example, Zigler and Glick (1984), calling theirs "an unorthodox view," support such an argument by citing research which shows significant dissimilarities between paranoid and nonparanoid schizophrenics, and significant similarities between paranoid schizophrenics and depressed groups. This is of interest not only in regard to the tangled classification of paranoid disorders, but also as an example of the problems of classification, to which successive generations of psychopathologists contribute both partial solutions and new questions.

The breakdown of the Roman empire was accompanied by the loss of much classical learning in the West, during what have therefore been called the Dark and Middle Ages—the centuries between the flourishing and the revival of the classical tradition. However, the tradition was preserved in Byzantine culture; and Greek views of the mind and madness also survived in Islamic culture, in the works of such physicians as the Persian Rhazes (864-925), who additionally recognized drunkeness as a disorder and suggested psychological motivations for it, and in the works of another Persian, Avicenna (980-1037), who defined
mania as fury and thus distinguished it from melancholia or depression.

It should likewise be noted that other Mid-Eastern and Asian cultures had identified mental disorders long before the golden age of Greek culture, although the degree to which they influenced Greek thought, and indirectly ours, is not ascertainable. For example, Sumerian and Egyptian records from the third millennium B.C. refer to a melancholia-like syndrome, and another syndrome like hysteria.

Much of the classical Greek tradition that had been lost to much of the West began to filter back during the Crusades, and was accompanied by other Eastern traditions that had previously never reached the West.

The Renaissance

Although Menninger (1963) classifies Thomas Aquinas (1225-1274) as a Medieval theologian, he may be looked upon as the great synthesizer of Christian and classical thought, and therefore an early Renaissance man. As a teacher at the new University of Paris, he summarized in his two *Summae* all the scholarly knowledge available at the time, and this included the rediscovered psychology of Aristotle, Greek and Roman medical classifications of mental disorders, and Judeo-Christian doctrines which attributed madness as well as other ills to demonic
possession. In other words, he admitted both supernatural and natural etiologies for mental disorders. It is perhaps ironic that while Thomas Aquinas is considered to be an architect of the modern Roman Catholic Church, his doctrines may be seen as marking the point at which the modern Western world began to be secularized.

As Boring (1950) proposed, the Renaissance or the dissemination of the "new learning" was accelerated by the fall of Constantinople to the Turks in 1453 and the escape of Greek scholars to the West, and by the invention of the printing press by Gutenberg (c.1440). Boring also credited the democratization process with making the "new learning" accessible; this was brought about by (a) the invention of gunpowder (c. 1320) and its use in warfare, which weakened feudal estates and strengthened national units; and (b) the discovery of America by Columbus (1492), which made free land available.

By the 16th century, a new intellectual and social climate prevailed in Europe. A new sense of freedom and individualism asserted itself in the protests of Martin Luther (1521) and John Knox (1567) against the dogmatism of the Roman Catholic Church. A new view of the world, and of the place of human beings in it, was graphically depicted in the charts of Copernicus (1530), which showed that the universe did not revolve around the earth, and thus dispelled the geocentric illusion.
While there was not yet a new psychology or a new psychopathology in the late Renaissance, the way for the modern scientific study of human beings and their environment was being laid. Paracelsus (1493-1541), in Switzerland, advocated the use of chemical principles in the treatment of mental disorders; Vesalius (1514-1564), in Italy, made dissection the standard method for teaching anatomy; the microscope was invented by 1590 and the telescope by 1608 by Dutchmen whose names are not recorded, and in 1674 Van Leuvenhoek used the former to examine microorganisms.

There was also in England at the end of the Renaissance a great general interest in psychopathology, which perhaps predicted the development of modern psychology and psychopathology in that country, and later in the English-speaking United States of America. As had been the case in ancient Greece, this interest was perhaps most pronounced in the drama of the time; and it was particularly evident in the popular tragedies of revenge by Shakespeare (1604/1983) and other playwrights, which included portrayals of pathological behavior that we today can identify as paranoid.

Surely there could be no better example of delusional jealousy than that of Othello, who murdered his innocent wife, Desdemona, after being convinced of her unfaithfulness by a literally flimsy piece of evidence.
IAGO. 0, beware, my lord, of jealousy;
It is the green-eyed monster, which doth mock
The meat it feeds on....Trifles light as air
Are to the jealous confirmations strong
As holy writ....

   (Act III, Scene 3)

DESDEMONA. Alas the day, I never gave him cause!
EMILIA. But jealous souls will not be answered so;
They are not ever jealous for the cause,
But jealous for they're jealous: 'tis a monster
Begot upon itself, born on itself.

   (Act III, Scene 4)

OTHELLO. Ay, let her rot, and perish, and be damned
tonight; for she shall not live. No, my heart
is turned to stone: I strike it, and it hurts
my hand.

   (Act IV, Scene 1)

--William Shakespeare
Othello (1604)
Likewise, remembering that in those times an anointed king was believed to rule by divine right, we can see the ambitions of usurpers, like Hamlet's uncle Claudius, and Macbeth and Lady Macbeth, as pathologically grandiose. And surely the blind hatred of the Montagues and the Capulets for each other, which led to the deaths of Romeo and Juliet, has in it elements of paranoia on a societal level.

It seems unlikely that the two greatest bodies of drama in Western civilization, the classical Greek and the Elizabethan and Jacobean English, would have maintained their effectiveness over the centuries if they did not indeed "hold the mirror up to nature," and ring true to a great range of audiences and readers. This seems to reinforce the view of paranoia as a basic kind of human behavior, which cannot be ignored in the classification of psychopathology.

When the modern world began to emerge from the Renaissance world, therefore, the interest as well as the opportunities existed to develop psychology, including psychopathology, as both a scientific and clinical discipline. Concepts of psychopathology had been inherited from classical times and were also developing in the general culture that we have inherited; and among these were concepts of paranoia.
The Modern Era

The 17th century. Boring (1950), among others, has located the beginning of modern science in the 17th century, with the theoretical mathematical descriptions of planetary movements by Kepler (1571-1630), which were later verified, and with the astronomical discoveries supporting Copernican theory which were made by Galileo, using a telescope he had built himself. The strongest foundations of modern science were made later in the century by Isaac Newton (1642-1727), with his discoveries of differential and integral calculus, universal gravitation, the laws of motion, and the composition of light.

During the same period, modern medicine received initial impulses from the discovery of the circulation of the blood by Harvey (1628), and the discovery of microorganisms by Leeuwenhoek (1674).

While modern psychology is rooted in the scientific tradition, it was not until two centuries later, however, in the laboratory of Wilhelm Wundt in Leipzig (1879), that mathematics and experimental observation were used in the investigation of psychological phenomena. And while psychopathology has been heavily influenced by medicine, it was also not until the 19th century that medical research by Bell (1803), Flourens (1824), Broca (1861), and others began to specifically relate psychological phenomena to the structure and physiology of the central nervous system.
Indeed, even now, more than three centuries later, psychology remains a "preparadigmatic" science (Staats, 1983). And although vast amounts of research have been done and are being done on the brain and behavior, the fundamental nature of the mind-body relationship remains an unsolved problem. This apparent lag of psychology behind sciences which were established earlier, and the gaps between medical or physiological and psychological knowledge, are clearly due not to a lack of interest or effort, but to the complex and elusive nature of psychological phenomena.

Nevertheless, the beginnings of modern psychology per se may be found in the 17th century, in the works of Rene Descartes (1596-1650), who was at once a philosopher, psychologist, mathematician, scientist, and physiologist. As a philosopher and the first modern psychologist, he concluded, "Cogito, ergo sum" ("I think, therefore I am"). In other words, he concluded that the essence of a person is in mental activity; the self is to be identified as a psychological entity.

As a mathematician, Descartes invented analytical geometry, relating geometry to algebra, and making it possible for later psychologists, among others, to plot two or more variables on a "Cartesian" chart and show their relationship to each other.
As a scientist and physiologist, Descartes attempted to reconcile Copernican theory and physiological knowledge with the doctrines of the Roman Catholic Church, and found it necessary to develop a mechanistic view of physical reality while maintaining his religious view of God and the soul—the latter of which involved divine intent and free will as major determinants of natural events and human behavior. In other words, Descartes articulated the dualism which continues to exist in Western thought, including in approaches to psychopathology.

For example, the physiological/medical approach points to genetic determinants of schizophrenia, and has developed drugs to control this disorder as well as others, while the cognitive behavioral approach assumes that cognitive changes are under personal control and can effect behavioral changes, even in organic and psychotic disorders. Indeed, Cartesian dualism may be seen as the basic problem in the "insanity plea," which frequently has been of great public concern, and has involved conceptualizations and diagnoses of paranoid schizophrenia (Swanson, Bohnert, and Smith, 1970).

While Descartes' contributions were to all branches of modern psychology, and indeed to all of modern science, another great thinker in the 17th century was specifically interested in psychopathology. He was Robert Burton,
(1577-1640), an Oxford cleric and scholar, who compounded a lifetime of learning in his *Anatomy of Melancholy* (1628/1927). Melancholy, as noted earlier, had been used as a general term for chronic mental disorders in ancient times, and was so used during the Renaissance and into the modern era. In his book, Burton began by describing the "excellencies" as well as the "miseries" and "infirmities" of man, and catalogued all known diseases, including "diseases of the head"; he then summarized the teachings of the Church about the soul, and what was known of anatomy and physiology; and finally he proceeded to his comprehensive discussion of melancholy.

Burton first discussed the definition of the term, beginning with its derivation from the Greek words *melaina* chole, or black bile, an excess of which was believed to cause melancholia; but he also pointed out that "black bile" might be effect, disease, or symptom as well as cause. Burton then, in the manner still adhered to in modern psychology, referred to the definitions of 20 or so experts who had previously discussed melancholia, and inferred a compound definition: Melancholia is an anguish of the mind, without fever and without obvious cause, in which the will and the mind or reason are adversely affected; it is usually characterized by fear and sorrow, but sometimes by pleasure and boldness; and several kinds of melancholy may be distinguished, although they usually
But at my back I alwaies hear
Times winged Charriot hurrying near:
And yonder all before us lye
Dessarts of vast Eternity.

--Andrew Marvell
To his Coy Mistress (1681)
are mixed in affected persons. This definition seems to suggest paranoid as well as mood disorders.

Burton then discussed the causes of melancholy, distinguishing between the supernatural and the natural. Among the former, he discussed spirits, witches, and stars; among the latter, old age, inherited diseases and habits, poor diet, emotions and attitudes such as anger and pride, accidents, bad treatment, and poverty. The latter group, it must be noted, are still under investigation today as major causal factors of mental disorders.

Burton went on to discuss the cure of melancholy, beginning with statements that, again, sound completely modern if applied, for example, to paranoid schizophrenia: Though it may seem to be a lifelong "inexorable disease, hard to be cured, yet many times it may be helped even [when] violent, or at least...it may be mitigated and much eased" (p. 381). Burton then cautioned against seeking magical cures, and advised the use of "prayer and physick" together, observing that the patient must seek a skilful and honest doctor, and then must comply with the recommended treatment.

Among general means for restoring and maintaining health that Burton recommended were ones that sound not only modern but current: A low-fat diet, light drinking, clean water, daily baths, polution-free air, satisfactory sexual relations, regular exercise of body and mind, and
sufficient relaxed sleep. But most important of all for the cure of melancholy, Burton said, is the patient's avoidance of fearful and sorrowful thoughts, and the deliberate thinking of happy and hopeful thoughts—a recommendation with which most contemporary cognitive behavioral therapists would surely agree. Also, Burton insisted, the melancholy person should confess his fears to, and seek the counsel of, a friend or doctor who is both kind and wise. Burton then quoted Plutarch, who had quoted Aeschylus and Euripides, in words that could become a motto for contemporary psychotherapists: "A gentle speech is the true cure of a wounded soul...if it be wisely administered, it easeth grief and pain, as divers remedies do many other diseases" (p. 475).

Burton went on to describe the beneficial effects of music, laughter, and good company in the treatment of melancholy; and he suggested ways of addressing the specific concerns, characteristics, and experiences of affected persons who might come for counseling. He also enumerated physical treatments for melancholia, and finally discussed "love-melancholia" as a common variation of the disease.

Burton's *Anatomy of Melancholy* (1628/1927), of which five editions were published during his lifetime, and a sixth, with his final revisions, shortly after his death, has been largely ignored by modern psychologists; however,
It may be seen as the first modern handbook for mental disorders, and Burton may be seen as the first modern psychotherapist. Although the classification of mental disorders has become far more sophisticated since the 17th century, and vastly more is known about their physiological etiologies and treatments, Burton's conceptualization of disorders, including those with paranoid features, can extend our understanding even today; and his approach to the treatment of them still has much to offer in the way of counseling counselors.

In addition to Descartes and Burton, a third thinker in the 17th century must be mentioned as an early modern psychologist: Sir Thomas Browne (1605-1682), a successful physician, respected classicist, skeptical philosopher, and author of *Pseudodoxia Epidemica* (1646), among other works admired for both their content and style. Like Burton, Browne was particularly interested in wrong thinking, and looked for it across the widest dimensions in his field of learning; but while Burton was interested in individual cases, Browne was interested in group phenomena—hence the Latin title of his book, meaning errors among the people. In his book, Browne discussed what he believed to be the sources of common errors, including human fallibility and diabolical influence; he then catalogued common errors according to misunderstandings about the natural world,
mankind, history, geography, art and literature; and he refuted and replaced these errors by use of rational arguments and careful scholarship.

Browne's work is of particular interest for the purposes of this dissertation, as it offers early support of the contention that large groups of people may be seen as suffering from a common disorder in thinking, and that the concept of societal paranoia is a valid one.

The foregoing discussion of the roots and earliest appearances of modern psychology and psychopathology, including the conceptualization of paranoia, has been presented in considerable detail for two reasons. The first is that most of what has been presented has usually been given little or no attention in other discussions of the historical categorization of paranoid disorders; in fact, it is customary to jump from the derivation of the term to its use in the 18th or even the late 19th century. But, to modify what Ebbinghaus (Boring, 1950) said of psychology in general, paranoia may have only a short history, but it has a long past.

The second and related reason is that the past is well worth careful examination rather than quick dismissal; valuable ideas and viewpoints, as well as artifacts, can be buried and lost over time—as was discovered in the Renaissance but perhaps has been since forgotten. It is
only relatively recently that psychologists have given much attention to ethnocentricity; we perhaps should also be aware of what might be called, to coin a word, "temperocentricity."

The 18th century. Scientific observation and classification came into their own with the work of Linnaeus (1707-1778), who provided modern botany and zoology with their basic taxonomies. Enthusiasm for such scientific activities pervaded intellectual circles in Europe, and extended into psychological investigation, which since Descartes had been developing in an empirical direction within the philosophy of Locke, Berkeley, and Hume, as well as within physiology.

It was in 1759 and 1763, as Lewis (1970) has reported in his detailed history of the words paranoid and paranoia, that a French physician who was also a botanist, Bossier de Sauvages, published works on pathology and nosology, and, among other innovations, brought the Greek term paranoia into modern usage. De Sauvages used the term to classify chronic global disorders affecting rationality and judgement, and differentiated them from the delirium of fever. A German follower of de Sauvages, R. A. Vogel, in 1772, used the term to also include mania and melancholia; and a Scottish neuropathologist and admirer of Vogel,
William Cullen, used the word with its general meaning for the first time in English, in 1783.

From this point on, the history of the concept of paranoia can be traced in the psychological literature to the present time, as indicated in Table 1.

The 19th century. The first specific use of the term paranoia, as Lewis (1970) has pointed out and as Menninger (1963) has described in detail, was in the first modern classification system to be widely accepted— that of Heinroth, published in Leipzig in 1818; and in that system it was given prominence, although Heinroth used the German term Verrucktheit interchangeably with the Greek term. In Heinroth's system, all mental disorders fall into three classes: The hypersthenias or exaltations, which were subdivided according to whether they affected the faculties of emotion, intellection (defined as the act of understanding), or volition; the depressions, which were subdivided in the same way; and the "mixed order" group, which affected more than one of the faculties. Verrucktheit or paranoia was categorized as an exaltation affecting intellection. It may be noted that this was a separate category from melancholia, a depression affecting the emotions, and from the mixed category of delusional melancholia.
Table 1.

Summary of Descriptions of Paranoid and Related Disorders

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<th>Author</th>
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<td>de Sauvages (1763)</td>
<td>Paranoia</td>
<td>Amentia, dementia, delirium without fever (term revived from classical Greek)</td>
</tr>
<tr>
<td>Vogel (1772)</td>
<td>Paranoia</td>
<td>Morbid mental states, including amentia, dementia, mania, and melancholia</td>
</tr>
<tr>
<td>Cullen (1783)</td>
<td>Paranoia</td>
<td>Impaired judgment; no hallucinations (first use of the term in English)</td>
</tr>
<tr>
<td>Heinroth (1818)</td>
<td>Verruckheit</td>
<td>One of three major classes of mental disorders; affects understanding; includes megalomania</td>
</tr>
<tr>
<td>Ray (1838)</td>
<td>Intellectual mania</td>
<td>Mania confined to a particular idea or train of ideas</td>
</tr>
<tr>
<td>Esquirol (1845)</td>
<td>Monomania</td>
<td>Errors of understanding with fixed and dominant sentiments</td>
</tr>
<tr>
<td>Griesinger (1845)</td>
<td>Verruckheit, partial</td>
<td>Persecutory and grandiose delusions, secondary to melancholia</td>
</tr>
<tr>
<td>Kahlbaum (1863)</td>
<td>Paranoia</td>
<td>Primary or original disorder; incurable; may proceed to dementia</td>
</tr>
<tr>
<td>Kraepelin (1896-1912)</td>
<td>Paranoia</td>
<td>Chronic delusional system centering on persecution, jealousy, grandeur, or erotomania; distinct from dementia praecox, no deterioration; rare</td>
</tr>
<tr>
<td>Paraphrenia</td>
<td>Disorder midway between paranoia and dementia praecox</td>
<td></td>
</tr>
<tr>
<td>Freud (1896-1933)</td>
<td>Paranoia</td>
<td>Delusional projections of homosexual conflict in persons regressed to the narcissistic developmental level</td>
</tr>
<tr>
<td>Meyer (1906)</td>
<td>Paranoia</td>
<td>A mental perversion slowly developed, with transformation of the personality</td>
</tr>
<tr>
<td>Bleuler (1911)</td>
<td>Paranoia</td>
<td>One of the schizophrenic disorders; may include hallucinatory subtypes</td>
</tr>
<tr>
<td>Pavlov (1934)</td>
<td>Paranoia</td>
<td>Abnormal signal transmission, increasing the elaboration and stability of the conditioned reflex</td>
</tr>
</tbody>
</table>
Table 1. (Continued) Summary of Descriptions of Paranoid and Related Disorders

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Diagnosis/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameron</td>
<td>1959-1967</td>
<td>Paranoid reactions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Delusional projections, elaborate and chronic in paranoia,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>simpler and sometimes brief in paranoid states</td>
</tr>
<tr>
<td>Million</td>
<td>1969-1986</td>
<td>Paranoid personality</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Characteristically defensive, suspicious, irascible, projective in thinking, self-important, and resistant to change</td>
</tr>
<tr>
<td>Swanson</td>
<td>1970</td>
<td>Paranoid disorder</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A mode of thinking marked by projection, hostility, suspiciousness, centrality, delusions, fear of loss of autonomy, and grandiosity</td>
</tr>
<tr>
<td>Lewis</td>
<td>1970</td>
<td>Paranoid syndrome</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Delusions of self-reference: persecution, grandeur, litigation, jealousy, love, envy, hate, honor, or the supernatural</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paranoid personality</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paranoid syndrome made by dominant ideas rather than delusions</td>
</tr>
<tr>
<td>Winokur</td>
<td>1977</td>
<td>Delusional disorder</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Delusions without depression, blurred or inappropriate affect, incoherence, or sensory or memory problems</td>
</tr>
<tr>
<td>Kendler</td>
<td>1980-1982</td>
<td>Paranoia (delusional disorder)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prominent delusions not due to organic or affective disturbances; no close resemblance to schizophrenia</td>
</tr>
<tr>
<td>Magaro</td>
<td>1981</td>
<td>Paranoia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pathological levels of biased information processing; distinct from schizophrenia</td>
</tr>
<tr>
<td>Meissner</td>
<td>1981</td>
<td>Paranoid process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Characteristic mental process, positive or deviant, independent of schizophrenia</td>
</tr>
<tr>
<td>Munro</td>
<td>1982, 1987</td>
<td>Paranoia (delusional disorders)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Spectrum of disorders; not rare; treatable; may be primary or secondary, or brief; includes paraphrenia</td>
</tr>
<tr>
<td>Zigler</td>
<td>1984</td>
<td>Paranoid schizophrenia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A phenotypic expression of a depressive mode rather than schizophrenia</td>
</tr>
<tr>
<td>Mirowsky</td>
<td>1985</td>
<td>Paranoia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sense of persecution developed under social conditions perceived as threatening</td>
</tr>
<tr>
<td>Haynes</td>
<td>1986</td>
<td>Paranoia behaviors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Delusions of reference unaffected by contradictory evidence or social network; on a continuum from normal behaviors</td>
</tr>
<tr>
<td>Marinello</td>
<td>1989</td>
<td>Paranoia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maintenance of a physiological emergency state</td>
</tr>
</tbody>
</table>
Further, Heinroth distinguished among four kinds of paranoia: One in which the patient holds a single false idea which governs his actions, a second in which he holds false ideas about the supernatural, a third marked by megalomania, and a fourth mixed category.

Heinroth's system was elaborated and used fifty years later by the physiologist Carl Wernicke, and was also modified and used by Hack Tuke (1827-1895) as part of his efforts in England, like those of Pinel in France and Rush in the United States, to have mentally disordered persons treated as medical rather than criminal or diabolical cases.

Although this initial specific conceptualization of paranoia has subsequently undergone many changes, its lasting influence can be seen up to the present: Paranoia has almost always been regarded, and still is, as a primarily intellectual rather than emotional disorder, usually not affecting the person's daily functioning, and characterized by strongly held false ideas or delusions, which frequently are grandiose. Further, although the existence of paranoia as something other than a construct has been questioned more than once since Heinroth's time, the conceptualization of it as a primary category of mental disorder has persisted in the literature.

Recognition was also given in other 19th century classification systems to specific syndromes identifiable
as paranoid, although other terms were used. An especially noteworthy example of this may be found in a treatise written by an English physician, Isaac Ray (1838), to provide a medical reference for legal regulations and decisions about the disposal of the property of persons found to be insane. This book was the first of its kind in English, and Ray may therefore be seen as the father of forensic psychology.

Ray distinguished among mental deficiency, mania, and dementia; the manias he divided into "intellectual" and "moral" categories, and subdivided the former into "general" and "partial" types, describing the partial type as "confined to a particular idea or train of ideas, once called melancholia" (p. 170). This provides a missing link with earlier terminology.

Another example of recognition of a specific syndrome identifiable as paranoid is found in Esquirol's (1845) treatise on insanity. This actually used terminology very close to that of DSM-III-R: "Delusions" were seen as equivalent to "monomania," one of the twelve basic categories of disorders which Esquirol listed; and he described an erotic as well as a grandiose subtype.

Later in the 19th century, as neurophysiology progressed with the work of scientists like Wernicke and Broca, Griesinger (1882) attempted to devise a classification system based on the assumption that all
mental diseases are brain diseases; however, he was unable to locate "monomania" more specifically than among Heinroth's "exaltations."

Meanwhile, the conceptualization of paranoia per se was undergoing a far-reaching change in the classification system devised by Kahlbaum (1863), which was based not on theoretical divisions among intellectual, emotional, and volitional faculties, like Heinroth's system, but on clinical observations of the symptoms, etiology, course, and outcome of disorders. Kahlbaum thereby established a medical model for the diagnosis of mental disorders, although he distinguished between those which had no known organic origins and those which did. On this basis, he viewed paranoia as a chronic mental disease, with no known organic cause, of which delusions were the primary symptoms.

Kahlbaum's conceptualization can be seen as being at the root of many important questions which still vex those interested in psychopathology in general and paranoia in particular. They involve, for example, the appropriateness of the medical model for disorders with no known organic origins; the implications of the medical model for determinism vs. free will; the nature of the "real" problems in paranoia and other disorders vs. the "symptoms"; and the meaning of a diagnosis of chronicity in paranoia and other disorders in regard to treatment, which
it may discourage, while the diagnosis may mean only that effective treatments have not been devised or applied.

By the end of the 19th century, as Lewis (1970) has pointed out, there was widespread controversy about paranoia among psychiatrists not only in Germany but in France, Britain, and the United States, in regard to the use of the term itself, and the "stages," prognosis, and other medical dimensions of the disorder. A striking example in regard to prevalence is that while up to 50% of patients admitted to various mental hospitals were diagnosed as paranoid, a few prominent psychiatrists said they had seen only a handful of cases throughout their careers.

The late 19th century interest in paranoia was not confined to professional psychopathologists, however, as indicated by the history of the use of the word in the Oxford English Dictionary (1933). The word appeared in general medical reference books as early as 1857, and in Allbutt's compendium in 1899. In the latter, there was a suggestion about the etiology of the disorder that will be explored later in this dissertation: "A victim of foul play, [the paranoid person] is proud, defiant, and self-centered (p. 399)."

The concept of paranoia had even entered public consciousness: The word appeared in the New York Tribune in 1891, in the Review of Reviews in 1892, and in the
Atlantic Monthly in 1899. Since then, despite the vicissitudes of the concept in the professional literatures, the word has remained firmly embedded in the English language, with its general meaning of a mental disorder involving systematized delusions of persecution or grandeur (Webster, 1985).

The early 20th century: Giant steps. There surely have been no more influential figures in modern psychopathology than Emil Kraepelin (1855-1926) and Sigmund Freud (1856-1939); and their conceptualizations of paranoia held key positions in their work, and have had profound and lasting effects on later conceptualizations of the disorder.

The writings of both men on paranoia began late in the 19th century, but the bulk of them, and the best known, were written in the 20th century; they will therefore be discussed in this section of the history of the concept of paranoia.

Kraepelin is customarily referred to in histories of psychopathology as the creator of the modern classification system for mental disorders. However, he may be seen as a synthesizer of various 19th century approaches to the classification of mental disorders, including the descriptive, neurological, and course-outcome approaches,
The history of the conception of paranoia is very closely connected with the whole development of our clinical views of psychiatry.

--Emil Kraepelin
Manic-Depressive Insanity and Paranoia (1921)
rather than as the originator of a new approach—although the synthesis itself became the dominant medical approach to the classification of mental disorders (Menninger, 1963).

From 1892 on, however, Kraepelin, following the lead of Kahlbaum, considered course and outcome to be of overriding importance in the classification of mental disorders (Lewis, 1970). Thus, by 1899 he had distinguished between two major disorders, dementia praecox, or early mental deterioration (later renamed schizophrenia by Bleuler, 1911), and manic depressive psychosis, which was cyclical in nature. This distinction may be seen as Kraepelin's second decisive contribution to the modern classification of mental disorders.

Kraepelin's conceptualizations of paranoia and other paranoid disorders were an important part of his schemata, and changed throughout the nine editions of his textbook, which were published from 1883 to 1927, a year after his death. With the publication of the eighth edition (1915), usually considered to be the definitive one, Kraepelin had expanded his original 400-page compendium to four volumes containing more than 3,000 pages, based on clinically observed and statistically recorded details which had been organized and reorganized in accordance with his comprehensive medical model of mental diseases; and he had made basic distinctions among paranoid disorders.
General changes in his classification system which Kraepelin made from edition to edition of his textbook have been described by Menninger (1983), and specific changes in regard to paranoia and other paranoid disorders have been traced by Lewis (1970), and by Kendler and Tsuang (1981). The latter have written a specific account of the nosology of paranoid schizophrenia, beginning with the fifth edition of Kraepelin's textbook; however, one might argue with their premise that "the history of the paranoid psychotic disorder properly begins with the writings of Emil Kraepelin" (p. 594).

In fact, the history of the concept of paranoia presented earlier in this chapter is reflected in Kraepelin's early editions. The first disorder described by Kraepelin in the first edition (1883) of his textbook he called depression, alternately referring to it as melancholia with delusions. In the second edition (1887), Kraepelin provided a category for Verruckheit, and listed two subtypes, a depressive form which included delusions of persecution, and an "expansive" form characterized by delusions of grandeur; this category was repeated in the third edition (1889). In the fourth edition (1891), however, the category was called Verruckheit, alias Paranoia, although the subtypes had been changed to "combinatory" and "phantastic"; and this category was continued in the fifth edition (1896), in which Kraepelin
defined the primary feature of paranoia as the "insidious development of a permanent and unshakeable delusional system resulting from internal causes...accompanied by perfect preservation of clear and orderly thinking, willing, and acting" (Kraepelin, 1896/1921, p. 212). This definition has persisted even in the description of delusional disorder in DSM-III-R.

Also in the fifth edition, for the first time, Kraepelin used the term dementia paranoides to classify patients who had deteriorated from persecutory and grandiose delusions to hallucinations and permanent confusion—or, in later terms, who could be identified as paranoid schizophrenics.

In the sixth (1899) and seventh (1903) editions of his textbook, Kraepelin continued to use both the German and Greek terms to identify the category for non-deteriorating persecutory and grandiose delusions, but in the eighth edition he referred simply to paranoia. Thus the term became established in modern classification.

It was in the sixth edition that Kraepelin distinguished between the delusions seen in paranoia and those seen in dementia praecox: The former gradually developed from real events, were stable, and did not affect other perception or thinking, while the latter were fantastic, changing, and disorganized. These are still used as basic distinctions between the paranoid and the
schizophrenic disorders, and have served to classify paranoid schizophrenia with the latter.

It was also in the sixth edition that Kraepelin identified a delusional disorder occurring after age 55, which in the eighth edition he called paraphrenia and categorized as a subtype of endogenous deteriorating disease, the other subtype being dementia praecox; however, he noted that the symptoms of paraphrenia were comparatively mild in nature. Paraphrenia has been widely recognized but, oddly enough, has never been used as a diagnostic category per se in the DSM series—a matter which will be discussed in the next chapter.

Also in the eighth edition, in response to critics who had observed that some patients diagnosed with the paranoid form of dementia praecox showed no deterioration, Kraepelin modified this category by dividing it into rapidly and slowly deteriorating groups; he thus accommodated to his basic emphasis on course and outcome as determinants of the classification of mental diseases. However, paranoid schizophrenia has been a controversial category ever since; this will be discussed later.

In addition, in the eighth edition of his textbook, Kraepelin acknowledged that, in accordance with observations made by other clinicians, acute and curable forms of paranoia could be said to exist. Since he had previously defined paranoia as a chronic disorder, he had
assigned acute disorders with paranoid symptomatology to the categories of manic-depressive or situationally induced disorders. However, he was now willing to classify them with chronic disorders on the grounds that they showed chronic tendencies to delusion formation; Kraepelin thus preserved course and outcome as basic criteria for classification. Kraepelin's textbooks have provided a sort of bible for modern psychopathology; and, as is the case with the Judeo-Christian Bible, statements are occasionally quoted out of context to support the quoter's rather than the writer's stance. Reference to Kraepelin's specific denial in 1896 of acute paranoia as a valid category offers an example of this (e.g., Lewis, 1970, p. 5): Kraepelin may have denied it in 1896 but came to accept it by 1915.

Overall, regardless of the problems presented by the medical model and a course-outcome emphasis, Kraepelin's monumental accomplishments may be seen exemplified in his establishment of paranoia as a term and a concept for a psychosis distinct from the two other psychoses which he identified, as well as in his recognition and differentiation of paranoid "dementia praecox," paraphrenia, and acute paranoia.

Kraepelin, inevitably, had and continues to have many critics. The critic who made the most positive contributions, perhaps, was Bleuler (1857-1939), who, as
mentioned previously, replaced the term dementia praecox (Greek for early mental deterioration), with the term schizophrenia (from the Greek schizo, to split, and phren, mind, referring to a split between the mental faculties of intellect and emotion—without any implication of split personality, as is commonly assumed). This change in terminology obviously indicated a conceptual change from a medical model based on the assumption of brain damage to a model which depended on observable behaviors for diagnosis; further, Bleuler, whose observations included a longitudinal study of 647 cases, determined that the course of the disorder was not necessarily a deteriorating one, and that prognosis depended on the mildness or severity of the symptoms (1911).

To return momentarily to the arguments presented in the previous chapter in regard to the importance of theory as well as experimentation in psychology, it is interesting to note that both Kraepelin and Bleuler were scrupulous scientists in their investigation and reporting of their findings; the wide divergence of their conclusions resulted from theory, not methodology.

However, Bleuler overgeneralized his concept of schizophrenia, and not only insisted that paraphrenia should be classified with schizophrenia rather than paranoid disorders, but that paranoia itself, in both its chronic and acute forms, might be forms of schizophrenia,
since delusions existed in all of these disorders. This curiously reversed the position of delusions as the primary feature of paranoia; and while Bleuler's terminology and conclusions about schizophrenia--later including autism--came to be widely accepted, his suggestions about paranoia and other paranoid disorders were not: In theory and clinical practice they remained distinct from other disorders.

The other foremost figure in modern psychopathology, as suggested at the beginning of this section, was Freud. It is interesting that Freud, Kraepelin, and Bleuler were almost exact contemporaries, born 1855-1857, in the German-speaking geographical-cultural area that runs from Switzerland to Austria, and that all were rigorously trained in the scientific method as applied to physiology; Kraepelin, in fact, was one of Wundt's students in the world's first psychological laboratory, in Leipzig.

However, while Kraepelin and Bleuler continued the objective investigation of psychopathology throughout their careers, acquiring and interpreting large masses of data, Freud became increasingly inward-oriented and speculative, building his schemata on single case studies as his interests proceeded from neurology to hypnosis, and then to psychoanalysis and the building of universal theories about the structure of the mind, the development of personality,
and the nature of motivation—all of which he related to early sexual development. Although lacking empirical validation, Freud's revolutionary theories had, and continue to have, profound and far-reaching effects on professional thinking (including that of Bleuler) and also on public thinking (often through creative writers) about psychopathology. Among Freud's influential concepts of mental disorders, which were embedded in his general theories, was that of paranoia.

Freud (1896/1962a) used the diagnosis of paranoia early in his career for a case involving persistent delusions, and apparently found it a valid and useful category throughout his career. In his own classification system, based on the purposes served by psychoses and neuroses in the minds of affected persons, he placed paranoia among the psychoses of defense, saying that it resulted from the repression of distressing memories through the mechanism of projection—that is, self-reproach is converted to the reproach of others, with subsequent distrust of them. Further, Freud said, the repressed image is expressed in an analogous rather than a direct form, and as recent rather than from the more distant past. He also said that the repressed self-reproaches return as audible voices; in 1926, however, he changed the diagnosis in the case described in 1896 to dementia paranoides or, as it was later called, paranoid schizophrenia.
These are the most difficult problems that are set to us, but their difficulty does not lie in any insufficiency of observations; what present us with these riddles are actually the commonest and most familiar of phenomena. Nor does the difficulty lie in the recondite nature of the speculations to which they give rise; speculative consideration plays little part in this sphere. But it is truly a matter of conceptions—that is to say, of introducing the right abstract ideas, whose application to the raw material of observation will produce order and clarity in it.

--Sigmund Freud, on Anxiety

New Introductory Lectures on Psychoanalysis (1933)
Freud (1906/1962b) further clarified his conceptualization of paranoia in an introduction to a discussion of hysterical phantasies or delusions: He noted that delusions are present in all the psychoneuroses, but differ in their concerns; in paranoia the concern is with the greatness and sufferings of the affected person. One cannot help but reflect that Freud would not have been in favor of renaming paranoia "delusional disorder."

In addition, Freud linked sex with phantasies or delusions, saying that their source and prototype are to be found in youthful daydreams, which are invariably erotic—at least in women, though in men the eroticism may be circulated through ambition. One must reflect that this statement shows not only a 19th century biased view of women, but also a rather curious naivete on the part of Freud.

Freud (1906/1962c) also linked delusions, dreams, and creative writing, in his first published analysis of a literary work, Gravida, a short novel written in 1903 by Wilhelm Jensen. In the introduction to his lengthy discussion of delusions and dreams in the novel, Freud defined dreams as fulfilled wishes, including "dreams that have never been dreamt at all, but ascribed to invented characters by imaginative writers" (p. 7); and later he inferred that the delusions of the hero were the product of obsessive romantic daydreaming, a lively imagination, and a
highly functioning intellect. Freud did not, however, use the terms paranoia or erotomania to refer to the hero's delusional system, perhaps because he believed that delusions were necessary but not sufficient for such a diagnosis.

Freud's best-known work on paranoid disorders—and, in fact, one of his best-known works overall—is his analysis of the case of Schreber (Freud, 1911/1962d); actually, this is an analysis of Schreber's description of his own case in his memoirs, which were published in 1903. In the introduction to his analysis, Freud used the terms paranoia and dementia paranoides interchangeably; it was later, as was indicated in regard to his 1896 publication, that Freud distinguished between paranoia and other paranoid disorders, with hallucinations and a deteriorating course being found in the latter but not in the former.

In the introduction to his analysis, Freud also said that he saw many such cases, and that they were difficult to diagnose and treat. However, Schreber's case was of particular interest because he was a highly intelligent and observant man, a former judge and president of the Reichstag senate in Dresden, and had written his memoirs in the hope of contributing to science.

Schreber described himself in his memoirs as having suffered from both hallucinations and delusions during two hospitalizations, which he attributed to what would now be
called environmental stress; the official diagnosis, however, was hypochondria. Freud's post factum diagnosis was paranoia, based on not only the nature but the source of Schreber's delusions. Schreber's two major delusions had been that he had a mission to save the world and to restore it to a state of bliss, and that he could accomplish this only by changing into a woman. Freud analyzed these delusions by tracing their gradual and elaborate development, with associated delusions of persecution, and concluded that their source was the repression and projection of passive homosexual impulses, which Schreber had originally felt toward his father and brother, and finally toward his physician. Or, to put it into other Freudian terms, Schreber's delusion of divinely justified feminization served the purpose of subconscious wish fulfillment, although it exacted a terrible price in terms of his real life. He did recover during the seven years of his second hospitalization, and spent five happy years with his wife; however, two weeks after she suffered a stroke in 1907, he was hospitalized for a third time, and died shortly before the publication of Freud's analysis of his case.

Freud's analysis is a very detailed, clever, and convincing piece of detective work; but he went on to generalize from it in regard to repressed homosexuality as the root cause of paranoia, citing the similar opinions of
two colleagues about cases they had seen, presenting arguments pro and con and demolishing the latter, and admitting that the number of cases observed was not sufficient to generalize without exception.

Freud's insistence on repressed homosexuality as the basic cause of paranoia became even more evident in his interpretation of a case which appeared to run counter to his theory (Freud, 1915/1962e). The case was that of a woman who had sought legal protection from a former lover who, she said, had had photos taken of them making love and could use these to ruin her. In a series of convoluted arguments, Freud proved to his own satisfaction that the woman's delusions were her defense against a homosexual love of her mother, that "she herself became her mother" (p. 269), and that his theory was correct after all.

While Freud's homosexual/libidinal theory of paranoia has not been given empirical or general support, and though he and Kraepelin took different approaches to the study of the disorder, Freud's general description of it agreed with the definitive one of Kraepelin: Freud saw paranoia as a major disorder, distinct from dementia praecox or schizophrenia, and featuring systematized grandiose, persecutory, or related delusions. Both men described paranoia as very difficult to treat, but believed some cases could be cured. However, while Kraepelin found
paranoia to be a rare disorder, Freud (1911/1962d) reported seeing "plenty of cases."

Overall, however, their conceptualizations of paranoia complimented each other: Kraepelin's was expressed in his classification system, which was based on clinical data obtained from thousands of cases and statistically analyzed; Freud's was expressed narratively, based on psychological mechanisms used by individuals to defend themselves against unbearable thoughts and emotions. Kraepelin provided objective criteria for diagnosing the disorder; Freud provided case histories and analyses for understanding the disorder.

Though continually subjected to examination and modification--which is necessary for the advancement of knowledge, the works of Kraepelin and Freud remain dominant forces in the field of psychopathology today: The DSM series are directly descended from Kraepelin's system of classification, and Freudian concepts and deductive method of thinking about mental disorders have permeated both professional approaches and the general culture. This will be evident in the history of the conceptualization of paranoia and related disorders since Kraepelin and Freud, which is about to be discussed.

Before that, however, it may be interesting to reflect that the different approaches to psychopathology in general and paranoia in particular used by Kraepelin and Freud were
in the long traditions of the two different approaches described at the beginning of this chapter: Kraepelin's work was in the tradition of the ancient Greek physicians, and Freud's was in the tradition of the philosophers. And it is literally the task of contemporary clinical psychologists to use both of these approaches in their diagnosis and treatment of mental disorders—to use an agreed-upon objective system of classification, and to examine and treat each case as that of a unique individual.

Official classification systems. As indicated above, the history of the conceptualization of paranoia since Kraepelin and Freud can be traced in official classification systems, particularly in the DSM series, and also elsewhere in the literature of psychopathology. While the tracing may be done along separate lines, the lines are, of course, intertwined: Official classification is determined by and also influences those who publish in the field.

The first attempt of the American Psychiatric Association (or, as it called itself then, the American Medico-Psychological Association) to standardize the nomenclature used by psychiatrists was in 1916 (Menninger, 1963); it consisted of 21 main items representing a simplification of Kraepelin's diagnostic system, including paranoia. This was augmented in the following year by one
item, and was used with minimal modification in mental hospitals throughout the country for the next 17 years. In 1934, a revised and extended classification system, based on etiology, became the official one; this included not only paranoia and paranoid conditions as an independent category, but paranoid types of senile and involutional psychoses, and a paranoid type of dementia praecox or schizophrenia. It also included, for the first time, the category of primary behavior disorders.

It was in 1952 that the first Diagnostic and Statistical Manual of the American Psychiatric Association was published. It had the major advantage over earlier official publications of containing definitions of terms and descriptions of syndromes. It was divided into disorders caused by or associated with brain damage, and disorders of psychogenic origin or without physical cause. Among the latter, under psychotic disorders, were paranoid schizophrenia and paranoid reactions, which were divided into paranoia and paranoid state; and under personality disorders, paranoid personality was included as a type.

Paranoid schizophrenia and paranoia were described in familiar Kraepelinian terms, and paranoid state as characterized by paranoid delusions without systematization or deterioration, and often by short duration—a syndrome which bore some resemblance to both paraphrenia and acute paranoia as described by Kraepelin. Paranoid personality,
on the other hand, was described as resembling schizoid personality, but exhibiting an "exquisite" sensitivity in interpersonal relations and a tendency to use the mechanism of projection, expressed in suspiciousness, envy, jealousy, and stubbornness. The reference to projection, without any explanation of the term, indicated how far Freudian concepts had permeated thinking about psychopathology.

DSM-II was not published until 16 years later, but the definition of paranoia remained essentially the same. Finer discriminations were made in regard to paranoid state, however: It was renamed involutional paranoid state (involutional paraphrenia), and a residual category had been added for other unclassified paranoid psychotic reactions. Likewise, three subtypes were added to the description of paranoid schizophrenia--hostile, grandiose, and hallucinatory; and the use of projection was added to the features of the disorder, although it was dropped from the description of paranoid personality.

DSM-III appeared in 1980, and was notable for providing for multiaxial evaluation (e.g., according to severity of psychosocial stressors), as well as very detailed descriptions of disorders, including essential and associated features, age at onset, course, impairment, complications, predisposing factors, prevalence, sex ratio and familial pattern, and differential diagnoses, with
summaries of diagnostic criteria enumerated and highlighted.

Types of paranoid disorders included in the general category were paranoia, shared paranoid disorder, acute paranoid disorder, and the residual category of atypical paranoid disorder. Paranoid schizophrenia was classified and described among the schizophrenic disorders, and paranoid personality among the personality disorders. The descriptions of all types of disorders were followed by lists of specific diagnostic criteria.

The general description of paranoid disorders was an elaborated form of the Kraepelinian one: The essential features were described as persistent persecutory delusions or delusional jealousy; grandiosity and ideas or delusions of reference were described as associated features, along with resentment, anger, and possible violence. Intellectual and occupational functioning were seen as usually preserved, while social and marital functioning were often severely impaired. Paranoid disorders were described as rare.

The description of the paranoid type of schizophrenia was also consistent with earlier official descriptions, but the reference to projection as a feature of the disorder was dropped, and a reference to gender identity or homosexual problems was added, indicating the persistence of Freudian theory. The description of paranoid
personality, although much expanded from earlier DSM descriptions, did not essentially differ from them.

Notable differences between DSM-III and earlier official descriptions of paranoid and related disorders included not only information about predisposing factors, but the specification of situational stresses among these factors. Also notable was the inclusion, among types of paranoid disorders, of the long-recognized folie à deux, renamed shared personality disorder, and acute paranoid disorder, which had been recognized by Kraepelin among others.

On the whole, DSM-III organized and summarized a sizable body of information and opinion about paranoia and related disorders which had accumulated during the history of psychopathology up to 1980.

In 1987, DSM-III-R attacked the concept of paranoia and demolished previous perceptions of a spectrum of paranoid disorders. The name of the specific syndrome referred to as paranoia since 1818 was changed to delusional disorder; and other syndromes identified over many decades as paranoid disorders were renamed and assigned to the "psychotic disorder not otherwise specified" category: Shared personality disorder became induced psychotic disorder, acute paranoid disorder became a psychotic disorder not otherwise specified, atypical paranoid disorder was merged with the latter, and all were
classified under psychotic disorders not elsewhere classified. The reason given in the introduction to delusional disorder in DSM-III-R was that the term paranoia "can cause confusion"—in contrast to the clarity just described, we must assume.

Paranoid schizophrenia and paranoid personality disorder, however, were permitted (if only by default) to retain the paranoid adjective, though there was no longer a noun from which to officially derive the meaning of the adjective. This seems to have been wise if inconsistent in regard to paranoid schizophrenia, since DSM-III-R refers to delusions as the primary feature of schizophrenia in general, and therefore paranoid schizophrenia must have other distinguishing features (i.e., the word paranoid means more, and has always meant more, than delusional). The inconsistency in not changing the name of paranoid personality to delusional personality amounts to a canny avoidance of folly, since the description of this personality disorder in DSM-III-R specifies that delusions are not present. In regard to both disorders, then, it seems essential not only to retain the word paranoid, but to reconsider its meaning and its general use in the DSM series.

Nevertheless, the brief general description of delusional (paranoid) disorder in DSM-III-R does not depart from DSM-III in what it says, that the essential feature of
the disorder is a persistent nonbizarre delusion, but only
in what it omits, which is recognition of associated
features. Some of these, however, are referred to in
descriptions of four types of the disorder, named according
to the content of the delusion: Grandiose, jealous,
persecutory, and somatic. Of these, the first three have
long been recognized in the literature as kinds of paranoid
delusions, but have been presented for the first time in an
organized and detailed way in DSM-III-R. The fourth type
is a new diagnostic category, differentiated by the greater
intensity of the delusional belief from body dismorphic
disorder (a somatoform disorder related to the historical
categories of hysteria and hypochondriasis). Whether a
difference in intensity justifies the creation of a new
category is an arguable point, however. There is also a
fifth type listed in the diagnostic criteria for delusional
disorder, the unspecified type, for delusions that do not
fit into the other categories; this may include
combinations of other types, or delusions of reference
without malevolent content.

The present DSM conceptualization of paranoia, then,
seems to be that it is an outmoded concept, the term itself
is abolished from use except in an historical context, and
the syndrome is not really related to any other disorders
of current interest. Paranoia has been replaced by a
unidimensional concept, delusional disorder, diagnosable by the presence of a single persistent nonbizarre delusion. Delusions are identified by content, but various possible contents are unrelated; inclusion in this category is determined only by intensity.

Nevertheless, paranoia and other paranoid disorders have retained official recognition in ICD-9 (the 9th edition of the International Classification of Diseases, 1989)—although what changes may be made in the next revision remain to be seen. This classification system is published by WHO (World Health Organization, an agency of the United Nations); it is used to record statistical information on morbidity and mortality from all causes all over the world, and to facilitate the retrieval of such information for study, treatment, and prevention. Mental disorders are included as one of 17 categories of disorders, diseases, conditions, and other causes of morbidity and mortality, which range from infections and parasitic diseases to injury and poisoning.

The ICD series originated as the International List of Causes of Death, compiled at a conference in Paris in 1900; it was not until the 5th revision of the list, in 1938, that mental disorders were included. These were subcategorized into mental deficiency, schizophrenia, manic depressive psychosis, and all other mental disorders—a
division of disorders which psychiatrists found unsatisfactory, and finally succeeded in changing and expanding in the 8th **ICD** edition, published in 1965. In 1974, a glossary was published for use in conjunction with **ICD-8**; and in 1975, **ICD-9** was published, and has since been revised.

The 1989 revision of **ICD-9** includes a comprehensive if not highly organized list of paranoid disorders, which may be found elsewhere in the literature if not in the **DSM** series--at least not using **DSM** nomenclature. Under paranoid states are listed simple paranoid state, paranoia, paraphrenia, shared paranoid disorder, other specified paranoid states, and unspecified paranoid state. Acute paranoid reaction and psychogenic paranoid psychosis are listed under other nonorganic psychoses; paranoid schizophrenia is listed under schizophrenia; and paranoid personality is under personality disorders. In addition, paranoid and/or hallucinatory states induced by drugs are listed under drug psychoses; and there are listings within other categories for presenile, senile, and arteriosclerotic dementias with delusional features, and for alcoholic jealousy.

It is not difficult to imagine the difficulties of reconciling the nomenclature and classification of paranoid and delusional disorders in the WHO international
classification system with those now used by the American Psychiatric Association.

Variations in the classification of these disorders throughout the DSM series and in ICD-9 have been summarized for comparison in Table 4.

Specific problems in regard to the DSM-III-R classification of these disorders, and possible resolutions, will be discussed in the next chapter.

The history of the conceptualization of paranoia and other paranoid disorders has now been traced in the official classification systems. Such systems, however, as indicated earlier, are only a general index to the thinking of persons who have worked and published in the field over the preceding years; and some of these people have held opinions other than those which have been incorporated into the official systems. The more significant work of some of the people who followed Kraepelin and Freud will therefore now be discussed.

Commonsense psychiatry and behavioral psychology. The birth of Adolf Meyer in 1866 followed that of Kraepelin and Freud by only a decade, and he outlived Freud by the same amount of time, dying in 1950; and, like Bleuler, he had been born and educated in Zurich. Unlike the others, however, Meyer emigrated to the United States; and for half
a century, as a professor at the Johns Hopkins Medical School, he was a leading influence in the development of American psychiatry (Lief, 1948).

It was Meyer who introduced Kraepelin's classification system into American psychiatry, although eventually he became impatient with the unvalidated use of the disease model for mental problems, and also with the classification of individuals according to group norms (Menninger, 1963). However, he was even more impatient with Freudian concepts, saying that sex was only one of many factors in personality development, and that the difference between the conscious and the unconscious was that some things did not immediately come to mind.

Instead, Meyer developed a theory for the understanding and treatment of mental disorders which was influenced by a neurological approach to behavior, and required the study of the individual from biological, social, and psychological viewpoints, followed by the guided self-training of the person to change his habits and make the best possible adjustment to life. As Meyer said in an interview with Lief (1948, p. vii), "The main thing is that your point of reference should always be life itself."

Meyer's conceptualization of paranoia exemplified his general approach to psychopathology. While agreeing with the Kraepelinian definition of paranoia as a gradually developing, persistent delusional system without any other
Emotional and intellectual determinants are frequently worth weighing independently for their different bearing as well as for the fact that different parts of our organism are involved. Yet empirically we deal with the situation as with a compound which loses its essential traits by decomposition.

--Adolf Meyer

*The Relation of Emotional and Intellectual Functions in Paranoia and Obsessions* (1906)
disturbance of thought, he regarded the ongoing argument about whether paranoia was an intellectual or emotional disorder as both unprofitable and dogmatic (Meyer, 1906a). He was far more interested in the real-life effects of the disorder, for example, in regard to crime (Meyer, 1906b). He also was very much interested in the understanding and treatment of individual cases of the disorder, and advised therapists to be reluctant to call the notions of patients foolish, because delusions might well represent the attempts of the patient to state the truth (Meyer, 1921).

Meyer's commonsense psychiatry has a strikingly contemporary ring, and clearly was a significant departure in several respects from the highly complex thinking of Kraepelin and Freud. Also, Meyer was prominent enough in his time to be invited by G. Stanley Hall to the celebration of the 20th anniversary of Clark University in 1909, along with Freud, Jung, Tichener, William James, Cattell, Ebbinghaus—who died shortly before the event, Franz Boaz, and other luminaries whose names are on the charter list of modern social scientists (Boring, 1950). Why, then, has Meyer's name been virtually dropped from the "short list" of those who have figured prominently in the development of psychopathology in the 20th century?

One reason may be that Meyer was indeed ahead of his time, and made a positive but not lasting impression on powerful contemporaries. Another reason almost certainly
is that he never wrote a single extended work which
presented his approach to psychopathology in an organized
and comprehensive way. All we have in book form is an
annotated selection of 52 papers on specific topics from
approximately 200 that he wrote--some as lectures, some as
formal reports--which were compiled by an admiring Alfred
Lief (1948). As Meyer said in one of his interviews with
Lief, his interest was in ordinary daily life and daily
observation, and he was not interested in leadership and
power. The implication seems to be that he didn't choose
to spend his time writing books.

Many intriguing questions remain about Adolf Meyer and
his incisive thinking. For example, what is the extent of
the debt owed him by the American behaviorists, who came to
dominate mid-20th century American psychology? It has
rarely been noted that not only were he and the proclaimed
founder of American behaviorism, J. B. Watson, both at
Johns Hopkins during the second decade of the century, but
it was Meyer who provided Watson--12 years his junior and
also grounded in neurology--with laboratory space in the
Phipps Clinic. Present at a turning point in the history
of American psychology were not only Watson and Rosalie
Raynor, and little Albert and the white rat, but also Adolf
Meyer. In any case, for his influence on others as well as
the intrinsic value of his work, Adolf Meyer deserves far
more attention than he has thus far received.
Although Meyer as a psychiatrist and Watson as a psychologist had a highly compatible professional relationship, psychiatry and psychology in general took divergent paths as the 20th century moved on. In regard to the latter, psychiatry continued to follow the disease-model approach to official diagnosis, and many psychiatrists used a psychodynamic approach in treatment. On the other hand, behaviorists were interested in changing present behaviors rather than applying labels to them and examining their origins. A notable exception to this, however, that must be mentioned, was Pavlov's (1934) suggestion that paranoia was the result of abnormal signal transmission, which increased the elaboration and stability of the conditioned reflex. Changes in the conceptualization of mental disorders in general, however, and of paranoia and paranoid disorders in particular, were more likely than not to be extensions or modifications of Kraepelinian or psychodynamic approaches.

The issue of the relationship of paranoia and schizophrenia. A basic and persistent issue in regard to the conceptualization of paranoia has been the relationship of paranoia and schizophrenia. As Kendler and Tsuang (1981) have pointed out, some European psychiatrists earlier in the century agreed with Bleuler's criticism of
Kraepelin, and classified all paranoid psychotic disorders under schizophrenia. Wilhelm Mayer in 1921, for example, on the basis of studies of 78 patients followed up for signs of deterioration, decided that paraphrenia was a mild schizophrenic disorder; and Kolle in 1931, on the basis of a study of 66 families in which both schizophrenia and paranoia occurred, decided that paranoia was a schizophrenic disorder.

However, as Kendler and Tsuang go on to point out, Kretschmer in 1927 and again in 1974 observed that delusions in schizophrenia were bizarre while those in paranoia were not, and that nonbizarre delusions developed when a certain personality type was subjected to stressors involving self-esteem. Further, according to Kretschmer, followup studies showed that the latter cases did not show deterioration while schizophrenic cases did. Scandinavian psychiatrists also have emphasized the role of stress in paranoid psychoses, following the 1963 lead of Karl Jaspers, who described such psychoses as comparatively common and curable reactions to stressful events. And from a position diametrically opposed to Bleuler's, British psychiatrists Henderson and and Gillespie (1944), recommended that all paranoid disorders, including paranoid schizophrenia, should be classified with paranoia.

In the United States, Kendler (1980a, 1980b) attacked the DSM-III (1980) position that all delusions except
persecutory and jealous types should be assigned to schizophrenia, and defended the nosologic validity of paranoia. Magaro (1981) reviewed research in information processing and hemispheric functioning, and proposed that paranoid and schizophrenic individuals use different styles in their cognitive processing, which involves the formation of a perceptual image, called an icon; the identification or encoding of the icon for placement in memory; the association of icons into categories called assemblies; and the association of assemblies into larger categories called schemata.

More specifically, Magaro proposed that schizophrenic persons have deficits in the ability to associate perceptual data, while paranoid persons tend to overassociate data; that therefore schizophrenics may be primarily right-brain or visuospatial processors, and paranoids left-brain or abstract-thought processors; and that consequently schizophrenia and paranoia should be separate diagnostic categories. Subsequently, Magaro and Page (1983) assigned a series of cognitive tasks to 8 nonparanoid schizophrenics, 8 paranoid schizophrenics, and 8 normal controls, and found that the nonparanoid schizophrenics had problems in serial processing in the left hemisphere, while the paranoids matched the processing of the controls in both hemispheres.
Presenting a slightly different viewpoint from Magaro's in the same issue of the *Schizophrenia Bulletin*, W. W. Meissner (1981) cited data suggesting that the schizophrenic process results from the combination of genetic susceptibility and environmental stress, while paranoia, seen from a psychodynamic viewpoint, results from the interaction of introjection and projection, which shape the person's self-organization and affect interaction with others. However, Meissner concluded, although the schizophrenic and paranoid processes may operate independently, they may interact as a form of schizophrenia. It should be noted, however, that Kretschmer, Jaspers, and others cited above saw paranoia also as a product of predisposition and stress.

On the whole, Americans and Europeans cited above have conceptualized paranoid disorders as distinct from schizophrenia, although Cromwell and Pithers (1981) noted that the relationship of paranoid and nonparanoid schizophrenia remains to be determined.

The issue of paraphrenia as a diagnosis. While most of the literature having to do with paranoid disorders has been concerned with paranoid schizophrenia, as noted in the first chapter of this dissertation, another controversial subcategory has been the one that Kraepelin named
paraphrenia, indicating that it is a disorder midway between paranoia and schizophrenia.

As observed earlier, the DSM series has never recognized paraphrenia per se as one of the paranoid disorders, although DSM-II (1968) listed involutional paranoia (involutional paraphrenia) as the new name for a paranoid variety of involutional psychotic reaction, featuring delusion formation with onset in the involutional period, and distinguishable from paranoid disorders by the absence of thought disorders. This type was omitted from DSM-III (1980).

Nevertheless, paraphrenia continued to be referred to elsewhere in the literature. In Britain, for example, Post (1966), and Herbert and Jacobson (1967), conducted separate studies about persecutory states or paraphrenia in the elderly. Post identified disadvantaged social class, faulty perceptions, and subacute brain syndromes as etiological; Herbert and Jacobson found high correlations of symptoms with illness, perceptual loss, abnormal personality traits, and environmental stressors, including isolation from family and community. They also found that the use of tranquillizers and community care made it possible for many of these women to live outside the hospital. The call by these investigators for attention to paraphrenia seems urgent in the United States 25 years
later, as the population ages and extended institutional care becomes prohibitively expensive.

Similarly concerned, Bridge and Wyatt (1980) published two comprehensive papers on European and American research in paraphrenia, and determined that the disorder was commonly misdiagnosed or overlooked in the United States, that it was not rare, that the diagnosis is clinically useful, and that it should be studied to throw light on both schizophrenia and aging.

Nevertheless, paraphrenia was not included in the overall conceptualization of paranoid disorders in DSM-III (1980)—and certainly not in DSM-III-R (1987), since the concept of paranoid disorders itself was dropped from that edition.

The development of the conceptualization of paranoid personality. A third disorder among the paranoid and related disorders which has received special attention in the middle and latter parts of this century is paranoid personality disorder; the attention, however, has been augmentative rather than controversial. An index to this is that DSM-I (1952) describes the disorder in four lines, and DSM-III-R (1987) in three pages; nevertheless, the three pages are built around the core of suspiciousness, envy, jealousy, and rigidity ("stubbornness") included in the four lines.
Much of this augmentation has been the work of Theodore Millon, who developed his views of personality disorders in general and paranoid personality disorder in particular over several decades (e.g., see Millon, 1969), and who played a key role in their conceptualization in DSM-III (1980), which included the first extended descriptions of these disorders. In addition to describing paranoid personality disorder in great detail, Millon (1986) has distinguished between basic personality patterns and pathological personality syndromes, dividing the latter into the following types: Schizoid, avoidant, dependent, histrionic, narcissistic, antisocial, aggressive, compulsive, passive-aggressive, self-defeating, schizotypal, borderline, and paranoid. Most of these types have been grouped into three major clusters in DSM-III-R (1987): Cluster A, the odd or eccentric group, includes paranoid, schizoid, and schizotypal personality disorders; Cluster B, the dramatic, emotional, or erratic group, includes antisocial, borderline, histrionic, and narcissistic personality disorders; and Cluster C, the anxious or fearful group, includes avoidant, dependent, obsessive compulsive, and passive aggressive personality disorders.

Millon's work, like that of numerous others engaged in personality research and assessment, has been largely in the tradition of Gordon Allport, who in the middle of the
20th century developed the first comprehensive theory of personality based on traits as the elementary units of description. Millon (1983) has described paranoid individuals as suspicious, resentful, hostile, and angry, and as exhibiting these characteristics in the areas of behavioral appearance, interpersonal conduct, cognitive style, affective expression, self-perception, and the primary defense mechanism which they use—that is, projection. In 1986, Millon added internalized content and intrapsychic organization to this list, and also incorporated psychodynamic conceptualizations into his own by specifying life experiences, particularly early negative experiences with parents, that may determine the development of personality disorders, including the paranoid type.

Developments in the general conceptualization of paranoid disorders. Other middle and late 20th century theoreticians and researchers have contributed to the general conceptualization of paranoia and paranoid disorders. Among these was Harry Stack Sullivan, who, although born in 1892, became widely known only after his death in 1949. The tardiness of this recognition was not due to lack of perceptiveness on the part of other persons in or interested in the field, however, but to lack of publications on the part of Sullivan. One cannot help but
reflect, also remembering Adolf Meyer, that "publish or perish" does not refer only to academic positions. However, Sullivan did leave behind him five series of unpublished lectures, some of which had been recorded, and he also left very carefully written notebooks; these were acquired by a foundation established by his students and colleagues, and a book containing a comprehensive view of his interpersonal theory of psychiatry was published under his name in 1953. The editors, Helen Perry and Mary Gawel, had put some of the lecture outlines into narrative form as chapters in the book. Among these was a chapter on paranoia.

Sullivan's approach to psychopathology was a developmental one: He viewed human development as a matter of forming interpersonal relationships, and he viewed mental disorders as manifestations of inadequate or inappropriate interpersonal relationships. Manifestations occurring earlier in life, Sullivan said, included schizoid and schizophrenic disorders, and those later in life included paranoia and paranoid disorders. The basic problem in these later disorders, he believed, was a failure to achieve the normal condition of late adolescence by persons with low self-esteem; the attempted solution to this problem by those persons was to disparage others. However, the difficulties began with fear, shame, guilt, and anxiety inculcated in childhood, leading to resentment and the viewing of other people as enemies. These emotions
and attitudes may have been perpetuated and exacerbated by being excluded from desirable groups during adolescence, practicing selective inattention, feeling jealousy and anger, creating wish-fulfilling phantasies, living in self-imposed social isolation, having exploitive attitudes toward others, indulging in self-pity or hypochondriacal complaints, and, in some cases of full-blown paranoia, experiencing auditory hallucinations.

As Sullivan himself noted, it is a common human failing to build oneself up by putting others down; and it may also be noted that it must be a rare child who has not experienced fear, shame, guilt, and anxiety, and a rare adolescent who has not experienced being "out"--or, in fact, who has not at some time experienced almost everything else on the list except auditory hallucinations. While Sullivan's description has helped in understanding how paranoid disorders develop, it does not deal with the question of why they develop only in some persons at some times. Sullivan's major contribution, perhaps, lies in his humanizing and empathetic approach even to cases as difficult as paranoia--an approach not to be found in official classification systems, and all too often absent from clinical descriptions, perhaps especially those of paranoia.
Norman Cameron has been widely recognized for his conceptualization of paranoia and other paranoid disorders and of their development. In response to attempts by other psychiatrists to abolish all categories of paranoid disorders except for paranoid schizophrenia, because of the knotty nosological problems involved, Cameron (1959) pointed out that Freud himself had urged that paranoia be kept as a separate clinical type no matter how often it was complicated by schizophrenic factors. Cameron also pointed out that though paranoia may be rare, other paranoid reactions are probably frequent in the general population, and that mild paranoid characteristics are even more widely distributed in the normal population: Denial and projection, he said, are components of everyone's defensive system; partly because of this, people experiencing paranoid reactions are not likely to seek, and in some cases do not need, professional treatment.

Cameron explained the usual development of paranoid reactions after the age of 30 as possible reactions to the threats, frustrations, and restrictions of advancing years--an explanation which seems to be negated by contemporary society, in which age-related limitations are decreasing, while delusional suspiciousness and hostility seem to be, if anything, increasing. However, Cameron did describe a personality type vulnerable to paranoid disorders that agrees with current descriptions of paranoid
personality; and he described precipitating factors as including the loss of major sources of gratification, or the presence of new or increased demands, threats to one's security or status, or humiliation. It might be observed that the first two and the last of these factors could be subsumed under the third.

The crystallization of a paranoid reaction occurs, according to Cameron, when a focus is found for the projections; he called this focus the "paranoid pseudo-community"—an imaginary organization of real and imagined people united to carry out some action upon the affected person. The person then reacts to this with hostility, accusation, litigation, flight, or violence, and may be diagnosed as paranoid. Later, Cameron (1970) reformulated the pseudo-community as a cognitive structure which attempts to reconcile social reality with paranoid projection, in order to justify taking aggressive action.

Cameron's notion of the pseudo-community has not become part of general conceptualizations of paranoia and paranoid disorders, perhaps because it is not invariably present; however, the precipitating factors proposed by him seem to be highly valid, and will be further discussed in Chapter IV.

Virtually all of the documents in the literature on paranoia and other paranoid disorders, or references to
these disorders in other literatures, are relatively brief, as the foregoing history of the conceptualization of the disorders indicates; however, at least one book dealing in its entirety with the subject has been written, by Swanson, Bohnert, and Smith, and was published in 1970.

The authors defined paranoid phenomena as a mode of thinking characterized by projection, hostility, suspiciousness, centrality, delusions, fear of loss of autonomy, and grandiosity. The authors briefly reviewed the history of the concept of paranoia, and concluded that although paranoid syndromes (i.e., according to DSM-II, in use in 1970, paranoid personality, paranoid state, paranoia, and paranoid type of schizophrenia) may differ in etiology, they are on a continuum and show gradually deteriorating symptomatology. Nevertheless, the authors believed, patients could recover spontaneously or with treatment.

The authors also discussed various clinical aspects of paranoid syndromes from the psychiatric viewpoint, including examination, diagnosis, and treatment; and they included a chapter by F. A. Dinello on psychological testing, in which Dinello described commonly used objective and subjective tests, and concluded that paranoid patients are extremely difficult to diagnose by the use of those tests.
Swanson, Bohnert, and Smith then discussed various "theoretical considerations," including paranoid symptomatology in organic brain disorders; predominantly psychodynamic views of psychological and sociological factors in the etiology of paranoid syndromes; relationships between paranoid and other "pathological mechanisms" (essentially the same as differential diagnosis); and largely unsuccessful attempts to describe the evolution of the "paranoid process" from childhood, using retrospective data from adult patients.

In the final section of their book, the authors discussed the "spheres of influence" in which the paranoid person operates, ranging from family and community life to national government and historical events, and described both theoretical and actual examples of the pernicious influence of paranoid persons in these areas. The concern of the authors was primarily with individual psychopathology, although they discussed folie a deux in connection with families, and, citing Hofstadter (1965), they also discussed political groups with paranoid characteristics in connection with paranoid persons in government.

Since the publication of the Swanson, Bohnert, and Smith book in 1970, the official psychiatric categorization and descriptions of paranoid disorders have undergone many changes, with the most recent changes being radical ones;
however, the notion of a paranoid continuum which the authors inherited and intended to pass on is still a viable one. And while their orientation was basically psychodynamic, the chapter on psychological testing for paranoid disorders is still applicable—although unfortunately this means that psychologists have not advanced very far in this area.

The final section of the book, however, on the impact of paranoid persons on those within their spheres of influence, offers a great deal of support for two of the proposals presented in this dissertation: First, that paranoia and paranoid disorders exist as a distinct group of disorders which cannot be contained in the unidimensional category of delusional disorder, and so should be restored to their previous place in the official classification system—noting that the theoretical importance of this is reinforced by the social importance of these disorders. And, second, that the official classification system, in addition to undergoing other revisions in regard to subtypes, should also recognize and include a new subtype, that of societal paranoia, which involves large groups of people as well as paranoid individuals; and that it is important to identify and study this form of paranoia for the sake of society and of the individuals involved.
As this history has shown, up to this point and through the publication of DSM-III in 1980, as well as other publications in the field later in the decade, the conceptualization of paranoid disorders had been cumulative, although scarcely in a direct line. The general conceptualization seemed to be that these were a distinct group of disorders, characterized by encapsulated specific delusions which were persecutory, grandiose, or otherwise self-referential in nature, and were strongly associated with anger and violence; the types of paranoid disorders were seen as varying, however, according to the content and duration of the delusions, other characteristics of delusional persons, or the involvement of other persons in the delusional system. Thus, there was both a core of consensus in regard to the basic nature of paranoid disorders and constant controversy about the classification and nomenclature of the types of the disorders, as well as about their relationship to paranoid personality and paranoid schizophrenia—from the former of which delusions were absent, and the latter of which was considered to be a form of schizophrenia.

**Delusional Disorder vs. Paranoid Disorders.** At the same time a general conceptualization of paranoid disorders was accumulating, however, there were psychopathologists
who were attempting to dismantle it and discard much of it. As described in some detail earlier, Kraepelin's classification of these disorders as independent of schizophrenia was challenged, unsuccessfully, by Bleuler; Freud found it necessary to defend his recognition of paranoia against a number of other psychiatrists; and Freud's position was taken again by Cameron to ward off a new generation of challengers. Nevertheless, opposition to the official recognition of paranoia as a major disorder continued.

Lewis (1970), in his review of the history of the use of the words paranoia and paranoid, said that, in regard to the concept of paranoia, if Kraepelin "had lived a little longer he would perhaps have surrendered it altogether" (p. 5), and that in German psychiatry after Kraepelin its "shadowy, fluttering existence qualified it for use in darkening counsel" (p. 7); that the word paranoia was "never heartily welcomed in France" (p. 8), and in Britain it was "almost entirely given up" (p. 10); and that the notion of a paranoid continuum "in America...would make classification and definition of...diagnostic terms [for paranoid disorders] a rather superfluous exercise" (p. 10). It must be noted that Lewis's views have not been universally adopted: Paranoia is still discussed in an Oxford encyclopedia as being "of considerable interest and importance" (Rycroft, 1987, p. 576).
Lewis did compliment Cameron's paper as "the most recent and thoughtful American contribution to the topic" (p. 10), but quoted from it only Cameron's opinions that paranoid states are mild forms of paranoia and that inheritance plays no part in paranoia; Lewis concluded, therefore, that the disorder "cannot be declared an endogenous disorder," seeming to imply that the concept was invalid.

Lewis concluded his article by defining a paranoid syndrome in a traditional way, as including delusions of self-reference not derived from a prevailing morbid mood; however, he said it could be [only] a symptomatic, toxic, or schizophrenic condition, that the presence of it was preliminary to diagnosis rather than a diagnosis, and that it "will eventually be classifiable in one of the major categories of mental disorder" (p. 11). He did not offer any evidence to support his views.

Lewis's article is remarkable for cleverly turned phrases, scores of 19th century references, and extensive quotations (without translation) from Latin, French, and German sources. It is found frequently in reference lists in the literature on paranoia and paranoid disorders, and no doubt has had its effects.

The statements which had vastly more far-reaching effects on the conceptualization of paranoia and other
paranoid disorders in the recent history of their conceptualization, however, were statements made in his presidential address at the annual meeting of the American Psychopathological Association by George Winokur in 1977. The address was entitled "Delusional Disorder (Paranoia)," and in it Winokur said that Kraepelin's concept of paranoia was similar to his (Winokur's) concept of delusional disorder, which he had derived from clinical practice. Winokur went on to say that it was "useless to continue to explore the fine points between various delusional illnesses," and that to do so "becomes mostly a semantic, philosophic, epistemologic experience" (p. 511). He referred to previous efforts in this direction as creating a Gordian knot, and he clearly intended to slice through it with his psychiatric scapel. Ten years later, the pieces were scattered throughout DSM-III-R.

Winokur placed delusional disorder squarely in the disease-model tradition, using a rigorous definition of the disorder which required for diagnosis only the presence of systematized nonbizarre delusions, and the absence of hallucinations, organic brain syndrome, onset after the age of 60, depression or mania, inappropriate or flattened affect, or problems in daily functioning. He described the disorder as uncommon, more likely to be seen in men than women, likely to create interpersonal conflicts, and to be
unrelated to I.Q. but possibly related to schizophrenia and to have a genetic component.

Except for the suggestion of a relationship to schizophrenia and the possibility of genetic inheritance (which have not been supported by subsequent research), this definition of delusional disorder was consonant with the minimal definition of paranoia as one of the paranoid disorders to be found in the DSM series and as the core of the general conceptualization of paranoid disorders which had accumulated in the literature. However, by rejecting both the name and the concept of a group of related disorders, and perhaps especially by dropping the requirement that the delusions be self-referential, Winokur created a new category from which a great amount of old information and insight was excluded—and, in fact, not very usefully filed anywhere else.

Winokur's reconceptualization of paranoia as delusional disorder was essentially that of a monosymptomatic disorder, divested of emotional or motivational implications, without subtypes (which were added in DSM-III-R, as defined by common kinds of contents of delusions), and unrelated to other disorders which had been seen as paranoid throughout the history of modern psychopathology. Winokur's definition of delusional disorder exemplifies the ultimate in modern scientific reductionism and its use in the medical model of mental as well as physical diseases:
"What [these patients] have is simply a delusion, nothing more, nothing less" (Winokur, 1977, p. 511).

Even taking the reductionist point of view, however, one must ask whether a category should have as its only positive requirements certain value ratings (in this case, duration, systematization and nonbizarreness) of a single feature (in this case, delusions) which may be found in other disorders (in this case, organic disorders, schizophrenia, mood disorders, somatoform disorders, etc.). One must also ask if the purpose of classification is not to relate as well as to differentiate. And far more importantly, one must ask, even using the traditional medical model, how much one can understand about what is wrong with a patient by identifying a single symptom. In fact, medicine itself has been moving away from the one disease-one cause-one cure model of illness toward a holistic view of the person who is ill, the holistic view requires consideration of various aspects of the illness, and of various factors that contributed to the illness and should be addressed in treatment.

Winokur's paper had no apparent effect on DSM-III (1980); but Kendler and others used Winokur's nomenclature in several papers, perhaps most effectively in the 1981 issue of the Schizophrenia Bulletin, which, as described earlier, was notable not only for its contributions to the
"Vengeance on a dumb brute!" cried Starbuck, "that simply smote thee from blindest instinct! Madness! To be enraged with a dumb thing, Captain Ahab, seems blasphemous."

"Hark ye yet again,—the little lower layer. All visible objects, man, are but as pasteboard masks. But in each event—in the living act, the undoubted deed—there, some unknown but still reasoning thing puts forth the mouldings of its features from behind the unreasoning mask. If man will strike, strike through the mask! How can the prisoner reach outside except by thrusting through the wall? To me, the white whale is that wall, shoved near to me. Sometimes I think there's naught beyond. But 'tis enough. He tasks me, he heaps me; I see in him outrageous strength, with an inscrutable malice sinewing it. That inscrutable thing is chiefly what I hate; and be the white whale agent, or be the white whale principal, I will wreak that hate upon him. Talk not to me of blasphemy, man; I'd strike the sun if it insulted me.

--Herman Melville
Moby Dick (1851)
field but for the fact that it gave extended attention to paranoid disorders—a distinction it shared with the 1970 book by Swanson, Bohnert, and Smith. None of these authors, however, were among the contributors to the journal issue, nor was their work listed in any of the reference lists—another example, perhaps, of the general lack of organization in the literature pertaining to paranoia and other paranoid disorders.

In his 1981 paper with Tsung, Kendler presented his own diagnostic criteria for delusional disorder, somewhat reducing the stringency of Winokur's criteria. He did this by first dividing the disorder into two types, simple delusional disorder and hallucinatory delusional disorder; he also added to Winokur's criterion of "nonbizarre delusions of any type" a tentative "and/or persistent, pervasive ideas of reference lasting at least 2 weeks." In regard to the second type of delusional disorder, Kendler specified that any hallucinations must not be of the kinds described by Schneider as indicating schizophrenia.

The influence of Kendler's modifications of Winokur's criteria for delusional disorder may be seen in DSM-III-R: The delusions are characterized as persistent; the disorder is broken down into types, according to the content of the delusions; and nonprominent auditory or visual hallucinations may be included in the diagnosis.
Among all papers dealing with paranoid and delusional disorders which were published in the 1980s, or perhaps at any other time, none are more cogent than those by Alistair Munro. In a paper published in 1982, Munro noted that there had been few diagnostic or therapeutic advances since Kraepelin, but that a revival of interest had lately become apparent. He then reviewed what he considered to be inaccurate criteria in DSM-III (1980); in particular, he challenged the assumptions that paranoia was rare and unresponsive to treatment, and the implication that it was therefore a negligible disorder. He also said that the overall concept of paranoia had been fragmented by the identification of several kinds of paranoid disorders; that primary cases of paranoia should be distinguished from other disorders in which delusions and other paranoid symptoms occurred; that if the word paranoid really meant delusional, then the name of paranoid personality was a contradiction in terms and perhaps should be changed; and that overall the definition and classification of paranoid disorders needed to be clarified throughout the literature.

In addition, Munro proposed a simple diagnostic schema of the paranoid spectrum which included paranoia, paraphrenia, shared delusional disorder, and paranoid schizophrenia. In response to the question of whether paranoia should be renamed, he suggested that "paranoia
remains as good a term as any" (p. 376). And, finally, he said that "since paranoia is a circumscribed and definable disorder, it can be viewed as a kind of naturally occurring model psychosis, and theories of aetiology and treatment may be tested against it" (p. 347).

Kendler was among the 15 members of the work group in charge of revising DSM-III, and of the 13-member committee for psychotic disorders; Munro was also one of the 13. In 1987, Munro published a paper about the problems in conceptualizing and diagnosing what he referred to as paranoid (delusional) disorders; he commented on the proposed improvements to appear in DSM-III-R, and made further proposals for DSM-IV. At the beginning of his paper, Munro reviewed problems in DSM-III, adding that acute paranoid disorder would fit better in another category, that paraphrenia had not been included, that paranoid schizophrenia seemed to be related more to paranoia than to schizophrenia, although it was classified with the latter, and that nonsymptomatic hypochondriacal psychosis was another form of paranoia that had not been recognized. He also suggested that there were other forms of paranoia that had not yet been diagnosed because of the restriction on content imposed by the official classification system.

Munro then reviewed the changes proposed for DSM-III-R, and saw them as valuable for emphasizing delusions as the
main criterion in the diagnosis of paranoid disorders. However, although earlier in the paper he had referred to the renaming of these disorders as very sensible, in his final comments he said parenthetically that he regretted the change in nomenclature. More emphatically, he expressed concern about the failure to include paraphrenia as a diagnosis; and he also recognized as arguable the change in the classification and nomenclature of shared paranoid disorder. Looking toward DSM-IV, in addition to recommending once more that paraphrenia be included as a delusional disorder, he recommended that the descriptions of induced psychotic disorder and dysmorphic somatoform disorder be reviewed, as well as the relationship of delusional disorders to paranoid schizophrenia, affective disorders [renamed mood disorders in DSM-III-R], and schizoaffective disorders.

In a paper published in 1988, after the publication of DSM-III-R, Munro still used the plural rather than the official singular form of delusional disorder, and said that the new classification system included a decisive definition of at least one group of these disorders but was otherwise too restrictive: Cases which should be identified as paraphrenia were now assigned to the "grab-bag" of Psychotic Disorder NOS, and the failure to link delusional disorders with paranoid schizophrenia and affective disorders was leading to diagnostic confusion and
inappropriate treatment. However, Munro still opposed the inclusion of shared paranoid disorder among the delusional disorders, saying that the second person was either impressional rather than deluded, or else diagnosable as an independently deluded person. He also opposed the inclusion of acute paranoid disorder, as chronicity was usually a feature of the delusional disorders. Nevertheless, Munro said that the traditional concept of a paranoid spectrum continued to be a useful one; and he diagrammed this spectrum as including delusional disorder and paraphrenia, and as on a continuum with paranoid personality disorder at one end and paranoid schizophrenia at the other.

The basic concern in Munro's papers appears to be the inadequacy of the conceptualization of paranoid or delusional disorders as expressed in the official classification system, with its attendant problems in diagnosis and treatment. This is also the basic concern to be addressed in the following chapter, with suggestions for identifying and relating the components of the paranoid spectrum.

As Munro's recommendations for DSM-IV implied, the question of the relationship of paranoia and depression or other mood disorders, which appeared to have been laid to rest early in the history of modern psychopathology, and which seemed to have been forgotten in the long debate
about the relationship of paranoia and schizophrenia, was
briefly revived in the mid-1980s. Zigler and Glick (1984),
calling their view an "unorthodox" one and not referring to
earlier debates, cited research which showed
dissimilarities between paranoid and nonparanoid
schizophrenics, and similarities between paranoid
schizophrenics and affective disorder groups, and concluded
that paranoid schizophrenia could better be conceptualized
as an expression of a depressive mode rather than as a type
of schizophrenia. Research which they cited included that
of Kendler and others who had suggested that paranoid
schizophrenia was not closely related to schizophrenia.

Zigler and Glick addressed a number of basic issues in
regard to the conceptualization and classification of
mental disorders, applying them to paranoid schizophrenia.
They observed general confusion in the field of
psychopathology, and suggested that the confusion is due
largely to lack of knowledge about the causes of the major
disorders. They also suggested that too little attention
is given to individual differences within categories of
mental disorders, and to the permissible range of
differences for inclusion in particular categories. They
went on to discuss the importance of theoretical constructs
in explaining or predicting the clusters of symptoms on
which the current official classification system is based,
noting that data without theory can be only correlational.
In discussing paranoid schizophrenia in particular, Zigler and Glick adopted the psychodynamic view that paranoia represents a defense against depression, and said that it may actually progress into mania; therefore they saw paranoid schizophrenia as primarily related to depression.

Zigler and Glick's discussion of basic issues regarding the conceptualization and classification of mental disorders can be applied to this dissertation. The confusion which they observed in psychopathology surely exists in regard to paranoid and delusional disorders. In the next two chapters, based in part on a theoretical interactional model of behavior, suggestions will be made about possible causes of these disorders, and about types of them which may be related and also differentiated according to a minimal number of features. Zigler and Glick's linking of paranoia and depression, however, is a matter for future investigation.

Other new developments. In the last half of the 1980s, there were at least three other significant contributions to the conceptualization of paranoia and paranoid disorders (not referred to parenthetically or directly as delusional disorders by any of the authors). All three are theoretical in nature, concerned with the causes of the disorders, and serve as models of the disorders representing different theoretical orientations. These
contributions were by Mirowsky (1985) and Mirowsky and Ross (1983), who posited sociological origins of paranoia, including alienation, victimization, and other threatening conditions; by Haynes (1986), who developed a behavioral model of paranoia, describing its origins in external attribution, aversive learning, and social isolation; and by Marinello (1989), who traced the development and maintenance of paranoia as a physiological emergency state. These models will be discussed in more detail, in addition to other models, in the next section of this chapter; and they will be seen as complementary rather than competitive. Their synthesis in a master model will be described in Chapter IV.

Research on delusions. The renaming of paranoid disorders to delusional disorder, by Winokur (1977) and in DSM-III-R (1987) through the efforts of Kendler and others, seems to have had a salutary effect on the investigation of delusions per se—although delusions, seen as paranoid or not, had been of psychological interest long before the advent of DSM-III-R. As mentioned earlier, Mackay's book on popular delusions and the madness of crowds, published in London in 1841, illustrates this; so does Freud's (1906/1962c) analysis of delusions in a novel by Wilhelm Jensen. Another comparatively early and lengthy publication was by C. M. Campbell (1927), a professor of
psychiatry at Harvard Medical School. Campbell was interested in beliefs and delusions as they affect adaptation to the environment, and said that "delusion is an attempt of the personality to deal with special difficulties" (p. 8)--a view which has unfortunately been lost from the DSM description of delusions, but which is being proposed in this dissertation as being essential to the understanding of them, particularly in paranoia.

Contemporary investigations of delusions (e.g., Hendrie, Dunlop, & El-Khalili, 1988; Spitzer, 1990) often begin with references to Karl Jaspers (1883-1969), a psychiatrist and an existential philosopher who was concerned with the nature of being, with major human experiences such as suffering and death, and with communication between human beings using various systems of thought--all of which were related to his interest in delusions. In his textbook on general psychopathology, Jaspers (1923/1964) noted that delusion has always been the basic characteristic of madness, but it has been very little investigated. He stated three criteria for delusions: Certainty, incorrigibility, and impossibility or falsity of content. Jaspers also distinguished among primary delusions, delusionlike ideas, and overvalued ideas, confining the first to schizophrenia, the second to affective disorders, and the third to paranoid disorders. While his third criterion for delusions and his
subdivisions of delusions have not been generally accepted, his emphasis on the importance of delusions has been highly influential.

A few years later, Strauss (1969) carried out a basic investigation of the nature of delusions and hallucinations, questioning the use of their presence or absence ("a patient either has them or he does not," p. 581) as key diagnostic criteria. In a study of 119 psychiatric patients, using the Present State Examination (PSE), Strauss found that delusions and hallucinations are not discrete and discontinuous but on a continua function with normal experience. Strauss rated the delusions and hallucinations according to the patients' degree of conviction of them and preoccupation with them, their degree of implausibility, and their determination by cultural or other direct stimuli.

It was only in the 1980s, however, that a number of notable studies of delusions were undertaken. Kendler (1980a) reviewed empirical evidence which indicated that the type of delusion experienced does not predict the outcome of a case; and in 1983, Kendler, Glazer, and Morganstern published a 7-point Likert scale to measure delusions according to conviction, extension, bizarreness, disorganization, and pressure (preoccupation).

Garety (1985) identified problems in the definition and measurement of delusions, particularly in regard to fixity
and intensity, and modified Shapiro's personal questionnaire to measure these dimensions. Subsequently, Brett-Jones, Garety, and Hemsley (1987) developed measures for a larger set of dimensions, derived from Strauss's (1969) study and the Kendler, Glazer, and Morganstern (1981) scale, which included conviction, preoccupation, interference [with behavior], reaction to hypothetical contradiction, and accommodation. Using the measures in a series of nine single-case studies, they found that the personal questionnaire (Garety, 1985) was a highly reliable measure of conviction, and that conviction was the main predictor of recovery. Preoccupation was not reliably measured, but the measure of interference, by means of an interview, was found to be reliable. However, it was noted that strong beliefs had little effect on daily lives when the affective content of the beliefs was low. The measures of reaction to hypothetical contradiction and accommodation were described as rudimentary, but as giving rise to speculation about the suitability of patients for cognitive therapy and about a general lack of reality testing. There was little covariance among these dimensions of delusions, and the authors suggested that it is content that distinguishes delusional from nondelusional beliefs.

Harrow, Rattenbury, and Stoll (1988) analyzed data on the course of delusions in 34 psychotic patients over several months, along the dimensions of belief-conviction,
perspective on the opinions of others, and emotional commitment to the delusions; they found that belief-conviction was both high and persistent, that there was little perspective on the opinions of others, and that strong emotional commitment was a major factor in the acute psychoses and hospitalization, while declining emotional commitment was a major factor in determining readiness for discharge. This last finding could be added to the data supporting Garety's (1985) conclusion about the decisive importance of the emotional content of beliefs, and also Rachman's (1983) suggestion that emotion may be primary in irrational thinking.

In investigating the content of delusions, Mitchell and Vierkant (1989) compared matched samples of 150 psychotic patients from hospital records of the 1930s and the 1980s, and found that the content of their delusions and hallucinations was consistent with the subcultural milieu of each decade but differed widely from the earlier to the later decade: Those of the first group were primarily concerned with material deprivation and powerlessness, and those of the second with bloody or dead people and animals. Westermeyer (1988) also found that content tends to vary with culture. However, Belcher-Timme (1989), using the Kendler, Glazer, and Morgenstern (1983) scale to measure the dimensions of delusions in a study of 91 schizophrenics, found that the measurements changed
dramatically over time, while there was basic stability in the attributional content core. Belcher-Timme also argued, in line with Strauss (1969), Hemsley and Garety (1986), Maher (1988), and others, that the formation and maintenance of delusions is on a continuum with normal belief formation.

Along with the nature of delusions, their relationship to hallucinations has important implications for diagnosis. Among the few investigations of this relationship is a study by Zigler and Levine (1983), in which Zigler and Phillips' social competence index was administered to 539 schizophrenics. The results suggested that delusions and hallucinations are on a developmental continuum, with delusions being experienced by people on higher levels of social competence, hallucinations by those on lower levels, and both phenomena by those on intermediate levels. This infers serious questions about the strict delineation that has previously been made between these phenomena and between the disorders in which they occur.

In regard to the etiology of delusions, Winters and Neale (1983) noted that little empirical evidence exists, but that theories about delusions have had two main themes, one motivational (i.e., that delusions are formed to explain unusual perceptions or reduce psychological discomfort), and the other a defect theme (i.e.,
delusions result from cognitive-attentional defects). Prominent among such studies are those of Maher (e.g., 1974, 1988), who has posited that delusions represent responses to anomalous experiences, and that such experiences may arise from defects in attentional focusing.

Chapman and Chapman (1988) investigated the genesis of delusions in regard to both anomalous experiences and cognitive-attentional defects, in a study of 162 college students who had scored two or more standard deviations above the mean on one or both of two scales to measure proneness to schizophrenia, and 158 controls. All participants were interviewed initially with the use of a modified version of the SADS (Schedule for Affective Disorders and Schizophrenia) to measure psychotic symptoms, including delusions and milder aberrant beliefs. On this basis, approximately half of the psychosis-prone group were diagnosed with schizotypal personality disorder; and by the time of the two-year follow-up interview, three of the at-risk group, but none of the controls, had received treatment for psychotic disorders. Among Chapman and Chapman's findings were that only some of the delusions or aberrant beliefs found in the entire group during the course of the study were related to unusual perceptions or anomalous experiences; rather, many such experiences were interpreted by those who had them in nondelusional or nonaberrant ways; and furthermore, some individuals
developed delusional or aberrant beliefs in response to
normal experiences, and still others appeared to have
anomalous experiences as the result of delusional or
aberrant beliefs.

In regard to cognitive-attentional defects as leading
to the formation of delusions, Chapman and Chapman observed
that cognitive slippage, tending toward formal thought
disorder, increased during discussions of delusions, of
aberrant beliefs, and of other psychotic or psychotic-like
experiences, though not during discussions of normal
experiences. They proposed that these defects resulted
from selective attention to strong or prominent stimuli and
neglect of weaker stimuli, rather than from a failure to
select stimuli to which to respond, as posited by Maher
(1974). Finally, they suggested that delusions, anomalous
experiences, and thought disorders may augment each other,
but none regularly occurs first in a causal sequence, nor
are any necessary to the occurrence of the others.

In 1988, an entire book on delusional beliefs was
edited by Oltmanns and Maher, indicating a growing interest
in the topic and various ways in which it is being
investigated. The volume includes chapters by various
contributors on theories of delusions, descriptions and
definitions, and approaches to treatment; references to a
number of these contributions are included in this section
and in other parts of this dissertation. Two chapters of
Interesting and unusual content not referred to elsewhere are a chapter by Kilstrom and Hoyt on "Hypnosis and the Psychology of Delusions," and a chapter by Heise on "Delusions and the Construct of Reality."

Kilstrom and Hoyt suggested that hypnosis be used as a laboratory model for research on delusions, since it is a state in which anomalies of perception, memory, and action—in other words, delusions—are induced. This may be seen as especially interesting in regard to shared paranoid disorder, or induced psychotic disorder as it was renamed in DSM-III-R (1987), particularly as it brings to mind the use of the term "hypnotic" in descriptions of the speeches of Adolf Hitler and other paranoid leaders.

Heise in his chapter offers a philosophical and cross-cultural analysis of delusions as being identified through social judgments, observing that in our time and our society, truth is defined in terms of scientific facts about the material world, while in other times or other societies, truth may be defined in other terms, such as those of spiritual revelation. Delusions, therefore, or departures from truth, may be seen as departures from specific norms rather than departures from some absolute standard. Further, Heise suggests that the judgment of delusions is concerned with social control, "involving a comparison of minds in which one is treated as authoritative and the other as deficient." From the
sociological viewpoint, then, the question is not why or how delusions occur, but "what kinds of thinking are being controlled and discouraged in the process of judging delusion?" (p. 267). Heise's chapter, like Kilstrom and Hoyt's, suggests that delusions are sociologically and politically relevant phenomena.

Among very recent publications, an article by Spitzer (1990) also returns to the basic question of the definition of delusions, but from a therapeutic rather than an academic viewpoint. Spitzer attacks the DSM-III-R definition as inconsistent and incomplete; he reviews Jasper's criteria for delusions, and Kurt Schneider's unsuccessful attempt to replace the third criterion (impossibility or falsity of content) with the notion of delusional perception, and he then offers a new definition, which posits that the third criterion should be unjustified claims about external reality. That is, Spitzer maintains that the content of delusions may be true or false; it is the person's refusal to offer or consider evidence that distinguishes delusional from nondelusional thought. Spitzer also says that perceptions themselves cannot be delusional, as they are descriptions of a person's inner experience; and he suggests that a division be made between delusions and disorders of experience, and that clinicians should not disregard perceptions as delusional.
In summary, then, theory and research on delusions may be seen as indicating that delusions are not unitary, discrete, discontinuous, or easily isolated from other psychological phenomena. While they can be measured along several dimensions, results have been unreliable, except in regard to the conviction with which they are held; but emotional commitment to them appears to be an important dimension for further investigation. The imagery in the delusional content may be situation dependent, but personal attributional content appears to be relatively stable; in any case, situational as well as personal etiological factors, both perceptual and cognitive, remain to be further identified and evaluated, as does the relationship between delusions and hallucinations and its place in diagnosis. In regard to the relationship of delusions and overt behaviors, delusions may be harmless, but high emotional content appears to determine behavior and to contribute to the views that others have of the delusional person. This has very important implications for treatment, which up to the present has been minimal and minimally effective.

In regard to the relationship of delusions and paranoid disorders, theory and research on both appear to indicate that, contrary to the disputable definition and description of delusional disorder in DSM-III-R, delusions and their dimensions per se are not reliable as the sole definitive
symptoms of a particular kind of psychopathology; rather, the psychopathology lies in the ideational, emotional, and attributional content of particular kinds of delusions, and in behaviors consequent to them. Further, it is vital to consider the possible etiology of delusions in making a diagnosis with a view toward treatment. In other words, the disorder of concern in this dissertation may better be described as paranoid than as delusional—although the research in regard to delusions will undoubtedly do much to advance the diagnosis, treatment, and prevention of paranoid disorders.

The history and current status of the conceptualization of paranoia and other paranoid (delusional) disorders has now been traced from the time of the invention of the word by the ancient Greeks, through its revival in the 18th century and its specification in the 19th, to its significant if disputed place in modern psychopathology (see Table 1 for a summary of various viewpoints). The development of this conceptualization will no doubt continue indefinitely, however, because it represents attempts to understand what appears to be a basic kind of human behavior, whether or not it is labelled paranoid.
Major Models of Paranoia

The history of the concept of paranoia and other paranoid (delusional) disorders, and the examination of their present status, indicates that the concept has evolved over time with other general advances in psychology and psychopathology. While the views of paranoia offered by these major approaches may be seen as contrasting, they need not be contradictory, any more than a front view of a structure is contradictory to a rear view, a side view, a bird's-eye view, or internal views of the same structure—unless any particular viewer feels that his view is the only valid one, and projects from it the design of the entire structure. A holistic view of paranoia and other paranoid (delusional) disorders, intended to incorporate various particular views, will be presented later in this dissertation; particular views or models of paranoia found in major modern approaches to psychopathology will be presented first.

Most of the models of paranoia to be described have not been presented in the literature as models per se, but have been extracted and compounded from particular studies. The term "model" will be used according to its current primary meaning: a standard for imitation or comparison; a pattern; an exemplar; a representation, generally in miniature, to show the construction or serve as a copy of
something (Webster, 1985). By their very nature, therefore, models tend to be simplistic, are unlikely to precisely fit particular cases, and should be continually reexamined. This is true of the models to be presented.

Since theories or models of paranoia, as found in the literature of the major approaches to psychopathology, are each based on descriptions of the disorder seen from a particular viewpoint, they vary as to the dimensions of the disorder with which they are concerned; possible predisposing, causal, or maintaining factors of the disorder; and the probable course and outcome of the disorder, with implications for treatment and prevention. The following models will therefore be discussed mainly in terms of these variations.

The Psychiatric Model

The psychiatric or medical model is the one found in official psychiatric classification systems, used primarily for the diagnosis and reporting of mental disorders. As discussed earlier in this chapter, the current (third, revised) edition of the manual of the American Psychiatric Association, DSM-III-R (1987), and the current (9th) edition of the manual of the World Health Organization, ICD-9 (1989), are both derived, like previous editions, from the diagnostic system developed by Kraepelin and published in nine editions between 1883 and 1927.
In this model, paranoia (delusional disorder in DSM-III-R) and other paranoid disorders are described essentially as if they were physical diseases. They are classified according to the major groups of disorders to which they belong, with identified types and subtypes listed under them. Epidemiological data, including age, sex, and family history are reported. Features or symptoms, both essential and associated, receive the most attention, followed by differential diagnosis. Course, impairment, and complications are briefly described. In the absence of proven causes, etiology is discussed in terms of predisposing factors. Treatment is not discussed in the diagnostic manuals, but the psychiatric model includes treatment with drugs.

In the psychiatric model, then, although versions of it have differed over time and are likely to continue to do so, paranoia and other paranoid (delusional) disorders have been consistently described as rare disorders occurring in middle or late life, and more often affecting men than women. They are classified among the psychoses or major disorders, and they include several types; in DSM-III-R, the types of the unitary delusional (paranoid) disorder represent the kinds of systematized nonbizarre delusions first enumerated by Kraepelin: Erotomanic, grandiose, jealous, persecutory, and somatic (referred to by Kraepelin as hypochondriacal).
Delusions are the outstanding feature and the dimension of most concern in this model, although recent DSM descriptions of the disorder include impaired marital and social functioning, and possible aggression and violence, as sequelae. While Kraepelin considered the course to be chronic, however, it is now seen as variable, with the possibility of remission. And while Kraepelin attributed the disorder to personal peculiarities which cause difficulties in community life, including self-consciousness or concern with the self, comparatively recent research has pointed to other possible predisposing factors, such as immigration, emigration, deafness, severe stress, and low socio-economic status. Finally, although psychiatric descriptions of the disorder have usually regarded it as hopeless, Alistair Munro (1988) reports pimozide as a specific and effective treatment for the somatic subtype of the disorder, and refers to anecdotal reports of the uses of other drugs as well.

Overall, the psychiatric model is mainly concerned with objective data regarding the presence or absence and the nature of delusions; it appears to be useful mostly for differential diagnosis.

The Psychodynamic Model

The psychodynamic model of paranoia, developed by Freud, has continued to influence psychiatric thinking
about the disorder (e.g., Cameron, 1959; Swanson, Bohnert, & Smith, 1970; Blum, 1980; Meissner, 1981;). It has also influenced creative lay writing (e.g., Siegel, 1978), and has undoubtedly helped to popularize the word, along with various Freudian terms that have filtered down into general usage.

Freud was not very much interested in epidemiology, and generally accepted psychiatric classification, although he insisted that paranoia be maintained as a separate diagnostic category; and his initial interest in symptoms in any particular case soon deepened into efforts to discover the subconscious origins of those symptoms, and to cure the patient by bringing those origins into consciousness. The course, impairment, and complications of a case were integrated by Freud into the search for its origins.

As discussed in some detail earlier in this chapter, one of the most famous of all of the cases which Freud (1911/1962d) described in detail was a case of paranoia, that of Schreber, a former judge and government official, whose delusions of persecution Freud traced to the repression and projection of passive homosexual impulses. It was this case that provided the classic psychodynamic model of the disorder--one which Freud insisted on following even when doing so required considerable manipulation of the records (Freud, 1915/1962e).
In the original psychodynamic model, therefore, the dimension of most concern is persecutory delusions brought about by the defense mechanism of projection; a related concern is the paranoid person's regression to a narcissistic stage of psychosexual development. The original cause is seen as subconscious homosexual conflict beginning in childhood; the immediate cause, precipitating the delusions, is seen as disappointment in a same-sex relationship.

The original psychodynamic model, however, has been modified to include other than homosexual etiology. Meissner (1981), for example, has proposed that hostile interactions with parents or other significant figures in childhood, or even the witnessing of them, could lead to paranoid delusions. Nevertheless, the experience of inner turmoil, and the projection of hostility, remain basic to the model.

The psychodynamic model, then, in contrast to the observational viewpoint of the official psychiatric model, is concerned with the inner experience of the paranoid person, and may be used to enhance the understanding of the patient by both himself and his therapist.

The Behavioral Model

Behaviorists have also traced delusional systems to family interactions. For example, Koffman (1985) specified
I fled Him, down the nights and down the days;
I fled Him, down the arches of the years;
I fled Him down the labyrinthine ways
   Of my own mind; and in the midst of tears
I hid from Him, and under running laughter.
   Up vistaeed hopes I sped;
   And shot, precipitated,
Adown Titantic glooms of chasmed fears,
From those strong Feet that followed, followed after.

--Francis Thompson
The Hound of Heaven (1893)
the mutual reinforcement of inflexible rules, irrational beliefs, distrust, apprehensiveness, and hatred as generating and maintaining a paranoid system. And in 1986, Haynes presented, as he said, the first behavioral model of paranoia, which he saw as a clinically and socially significant set of problems. He described the problems in terms of the DSM-III (1980) description of paranoid disorders, and noted that as there was a lack of relevant research on the topic, he had derived his model from clinical inference, behavioral research on other disorders, and nonbehavioral research and models of paranoia.

Haynes limited his model to the etiology of paranoid behaviors which are not associated with biological dysfunctions, sensory deficits, or schizophrenia; he included both overt behaviors and cognitions. His model is not concerned, therefore, with epidemiological data, classification problems, differential diagnosis, or specific treatment; and the course, impairment, and complications of the behaviors are inherent in the description of their development. In the conclusion to his paper, Haynes stressed the importance of detailed behavioral assessment and intervention based on it.

The cognitive dimension of paranoid behaviors is of primary concern in this model; the cognitive process of special interest is the formation of rigidly held delusions
of reference or centrality, grandeur, and/or persecution. Delusions are defined as false convictions and beliefs which are unaffected by disconfirming evidence and are not part of the culture to which the paranoid person belongs. Paranoid delusions are nevertheless seen as being on a continuum with normal behavior, differing from it in regard to rigidity, impact, and duration, rather than in occurrence or content.

This model posits two groups of historical determinants of paranoid behaviors, two groups of maintaining factors, and life stressors as contributing factors. Specific historical determinants enumerated include the modeling, reinforcement, and prompting of paranoid behaviors; their insufficient punishment and the insufficient reinforcement of alternative nonparanoid behaviors; situational control of paranoid behaviors; and a history of confirmed suspicions. Nonspecific historical determinants include an insular family, aversive family interactions, inconsistency, and nonreinforcement of appropriate social behaviors. Specific maintaining factors include contingency control of paranoid behaviors, and the impact of paranoid behaviors on others; nonspecific maintaining factors include the disruption of social feedback systems, and social skills deficits. Life stressors include sudden loss or isolation, or serious threats to self-concept, which may trigger previously learned behaviors such as
suspiciousness and external attribution; further, the physiological arousal prompted by stress is seen as tending to increase hypervigilance and selective attention. This is consistent with attribution theory.

Overall, the behavioral model suggests specific social learning, both historical and current, as an explanation for paranoid behaviors. It should be especially useful in providing a comprehensive checklist of paranoid behaviors for both assessment and intervention.

The Cognitive Model

Paranoia and other paranoid (delusional) disorders, as the history of their concept presented earlier in this chapter has shown, have historically been perceived as disorders of the intellect—in contrast to the affective disorders, or the disorders which have obvious physiological components or correlates. All models of paranoia, therefore, must to some extent be cognitive models, identifying or explaining the cognitions called delusions or false beliefs. However, the cognitive model to be described here is a model primarily concerned with the mental processes whereby the delusions or beliefs are formed.

Colby (1975, 1977) produced an interactive computer simulation of paranoid processes, to serve as a model of
paranoia, to provide clinicians with experience in the paranoid mode of thinking, and to be used for comparison with natural human counterparts. Colby clearly delineated the boundaries of his model, limiting paranoid delusions to those of persecution, and defining the paranoid mode as the arousal state of emergency. He summarized the main phenomena of paranoid disorders as suspiciousness, self-reference, hypersensitivity, fearfulness, hostility, and rigidity.

Colby (1977) based his model on a shame-humiliation theory of paranoia, which posited that the strategy of blaming others springs from an effort to avoid shame and humiliation. Colby further suggested that homosexual conflict represents a special case of the shame-humiliation theory, as does conflict about hostility felt toward others, and as does a sense of inadequacy and resultant feelings of guilt.

This model or computer simulation of paranoia, named PARRY, is in the form of a dialogue between a paranoid patient and a professional interviewer, with likely responses by the patient including ones indicating the presence of the kinds of delusions, phenomena, and original motivation described above. The dialogue begins with an input question, or an imperative or a declarative statement by the interviewer, and proceeds according to whether these and following sentences are classified as having
Blow, blow ye winds with heavier gust!
And freeze, thou bitter-biting frost!
Descend, ye chilly, smothering snows!
Not all your rage, as now united, shows
More hard unkindness, unrelenting,
Vengeful malice, unrepenting,
Than heav'n-illumined man on brother man bestows.

--Robert Burns
_A Winter Night_ (1786)
malevolent, benevolent, or neutral meanings. The sentences are selected by the use of a series of algorithms from a clinically-derived pool of sentences. The model may be set for weak or strong versions, and has other features described by Colby (as were the preceding) in highly technical language.

As this model of paranoia was designed to illustrate paranoid information processing, it does not include within itself any considerations of epidemiology, course, impairment, complications, treatment, or prevention. However, Colby suggested that the theory on which it was based does have implications for treatment and prevention: Paranoid persons should be removed if possible from chronically humiliating situations; and children should never be subjected to shaming or humiliating procedures.

As a model of paranoia per se, however, this little-used but often cited computer simulation appears to be in need of revision if it is to be used in the future. It was designed before DSM-III (1980) and various important developments in the classification, nomenclature, and description of features used in the diagnosis of this disorder. However, the fact that this model has been so little used for clinical purposes, or in research, may be due largely to the complex format and highly technical language used by Colby to describe it.
Overall, however, the computer simulation model of paranoia is of intrinsic interest as an original use of computer technology to aid in understanding the operations of that most complex and powerful of all computers, the human brain—and particularly in the understanding of how problems may develop, and how they may be prevented or solved.

Other investigators, such as Locascio and Snyder (1975), and especially Magaro (1980, 1981), have pursued the tracing of paranoid cognitive processes through sequences of normal cognitive processes: The production of an image, called an icon, by a stimulus; the automatic discrimination of the icon from its background, and the controlled encoding or identification of it as a particular object, whereupon it is referred to as a percept; the placement of the percept into short-term memory as a cogit, or basic unit of information; its incorporation into an assembly or association of related cogits; and, finally, the incorporation of the assembly into a concept, or schema. This sequential processing, however, also involves backward processing, or loops: The discrimination of the icon, for example, requires prior information about dimensions, or a perceptual set or schema; and the encoding or identification of the icon requires the recall of
comparable units in long-term memory, or a categorical set or schema.

In describing paranoid cognitive processing, Magaro posited that the paranoid person consistently processes information backward from the schema to the icon, scanning input for characteristics that will make it fit into a particular categorical set rather than for its characteristics per se; consequently the paranoid person is consistently biased in his thinking and not open to other interpretations of incoming information. Magaro viewed this as a deficit in information processing. He also posited that schizophrenic information processing goes from the icon to the schema, but shows deficits in the ability to organize information; schizophrenic persons therefore are likely to be right-brain processors, with left-brain deficits, while the opposite is true of paranoid persons; and therefore paranoia and schizophrenia are separate and distinct disorders.

Magaro's model of paranoid information processing applies almost exclusively to the cognitive dimension of paranoia, although it springs from a concern with the classification of paranoia as distinct from schizophrenia, and with the differential diagnosis of the two disorders. However, Magaro made a distinction between paranoid information processing and paranoia, saying that paranoid processing is on a continuum with normal behavior, as in
the case of paranoid personality; that it may exist without pathological symptoms; and that under some circumstances it may be adaptive. Magaro did agree with the Piagetian view, however, that an equilibrium between perceptual processes and conceptual structures is needed for normal mental development and successful adaptation, and suggested that an uncorrected preference for a conceptual or perceptual cognitive style developed early in life may lead to, or at least predispose persons to, paranoia or schizophrenia. Magaro further suggested, therefore, that specific cognitive tasks to correct preferential cognitive styles be used in the treatment or prevention of these disorders.

Magaro's model of paranoia, then, may be found embedded in his model of paranoid information processing: Paranoia represents a pathological level of such processing, involving the formation of delusions and an intensification of suspiciousness and other paranoid personality traits. Its proposed etiology, course, impairment, complications, treatment, and prevention are found in the matrix model.

Overall, what may be seen as a general cognitive model of paranoia affirms its traditional conception as a disorder of the intellect or judgment, by demonstrating persistently biased information processing in this disorder. It is a generative model, experimental and empirical in approach, and can be increasingly facilitated
by the use of computer technology and advances in cognitive psychology.

The Psychobiologic Model

Although paranoia and other paranoid (delusional) disorders have generally been perceived as disorders of the intellect rather than the emotions or neurobiological systems, there surely is no doubt that such distinctions represent different aspects of human beings rather than unrelated entities, and that they are connected in complex ways which we are only beginning to understand through psychological investigation, particularly in such areas as neuropsychology and behavioral medicine. It is perhaps not surprising, then, that a psychobiologic model of paranoia has not been developed as fully as the psychiatric, psychodynamic, behavioral, and cognitive models have been. Nevertheless, there have been important beginnings.

Noteworthy for its early appearance and its authorship, a brief paper was published by Pavlov in 1934, suggesting that paranoia, as well as obsessional neurosis, could be partly explained in terms of neurological signal transmission, which, when abnormal, could elaborate and prolong the conditioned reflex—in other words, create highly systematized and persistent responses to stimuli. This paper has been little cited, and its proposal still remains open to investigation.
Traditionally, as indicated above, only a few investigators of paranoia linked physiological phenomena with the disorder—among them being Maher (1974), who posited that paranoid delusions were due to primary perceptual disorders, and Colby (1975), as mentioned earlier, who defined the paranoid mode as the arousal state of emergency.

It was not until the 1980s, in fact, that much attention was given to consideration of the psychobiological aspects of paranoia. Hemispheric imbalance was suggested by Magaro (1980, 1981), as mentioned earlier, and also by Gruzeller (1981), who agreed that paranoid and nonparanoid schizophrenics differed significantly in laterality; and Magaro and Page (1983) later expanded on this position. However, paranoid persons have not been shown to differ significantly from normal controls in tasks that assess laterality.

Another suggestive finding was that of Kovelman and Scheibel (1984), who observed in a postmortem study of 10 paranoid schizophrenics that pyramidal cells in their left hippocampi were significantly disorganized, in contrast to the cells of 8 nonpsychotic patients; and this appeared to have developed in utero. However, there are no such studies comparing paranoid and nonparanoid schizophrenics, or including nonschizophrenic paranoid persons and normal controls.
Other physiological findings involving paranoid symptomatology have been recently reported. Alarcon and Franceschini (1984) found a case of secondary paranoid psychosis in the literature on psychiatric manifestations of hyperparathyroidism. Emsley and Paster (1985) observed two cases in which paranoid symptoms were the presenting feature, but the diagnosis was lipoid proteinosis, with medial temporal lobe calcification. Brown, Fischman, and Showalter (1987) reported not only paranoid delusions but attempted murder linked to hypercalcemia and hyperparathyroidism. Paranoid symptomatology has also appeared in some cases of temporal lobe epilepsy, Huntington's chorea, and lesions of the right cerebral hemisphere (DSM-III-R, 1987), and in mercury poisoning (Uzzel, 1988). A comparative study of these findings, along with those of Magaro and his coworkers, and of Kovelman and Scheibel, as well as others, might suggest neurological patterns in the production of primary as well as secondary paranoid symptomatology.

Sensory deprivation has long been associated with paraphrenia (e.g., Herbert & Jacobson, 1967), and recent investigation of hearing deficits, both naturally occurring and experimentally induced, have been found respectively by Watt (1985) and Zimbardo, Anderson, and Kabat (1981) to evoke paranoid symptomatology. However, the effects of sensory deficits seem more likely than those of the
physical anomalies and diseases mentioned above to be mediated by psychological factors.

Kendler and Davis (1981) reviewed the genetics and biochemistry of paranoid schizophrenia and other paranoid psychoses, and concluded that paranoid psychosis and schizophrenia bear little genetic resemblance to each other, and both appear to be unrelated to affective disorders; that there may be a genetic component to paranoid disorders, but it is difficult to separate from environmental components; and that brain norepinephrine levels may be higher in paranoid than in nonparanoid schizophrenics, although this is also difficult to determine because schizophrenic patients, and particularly the more disorganized ones, are likely to have been prescribed medications which reduce NE levels. This study has not been superceded. Genetic research is proceeding, however, as exemplified by the finding of Axelsson and Wahlstrom (1984) of various chromosome aberrations in one third of 134 consecutive paranoid patients, as compared with no aberrations in 24 controls.

Investigations of possible epidemiological factors in paranoid disorders, including viruses, season of birth, and autoimmune reactions due to allergies, have produced no notable results (Marinello, 1989).
At this point, perhaps the clearest thing about the psychobiology of paranoid disorders is that it is an area greatly in need of further investigation. Especially nagging questions are raised by the existence of an organic delusional syndrome and particularly psychoactive substance-induced organic mental disorders (DSM-III-R, 1987), which may be differentiated from an acute paranoid disorder only by evidence of its etiology in the use of amphetamines, cannabis, cocaine, hallucinogens, or phencyclidine (PCP). The involvement of amphetamines is particularly interesting: They increase the production of dopamine; high levels of dopamine have been found in schizophrenia; and drugs commonly used in the treatment of schizophrenia, the phenothiazines, decrease levels of dopamine (Greene & Costain, 1981). Further, norepinephrine, described by Kendler and Davis (1981) as possibly being present at higher brain levels in paranoid than in nonparanoid schizophrenics, is synthesized from dopamine as part of a physiological reaction to an emergency.

While amphetamine intoxication may serve as a model of organic delusional disorder, however, delusional (paranoid) disorder has no known organic etiology, and is a chronic rather than an acute disorder. Further, even acute paranoid disorder, as described in DSM-III (1980), has no known organic etiology. There is also a further and profound
difficulty in using a strictly organic model of a mental disorder: The biological viewpoint is essentially a deterministic one, in which persons are seen as being acted upon, even though they may have chosen to take the drugs that act upon them; but from the mainstream psychotherapeutic viewpoint, persons are seen as being active agents in the determination of their mental states, and a psychobiologic model of a mental disorder must allow for this.

Thus, the two divergent approaches to mental disorders, the physiological and the psychological, which were discussed earlier in this chapter as beginning in ancient Greek thought and continuing through the dualism of later Western thought, are still with us today; and the problems of the body-mind relationship, and the existence and nature of the human will, remain unsolved--and, indeed, largely ignored since the time of William James (1892, 1902). Nevertheless, they are of basic importance, underlying both the theory and practice of psychology.

However, while there may be no psychobiologic model of paranoia based on biological etiological factors of the disorder, there is a model which describes the disorder in biological terms. It is the one suggested by Colby (1975) and much more fully developed by Marinello (1989): Paranoia is described as the maintenance of a physiological emergency state, involving the formation of delusions,
although the origins of the state are seen as primarily psychological. Although Marinello did not classify his theory in any particular way except as a new theoretical framework for identifying factors in the development, operation, and maintenance of a paranoid state, it might be seen as providing a psychomatic model of paranoia, while the studies previously discussed in this section represent the search for a "somatopsychic" model.

In tracing the origins of paranoia, Marinello took a developmental perspective, making use of Haynes' (1986) behavioral model as well as Piagetian theory. He hypothesized that failure to have needs met in infancy are perceived as threats to biological survival, evoke an emergency state with the production of adrenaline and norepinephrine, and lead to superstitious associations; one or more calamitous threats in early childhood also produce feelings of powerlessness and panic, and are followed by struggles to secure power, involving anger, the focusing of attention, and the formation of schemata in which power and invulnerability are secured; the emergency state and self-reassuring schemata are then maintained as responses to external stress. It may be noted here that Wolowitz (1969) and others also suggested childhood struggles for power as factors in the development of paranoia.

Marinello accurately described his theory or model as more integrated and comprehensive than previous theories,
but also pointed out that it was only a beginning attempt. Particularly problematical are Marinello's dismissal of differentiations among kinds of paranoid disorders as unreliable, and his decision not to differentiate among kinds of delusions, with a resultant loss of accumulated information.

Among implications for therapy, Marinello recommended that the therapist present himself to the paranoid person as a powerful friend, granting favors and entering the delusional system, although he may later find it necessary to show force and have the patient sent to a jail or hospital, or injected with phenothiazine as an alternative to hospitalization. Such recommendations are, of course, controversial.

Among implications for research, Marinello recommended the investigation of emergency chemicals in the body, cognitive learning styles, critical pubescent experiences, including winning the Oedipal experience, and the investigation of all these in paranoid persons, cocaine and other drug addicts, and persons engaged in self-induced emergency states [sensation seekers].

Like the psychodynamic and the behavioral models, Marinello's model takes a developmental approach, but the main focus is physiological.
Overall, these recent attempts to develop psychobiologic models of paranoia may be seen as contributions to a holistic approach to the disorder; and, like the cognitive models, they should generate further investigation, using pertinent ongoing advances in psychobiology and technology.

The Sociological Model

A sociological model of paranoia may be derived from two independent sources. Yeh (1972) cited case histories of 29 Chinese students in the United States who had experienced paranoid breakdowns, concluding that their breakdowns had been precipitated by problems of living in a strange culture, fearing failure, and experiencing sexual and other frustration; most of the students, however, had had serious psychological problems before coming to the United States, and had lived under a government which instilled fear.

A sociological viewpoint of paranoia was more recently and more directly articulated by Mirowsky and Ross (1983), based on a community mental health survey of 463 residents of El Paso, Texas, and Juarez, Mexico. Noting that little is known about sociodemographic variables in paranoia, they defined the disorder as alienation from others that has developed into a sense of persecution, fostered by powerlessness, threats of victimization and exploitation,
and the mistrust of others that these produce. Their research showed that belief in external control was associated with low SES, Mexican ethnicity, and being female; and this belief in part produces mistrust, which is directly associated with paranoia.

Mirowsky (1985) qualified his earlier hypotheses by saying that paranoid beliefs may also develop if a person is normally suspicious; he then linked paranoid beliefs to thought problems and schizophreniform hallucinations and delusions. Using the same data as in the earlier paper, he showed that paranoid beliefs are most likely to develop in persons with thought problems and schizophreniform symptomatology who live under threatening social conditions. In other words, he added a personal vulnerability variable to the situational variable in the development of paranoia.

Overall, the development of a sociological model of paranoia adds another important dimension to the understanding of the disorder, and, like the cognitive and psychobiologic models, suggests new directions for research.

However, the sociological model could undoubtedly be augmented by hypotheses and findings in community psychology research which are not directly concerned with paranoia or, in fact, with other mental disorders per se. For example, contributing factors to mental disorders in
general and paranoia in particular could be examined according to Bronfenbrenner's (1979) theoretical divisions of the ecology of human development into meso-, exo-, and macrosystems; the results could be both comprehensive and suggestive of specific points for intervention.

An example of the use of Bronfenbrenner's framework in producing specific findings and recommendations is O'Donnell's (1980) research on the relationship of environmental design and psychological problems; and an example of the possible application of such research to paranoia in particular may be found in Katovsky's (1982) observation that group density affects paranoid behaviors.

**Cross-Cultural Models**

Although cross-cultural perspectives in psychology have tended to be conspicuous by their absence, as critics of psychological testing especially have pointed out in recent years, a cross-cultural model of paranoia was proposed as early as 1932, by Reo Fortune, a psychologist who lived for four months with the Dobuans on an island off the coast of Papua, New Guinea (Torrey, 1981). Fortune described the Dobuans as jealous, dishonest, and fearful; and Ruth Benedict (1934) quoted his conclusions in her *Patterns of Culture*, thus making the Dobuans internationally infamous as an example of a paranoid society. However, Margaret Mead, the anthropologist who married Fortune, later
Just because you're paranoid doesn't mean that they're not out to get you.

--Anonymous
described Fortune himself as paranoid. In an effort to
evaluate the various reports, Torrey and colleagues
(Torrey, 1981) examined the records of all psychiatric
patients in Papua over a 14-year period, and found only
three Dobuans among them, none of whom was described in the
records as paranoid.

These reports on the Dobuans illustrate several kinds
of ongoing problems in the development of cross-cultural
models, including the use of the terms and concepts of one
culture in studying another culture; the design of research
projects and assessment instruments; the risks of using
secondary sources; the need for corrections to personal
biases; and the validity of considering an entire society
to be pathological, while nonpathological exceptions may be
literally abnormal.

However, in the half-century that has elapsed since the
publication of Patterns of Culture, anthropologists have
produced many careful studies of such patterns, including
patterns of psychopathology, which are described primarily
in terms of the culture in which they are found; an example
of this is in Spiro's (1967) book on supernaturalism in
Burma, where all mental disorders are attributed to
supernatural causes. Many advances have also been made by
cross-cultural psychologists in the comparative study of
psychopathology and in the development of its methodology,
particularly during the last three decades (e.g., Marsella, 1979; Marsellias & White, 1982).

While a cross-cultural model of paranoia has not yet been specified, Swanson, Bohnert, and Smith (1970) have listed a number of delusional and violent syndromes recognized in nonWestern cultures. These include amok, a syndrome found usually in Malaysian men, in which withdrawal and brooding are followed by murderous attacks on bystanders; whitico (wihtigo, windigo), a disorder found among Cree Eskimos in the Hudson's Bay area, and the Ojibwa and Salteaux Indians, which begins with gastrointestinal symptoms and fear of being turned into a "whitico" or ice-monster who eats humans, proceeds to a conviction that this has happened, and is sometimes followed by cannibalistic attacks on other members of the tribe; voodoo death, in which a person told that he is being prayed to death proceeds to die; and susto, a syndrome experienced usually by children and adolescents, which may follow a traumatic experience and includes a conviction that the soul has been lost.

To what extent these syndromes may represent cultural variations of paranoid disorders remains to be determined. However, Westermeyer (1988) has reviewed reports of delusions found in various disorders in nonWestern cultures, and concluded that delusional structure, such as grandiosity, does not vary across cultures, though content
may vary. This suggests that paranoid disorders may be universal phenomena, despite variations in nomenclature and specific behaviors.

Differences in approaches to paranoid disorders also exist among Western nations. A recent example of this is in a survey by Swanson and Swanson (1986) of Russian-language publications during the preceding 10 years, which showed that Soviet investigators gave almost exclusive attention to the phenomenology of paranoid disorders, their genetic, biochemical, immunological, and cerebral-electrical correlates, and their pharmacological treatment. They also refused to comment on the charge that Soviet dissidents had been confined to hospitals as paranoid. The situation may have changed radically following Gorbachev's political reforms, however, and a new study would seem in order. In fact, a paper published by Lomov and Tarabrina (1988), members of the U.S.S.R. Academy of Sciences, Institute of Psychology, in Moscow, may serve as a straw in the wind: It recommends closer cooperation between psychologists and physicians not only in practical tasks but in matters of social responsibility.

Another variation of cross-cultural studies, and undoubtedly the kind most frequently conducted, is that of subcultural groups within the United States, using standard American psychiatric criteria and
psychological methodology. An example of such a study pertaining to paranoid disorders is Westmeyer's (1989) longitudinal study of Hmong refugees, which assessed war and migration as risk factors in the development of these disorders, and described treatment and outcome.

Although no cross-cultural model of paranoia has yet clearly emerged from these various investigations, Torrey has stated that there are general beliefs among anthropologists and psychiatrists that distrust and suspiciousness are comparatively common attitudes in some cultures, and that these, along with authoritarian family structures, may be factors in the development of paranoid disorders. Other factors may be inferred from Torrey's report of studies which indicate that paranoid schizophrenia has increased in frequency in this century, that it occurs more frequently among the more educated, and that it occurs less frequently in underdeveloped societies; however, as Torrey also notes, these findings are contradicted by findings elsewhere in the literature.

Overall, while a cross-cultural model of paranoia must be tentative, it can contribute to the understanding of the disorder and related disorders not only in other cultures but in comparison and contrast to our own; and it can be used as a source for research hypotheses.
The seven models of paranoia presented in this section, as noted at the beginning of it, and as summarized in Table 2, represent major approaches to psychopathology: The psychiatric, psychodynamic, behavioral, cognitive, psychobiologic, sociological, and cross-cultural approaches. A developmental approach has not been specified as all of the models include developmental perspectives. Unusual psychological approaches, such as Lux's (1976) mystical-occult approach, have also not been included.

In regard to mainstream approaches, however, it may have been observed that no "third force" or humanistic approach has been included; this is because, as Mahrer (1978) made clear, the humanistic approach has specifically rejected psychiatric categories, including paranoia, agreeing with Szasz (1974) that such categories are constructs with little or no correspondence to reality. Nevertheless, it may be argued that the human mind inevitably differentiates and categorizes upon receiving information, as described earlier; and so the continual revision of established categories may be seen as preferable to their abolition. Indeed, as Lorr (1986) has pointed out, it is the use of a classification system for behavioral disorders that makes possible advances in theory, communication among professionals, prediction,
Table 2.
Summary of Models of Paranoid (Delusional) Disorders

<table>
<thead>
<tr>
<th>Psychiatric</th>
<th>Systematized delusions of persecution, jealousy, grandeur, or eroticism</th>
<th>Personal peculiarities causing difficulties in community life; be self-consciousness cannot be changed</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Kraepelin, 1896-1912)</td>
<td></td>
<td>Chronic,</td>
</tr>
<tr>
<td>(DSM-III-R, 1987)</td>
<td>Nonbizarre delusions; impaired social and marital functioning; occasional aggression and violence</td>
<td>Immigration, emigration, deafness, severe stress, low SES, respond personality disorders to drug</td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>Persecutory delusions as self-defensive projections; narcissism</td>
<td>Subconscious homosexual conflict; but</td>
</tr>
<tr>
<td>(Freud, 1896-1933)</td>
<td></td>
<td>May recur</td>
</tr>
<tr>
<td>(Meissner, 1981)</td>
<td>Pathological introjection and projection; belief and value constructs</td>
<td>Internalization of hostile interactions to off/with parents or significant others</td>
</tr>
<tr>
<td>Behavioral</td>
<td>Behavior patterns from current and historical which may be inferred social learning;</td>
<td>Chronic,</td>
</tr>
<tr>
<td>(Haynes, 1986)</td>
<td>rigid delusions of reference, centrality, testing, grandeur, or persecution</td>
<td>lack of reality</td>
</tr>
<tr>
<td>Cognitive</td>
<td>Processes involved in perceiving statements as malevolent rather than benevolent or neutral</td>
<td>Shame and humiliation; Depends severe assaults on self-esteem; isolation, false arrest, failure</td>
</tr>
<tr>
<td>(Colby, 1975)</td>
<td></td>
<td>chronic</td>
</tr>
<tr>
<td>(Magaro, 1981)</td>
<td>Biased information processing; delusions; high levels of suspiciousness</td>
<td>Failure to integrate perceptions and conceptions society</td>
</tr>
<tr>
<td>Psychobiologic</td>
<td>Neurological impulse transmission from the 1st signal system to the 2nd in paranoia</td>
<td>Abnormal tendency to elaborate the conditioned response; abnormal stability of the response</td>
</tr>
<tr>
<td>(Pavlov, 1934)</td>
<td></td>
<td>Chronic</td>
</tr>
<tr>
<td>(Marinello, 1989)</td>
<td>Similar physiological reactions in the paranoid and the normal emergency state</td>
<td>Childhood calamities; Chronic superstition; anger; or not; drugs useful</td>
</tr>
</tbody>
</table>
Table 2. (Continued) Summary of Models of Paranoid (Delusional) Disorders

<table>
<thead>
<tr>
<th>Sociological</th>
<th>Paranoia as a sense of social alienation, beyond separation to persecution</th>
<th>Belief in external control; threat of victimization; mistrust, suspicion, climate of suspicion</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Mirowsky &amp; Ross, 1983)</td>
<td></td>
<td>Chronic, likely to worsen</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cross-Cultural</th>
<th>Mistrust and suspiciousness as cultural norms</th>
<th>Authoritarianism; child-rearing practices</th>
<th>Chronic, adapts to society</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Torrey, 1981)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Note: Torrey does not promote this model but reports on the debate.)
measurement, criteria for decision-making, and record-keeping.

As was also noted at the beginning of this section, while the models of paranoia presented may be seen as contrasting, they need not be seen as contradictory. An effort will be made in Chapter IV to bring them together in a holistic model of paranoia, and in derived models of other paranoid (delusional) disorders.

Issues in the Literature on Paranoia and Related Disorder

It has been apparent throughout the preceding history of the concept of paranoia, and the discussion of models of the disorder, that unresolved issues abound in the literature, and that they are all more or less directly related to the basic issue of the conceptualization of the disorder and of related disorders. Issues previously discussed in their historical context will now be reviewed, along with other issues of current concern, organized according to the traditional areas of interest to which the issues pertain: Classification, including nomenclature, types and subtypes, and related disorders; diagnosis and assessment; epidemiology; etiology; course and prognosis; and treatment and prevention.
Classification. Issues in regard to the classification of paranoid and related disorders remain of fundamental importance, as classification is based directly on conceptualization, and is a major determinant of the directions which research and treatment may take.

The major issue at this point is the replacement of the category of paranoid disorders by the category of delusional disorder in DSM-III-R (1987). Although the change in nomenclature is a fait accompli, and the single-item category of delusional disorder corresponds generally to the paranoid disorder traditionally known simply as paranoia, ICD-9 (1989) continues to use the earlier classification system and nomenclature, and so have various other publications. This requires double referencing, which is not only cumbersome but inaccurate, as the terms paranoia and delusional disorder are not quite equivalent, with paranoia requiring more criteria for diagnosis than the presence of a nonbizarre delusion, and delusional disorder, at least theoretically, admitting nonbizarre delusions of any type. This problem in nomenclature, reflecting deeper problems in conceptualization, and involving problems in regard to delusions per se, as discussed in detail earlier, creates difficulties not only in theory but in research, diagnosis, and treatment.
However, while at least in the United States the DSM series have the effect of law, it may be well to remember that laws are sometimes overturned and often not conformed to; that even when there is conformity to the letter of the law, there may not be to the spirit; and that a further possibility is a kind of civil disobedience. In any case, the paranoid/delusional nomenclature appears to be a major issue.

There are also several issues in classification in regard to types of paranoid disorders or delusional disorder, and these are directly related to the nomenclature issue. The issues in regard to paranoid disorders formerly recognized in the DSM series, and/or consistently recognized in ICD-9 (1989) and other publications, include the DSM-III-R (1987) elimination of acute paranoid disorder and shared paranoid disorder from the paranoid or delusional category; the renaming of the latter to induced psychotic disorder, and its relegation to the catch-all category of psychotic disorders not otherwise classified; and the failure to include paraphrenia in the paranoid or delusional category. These issues are of importance in cross-referencing the literature, and of even more importance in officially diagnosing or rediagnosing persons with long-recognized syndromes.

Issues which may be raised in regard to types of delusional disorder, which are classified in DSM-III-R
(1987) as erotomanic, grandiose, jealous, persecutory, or somatic, include the apparent inappropriateness of the nomenclature for the erotomanic type, which appears to involve delusions of romantic rather than physical love, and the placing of somatic delusions in this category rather than with the somatoform disorders. It should be noted, however, that erotomania has long been recognized as a subtype of paranoia, and though the nomenclature may be inappropriate, for practical purposes it should probably not be changed.

Another set of issues in the classification of paranoid or delusional disorders include questions about the appropriateness of the present classification and nomenclature of paranoid personality and paranoid schizophrenia. In regard to the former, delusions have traditionally been seen as the primary feature of paranoia and other paranoid disorders, and are the only feature required for the diagnosis of delusional disorder; and yet delusions are specifically excluded from paranoid personality. In regard to the latter, and as discussed earlier, recent research (e.g., Kendler, 1982) has shown sufficient significant differences between paranoid and nonparanoid schizophrenics to make their common categorization questionable. The issues of the relationship of paranoia and schizophrenia, and of paranoia and paranoid personality, continue to be lively ones for
the understanding of paranoid or delusional disorders, and their diagnosis and treatment.

Possible solutions to these issues of the classification and nomenclature of paranoid or delusional disorders in the DSM series will be discussed in Chapter III.

**Diagnosis and Assessment.** The major issue in regard to the diagnosis of paranoid or delusional disorders by means of instruments for psychological assessment is the inadequacy of existing instruments. While this may be an issue in the diagnosis of most disorders, it is especially problematical in regard to paranoid disorders. One reason is that paranoid persons, in their defensiveness, are highly resistant to testing as well as treatment, and tend to reveal as little as possible when they are tested; this yields false negatives even when the tests used have built-in lie scales that are adequate for correcting the assessment of other disorders. Another reason is that very few instruments have been developed for the diagnosis of paranoid disorders; and a third related reason is that a comprehensive conceptualization of the disorders that could serve as a basis for devising or revising instruments has not been developed.

Differential diagnosis as well as diagnosis of paranoid disorders has therefore been difficult. Gaines (1987), for
example, using the MDSP (Millon Diagnostic Personality Schedule) and the MOMI (Millon Clinical Multiaxial Inventory) to investigate the relationship between borderline, schizotypal, and paranoid personality disorders in 307 patients, found significant differences between the first two groups, and was able to differentiate schizotypal from paranoid patients, but reported problems in assessing the severity of their disorder in paranoid patients and its overlap with other personality disorders. Gaines attributed this primarily to a lack of consensus in the definition of the disorder, and to the state of the instruments used.

However, Patrick (1988) compared results from testing 103 psychiatric inpatients with the MOMI and the MMPI for schizophrenia, major depression, and paranoid disorders, using criteria listed in DSM-III (1980), and found the MOMI to be more accurate than the MMPI in the diagnosis of schizophrenia and major depression, but less accurate in the diagnosis of paranoia.

Nevertheless, the MMPI paranoia scale has consistently been considered weak (Hathaway, 1956; Greene, 1988) for diagnosing paranoid symptomotology, including ideas of reference, persecution, grandiosity, suspiciousness, interpersonal sensitivity, and rigidity. Persons who give strong clinical impressions of paranoid tendencies, and even some hospitalized paranoid patients, frequently score
in the normal range on the paranoia scale. However, they may also score high on the lie scale. On the other hand, persons who score high on the schizophrenia scale may also score high on the paranoia scale, and a diagnosis of paranoid schizophrenia is likely to be confirmed in clinical interviews and observation (Dinello, 1970). The latest edition of the instrument, MMPI-2 (1989), has retained the same 40 items that were used in the original paranoia scale (1942), with apparently the same results.

It should be noted, however, that Gaines' attribution of problems in instrumental diagnosis to problems in conceptualization applies only indirectly to the MMPI, as it was constructed not on a conceptual but an empirical and correlational basis: Though it may indicate to what extent tested persons agree with diagnosed paranoid persons in their responses to various items, it does not articulate a conceptualization of paranoid disorders or directly test all possible criteria for diagnosis. Interpretations of responses to the items do, however, support various criteria long used in the conceptualization and diagnosis of paranoid disorders, and can be very helpful though not sufficient for diagnosis, particularly as the paranoia scale has rarely yielded false positives.

Potential contributions to the understanding of paranoid disorders through the use of the MMPI should also be noted. The hostility scale developed from the MMPI
(Cook and Medley, 1954), and the paranoid alienation scale developed as a subscale of the hostility scale (Costa, Zonderman, McCrae and Williams, 1988), have been used to predict heart disease (Barefoot, Dahstom, & Williams, 1983; Suarez & Williams, 1989). This suggests the existence of a dimension of paranoia, the psychosomatic, that has been traditionally omitted from studies of this primarily intellectual disorder, and it is a dimension that seems to be important to explore.

Other standard general purpose instruments that have been used in the diagnosis of paranoid disorders include, among objective tests, Cattell and Eber's 16PF (Sixteen Personality Factor Questionnaire), and the WAIS (Wechsler Adult Intelligence Scale); and, among projective tests, the Rorschach, the TAT (Thematic Apperception Test), and the DAP (Draw-a-Person Test), as discussed by Dinello (1970). Results may be summarized as follows: In the 16PF, the factor that relates most closely to paranoid personality is the one comparing tenseness with relaxed attitudes, with paranoid persons tending to score high on tenseness. In the WAIS, paranoid persons typically show above average abilities, particularly on the verbal, information, and vocabulary scales, though there may be wide discrepancies with other scales.
In the Rorschach, paranoid persons show productivity and organizational ability, but tend to reverse figure and ground, give more unusual detail responses than normals, much prefer movement to color, and reveal suspiciousness, fear, and maladjustment in their responses. In the TAT, the paranoid person may reiterate themes of manipulation, moralizing, and problems in sexual identity. Results of the DAP have been unreliable. On the whole, these tests are insufficient for diagnosis, but may contribute to it and to the conceptualization of paranoid disorders.

Instruments developed for the specific purpose of diagnosing or differentially diagnosing paranoid disorders have been very few indeed. Notable among them is the Maine Scale of Paranoid and Nonparanoid Schizophrenia (Magaro, Abrams, and Cantrell 1981), which represents an adaptation of earlier instruments designed to overcome problems in those instruments. It consists of paranoid and nonparanoid subscales, each containing five questions to be answered by the administrator of the test by checking one of five possible answers to each question; each set of answers is arranged in Likert-like fashion from normal to abnormal. The cut-off score for paranoids is 12, and for nonparanoids 10. The scale has been shown to have good test-retest and interrater reliability, and good criterion validity but
less satisfactory construct and concurrent validity. On the whole it shows improvement over earlier scales.

Johnson, Magaro and Stone (1986) have also demonstrated the reliability of the SADS--C (the Schedule for Affective Disorders and Schizophrenia, brief form, change version), when it is used in conjunction with the RDC (the Research Diagnostic Criteria) to rapidly screen people for major psychopathology, and to differentiate among affective disorders and paranoid and nonparanoid schizophrenia. However, no comparable instruments have been developed for diagnosing or differentially diagnosing other paranoid disorders.

As discussed earlier, however, methods have been developed to measure delusions, the most prominent feature of most paranoid disorders as traditionally defined, and the only essential feature of delusional disorder. Recent and comprehensive work has been done in this area by Brett-Jones, Garety, and Hemsley (1987), using a modified form of the Shapiro Personal Questionnaire (Garety, 1985) and selected dimensions of delusions specified by Strauss (1969) and Kendler, Glazer, and Morganstern (1981). In the questionnaire, beliefs are measured on Likert-like scales from 1 to 5, according to the amount of conviction with which they are held, the preoccupation with them, their interference with normal activities, the subject's reaction to hypothetical contradiction of the beliefs, and the
accommodation of the belief to reality. The questionnaire was used in nine single-case studies, and the dimension of conviction was found to be the most reliable and also the best predictor for recovery. Though very promising, the questionnaire remains to be fully tested for reliability and validity, and presumably further modified. And, of course, at issue here is the difference between beliefs and delusions.

There are also other measures for features found in paranoid disorders that could be useful in the diagnosis and conceptualization of these disorders—for example, resentment and aggression as measured in the MMPI; anger as measured by the STAXI (State-Trait Anger Expression Inventory); and fear as measured by the FFS (Fear Survey Schedule). However, the basic need is for the development of instruments specifically and comprehensively designed to diagnose and differentially diagnose paranoid disorders. The various other instruments discussed in this section could then be used for cross-validation.

Overall, it seems obvious that there are major unsolved problems and unresolved issues in regard to the diagnosis and differential diagnosis of paranoid or delusional disorders through the use of instruments for psychological and psychiatric assessment; however, these may also be seen as major opportunities for making contributions to a
neglected area of a neglected major form of psychopathology. And while it is well outside the limits of this dissertation to attempt to develop any such instruments, it is hoped that the holistic reconceptualization of paranoia and other paranoid disorders presented in this dissertation may help to provide a basis for the development of such instruments in the future.

**Epidemiology.** The most prominent issue in regard to the epidemiology of paranoid or delusional disorders is their assumed rarity; and the conceptualization of them as relatively inconsequential has no doubt contributed to their neglect—an exception being paranoid schizophrenia, which has been classified with the much-investigated schizophrenic rather than paranoid disorders. Paranoia was described in **DSM-I** (1952) and **DSM-II** (1965) as "extremely rare," in **DSM-III** (1980) as "thought to be rare," and in **DSM-III-R** (1987), renamed delusional disorder, as having a prevalence of "around 0.03%." Induced psychotic disorder (shared paranoid disorder) also was said to be rare in **DSM-III-R**, while the prevalence of schizophrenia, including the paranoid type, was given in **DSM-III** as between 0.2 and 1% or possibly higher. The prevalence of paranoid personality and other paranoid or related disorders is apparently unknown. **DSM-III** did note, however, that
paranoia involving jealousy may not be rare; and DSM-III-R noted that the prevalence of the erotic type of delusional disorder is sufficient for it to be a source of harassment to public figures.

Several prominent investigators of paranoid disorders, including Cameron (1959) and Munro (1982), have said that these disorders may not be rare. It may also be argued, as discussed earlier, that while paranoid disorders may rarely come to clinical attention, they may be both prominent and widespread on societal levels.

In regard to sex ratios, according to DSM-III-R, more women than men suffer from both delusional disorder and induced psychotic disorder, while according to DSM-III, more men than women suffer from paranoid personality disorder, but the numbers for paranoid schizophrenia appear to be equal. At issue here is what these differences imply about the nature and the relationships of the various disorders.

In regard to other epidemiological data, Swanson, Bohnert, and Smith (1970) reviewed studies done in Scandinavia and the United States, including inspections of hospital admissions records and a study of Japanese immigrants, and found that the incidence of paranoid disorders rose as social class fell and as the economy became depressed, and as urban dwelling and divorce increased. No causal effects were shown, but the value of
epidemiological studies in suggesting causal relationships and in contributing to the resolution of issues was apparent.

Torrey (1981) reviewed studies of paranoid schizophrenia in particular, and found that the epidemiological data was both scarce and poor, and that various results were contradictory; this leaves the following hypotheses as open issues: That paranoid schizophrenia occurs less frequently in developing countries; that some cultures produce large numbers of paranoid persons; that the disorder has increased in frequency during this century; and that paranoid schizophrenics attain higher educational levels than the nonparanoid. Torrey's overall conclusion was that the epidemiology of paranoid schizophrenia was mostly terra incognita.

It would seem appropriate to generalize this conclusion to other paranoid and related disorders, recognizing the potential importance of exploring their epidemiology.

Etiology. The etiology of paranoid disorders, as may have become evident, has been among the most debated issues in regard to these disorders, and has been intimately associated with the conceptualization of them. As discussed in detail earlier, Freud was interested in paranoia throughout his career, and his most influential
publication (1911) on the topic was a study of the self-report of a former judge and president of the Reichstag Senate in Dresden, D. P. Schreber, who had suffered severe paranoid episodes. Freud traced the paranoia to subconscious homosexual conflict beginning in early childhood, exacerbated by disappointment in a same-sex (but not overtly sexual) relationship in adulthood, and characterized by delusional projection. Freud then extrapolated from this one case to other cases of paranoia, convinced that paranoia was primarily a psychosis of defense against homosexual impulses.

While the defensiveness of paranoid persons has been universally recognized, the relationship of paranoid disorders and homosexuality has been unendingly debated. Swanson, Bohnert, and Smith (1970) have presented arguments in detail, showing that Freud's position was accepted and restated by many influential psychoanalysts (e.g., Abraham and Ferenczi), while others developed variations of it, proposing the origin of paranoid disorders in sex-related infantile experiences that were not necessarily homosexual (e.g., Melanie Klein).

Research conducted on Freud's hypothesis has produced contradictory results. In a 1962 study by Planansky and Johnson, for example, no significant relationship was found between sexual difficulties or specifically homosexual concerns and behavior and the severity of paranoid
disorders. On the other hand, Klaf and Davis found in a 1960 study of 150 paranoid schizophrenics and 150 controls that the paranoid patients had seven times more homosexual thoughts than the controls, and had had twice as many homosexual contacts. As Swanson, Bohnert, and Smith (1970) pointed out, however, the more positive studies inferred the presence of homosexuality on religiosity or other presumed evidence of homosexual conflict, and by thus enlarging the scope of criteria were able to find what they were looking for. Another possible explanation for contradictory data is that homosexual tendencies may contribute to a special fraction of cases of paranoia.

Sullivan (1953) took the conciliating position that although homosexuality may be present in paranoid disorders, it is not causal but represents the causal difficulties in interpersonal relationships. These he saw as originating in early experience with authority figures that evoked fear, anxiety, shame, and guilt, with the development of resentment and the viewing of others as enemies. These emotions and attitudes could also be exacerbated by or possibly originate in juvenile experiences of ostracism, disparagement, loss of self-esteem, and self-blame. Other contributions to paranoia—presumably at any time in life, although Sullivan's notes do not specifically say so—might include jealousy, wish-fulfilling fantasies, concealment and social
isolation by choice, a direct or indirect exploitive attitude toward others, and hypochondriacal preoccupations. This interpersonal hostility theory can be seen as having been enlarged by Meissner's (1981) suggestion that even the witnessing of hostile relationships may contribute to the development of paranoia.

In any case, the old issue of the relationship between paranoid disorders and homosexuality remains unsettled, although a cause and effect relationship has not been supported, and little attention has recently been given to the Freudian hypothesis, while various other correlates or causes have been identified or proposed.

Sullivan's emphasis on possible emotional but not primarily sexual origins of paranoid disorders was shared by others, including Adolph Meyer (1906), who, in response to the question of whether paranoia was fundamentally an intellectual or emotional disorder, responded that it might be seen as a circumscribed affect psychosis, beginning with general feelings of maladjustment and proceeding to specific delusions. This association of paranoid with emotional disorders, though the argument was long ago abandoned, has resurfaced as an issue during the past decade (Zigler & Glick, 1984).

Meyer also noted, however, that emotions and intellect cannot be separated but represent aspects of a whole; and
he also recognized that there are biological and sociological as well as psychological contributions to mental disorders. In this holistic approach, as well as elsewhere in his work, as discussed earlier, we may see how far ahead of his time Meyer was: The need for a holistic approach in scientific investigation is a major theoretical issue today (Lincoln & Guba, 1985), and one which this dissertation seeks to support.

Cognitive psychologists, on the other hand, as discussed earlier, have proposed primarily intellectual origins for paranoid disorders, or at least emphasized intellectual processes at work in these disorders. Locascio and Snyder (1975), for example, proposed selective attention to threatening stimuli and field independence as factors in the etiology of paranoid behaviors. In a more extensive work, Colby (1975), as part of a training program for clinicians, devised a computer simulation of the process of arriving at delusions of persecution through negatively biased perceptions; however, he based his model on a theory that paranoia represents an effort to avoid shame and humiliation—in other words, he implied emotional origins for the intellectual process, as a kind of deus ex machina.

Magaro (1981), however, who is perhaps the foremost researcher in this area, has consistently viewed the paranoid process as an intellectual one, in which the
paranoid person does "backward" processing from concept to perception, which results in or reinforces erroneous concepts or delusions. Magaro has attributed this to the failure in early mental development to balance perceptions and concepts in a normal way, and has also associated it with hemispheric imbalance. Briefly, then, from the cognitive viewpoint, the etiology of paranoid disorders or at least of their symptomatology lies in biased information processing.

The etiology of biased information processing, however, has been a neglected issue—an intriguing exception being Rust's (1991) proposal that delusions arise when rationality conflicts with the need of the species to survive. This seems important to investigate in view of the basic conflict between self-preservation and the preservation of the species, perhaps particularly as described in terms of the neocortex and the limbic system (MacLean, 1958). Such investigation could also address the issue of links between cognitive and psychobiologic aspects of paranoid disorders.

Behavioral psychologists, in contrast, have been more interested in the immediate antecedents of specific overt behaviors than in the original causes of clusters of primarily covert behaviors which have been labeled as disorders. It is not surprising that it was only in the 1980s that the etiology of paranoid disorders was discussed.
in behavioral terms, when Haynes (1986) proposed specific causal factors in the learning and maintaining of paranoid behaviors. These factors include the following: The early reinforcement, modeling, and prompting of paranoid behaviors; insufficient reinforcement of nonparanoid behaviors; situational control; a history of confirmed suspicions; an insular family; aversive parent-child interactions; exposure to inconsistent behavior chains; nonreinforcement of appropriate social behaviors; the impact of paranoid behaviors on others; the disruption of social feedback systems; and life stressors. Virtually all of these are long-recognized and well-researched behavioral determinants or behavioral patterns, often associated with depressive disorders; the issue is to test them as causal or at least contributional to paranoid disorders, and to determine to what degree they may be so.

In addition to the various possible psychological etiologies of paranoid disorders discussed above, biological and sociological etiologies have also been proposed; they have been, however, fewer in number and less in impact, and all remain as unresolved issues. As discussed previously, Pavlov (1934) proposed abnormal signal transmission as causative; Maher (1974, 1988) proposed primary perceptual disorders leading to attentional defects; Kendler and Davis (1981) found suggestions of genetic and biochemical differences between
paranoid and nonparanoid schizophrenics; Gruzlier (1981), Magaro (1981), and Magaro and Page (1983) implicated hemispheric imbalance; and Colby (1975) briefly alluded to, and Marinello (1989) later elaborated on, paranoia as the arousal state of emergency, thus inferring that this state is part of the causal chain, if not the original cause, of paranoid behaviors.

As discussed in detail earlier, paranoid behaviors have also been observed in various physical illnesses, in sensory deprivation, and in various kinds of intoxication; but in these cases they are secondary symptoms of physical disorders. However, the investigation of them could reveal neuropsychological correlates of paranoid disorders.

Proposals for sociological etiologies of paranoid disorders have been few but important. Yeh (1972) attributed paranoid breakdown in 29 Chinese students living abroad to situational and interpersonal difficulties, particularly failure or the threat of failure, and frustration. Most of the students, however, had a history of serious psychological problems involving family relationships, had lived under a dictatorship, and had been unprepared for living in Western society.

More recently, Mirowsky and Ross (1983) attributed the mistrust and sense of persecution characteristic of paranoia to a belief in external control, fostered by powerlessness and threats of victimization and
exploitation. The authors offered as evidence the results of community surveys made in El Paso, Texas, and Juarez, Mexico, in which belief in external control was significantly correlated with low SES, Mexican ethnicity, and being female. Subsequently, however, Mirowsky (1985) added personal vulnerability to the risk factors. The relationship of sociological and personal risk factors also found to be important in Westmeyer's (1989) study of Hmong immigrants in the United States.

Similarly, etiologies of paranoid disorders have been proposed as including cultural patterns and norms found in various societies. However, the equating of disorders across cultures is fraught with problems (Marsella, 1979; Torrey, 1981); and so the issue remains both open and challenging for investigation in the future.

Although sociological and cultural contributions to paranoid disorders have thus far received little attention in the literature, they nevertheless have been recognized as important. This is indicated in DSM-III-R (1987), which does not refer to etiologies but to predisposing factors for disorders: Foremost among those listed for delusional disorder are immigration and emigration, followed by deafness and other severe stresses, with personality disorders mentioned as possibilities. The time for major attention to issues in cross-cultural and community psychology may well be at hand, perhaps particularly in
Although the etiology of most functional psychiatric disorders remains indeterminate, there is one deficiency common to most disorders. From the schizophrenics to the depressions, from the hysterias to the obsessions, the deprivation of simple human acceptance is found in nearly every history. To be regularly—and individually—friendless, discounted, degraded, and humiliated is a psychosocial experience with which few humans can cope for a long time.

--J. C. Glidewell
_A Social Psychology of Mental Health_ (1972)
regard to the etiology of paranoid and other disorders of serious consequence to society.

Course and prognosis. Issues in regard to the course and prognosis of paranoid disorders have been few and little disputed in the literature. Kahlbaum, in his prototype of the modern classification system of mental disorders, published in 1863, described paranoia as following a deteriorating course and being incurable; but Kraepelin contradicted this at various places in the eight editions of his textbook, published between 1896 and 1927, saying that paranoia did not follow a deteriorating course, that there were several forms of paranoia, and that some of these were curable. This view has generally prevailed, although some investigators (e.g., Ritzler, 1981) have noted that paranoid schizophrenia in a minority of cases may deteriorate into nonparanoid schizophrenia, for reasons that are not clear.

Beyond the prognosis of no deterioration for most paranoid schizophrenics, however, as Ritzler also pointed out, their prognosis appears to be good for a return to social and professional functioning after hospitalization, in line with their usually good premorbid functioning and their comparatively short stays in hospitals, though this depends also on favorable marital and socioeconomic status. Nevertheless, the prognosis for complete remission
of symptoms is poor, and includes a risk of repeated hospitalization.

Comparatively recent follow-up studies appear to confirm these conclusions. A 5-26 year follow-up of 71 psychotic paranoid patients by Refsum, Zivanovic, and Astrup (1983) showed that 18 of the patients were still seen as chronic, but only 1 had required prolonged hospitalization; most long-term outcomes were described as benign. A 22-37 year follow-up of 125 paranoid patients by Opjordsmoen (1986) showed that their symptoms had slightly worsened, but outcomes were more favorable than for schizophrenic patients; and a further study of the same group (Opjordsmoen, 1987) showed that outcome was most favorable in acute paranoid cases. Opjordsmoen and Retterstol (1987) also compared the course and outcome of hypochondriacal delusions for 15 paranoid, depressed, and schizophrenic patients after 23-39 years, and found that while prognosis was best for the depressed, it was better for paranoid than schizophrenic patients. And in a study of the course and outcome of delusional jealousy after 3-27 years, Opjordsmoen and Retterstol (1990) found that 11 of 18 patients had recovered.

More studies similar to the Scandinavian are needed, however, as are studies to address such issues as why some persons deteriorate while most do not, how social recovery may take place although symptoms persist, what may trigger
relapse, how full recovery is ascertained, and to what extent, as Pandeleon, Fruittiso, and Cuchet (1981) suggested, an acute paranoid episode may be useful in a person's life.

Treatment and prevention. Investigators of paranoid disorders seem to invariably agree that these disorders are extremely difficult to treat. Because of the very nature of the disorders, persons suffering from them are unlikely to seek treatment or to cooperate if they are brought to treatment, and may, in fact, attempt to avoid a paranoid diagnosis by falsifying their responses, as noted earlier in regard to assessment. Swanson, Bohnert, and Smith (1970) recommended direct confrontation of the severely paranoid person by members of his or her family, with insistence on hospitalization; they noted, however, that psychosurgery, insulin coma, and electroconvulsive therapy had had little or no effect on such patients, and that pharmacotherapy has had limited effectiveness. They further cautioned that to be effective, psychotherapy must be prolonged, and that the therapist must be nonthreatening but nevertheless must challenge the patient's delusions.

However, Munro (1982) suggested that paranoid disorders may not be as difficult to treat as has previously been assumed. More recently, Munro (1988) reported that daily doses of 4-6 mg. of pimozide offer specific and effective treatment for the somatic type of delusional disorder, and
possibly for erotomanic and jealous types as well; however, the treatment may have to be continued indefinitely to prevent relapse. Munro also said that [other] neuroleptic drugs may be effective in treating paraphrenia and paranoid schizophrenia, but that their effects are not specific. However, Ritzler (1981) summarized findings from the previous ten years which indicated that the phenothiazines—which are the most widely used neuroleptics—may help to overcome general withdrawal in paranoid patients, but leave the paranoid symptoms per se intact.

Heinrichs (1988) has maintained that neuroleptics are not selectively or specifically antidelusional, and that they do not differ significantly from each other in their antidelusional effects, although they may be useful in treating acute psychotic episodes. However, in the same volume as Heinrichs' chapter, Hendrie, Dunlop, and El-Khalili (1988), citing studies by Munro and others, concluded that pimozide may be a specific and effective treatment for monosymptomatic hypochondriacal psychosis, especially in patients who present with delusions of parasitosis, and that it may also be effective in the treatment of other paranoid disorders. They also concluded that [other] neuroleptics are effective in the treatment of paraphrenia. Overall, the pharmacological treatment of paranoid and delusional disorders shows limited success.
In addition, possible side effects, as described in the PDR (Physicians Desk Reference, 1990), must be evaluated: All neuroleptics put patients at risk for tardive dyskinesia; and pimozide also puts patients at risk for ventricular arrhythmia, liver and kidney problems, and possibly tumor formation.

Various psychological treatments for paranoid disorders have also been reported. Most of these, however, as Ritzler (1981) pointed out, have been flawed in regard to controls, criteria, hypotheses, procedures, statistical analyses, or conclusions. In fact, Ritzler cited only two controlled studies of the use of individual psychotherapy: A 1969 study by Frost, who concluded that paraphrenia patients were more motivated to achieve self-awareness than paranoid schizophrenics; and a 1976 study by Levy, who concluded that therapists working with paranoid patients should limit their own self-expression, especially early in therapy, and should also not make impersonal demands on the patient to be highly self-disclosing. Ritzler also, however, cited numerous case studies which claimed that psychoanalytic techniques, reality therapy, family therapy, short-term art therapy, and hypnosis with direct suggestion all have been at least to some extent effective in treating some persons with paranoid disorders. More specifically, Ritzler cited instances of the partially successful use of behavioral techniques such as token economies, other
reinforcements suitable to individual cases, systematic desensitization, social skills and assertiveness training, self-monitoring, guided participation, and role-playing.

Other specific techniques have been reported elsewhere in the literature as having been used with some success in treating paranoid persons. Of particular interest is a study of confrontation vs. belief modification, by Milton, Patwa, and Hafner (1978); as Hendrie, Dunlop, and El-Khalili (1988) have pointed out, both psychodynamic and behavioral therapists differ within their own groups as to which of these techniques is more effective. In their study, Milton, Patwa, and Hafner (1978) exposed 7 of 14 patients with long-term systematized delusions to confrontation by an authority figure, while the other 7 were engaged in a belief modification procedure in which they were asked to develop alternate explanations for their beliefs, beginning with the beliefs which they held with the least conviction. After five therapy sessions, all of the patients showed decreases in the strength of their beliefs; after six weeks, however, only the seven who had received the belief modification treatment showed continued decreases in the strength of their beliefs, while three of the other seven showed no reduction, and four showed increases.

Other techniques reported as more or less successful in the treatment of paranoid disorders have included an
initial agreement about laws to which both therapist and patients were held, while maintaining physical distance (Pellet, Berger, Lang, & Allary, 1979); therapy by telephone for persons resistant to appearing in person (Ranan & Blodgett, 1983); and increasing the patient's awareness of the possible consequences of delusional speech and action, and of the possibility of self-control, while educating significant others in the patient's life about the patient's delusions and ways to cope with them (Heinrichs, 1988). The use of relaxation has also been attempted, but without success (Philibert & Baumstimmer, 1977).

General approaches to the treatment of paranoid disorders, as well as specific techniques, have been proposed as parts of major models of the disorders which were described earlier. Most notably, Haynes (1986) stressed the importance of careful behavioral assessment and individually designed intervention programs; and Magaro (1981) recommended the assignment of specific cognitive tasks which increase attention to stimuli, discrimination of similarities and differences, the integration of perceptual and conceptual processes, and the generation of multiple hypotheses.

Implications for the treatment of paranoid disorders may also be found elsewhere in the literature. An outstanding example of this is offered by Rachman's (1983)
attempt to bring together findings in cognitive research and treatment approaches to the changing of irrational thinking, including delusional thinking; specified among the treatment approaches were Ellis's (1973) rational-emotive therapy, Beck's (1976) cognitive therapy, and Meichenbaum's (1977) cognitive-behavior modification. Rachman reviewed both research findings and treatment theories, and recommended that cognitive therapists should recognize that there are limits to rational forms of therapy, since all persons regularly commit cognitive errors, irrational cognitions appear to be the result rather than the cause of emotional disturbances, and emotion affects both judgment and memory.

In regard to the treatment of paranoid disorders, then, it appears that both a few pharmacological and a variety of psychological treatments may help to return the paranoid patient to social functioning; but as most therapists have noted, eliminating paranoid symptomatology is exceedingly difficult. The issues seem to be to determine what the effective elements have been in various treatments that have been at all successful in alleviating various paranoid or delusional features in particular kinds of patients, over specified periods of time; to attempt to determine why other treatments have not been successful; and to develop old or devise new treatments. In other words, there is a
need to conduct a meta-analysis of treatments for paranoid and delusional disorders, taking into account diagnostic, treatment, and patient variables, reporting negative as well as positive results, and making recommendations for future treatment on the basis of these results.

Given the difficulty of bringing paranoid persons to treatment, however, it would appear that the only largely effective intervention would be the primary one of prevention. Unfortunately, the literature contains few direct suggestions about the prevention of paranoid disorders— one already noted being Colby's (1975) admonition that children should never be subjected to shaming or humiliation. Nevertheless, various inferences can be drawn from the literature: For example, psychodynamic, behavioral, and cognitive theory all propose that very early experience or learning or ways of thinking may predispose the child to delusional thinking; thus it may be inferred that intervention should also begin when any such tendencies are noticed. The issue in this case would be how to make caregivers aware of such tendencies and the need to ameliorate them. In addition, psychobiological theory provides for constitutional factors which may predispose to paranoid disorders, and caregivers need to be aware of these also. Finally, cultural, sociological, and stress theories point to the part played in the evoking of paranoid behaviors by hostile cultural
attitudes and environmental conditions, and stressful personal or public events or situations. The issue here is how to help prevent paranoid disorders through social reforms, as well as by increasing prosocial individual skills for coping with stress.

Among ways of enabling caregivers and other persons in positions of responsibility to intervene in the development of paranoid disorders, whether in young children or other populations at risk for such development, is to make more information available about these disorders, and at the same time correct erroneous impressions about them that may be held by professionals as well as by lay persons. Although such information is widely available about the two other major disorders, schizophrenia and depression, and also about many other disorders, including alcoholism, anorexia, panic, phobia, and PTSD, virtually no information about paranoid disorders has been published for non-specialists--despite the fact that these disorders may have profound impact on society, or perhaps because this impact has not been widely recognized. Another reason for the general unavailability of information about the paranoid disorders, undoubtedly, is that far less information exists than about the other disorders mentioned, and much of what does exist is very difficult to evaluate and present coherently. It is hoped that this dissertation will help to integrate existing information,
to increase awareness about the nature and significance of paranoid disorders, and therefore to generate more research and resultant publications in both professional and lay literatures.

Regardless of how little or how much attention the paranoid disorders may receive, however, the goal of both their treatment and prevention may be defined in terms of Sulzman's (1974) goal in the treatment of personality disorders: It is to enable persons to relate to others without serious perceptual or conceptual distortions. In other words, it is to help people have less biased views of themselves and each other, and so develop mutually beneficial rather than antagonistic relationships.

The long past, if short history, of the concept of paranoia and related disorders has now been traced; and current models of these disorders, and unresolved related issues, have been presented. In the following chapters, there will be an attempt to develop the conceptualization of these disorders into a comprehensive model, and thus facilitate the addressing of the issues.
The need for a reconceptualization of paranoia was discussed in the first chapter of this dissertation, and became increasingly evident in the second chapter, in detailed discussions of the disputatious history of the concept, the divergent models of the disorder, and the numerous issues to be found in the literature.

This need is especially evident in DSM-III-R (1987), in which the earlier nomenclature and concepts of paranoia and paranoid disorders were replaced by the nomenclature and unidimensional concept of delusional disorder. Although designed to dispose of earlier problems, these changes have led to additional problems in diagnosis, in cross-referencing the literature, and in determining directions for treatment and research. The changes are also of concern to other disciplines, particularly political science, because the concept of paranoia has proven to be a highly useful one.

This chapter, therefore, will address problems found in DSM-III-R and elsewhere in the literature involving delusional and paranoid disorders, and it will propose changes in the official classification system.
We must seriously consider how far the phenomena on which we normally base our diagnosis really do afford insight into the basic pathological process. While it may be admitted that this procedure is generally valuable, there is a fairly extensive area in which such distinguishing criteria are lacking: either they're insufficiently well-marked or they are unreliable.

--Emil Kraepelin
Manic-Depressive Insanity and Paranoia (1921)
The Place of Paranoia Among the Disorders

The Historical and Present Position of the Concept of Paranoia

First of all, this dissertation proposes that paranoia should be retained as a major concept in psychopathology, and should be restored to the DSM series. It further proposes specific ways of revising and developing the concept; these will be discussed in this chapter and in the following one.

In the foregoing history of the concept of paranoia, arguments have been presented for the identification of the disorder as a subtype of schizophrenia (most notably by Bleuler, 1911/1950); as a subtype of depression (most recently by Zigler and Glick, 1984); and as a dying or confusing construct, and therefore best abandoned (Lewis, 1970; Winokur, 1977). Nevertheless, Kraepelin's (1896/1921) and Freud's (1896-1933/1962) identification of paranoia as a major disorder, distinct from schizophrenia and other disorders, prevailed over Bleuler's views; and paranoid disorders continued to be recognized as distinct entities through the years by outstanding psychiatrists and psychologists, including Meyer (1906a, 1906b, 1921), Sullivan (1953), Cameron (1957, 1970), and Millon (1969,
In particular, investigations conducted by Kendler and his co-workers (1980a, 1980b, 1981, 1982), among others, have established significant differences between paranoid disorders and schizophrenia. Meanwhile, although paranoia has been associated with depression, classification under it has never had more than passing support; and predictions of the imminent decease of the concept of paranoia have not come to pass: Although discarded by DSM-III-R, it continues to survive in ICD-9 and elsewhere in both professional and lay literatures. That it does so may be attributed to the fact that it identifies a pattern of thinking and behaving that has been widely recognized over a very long period of time, and that has not been adequately described by any other name—at least not in the Western cultures which trace their thinking, like the word paranoia itself, to Greek roots.

Description and definition

Since the beginnings of modern psychopathology, as descriptions in Table 1 indicate, the pattern of thinking and behaving called paranoid has involved persistent irrational or delusional thinking in regard to specific self-referential topics; it has also often included strong emotions, usually negative, and serious problems in interpersonal relationships. The descriptions of paranoia in the first three editions of the DSM series (1952, 1968,
1980) were consonant with this consensual historical description, though not fully expressive of it.

The definition of paranoia offered in this dissertation is consonant with all of these: Paranoia is a mental disorder characterized by the presence of persistent nonbizarre delusions of persecutory, grandiose, or other self-referential content, which are not due to other mental or organic disorders. Social and marital functioning may be impaired, while nondelusional intellectual and occupational functioning may be satisfactory. Excessively self-defensive or aggressive and violent behaviors related to the delusions may occur.

This description and definition will serve as a reference point in discussing delusional disorder, and as the core of a comprehensive reconceptualization of paranoia and related disorders.

**Paranoid Disorders vs. Delusional Disorder**

The above definition of paranoia may be extracted from the total description of delusional disorder in DSM-III-R (1987), which includes a definitive statement and detailed descriptions of types of delusions originally identified as paranoid by Kraepelin--erotomanic, grandiose, jealous, and persecutory, of which only the latter two were specified in DSM-III. The category is parenthetically called paranoid, and the introduction to it infers that the change is
nosological rather than substantive. While paranoia might seem to have survived in concept, and even been clarified, the change in the name signals profound changes in the concept: The definitive statement for delusional disorder in DSM-III-R requires only the presence of a persistent nonbizarre delusion for diagnosis, and nonparanoid types of delusions are included as types of the disorder. Further, other disorders formerly classified as paranoid have been reclassified or deleted. Delusional disorder, therefore, is not the same as paranoia or paranoid disorders, but has in fact replaced them in the official classification system.

The Nomenclature of the Disorder

The reason given for changing the name of paranoid disorders to delusional disorder, in the DSM-III-R comparative listing of entries in this and the previous edition of the manual, is that "the ordinary English meaning of the term 'paranoid' suggests only suspiciousness," and that therefore a "more nosologically descriptive term" has been used (p. 420). However, the New Webster's Dictionary of the English Language (1984), presumably the edition available to the decision-makers, does not support that decision according to the reason given: Paranoid is defined as "of, like, or characterized by paranoia," and paranoia is defined as "a mental disorder
characterized chiefly [not solely] by systematized
delusions, especially [not only] of persecution or
grandeur"; suspiciousness is not mentioned. On the other
hand, delusion is defined as "an abnormal phenomenon [not
disorder] whereby a belief is held in the presence of
evidence normally sufficient to destroy it," with the term
delusional given only as the form of the adjective; this
hardly seems more descriptive for a mental disorder than
the term paranoid, at least as defined by Webster.

In addition, while the term paranoid is rejected as
described above for being too limited, it is rejected in
the description of delusional disorder, in the same manual,
for having "multiple other meanings, which can cause
confusion"--although no examples of such meanings or
confusion are offered. However, despite the apparent
contradiction, it may be argued that the term "delusional
disorder" also is at once both too limited and too multiple
in meaning: It identifies a major disorder by a single
feature, and it implies that that feature is unique to the
disorder, while in fact it is prominent in other psychotic
disorders. Although a positive effect of this renaming may
have been to stimulate research on delusions, as the
preceding review of such research indicates, negative
effects may have been to deflect attention from other
features of the disorder, and from the disorder itself:
The presence of delusions per se does not seem like a major
problem, involving suffering or danger to either self or society.

Whatever the reasons for changing the name of the category from paranoid disorders to delusional disorder--including the possibility that changing the name of a major category may be seen as a major contribution to psychopathology, as was Bleuler's (1911/1950) changing of the name of dementia praecox to schizophrenia--the reasons given do not seem to justify this change: The new term seems less rather than more descriptive of a long-recognized disorder. Further, the historical discontinuity increases rather than decreases confusion in the field.

It is proposed, therefore, that the original name of the category, paranoid disorders, be restored; and that paranoia also be restored to its place as the core concept and primary disorder, and defined in full accordance with historical descriptions. Paranoia may be referred to parenthetically as delusional disorder, to provide continuity with DSM-III-R.

Criteria for Diagnosis

Winokur's (1977) declaration that "What [these patients] have is simply a delusion, nothing more, nothing less" (p. 511) apparently provided the basis for the DSM-III-R position that the only essential feature for the
diagnosis of delusional disorder is the presence of persistent nonbizarre delusions. However, this is not only not paranoia according to historical views, and it is not a very reasonable position.

It seems unlikely that the patients diagnosed as paranoid to whom Winokur referred in his paper, and from whom he drew his influential conclusions, had been hospitalized simply because they had delusions—especially as they were also unlikely to have been hospitalized entirely voluntarily, given the suspicious and self-righteous nature of the disorder. Surely overt behavior related to the delusions is essential for such persons even to be in a position to be diagnosed. As Cyril Franks posited in a lecture at the University of Hawaii in 1987, "No one has ever been locked up because he was crazy, but only because he acted crazy."

It is also unreasonable to assume that anyone could have a delusion totally unrelated to other significant cognitive, emotional, motivational, social, or physiological aspects of his or her life. In fact, reductionist thinking such as that which designated a single criterion for the diagnosis of a major disorder is out of line with both theoretical developments in scientific thinking (e.g., Lincoln and Guba, 1985), and with research reports that reveal multiple factors in both the origins and expressions of mental disorders. Indeed,
statistical techniques developed for data analysis, from
multiple regression through canonical correlation and other
advanced techniques, are based on an assumption of multiple
causality and multiple expression.

Research on delusions in particular has shown they are
neither simple nor discrete, and that strong conviction and
emotional commitment appear to be of prime importance in
their assessment, course, and outcome (e.g., Strauss, 1969;
Garety, 1985; Harrow, Rattenbury, & Stoll, 1988). Rachman
(1983) went so far as to suggest that emotion may be
primary in irrational thinking. It appears, therefore,
that not only behavioral but emotional/motivational
factors exhibited by persons with this disorder should be
criteria for the diagnosis of the disorder; however, even
the term "delusional disorder" excludes these factors,
while paranoia includes them.

Furthermore, as noted in a review by Winters and Neale
(1983), delusions are found in virtually all psychoses;
they are among the features of severe disorders, but are
not seen as disorders per se. For example, the first
characteristic symptom of schizophrenia listed in DSM-III-R
is multiple, fragmented, or bizarre delusions; and yet that
disorder is not called delusional disorder, or even bizarre
delusional disorder.

Finally, the definition of delusions in DSM-III-R, as
found in the glossary of technical terms and as inherent in
the description of delusional disorder, has recently been attacked by Spitzer (1990) for being based on a "concept that is all but clear, 'descriptive,' or free of any 'theory'" (p. 381), and which includes inconsistencies and false assumptions. Spitzer particularly attacks the basic assumption in the definition that delusions are necessarily false in content, and points out that they represent perceptions which are true for the person experiencing them; rather, he says, it is the person's refusal to consider disconfirming evidence that is characteristic of the disorder. Spitzer therefore, linking theory with practice, recommends that the therapist attend to the patient's experience, rather than dismiss it.

The use of a single criterion, then—the presence of persistent nonbizarre delusions—for the diagnosis of this major disorder appears to be insufficient, as other features, including characteristic behavioral and emotional/motivational features, are present and prominent in this disorder, and delusions are present and prominent in other disorders; further, the DSM-III-R definition of delusion itself is open to serious question.

It is proposed, therefore, that the essential criteria for paranoia include not only the presence of persistent nonbizarre delusions, but specification of their nature, with implications for the emotional/motivational factors involved; and that the criteria also include overt
behaviors which are problematical in social, marital, or other relationships, such as excessive self-defensiveness, or unjust accusations, harassment, or other kinds of attacks on other persons.

The inclusion of such criteria would be consonant with historical descriptions of the disorder, including those in earlier editions of the DSM series, and with descriptions of types of delusions in DSM-III-R. Specification of such criteria in individual cases would also facilitate the understanding and management of them.

Types of Delusions

Several types of delusional disorder are named in DSM-III-R according to the content traditionally specified for paranoid delusions (erotomanic, grandiose, jealous, and persecutory). Somatic and "unspecifed" delusions, such as those without malevolent content, are also included.

This is inconsistent with the cumulative description and definition of paranoia; the possibility of identifying a common emotional or motivational denominator among the types of delusions to explain their grouping appears to have been lost, and the addition of the other types to the traditional ones seems to serve the purpose of justifying the new nomenclature. This is perhaps especially apparent in the DSM-III-R glossary of technical terms, in which "it is recommended that the term paranoid delusion not be used,
because its meanings are multiple, confusing, and contradictory," and it has been used "to refer to both persecutory and grandiose delusions in the Paranoid Type of Schizophrenia" (p. 396). Examples of multiple, confusing, or contradictory meanings, however, are not given.

The somatic type. Somatic delusions appear to be out of place in a paranoid category, as they are neither self-defensive nor self-aggrandizing like the other types. Their inclusion has also been rejected on other grounds: Kraeplin (1896/1921) noted that while hypochondriacal delusions were frequently expressed by paranoid persons, they appeared to be secondary, and so he abstained from classifying them as a type of paranoid delusion; later clinicians appear to have agreed. Recently, detailed criticism of specific examples of somatic or hypochondriacal delusions listed in DSM-III-R have been made by de Leon, Bott, and Simpson (1989), who concluded, on the basis of both reported research and clinical experience, that these delusions would be better classified as types of somatoform disorders or psychotic disorders not otherwise classified: They fall between biological and psychogenic disorders, and their delusional and nondelusional or hallucinatory forms are impossible to distinguish from each other. They include the following specific somatic delusions/types of somatoform or other psychotic disorders: The belief or perception by the
patient that he or she is emitting foul odors, is infested by insects or parasites, is misshapen or ugly, or has nonfunctioning body parts.

**Other types.** The inclusion of delusions without malevolent content under the "unspecified type" may also be questioned: If certain other delusions are indeed harmless, why are they classified as pathological? In fact, investigators of delusions (e.g., Strauss, 1969; Hemsley & Garety, 1968; Maher, 1988) have agreed that delusions are on a continuum with normal beliefs; clinically, it may be impossible to distinguish between a delusion without malevolent content and a strong normal belief--and it may not be necessary.

Contrariwise, it might be asked why other nonbizarre delusions of reference, such as the delusion of poverty, or delusions of being otherwise doomed to disaster--the former of which is listed in the DSM-III-R glossary of technical terms--are not included among the delusions listed under delusional disorder. It is also curious, and unexplained, that the long-observed systematized nature of paranoid delusions in general is not mentioned in the description of delusional disorder, although systematized delusions are listed in the glossary--and, again, curiously--as if they were a discrete type.

It might also be mentioned that the name of the erotomaniac type of delusional disorder is at present
incongruent with the DSM description of that type, as the word indicates sexual desire, while persons so diagnosed are described as desiring romantic and spiritual relationships. However, it would be confusing to change the traditional term--and it is also possible that later data may confirm the original terminology, in which case the description should be changed.

In any case, the classification of delusions according to topical content needs to be qualified as open to additions and reevaluations, since such content has been found to vary among cultures and subcultures, and over time (Westermeyer, 1988; Mitchell & Vierkant, 1989); nevertheless, the classification of delusions by topical content--particularly erotomanic, grandiose, jealous, and persecutory content--has both historical support and heuristic value, and no doubt will continue.

It is proposed, therefore, that the types of delusions recognized since Kraepelin (1896/1921) as paranoid delusions--erotomanic, grandiose, jealous, and persecutory--should be classified as subtypes of paranoia; however, the somatic type, as listed under delusional disorder, should be carefully reconsidered according to its subtypes for classification in other disorders; and nonmalevolent delusions should be either further specified as psychopathological or deleted from the category.
In addition, other nonbizarre delusions, including those of being imminently reduced to poverty, or doomed to suffer some other major disaster, should be considered for inclusion among types of delusions; and the possibility of other additions to the types of delusions, or reevaluations of types presently recognized, should be noted, particularly in regard to cross-cultural research. Also, the usually systematized nature of paranoid delusions should be noted in the introduction to the category.

Types of Disorders

As noted earlier, not only was the category of delusional disorder used to replace that of paranoia in DSM-III-R, but types of delusions, formerly simply listed under paranoia, were used to replace other paranoid disorders, which then were assigned to other categories or deleted from the classification system.

Shared paranoid disorder. Shared paranoid disorder, defined in DSM-III (1980) as a persecutory delusional system that develops as a result of a close relationship with another person who already has a disorder with persecutory delusions, was renamed induced psychotic disorder in DSM-III-R (1987), although the definition was essentially unchanged; it was then assigned to the category of psychotic disorders not elsewhere classified. The reason given in the comparative listing of the two DSM
editions is that the disorder might involve delusions "without a paranoid content," and that "induced more accurately describes the essence of the disorder" (p. 420).

While the latter change or parenthetical alternative to the name seems reasonable, the reason given for the former change seems less than logical: It uses the term paranoid in reference to delusions, which was discouraged in the glossary, and it uses it with reference to persecutory delusions only, while in the preceding paragraph the term was said to refer to a range of delusions. Regardless of the stated reasons for the change, however, it is consistent with the effort to delete the term paranoid from the official diagnostic system, and to present delusional disorder as a unitary concept.

Munro (1988) used another argument in stating that shared paranoid disorder is not paranoid—that the second person is impressionable rather than deluded. It can be argued in return, however, that the person not only may be but perhaps must be both. It can be also be argued that persistent nonbizarre delusions, whether of persecutory or other self-referential content, are delusions of the types historically identified as paranoid; that, as the literature on folie a deux has shown, they can be shared or induced; that they may be accompanied by strong emotions—particularly when induced by a close relationship
with another person; that they may be expressed in behaviors which will bring the delusional person or persons to clinical attention, and hence require diagnosis; and that therefore in such cases a diagnosis of shared (induced) paranoid disorder would seem to be more accurately descriptive, and more helpfully informative for treatment, than a general and isolated diagnosis such as that of induced psychotic disorder, not elsewhere classified.

Acute paranoid disorder. Another disorder classified among the paranoid disorders in DSM-III, acute paranoid disorder, was said in the comparative listing of the two disorders in DSM-III-R to have been subsumed under psychotic disorders not elsewhere classified. Presumably it was subsumed specifically under brief reactive psychosis, which shares with it such characteristics as sudden onset, stressful precipitating events, brief duration, and good prognosis. It does not, however, share the essential paranoid feature of nonbizarre delusions; delusions of any kind may or may not be present. For this and related reasons, these do not appear to be the same disorder.

While acute paranoid disorder was described as occurring in specific populations, such as immigrants, refugees, prisoners of war, military inductees, or other persons leaving home for the first time, brief reactive
psychosis is described in terms of individuals experiencing events such as the death of a loved one or trauma in combat. While there clearly seems to be overlap in the disorders, the kinds and durations of stressors and of reactions to them may well differ: Persons diagnosed as suffering from acute paranoid disorder, especially in populations known to be at risk, are likely to have been subjected to prolonged or repeated stress in societal situations, and therefore to have developed delusions of persecution or other paranoid delusions; on the other hand, persons diagnosed as suffering from a brief reactive psychosis are described as having experienced sudden and discrete traumatic events, to which they apparently respond quickly and emotionally, without seeking a rational explanation for the events. Acute paranoid disorder, then, would be appropriately classified with other paranoid disorders rather than be subsumed under brief reactive psychosis, while the latter appears to have more in common with PTSD (post-traumatic stress disorder).

However, in the description of delusional disorder itself in DSM-III-R, immigration, emigration, and other severe stresses (unspecified) are listed as predisposing factors, with immigration and emigration heading the list. This information appears to be derived from the DSM-III description of acute paranoid disorder, although other information in that description may have been excluded from
the new category; acute paranoid disorder, therefore, might actually have been subsumed under delusional disorder rather than under brief reactive psychosis. This might seem appropriate, given the presence of delusions of persecution in both disorders. However, because of the previously observed occurrence of acute paranoid disorder with greater than normal frequency among certain populations, and its unusually sudden onset, brief duration, and good prognosis, it seems to be a distinct type of disorder in the delusional or paranoid category; and classifying and describing it as such would provide a relatively benign diagnosis for persons so affected, and encourage and facilitate research in the area.

The importance of such research in addressing community mental health problems has been made evident by investigators such as Yeh (1972), who successfully treated numerous Chinese students who had experienced paranoid breakdowns while studying abroad; Allodi (1982), who cited acute paranoid reactions among student as well as immigrant populations; Mirowsky and Ross (1983), who drew inferences about sociological factors in the development of paranoid disorders from their large-scale study of paranoid ideation among Mexicans in Texas and Mexico; and Westermeyer (1989), who conducted a longitudinal study of paranoid symptoms and disorders among Hmong refugees in America.
The elimination of acute paranoid disorder from 
DSM-III-R, then, gives rise to concerns that are more than 
thoretical and nosological. It seems to deny attention to 
a problem that exists not only in the United States but all 
over the world, in these times when unprecedented numbers 
of persons are migrating, are being separated from their 
families by international, border, or civil warfare and/or 
imprisonment, or are seeking employment or education in 
societies alien to them. Restoring the category of acute 
paranoid disorder to the official diagnostic system would 
seem to be a timely and socially responsible action to 
take.

It must be noted that replacing or discarding earlier 
recognized types of paranoid disorders was not unique to 
DSM-III-R, as Table 3 shows and as Winokur's (1977) 
criticisms indicated. In fact, the only type of paranoid 
disorder consistently included in the first three editions 
of the DSM series was paranoia itself; and, as discussed 
earlier, delusional disorder in the fourth edition of the 
DSM series was said to be essentially equivalent to 
paranoia—although there are important differences. The 
only other agreement across the series was in the last 
three editions, all of which allowed for the recognition of 
"other" or "atypical" or "unspecified" types of these 
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However, DSM-I (1952) also recognized a "paranoid state," which was said to be characterized by paranoid though not highly systematized delusions, and likely to be of relatively short duration; this seems to be what was called acute paranoid disorder in DSM-III (1980), as discussed in the preceding pages. And DSM-II (1968) also recognized an involutional paranoid state, or involutional paraphrenia, described as characterized by delusion formation in the onset of the involutionary period, without the conspicuous thought disorders typical of schizophrenia; this type was omitted, however, from the next two DSM editions. Shared paranoid disorder, as also discussed in the preceding pages, appeared for the first time in DSM-III, but was dropped from among the paranoid or delusional disorders in DSM-III-R (1987)—although it was renamed and reassigned to psychotic disorders not elsewhere classified in DSM-III-R.

It is not difficult to see that such lack of consistency in officially recognizing and describing types of paranoid disorders would inevitably cause problems in diagnosis, treatment, and research, and impede interaction among these activities. This appears to have been especially true of paraphrenia.

Paraphrenia. Paraphrenia has been of considerable concern as a disorder which has been given little or no official recognition. It was identified and named by
Kraepelin, and has received much attention in Europe; but it has been neglected in the United States (Bridge & Wyatt, 1980), despite its increasing importance as the population ages. Even if these things were not true, however, the present lack of official recognition of this disorder would still be a problem: As Munro (1988) has pointed out, there are cases in which delusions are less encapsulated than in paranoia or delusional disorder, but which are less deteriorative than schizophrenia, and which now must "be consigned to Psychotic Disorder NOS...a grab-bag of mixed diagnoses" (p. 399). Furthermore, as Munro also notes, although the disorder has usually been thought of as a disorder of old age, it can also be found in middle-aged or even younger persons; it thus is a disorder of general concern, and should be included in the DSM series.

It is proposed, therefore, that in addition to paranoia per se, types formerly recognized as paranoid in the DSM series, and currently recognized by another name in that series, or having substantial recognition elsewhere in the literature, be included in the category of paranoid disorders. These disorders are: Shared paranoid disorder (induced psychotic disorder), which could also economically be referred to as shared (induced) paranoia; acute paranoid disorder, which could likewise be referred to as acute paranoia; and paraphrenia.
It should be noted, however, that including these types of disorders in the paranoid category would not necessarily mean they would be described as they have been in the past. For example, in DSM-III (1980), shared paranoid disorder was described as equivalent to folie a deux, although "in rare cases" more than two persons might be involved; however, it can be proposed that large groups, including cults or even nations, may be involved in delusional paranoid thinking and other covert or overt paranoid behaviors—a matter which will be discussed in detail in the next few pages. Another example would be including students among the groups described in DSM-III as being particularly susceptible to acute paranoid disorder, as suggested by Allodi's (1982) paper; and a third example would be renaming and revising the description of involutional paranoid state (involutional paraphrenia) in DSM-II (1969) according to descriptions of paraphrenia such as Munro's (1988), thus nullifying the reason given in DSM-III for excluding it—that it was not distinct from other paranoid disorders.

In any case, the inclusion in the category of all types of paranoid disorders that have been widely recognized over the years, and not conclusively shown to be invalid, would prevent not only a loss of information for diagnosis and treatment, but also a loss of impetus for research on omitted though not invalidated types; it would also help
those with allied interests to more easily locate information in a field strewn with abandoned subcategories. Further, it would be consistent with the cumulative approach to the gathering of information which is basic to scientific disciplines, rather than with an isolated and competitive approach which can sometimes be valuable, but which has been overutilized in psychology; and, more specifically, it would be consistent with the notion of a paranoid spectrum of disorders which contributed to theory and research before the publication of DSM-III-R (1987).

The Paranoid Spectrum and the Paranoid Continuum

The fact that a number of disorders share paranoid characteristics as essential features, and yet may be readily distinguished from each other by additional unique characteristics, has been indicated by the names they have been given: Paranoia, paranoid state, paraphrenia, shared paranoid disorder, acute paranoid disorder, paranoid personality disorder, and paranoid schizophrenia. The relationships among these disorders, however, have not been very clear—particularly the relationships of the latter two disorders to the others, as they have always been placed in diagnostic categories other than the paranoid category. Further, the relationships between paranoia and delusional (paranoid) disorder, and between these and
organic delusional syndrome, among other organic disorders or conditions, are of particular contemporary concern. Consequently, the construction of a "paranoid spectrum" to illustrate relationships among various combinations of these disorders has been undertaken by several investigators, including Magaro (1981) and Munro (1982).

Magaro depicted the relationship of paranoid disorders as a cognitive process, which was discussed earlier in detail; he arranged them as progressing from low to high levels of paranoid cognition in the following order: Paranoid personality, paranoid personality disorder, simple delusional disorder, paranoia, acute paranoid disorder, and paranoid schizophrenia. Magaro further depicted the paranoid process as being diametrically opposed to the schizophrenic process, which proceeds from low to high levels in the following syndromes: Schizophrenic personality, schizoid personality disorder, schizophrenia, and disorganized schizophrenia. Magaro used this conception of the paranoid spectrum to differentiate between paranoia and schizophrenia, and particularly to show that paranoid schizophrenia is primarily paranoid, being significantly different from nonparanoid schizophrenia. He supported this position with data from factor analyses of inpatient symptom ratings and from psychodiagnostic tests, including the Rorschach, the WAIS, the behavioral Symptom Rating Scale, and the Maine scale of

Magaro's distinction between paranoid personality and paranoid personality disorder supports his view of paranoia as being on a continuum with normal cognitive processes. However, his distinction between delusional disorder and paranoia is unclear, perhaps because the former was a new concept and the latter was still used in official diagnosis. Also, his ranking of acute paranoid disorder as more pathological than paranoia seems questionable: While persons with acute paranoid disorder may exhibit a stronger tendency toward paranoid thinking at a particular time, by definition they return to normal, whereas persons with paranoia chronically think in paranoid ways (e.g., Ritzler, 1981). Magaro also did not include shared paranoid disorder among the paranoid disorders, although it had already been admitted to the official diagnostic system, along with acute paranoid disorder. And finally, differentiating between paranoid and nonparanoid schizophrenia does not seem in itself to support the classification of paranoid schizophrenia with paranoid rather than schizophrenic disorders.

Munro's (1982) schema of the paranoid spectrum is more inclusive than Magaro's, and also differs from it in several other ways. Munro arranged paranoid disorders according to a traditional view that they are on a continuum from
nondegenerative paranoia to degenerative schizophrenia; the latter he placed outside the paranoid spectrum at one end, with paranoid personality disorder outside the spectrum at the other end. Within the paranoid spectrum he included paranoia, the "midway" disorders of paraphrenia and shared delusional disorder, and paranoid schizophrenia, while he noted that the status of acute paranoid disorder was in doubt. Munro further detailed paranoia as including erotomania, paranoid jealousy, monosymptomatic hypochondriacal psychosis (a term which he coined), delusional grandiosity, and litigious paranoia. He also listed alternative names for paraphrenia, including paranoid state, paranoid psychosis, and senile paraphrenia, and noted that paraphrenia had not been included in DSM-III (1980). Finally, he posited that "secondary paranoid conditions occur at any point in the spectrum," as related to drug abuse or to certain physical or psychiatric conditions (p. 346).

Munro's depiction of the paranoid spectrum is comprehensive, except for the absence of a link with normal (vs. delusional) perceptions and behavior, which Magaro supplied by including paranoid personality in his schema. It is also regrettable that acute paranoid disorder was not given at least a tentative position in Munro's schema. The same criticism of the placement of that disorder in Magaro's schema can be applied to the placement of shared
delusional disorder in Munro's: At a specific time it may appear to be a more severe disorder than paranoia, but it is usually followed by complete recovery, while paranoia is chronic. All of these points, nevertheless, are open to argument.

There is, however, a far more difficult problem with Munro's schema, which reflects a problem of prime importance in the conceptualization of all mental disorders. It may be found in Munro's statement that conditions in the paranoid spectrum may be secondary to drug abuse or to certain physical or psychiatric conditions. If the word "conditions" includes disorders, as it seems to in the examples Munro gives of pathological jealousy and paranoid schizophrenia, and if the word "secondary" means "derived from," as it seems to in the example of a head-injury producing over-sensitive [paranoid] personality features, then Munro's statement seems to be inconsistent with the historical and current official criterion for the diagnosis of paranoid or delusional disorders, or many other mental disorders--that they have no known organic causes.

There are, however, ways of resolving the inconsistency. If paranoid symptoms following organic disorders or conditions do not meet the other criteria for paranoid disorders, they might be described as "complications" of the original disorders or conditions;
they could, however, be mentioned in regard to the differential diagnosis of paranoid and other disorders. If the paranoid symptoms do meet all the other criteria for paranoid disorders, then the organic disorders or conditions may be seen as having activated preexisting potentials for these disorders, rather than as having primarily caused them. That is, the activation would be seen as secondary, but the paranoid disorders would be seen as primary disorders co-existing with the organic disorders or conditions, and requiring separate diagnosis and treatment.

However, the problem involves not only the inference in Munro's depiction of the paranoid spectrum that paranoid disorders may be caused by organic disorders or conditions, but the DSM criterion for diagnosis of paranoid or delusional or various other mental disorders, that they have no known organic causes. First of all, observations such as Munro's regarding organic causes must be taken into account in revised descriptions of paranoid or delusional disorders. Secondly, even if paranoid or delusional or other mental disorders may not have gross or macro organic causes and still be called mental disorders as distinguished from organic mental disorders, the presence in these disorders of micro organic causes—or, more accurately, bi-directional influences—cannot be ruled out, and is in fact being established in neuropsychology.
Nevertheless, although the traditional distinction between organic and nonorganic mental disorders increasingly appears to be arbitrary and archaic, and DSM-III-R acknowledges as much in the introduction to organic mental disorders, this distinction is being retained for pragmatic purposes—and probably correctly so, given the present state of knowledge in these areas. The nonorganic criterion for paranoid or delusional and other mental disorders will also no doubt be retained for many years to come. Meanwhile, Munro's reference in his depiction of the paranoid spectrum to paranoid conditions as being sometimes secondary to organic disorders and conditions remains to be clarified.

A new schema for depicting the relationships among paranoid and associated disorders will now be proposed which adds a new concept to that of the paranoid spectrum, is based on a different rationale from those of the two schemata described earlier, includes all the paranoid disorders mentioned in both, and also proposes the inclusion of a new subtype of paranoid disorder. This schema is depicted in Figure 1.

In this schema, the paranoid spectrum is set within a larger range of disorders, called the paranoid continuum, which ranges from normal perceptions and behaviors at one end to severely abnormal or psychotic ones at the other;
Figure 1. The paranoid spectrum and the paranoid continuum.

The paranoid continuum and the paranoid spectrum are shown as proposed in this dissertation.
however, all the disorders in the continuum are marked by paranoid features, which include typically paranoid delusions or tendencies toward them, intense negative emotions inherent in such delusions, and negative behaviors consequent to them.

The paranoid spectrum, and therefore the paranoid continuum, are constructed around paranoia as the core disorder, historically and currently (as delusional disorder) characterized primarily by persistent nonbizarre delusions of erotomanic, grandiose, jealous, persecutory, or other self-referential content. The spectrum includes only those disorders in which paranoid delusions are the primary feature, although they are distinguished from paranoia by other prominent features; their arrangement within the spectrum is along the normal to severely abnormal or psychotic continuum.

The order of the disorders in the paranoid continuum and the paranoid spectrum are therefore as follows:

Paranoid personality, though part of the paranoid continuum, may be seen as bordering and indeed overlapping normal perceptions and behaviors; paranoid personality disorder, however, which is marked by a degree of suspiciousness approaching though not quite reaching delusional levels, is well within the paranoid continuum but is not part of the paranoid spectrum.
Shared (induced) paranoid disorder is within the paranoid spectrum, as it is characterized by paranoid delusions, usually of persecutory content; it differs from paranoia, however, in that more than one person is involved in the delusional system. As the person or people in whom the delusions are induced, however, may be as much compliant as paranoid, and may previously have functioned within the normal range and are likely to return to it when no longer closely associated with the other person, the disorder is closer to the normal range of perceptions and behaviors than other disorders within the paranoid spectrum.

Later in this chapter it will be proposed that shared or induced paranoid disorder be recognized as having two subtypes: A familial type, which is the type early recognized as *folie a deux*, described more generally in DSM-III (1980) as shared paranoid disorder, and renamed induced psychotic disorder in DSM-III-R (1987); and a new type involving large groups of people, for which the proposed name is societal paranoid disorder, or societal paranoia.

Acute paranoid disorder is also primarily marked by paranoid delusions, but differs from paranoia in that the delusions and other paranoid features are brief in duration, as the name suggests, while paranoia is chronic. However, since the delusions and other features may be
severe, and the person may have been predisposed to paranoid ideation, this disorder may be seen as more severe than shared (induced) paranoid disorder.

Paranoia, as previously discussed, is the core or defining disorder in the paranoid spectrum and the paranoid continuum. It features persistent nonbizarre delusions of self-reference, involving negative emotions/motivations and behaviors.

Paraphrenia is included in the paranoid spectrum as it is marked by paranoid delusions. It differs from paranoia and the other preceding disorders, however, in that the delusions are less systematized and encapsulated, and occur with relatively mild psychotic symptoms such as bizarre delusions and hallucinations. It borders the schizophrenias.

Paranoid schizophrenia is characterized by persistent systematized delusions and associated features such as anger and violence, but the delusions may be bizarre and frequently occur with hallucinations. It is therefore seen as outside the paranoid spectrum, but well within the paranoid continuum, overlapping with the schizophrenias. Its relationship to schizophrenia, however, as discussed earlier, has been a topic for recent research, and is currently questionable.

At the extreme end of the paranoid continuum is organic delusional syndrome, which, particularly when caused by
amphetamine ingestion, may be indistinguishable from a highly active phase of paranoia or paranoid schizophrenia, but which can be traced to a specific organic factor and thereby differs from all the preceding disorders, according to our present state of knowledge of the etiologies of paranoid, schizophrenic, and other mental disorders.

The rationale for this schema differs from that of Magaro's in that it refers to the characteristics of various other dimensions of paranoid and related disorders in addition to the cognitive; these are the behavioral, emotional, motivational, physiological, and sociological dimensions. In Table 4, characteristics of paranoia in all of these dimensions are reported in detail, as described in the DSM series and elsewhere in the literature, and characteristics of related disorders which differ from those of paranoia are then reported according to the dimensions in which they occur.

Thus, paranoid personality disorder is seen to differ from paranoia in the cognitive dimension, as notions and suspicions rather than delusions are present. Shared or induced paranoid disorder differs from paranoia in the sociological dimension, as other persons are drawn into the delusional system. Acute paranoid disorder also differs from paranoia in the sociological dimension, since it is prompted by the person's recent experiences in the society
Table 4.
Dimensions of Paranoia; Adjustments for Related Disorders

<table>
<thead>
<tr>
<th>Paranoia</th>
<th>Cognitive</th>
<th>Behavioral</th>
<th>Emotional</th>
<th>Motivational</th>
<th>Physiological</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Persistent, systematized, and dominant delusions of</td>
<td>Hypervigilance, avoidance, isolation, or other defensive</td>
<td>Mistrust; fear of being</td>
<td>Self-protection from threat or harm, self-justification,</td>
<td>Chronic nervous system arousal</td>
</tr>
<tr>
<td></td>
<td>self-importance, deception, or persecution; suspicions; highly</td>
<td>behaviors; occasional litigious, aggressive, or violent</td>
<td>demeaned, victimized; anger,resentment, jealousy, hostility; mild</td>
<td>self-aggrandizement; projection of unacceptable notions or emotions;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>selective information processing; no bizarre delusions or hallucinations;</td>
<td>behaviors; impaired social and marital functioning, usually adequate</td>
<td>depression</td>
<td>avoidance, escape, revenge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>no mental deterioration</td>
<td>occupational functioning</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Paranoid Personality Disorder</td>
<td>Notions and suspicions rather than delusions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shared (Induced) Paranoid Disorder</td>
<td>Second person(s) drawn into paranoia of first person</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Paranoid Disorder</td>
<td>Origins in recent experiences of threat or harm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paraphrenia</td>
<td>Delusions not systematized and may be brief, accompanied by schizophrenia-like features occurring in late life</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paranoid Schizophrenia</td>
<td>Bizarre delusions; frequent auditory hallucinations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organic Delusional Syndrome</td>
<td>Delusions due to a specific organic factor, such as amphetamine ingestion or cerebral lesions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(See references in Tables 1 & 2.)
in which he or she lives. Paraphrenia differs from paranoia in the cognitive and presumably the physiological dimensions, in that the delusions are not encapsulated, and occur with schizophrenic-like features, usually late in life. Paranoid schizophrenia differs in these dimensions also, as some of the delusions are likely to be bizarre and accompanied by hallucinations. Finally, organic delusional syndrome differs from paranoia in the physiological dimension, as it is due to specific organic factors.

This dimensional analysis of similarities and differences among paranoia and related disorders is, of course, extremely simplified: Such dimensions cannot be easily isolated from each other, and all are likely to be affected at least to some extent in any disorder. Nevertheless, such an analysis helps to differentiate among the disorders and, though simple, helps to increase understanding of their complexity.

The rationale of the new schema differs from that of Munro also, in that the disorders were not arranged primarily to indicate a deteriorating course from paranoia to schizophrenia, but, as the dimensional analysis also shows, to indicate several ways in which they are related to and also differ from each other. These similarities and differences were seen in terms of the defining features of paranoia—nonbizarre self-referential delusions, and associated maladaptive emotions/motivations and
behaviors—and also in terms of the unique features of each disorder. In other words, the purpose for this construction of the paranoid spectrum and the paranoid continuum was to produce a small map of a major area of psychopathology, using previously established guidelines whenever possible, and locating points from which diagnosis, treatment, and research can proceed.

This schema also, in distinguishing between a limited paranoid spectrum and a more extensive paranoid continuum, provides a rationale for the consistent assignment to separate major categories, throughout the DSM series, of paranoid or delusional disorders, paranoid personality, paranoid schizophrenia, and organic disorders with paranoid features—despite the implication in the nomenclature that they are all somehow related. The new schema, therefore, gives theoretical support to what has been a problematical clinical practice.

The new schema also warrants a proposal that these disorders be cross-referenced in future DSM editions in regard to their similarities as well as their differential diagnosis.

A Proposed New Category: Societal Paranoia

The fact that delusions may be shared by large numbers of people has long been noted by both professional and lay persons interested in mental aberration, as reported in the
The history of the concept of paranoia in the preceding chapter. One of the best known scholars and physicians of the late Renaissance, Sir Thomas Browne, published a book in 1646 on Pseudodoxia Epidemica, or errors of thought held with conviction by large numbers of people; he categorized them according to content and then refuted them. Browne's perceptiveness is indicated by the finding in recent research on delusions that the degree of conviction with which they are held is their most reliable dimension; and they are currently categorized in the official diagnostic manual according to content. Although Browne did not restrict his interest to errors of thought that were pathological per se, he did attribute all errors at least in part to human fallibility and diabolical influence.

In 1841 another English scholar and social observer, Charles Mackay, published a detailed history of Extraordinary Popular Delusions and the Madness of Crowds; he described examples of deception, delusion, and mania involving crusaders, collectors of religious relics, alchemists, witch-hunters, magnetisers, and investors in Mississippi, the South Seas, and Dutch tulips; and he used all of them to illustrate his premise that nations or communities, like individuals, can "become crazed" and act accordingly, not "recovering their senses" until they have suffered enormous losses.
Nevertheless, delusions or other kinds of madness involving large groups of people have yet to be recognized in the official classification system of mental disorders. On the contrary, delusions which are shared by large numbers of people have been specifically excluded from psychopathological classification: The definition of delusion in the Glossary of Technical Terms in *DSM-III-R* (1987) declares in the first sentence that a delusion is a belief "sustained in spite of what almost everyone else believes"; and the second sentence says that "the belief is not one ordinarily accepted by other members of the person's culture or subculture (i.e., it is not an article of religious faith" (p. 395). The word "ordinarily," of course, could be taken to indicate that a belief may be delusional if is shared by an acutely mentally disordered culture or subculture, and the use of "i.e." rather than "e.g." could be taken to indicate that a belief may also be seen as delusional although shared by other members of the culture or subculture if it is not a prescribed religious belief; but both of these possibilities seem remote. The sense of the definition seems clearly to be that a belief is not to be considered delusional if it is shared by a sizeable group of people.

This position is not peculiarly that of *DSM-III-R*, of course; Taylor (1966), for example, in his volume intended to describe with precision the causes and symptoms of
psychopathology, declared that "beliefs and customs established by social indoctrination are shared by all the orthodox members of a social group. They are therefore normal phenomena by the population standards of that group." Taylor went on to say that these beliefs and customs may not be acceptable to other groups, however, and this can cause friction or even warfare between groups--an example being the "irreconcilable" beliefs of capitalism and communism, and the consequent threat of world destruction by hydrogen bombs. Taylor concluded that "collective beliefs can thus cause much suffering and concern. Yet one cannot regard them as psychopathological. They are normal psychological phenomena in spite of the pathological consequences they may have" (pp. 112-113).

Although both DSM-III-R authors and Taylor intended to set up clear-cut definitions of delusional or psychopathological beliefs, they seem to have confused the statistical meaning of normal, which refers to the average, with the psychological meaning as stated by the Oxford English Dictionary: A normal variety of anything; that which, or a person who, is healthy and not impaired in any way. This meaning makes it very difficult to view beliefs which have pathological consequences for the believers and for others as entirely normal, although they may represent the statistically average beliefs of a particular population at a particular time. This also points up the
advisability, discussed earlier, of including behavioral criteria in the definition and description of delusional or other disorders. In fact, as beliefs of the type which Taylor described appear to involve grandiosity, cut-throat competition on a group level analogous to intense jealousy on a personal level, and a conviction of being the innocent objects of a single-minded intent not merely to persecute but to annihilate them, they may be seen not only as pathological beliefs but as classically paranoid delusions.

*DSM-III* (1980) and *DSM-III-R* (1987), however, the former in the description of shared paranoid disorder and the latter in the essentially equivalent description of induced psychotic disorder, do allow for paranoid delusions to be shared by at least two people; the latter, in fact, mentions that cases have been reported in which up to twelve people in the same family have shared a delusion—a considerable increase in the numerical criterion for the disorder referred to in the last century and early in this one as *folie a deux*. However, limiting the number of people who may share a delusion to two or twelve, and limiting their relationship to an intimate one, appears to be arbitrary, particularly in light of both historical and current examples of delusion-sharing outside such limitations, such as those cited in Mackaye's book and others referred to Chapter I.
One of the two most obvious examples in modern times of paranoia on a societal level, as cited in Chapter 1, was Hitler's and consequently the Nazi party's conviction that they represented the "master race," and that their supremacy was being undermined by Jews, social democrats and communists, conscientious objectors, homosexuals, and members of other minority groups or nonconforming members of established groups, such as Lutheran or Roman Catholic clergy who opposed governmental policies—all of whom must therefore be expunged from the Third Reich. The Nazi list of external enemies to be attacked included the Soviet Union, most of Europe, and the United States; and the resultant destruction of lives and property, in Germany as elsewhere, is beyond calculation. A similar scenario was played out in Japan, where a war that began with convictions of superiority and the right to attack ended with the leveling of Hiroshima and Nagasaki by atomic bombs.

The other most obvious example of paranoia on a societal level was the one touched on by Taylor, although he insisted that it was not pathological: The conviction held by both the Soviet Union and the United States that each had the only tolerable political and socioeconomic system, that each was a target for annihilation by the other, and that therefore each must build a nuclear arsenal that surpassed the other's in size and destructive
potential. Forty years of such paranoid ideation and activity has left both nations with high potentials for destroying themselves along with the rest of the world, through the accidental if not deliberate detonation of even a small fraction of the nuclear weapons each possesses, or else through the slower but presently irreversible spread of nuclear wastes in the atmosphere, bodies of water, and land masses around the globe; and meanwhile both nations are suffering severe socioeconomic problems directly related to huge military and defense industry expenditures.

Paranoia on a societal level, however, does not operate only on so grand a scale; more limited examples of it and of factors involved in it may be traced in the psychological and other literatures in the decades since World War II, as psychologists and other professionals have become increasingly interested in various kinds of pathological behaviors on a societal level. As an example of such interest even during World War II, Bettelheim (1943) endeavored to make life endurable in a German concentration camp by objectively observing, analyzing, and memorizing changes in his own and others' behaviors under the extreme conditions to which they were subjected. Among his conclusions were that the primary goal of those in charge was to break the will of the prisoners and make them completely subservient; that in time most prisoners tended to accept the values of the Gestapo as their own; and that
the best way to resist such changes was to form groups in which the members maintained their individuality and backed up each other's will to resist the changes. Not only did Bettelheim's conclusions indicate that group behaviors can be pathological, whether a group is victimizing or victimized, but they also are instructive for persons at risk for sharing or being induced to share the paranoid ideations or behaviors of more powerful persons or groups.

In 1950, Adorno, Frenkel-Brunswick, Levinson, and Sanford, as part of a large-scale long-range study of anti-Semitic and other prejudices, conducted at Berkeley, published the results of their investigation of personality as contributing to these phenomena. In their volume they identified personality patterns presumed to make persons particularly susceptible to antidemocratic propaganda, citing data from interviews, observations, and scales which they had devised to measure political, economic, and social convictions from which personality traits could be inferred, plus additional scales devised to measure such traits more directly. The search for an anti-Semitic type of personality had proceeded to searches for ethnocentric, fascist, and antidemocratic types, and finally for a type they called authoritarian.

The authoritarian personality was identified as one in which ideas and skills typical of a highly industrialized society were combined with irrational or anti-rational
The authors are imbued with the conviction that the sincere and systematic scientific elucidation of a phenomenon of such great historical meaning can contribute directly to an amelioration of the cultural atmosphere in which hatred breeds.... In the history of civilization there have been not a few instances when mass delusions were healed not by focused propaganda but, in the final analysis, because scholars, with their unobtrusive yet insistent work habits, studied what lay at the root of the delusion.

--Max Horkheimer, Preface to 
The Authoritarian Personality
by T. W. Adorno,
E. F. Frenkel-Brunswik,
D. J. Levenson, and
R. N. Sanford (1950)
beliefs. It correlated highly with ethnocentrism, and included a rigid adherence to conventional middle-class values; a tendency to look for, condemn, reject, and punish people who violate such values; an uncritical attitude toward authority; opposition to subjective or imaginative thinking; superstitious, stereotyped, and categorical thinking; preoccupation with power and toughness; generalized hostility and cynicism; projective thinking; and exaggerated concern with sexual mores. This personality type overall showed rigidity and intolerance for ambiguity.

Both the methodology and the findings of the study met with much criticism, and the DSM series has not recognized an authoritarian personality disorder, nor has the apparent overlap with parancid personality disorder been clarified. Nevertheless, both theory-building and research continued in the area (Kirscht and Dillehay, 1967); and the original study has remained in print, including an abridged paperback version first published in 1983. This suggests that the notion of an authoritarian type of personality, related to psychopathology on a societal level, is still current.

Allport also was concerned with anti-Semitic and other kinds of social discrimination, and produced a slim volume to identify and increase awareness of the process of
scapegoating, which was published in 1955 by the Anti-Defamation League of B'nal B'rith.

It was in 1963, however, that the historian Richard Hofstadter specifically linked a major category of psychopathology with societal behaviors, in a lecture at Oxford that identified a paranoid style in American politics; this lecture was expanded and published as an essay two years later. "I call it the paranoid style," he said, "simply because no other word adequately evokes the qualities of heated exaggeration, suspiciousness, and conspiratorial fantasy" (p. 3); and further on he added the qualities of grandiosity and feelings of persecution. He also made the important point that this style was limited neither to our time nor our country, and is commonly found both in fascism and in minority movements. He cited examples to prove his point, including the Stalin purge trials, speeches by Senator Joseph McCarthy, and an 1855 article in a Texas newspaper which charged that the monarchs of Europe and the pope of Rome were at that very moment plotting the destruction of American political, civil, and religious institutions. Hofstadter also discussed other groups which had been charged with conspiracy at some time in American history, including Masons, Catholics, slaveholders, Mormons, international bankers, munitions makers, the left wing press, the right wing, White Citizens Councils, and Black Muslims.
Hofstadter then identified the basic elements in the paranoid political style: The regarding of conspiracy as the motive force in historical events; the insistence that time is running out for resistance; the refusal to compromise; the view of the enemy as the embodiment and perpetrator of evil, and yet the imitation of the enemy's appearance or ways; the special approbation given to renegades from the enemy's camp; and the striving to provide evidence for the unbelievable, while behaving defensively and refusing to consider contrary evidence.

Finally, Hofstadter suggested that the recurrence of the paranoid style over long periods of time and in various places indicates that a disposition for paranoid thinking is always be present in a considerable minority of the population. Further, this disposition appears to be mobilized into action by social conflicts that involve ultimate values, fears of catastrophe, and hatreds, since the conflicting interests are believed to be irreconcilable. Finally, Hofstadter warned that such a situation worsens when representatives of a particular interest group cannot make themselves felt in the political process.

Hofstadter's analysis may be read as a scenario for catastrophe on the sociopolitical scene. However, he did not only show that delusional, highly emotional, and motivational paranoid thinking exists with significant
frequency in political leaders and their followers, but he provided specific ways of recognizing it, and inferred important reasons for doing so, along with possible ways of counteracting or preventing it.

The investigation of paranoia and related psychopathology in public life has been continued by a number of psychiatrists, psychologists, political scientists, and other professionals. Janis (1974), for example, well-known for having earlier conceptualize and described "groupthink" as determining American foreign-policy decisions leading to fiascoes, noted that the grossest errors in decisionmaking could be attributed to hypervigilance. He cited experimental evidence to show that the emotional state of panic or near-panic involved in hypervigilance interferes with cognitive performance, making rational decisionmaking almost impossible. While Janis was not concerned with paranoid disorders per se, it will be recalled that persons with paranoid personality disorder are referred to in DSM-III-R (1987) and elsewhere as "typically hypervigilant"; this paranoid characteristic, therefore, can be added to those described by Hofstadter as causes for concern when they are present in political leaders.

Kets de Vries (1977), a professor of organizational behavior at McGill University in Montreal, analyzed potentially paranoid leadership in another area of public
life, that of corporate business; he noted, however, that this area often overlaps with the political. He was particularly interested in the charismatic leader who seems to have both a strong need and an ability to influence his followers to do things they would not otherwise do, and who therefore has a potential for developing delusions of grandeur and, especially in a crisis situation, suspiciousness and delusions of persecution. Any consequent abuse of power may be prevented or controlled by internal safeguards such as organizational rules and regulations, or by external controls such as public opinion, legislation, unions, and competition; nevertheless, the paranoid potential of the charismatic leader is strong. Kets de Vries recommended, therefore, that leaders themselves prevent it, by periodically critically reappraising their values, strengthening their perceptions of reality, and seeking and preserving mature relationships with others, always remembering that they are not all-powerful. Thus "the leader might be able to master and transform his paranoid potential into a major force capable of strengthening any organization" (p. 364).

These recommendations for leaders may be seen as complementing Bettelheim's conclusion that subordinates can best resist the imposition of the psychopathological values of leaders by banding together and encouraging each other as independent thinkers. Together the techniques described
by Bettelheim and Kets de Vries offer ways of preventing the formation of shared (induced) paranoid disorder by any parties who might be involved.

On the other hand, Lasaga (1980) analyzed the techniques of control used by Jim Jones, a leader who realized his full paranoid potential by engaging hundreds of people in his delusional system, and leading them from California to Guyana, where they built Jonestown and eventually committed murder and suicide with him. The techniques used by Jones included the control of all property and income; the weakening of family ties; the creation of a sociopolitical caste system; the control of regression or escape; the control of verbal expression; cognitive control; and emotional control. Lasaga concluded that Jonestown was a miniature totalitarian state, but also noted that it was like cults which use many of the same techniques.

It may be noted that Jones's techniques served mainly to keep people under control after they had succumbed or while they were succumbing to the delusional system; he appears to have drawn his followers into the system by rhetoric such as that analyzed by Hofstadter, although he continued such rhetoric after they had entered not only the delusional system but the settlement in Guyana.
Although the paranoid political style analyzed by Hofstadter and the techniques of political control listed by Lasaga may be pathological in nature, they can be seen, like other paranoid behaviors, as being on a continuum with normal behaviors—a viewpoint discussed earlier in this chapter. Pinderhughes (1979) noted that differential bonding—affiliative as opposed to aggressive—is essential for human adaptation, and therefore some degree of stereotyping and paranoia is inevitable.

Likewise, Volkan (1985), in his presidential address to the International Society of Political Psychology, described discrimination between enemies and allies as being necessary to normal human development. He noted that individuals early develop a sense of self which includes ethnicity and nationality, and they especially protect these descriptors when threats of political or military conflict arise. Volkan further posited that the need to have enemies and allies is the basis of political psychology; and any attempts at resolving conflicts must take this developmental factor into account, as well as the political, economic, military, and historical factors which are usually considered. Volkan recommended then that the individual's protection of his or her ethnic and national identity should be used adaptively: Rituals of play between nations, such as the Olympic Games, should be increasingly used to disperse antagonisms; when conflict
has taken place, empathy should be developed for the pain and suffering of all involved; and new "compassionate and insightful" methods should be developed for settling disputes.

It might be mentioned in addition that responses to appeals to ethnic and national identity for maladaptive purposes should be discouraged; one way to do this would be to help people to be more aware of the paranoid nature of much rhetoric, so that they can learn to discriminate between that which is truly patriotic--i.e., that which is in the best interests of the nation and the people, both domestically and internationally--and that which may sound patriotic but is actually pathological.

Efforts have been made in recent years to study and increase awareness of specific ways in which perceptions can be maladaptively manipulated. Toris and DePaulo (1984), for example, conducted an experiment to determine the effects of actual deception and suspiciousness of deception on interpersonal perceptions, using 40 subjects as "interviewers" and 40 as "applicants." Half of the "applicants" were primed to respond dishonestly, and half of the "interviewers" were primed to expect deception. Findings showed that primed interviewers were no more accurate than the unprimed in detecting actual deception, but they perceived all applicants as being more deceptive than did the unprimed interviewers. This seems to suggest
that unjustifiable suspiciousness can be evoked by authorities even in a group of presumably normal persons.

Looking at psychological manipulation on a larger scale, Keen (1986) published a volume heavily illustrated with cartoons, posters, and other depictions of enemies in modern times, showing them as strangers, aggressors, enemies of God, barbarians, beasts, reptiles, and insects—anything but human beings; in doing so, Keen referred to "consensual paranoia." He also, however, suggested a "curriculum for compassion," to reeducate the public mind.

Silverstein (1989) likewise reported on research that had been carried out from the viewpoints of psychodynamic, cognitive, developmental, and social psychology to investigate the mental images that American and Soviet citizens had developed of each other as enemies during the Cold War; he suggested that these had played a large role in perpetuating the nuclear arms race, and that the thaw in the war should be used to correct such misperceptions.

Direct references to paranoia per se on a societal level appear to have been increasing during the past five years. Hilton (1986) used paranoia and particularly what he called the politics of paranoia as the topic of a lecture that he delivered in the Franos series in Switzerland. He posited that political institutions both receive and form the great images of human life, and that
there are certain to be analogies between "the state of the soul" and "the soul of the state"; in particular, he identified a governmental form of paranoia by directly applying items from the DSM description of paranoid personality disorder to the governments of the Soviet Union and the United States. He also suggested that the disorder might be cured if the governments could achieve the psychodynamic insight that survival depends upon surrender, with admissions of weakness and the need for community. It is at this writing too soon to say with certainty, but recent events in the Soviet Union appear to support Hilton's position.

Robins (1987), as Kets de Vries had done a decade earlier, examined the relationship of paranoia and charismatic leadership, but in a broader context than that of corporate business; in fact, he defined paranoia and charisma as being "among the most powerful forces in politics and often among the most destructive." He distinguished among egocentric, interactive, and charismatic types of paranoid persons, saying that the latter was by far the most dangerous and using Hitler and Stalin as examples. He concluded that the followers of such men were not attracted by evil but by "a person or a doctrine that seemed to be responsive to their needs and, in fact, stripped of its paranoidal qualities, could have been a salvation to their distress" (p. 41). Robins
further concluded that it was the paranoid idea of the enemy as the cause of their distress, and the concentration of their energies on the destruction of the enemy, that doomed the efforts of charismatic paranoid leaders to save their countries; and, although the obsession with the enemy was related to the history and immediate circumstances of the societies involved, it was primarily related to the personal psychopathology of the leaders.

Robins' ascribing of at least some prosocial motivation to paranoid leaders gives a more complex—and perhaps less paranoid—view of such persons than seems to have been given previously in the psychological literature; it also helps to make more comprehensible the willingness of their followers to share their delusions.

Taking a position that may be seen as the reverse of Robins', Glass (1988) found paranoid ideation in two works in the field of political philosophy that are generally held in esteem: Plato's *Laws* and Hobbes' *Leviathan*. Glass defined paranoia as an obsession with dominance, distrust, and persecution, and observed such obsession in both of the works, as both support power and authority, the control of behavior, and elaborate administrative structures to carry out the purposes of the ruler. From the negative point of view, neither favors participatory politics, individuality, or spontaneity. In other words, according to Glass, each seeks to impose a paranoid political structure on citizens,
and in its statement of political values seems "peculiarly modern," "given the contemporary prevalence of paranoia and paranoid reaction in political life" (p. 210).

After a detailed discussion, largely in psychoanalytic terms, of the *Laws* and the *Leviathan* and the political philosophy which they represent, Robins concluded that fear, anxiety, and the fear of domination are characteristic of a paranoid political system, whereas trust and participation, and community and cooperation, are characteristic of democratic society; and he suggested that political theory encouraging the latter should be developed from the psychoanalytic perspective. He might also have suggested, though he did not, that the same recommendation could be made in regard to other major therapeutic perspectives, since they too are concerned with the well-being of individual persons and, by extension, the well-being of societies.

Descriptions of paranoid systems involving both political leaders and large numbers of people influenced by them are obviously not new phenomena in Western literatures; however, they appear to be reaching new levels of visibility and sophistication in the popular press. On March 11, 1991, an issue of the *Nation* appeared in which the front-page editorial was headed "Folie a deux"; in this editorial Saddam Hussein and George Bush were described as "committed by the insane logic of their pride to an epic
drama of death," since both had refused to participate in meaningful negotiations. The resultant war was brief and victorious from the viewpoint of the United States, but not from that of the hundreds of thousands of Iraqi civilians who were killed, maimed, or left homeless, nor from the environmental viewpoint, since oil wells set on fire by Saddam's orders are expected to burn for years to come, destroying plant and animal life in the region and polluting the atmosphere of the earth. The editorial following the declaration of the war concluded that "the world must find ways to insure that this insanity does not happen again."

The other article on the front page of this issue of the Nation was headed "America on the Couch: The Gulf War as Mental Disorder." In it the author, Lloyd DeMause, who is the director of the Institute for Psychohistory and editor of its journal, said that "the current gulf war is a shared emotional disorder, with diagnostic symptoms, psychodynamics and childhood origins very similar to the disorders that occur in individuals." He went on to diagnose the disorder as shared PTSD, characterized by emotional instability, panic attacks, frantic spending and borrowing, drug use, constriction of empathy and affect, hypervigilance, and feelings of unreality, detachment, and estrangement.
In discussing the psychodynamics and childhood origins of the disorder, DeMause referred to portrayals of Saddam Hussein and other persons in the news, including popular entertainers, as symbolizing terrifying parents vs. the hurt child. Such portrayals, he said, were "national dreams" revealing the unconscious emotional life of the nation, which for at least a year had been one of depression, guilt, sinfulness, and even suicidal wishes. Such portrayals also functioned as "flashbacks" to childhood traumas suffered by average American children brought up before Dr. Spock began to advise their parents, triggering the misplaced feelings of guilt often experienced by the traumatized; and these feelings of guilt had been intensified by an upswing in the economy which the "guilty" felt they did not deserve. Atonement in the form of ritual human sacrifice was therefore felt to be necessary; and this in turn necessitated the creation of an enemy for ritual combat (Saddam Hussein), the ritual humiliation of the leader (depictions of George Bush as a "wimp"), the staging of the triumph of good over evil (the Gulf War), and the celebration of the rebirth of life (general emotional relief at the outbreak of the war).

DeMause may be an insightful Jungian, but he makes numerous assumptions in his description of the psychodynamics and childhood origins of the Gulf War that are at best tenuous, such as those of the generality of
pre-Spock childhood trauma as opposed to post-Spock
improvements; the upswing in the economy as having affected
most of the population; and the start of the war as having
been generally greeted with feelings of relief. However,
examination of such assumptions would be aside from the
point to be made for the purposes of this chapter, which is
that DeMause, like others, has recognized mental disorder
as existing on a societal as well as a personal level, and,
further, has seen it as having very serious consequences.

However, DeMause's diagnosis of PTSD as being the
disorder which the Gulf War represented is difficult to
support, given the first criterion in DSM-III-R (1987) for
such a diagnosis, that the patient developed the disorder
following a discrete event "outside the range of usual
human experience," such as a serious threat to life or
physical integrity, a similar threat or harm to a close
relative or friend, sudden destruction of one's home or
community, or seeing another person who has just been or is
being seriously injured or killed. In fact, DeMause used
an opposite assumption to support his thesis, that the
trauma were commonly experienced and included such things
as being put over a father's knee and being "whopped" with
a belt (Bush's experience) or being circumcised as a young
boy (Saddam's experience). DeMause's thesis is also
difficult to support with reference to the second criterion
for PTSD: His citing of popular portrayals of Saddam
Hussein and other people in the news as being equivalent to "flashbacks," or the reexperiencing of traumatic events, is less than precise. He also does not make a point of meeting the other criteria for the diagnosis of PTSD, although some connections can be inferred from the list of symptoms that he does present. It is possible, of course, that DeMause disagrees with the official criteria for the disorder, but that is not made clear.

In regard to DeMause's diagnosis of shared PTSD in contrast to a possible diagnosis of a societal subtype of shared (induced) paranoid disorder as being expressed in the Gulf War, it may be recalled that in Chapter I these disorders were seen as related, although their relationship remains to be worked out.

Another pertinent news article appeared in June, 1991, by Carl Cannon of the Knight-Ridder Service, which also discussed large-group pathology in terms of an individual mental disorder--in this case a bipolar disorder, with the Republicans described as manic and the Democrats as depressive. Although the writer did not appear to have extensive training in psychopathology, and his attitude was somewhat tongue-in-cheek, he made his case by quoting, by name and among others, a professor of American politics at Duke University; a Harvard Medical School professor; a practicing psychologist and a psychiatrist in Wichita, Kansas; Theodore Millon; Dorland's medical dictionary; and
office-holders in Washington. Cannon noted among other things that the Republicans in their euphoria about the Gulf War seemed unable to process information about how we had made conditions worse for the Kurds; and on the other hand, the Democrats were suffering from chronic low self-esteem and envy, and were generally negativistic. Cannon concluded that it was difficult to decide whether such mania or such depression hurt us more as a nation: Among other things, many voters weren't bothering to vote. However, he added, when Americans do make a choice between "mindless optimism" and "mindless pessimism," they are likely to choose the former.

It may be concluded, then, that when not only articles in professional literatures but also reasonably well-informed and informative articles in the popular press propose that large groups or even whole societies can suffer from mental disorders, it is time for such proposals to be seriously considered by authors of the official diagnostic manual of mental disorders. This is not only because the manual should be as comprehensive as possible, but because disorders of epidemic proportions urgently require diagnosis and intervention.

There is one more point that should be made in regard to mental disorders on societal levels, however, and that has to do with epidemics of physical illnesses: Just as in
We are mad, not only as individuals, but as nations also. We restrain manslaughter and isolated murders; but what of war and the so-called glory of killing a whole people?

--Seneca
Letter 95
Epistula Morales
(c. 50 A.D.)
individual cases, widespread maladaptive behaviors may have physical contributing causes. This was made clear in Matossian's (1983) study that linked ergot poisoning and witch-hunting, in Salem in the 17th century and elsewhere at other times: Periods of heavy rain and the consequent growth of the ergot fungus on grain, particularly rye, were found to coincide with periods of intensified witch-hunting in those regions where bread made from such grain was a staple. And ergot is recognized as a hallucinogen.

Examples of the impact of physical factors on societal states of mind and mood need not, of course, involve the excessive ingestion of hallucinogens. Hunger is a powerful motivation for violent action, as the French Revolution made clear; and long hot summers in ghettos such as the Watts district of Los Angeles have been commonly observed as contributing to riots and associated crimes. Meanwhile, the possible behavioral effects of genetic damage due to rising levels of radioactive particles in the atmosphere, soil, and bodies of water all over the world remain to be discovered.

The final proposal in this chapter, therefore, in regard to the reconceptualization of paranoid or delusional disorders and consequent changes in the DSM series, is that, in accordance with the preceding findings and discussion of them, a new subtype of shared (induced)
paranoid disorder be recognized. This new subtype exists in addition to the long-recognized familial subtype, and is one which is shared by large groups; it may therefore be called societal paranoid disorder, or societal paranoia. The definition of this disorder is derived, like the definitions of other disorders in the paranoid spectrum, from the historically derived definition of paranoia: It is characterized by the presence throughout the group of persistent nonbizarre delusions of grandiose, persecutory, or other group-referenced content; the societal functioning of the group in relation to other groups may be impaired, while internal functioning may be satisfactory; and excessively defensive or aggressive and violent behaviors related to the delusions may occur, particularly when the delusions are marked by strong conviction and high emotional content.

In the societal subtype of shared (induced) paranoid disorder, the delusions and associated emotions shared by a group of people, and their consequent maladaptive behaviors, may be induced by a charismatic paranoid leader who appeals to both the needs of the people and to their fears of an enemy, and who gains and seeks to maintain a high degree of intellectual, political, economic, and in some cases physical control over them, by means ranging from exaggerated rhetoric to imprisonment, or the threat of imprisonment or other personal catastrophe.
Characteristics of the rhetoric of such leaders include references to conspiracies, refusals to compromise, overattribution of ills to the enemy, and indications of hypervigilence and a desire to impose strict controls on others.

Objections to the maintenance of shared paranoid disorder as such in the DSM series, its subsequent exclusion from the paranoid or delusional category in DSM-III-R, and the case for its reinstatement, were discussed earlier. It might also be objected in regard to the proposed societal subtype of this disorder that there is no need for recognizing such a subtype, and that instead the numerical requirement for the shared disorder might be dropped. Doing so, however, would represent a great loss of information, including much of that offered above.

It might also be objected that there is no need for recognizing the new subtype because it is unlikely or even impossible that paranoid leaders or entire groups of people sharing a paranoid disorder would present themselves for diagnosis and treatment. However, it may not be at all unlikely that individuals previously or presently so involved, or at risk for becoming involved, would appear for treatment because of anger, fearfulness, or other symptomatology that is not specifically paranoid.
Another possible objection is more serious: It may be invalid to label an entire society as paranoid, because there are certain to be individuals in it who are not paranoid, and others whose paranoid characteristics are within the normal range. However, a parallel may be drawn with individuals who are diagnosed as paranoid: They are not paranoid all the time, and certainly not about everything; nevertheless, enough salient paranoid features are present in their cognitions and overt behaviors over time to warrant a diagnosis of psychopathology.

Not an objection to the classification of societal paranoia as a subtype of shared paranoia, but an alternative to it, is the possibility of categorizing all the disorders of the paranoid spectrum according to the levels of complexity of the units involved—that is, as individual disorders, as disorders shared by small intimate groups, or as disorders shared by large societal groups. Thus, it might be possible to distinguish among groups which exhibit sets of features analogous to sets found in individual paranoid personality disorder; groups in which paranoia is introduced by a paranoid leader; groups which have acute paranoid responses to stressful events or situations; and groups which appear to have persistent grandiose or persecutory delusions analogous to those found in individual cases of classic paranoia. Although it is unlikely that this method of classification
would find its way into an official diagnostic system which is primarily designed for use in individual cases, it could be very useful for better understanding and intervening in shared paranoid disorders apart from the classification system.

Recommendations discussed earlier for the treatment or prevention of societal paranoia, though not likely to be included in a *DSM* description of the disorder, may be summarized and considered for implementation as follows:

On all levels of human society, from the international to the local group, respect for ethnic, national, and community identity should be shown, and cooperation promoted. Productive ways of dealing with inevitable competition among groups should be strengthened, and new ones devised.

All concerned groups should be represented in any political process, and all must be willing to compromise when compromise is warranted. Systems of checks and balances within or among organizations must be preserved.

Persons in positions of leadership should monitor themselves for tendencies toward grandiose, persecutory, or other delusional ideation.

All persons should be willing to weigh but not uncritically adopt the opinions of others, and learn to recognize oversimplified or exaggerated visual or verbal
depictions of others as necessarily inaccurate. Likewise, suspicions should be examined in light of evidence; and the dehumanizing of individuals in any way should be unacceptable to other human beings.

Finally, it may be noted that while recommendations such as these may have no part in the DSM series, they are fully in keeping with the preamble to the Ethical Principles of Psychologists (1981), which states in its first sentence that "psychologists respect the dignity and worth of the individual and strive for the preservation and protection of fundamental human rights" (p. 633).
IV. FURTHER RECONCEPTUALIZATION OF PARANOIA: A HOLISTIC INTEGRATIVE MODEL

The reconceptualization of paranoia presented in the preceding chapter included not only grandiose, persecutory, or other self-referential delusions, but intense emotions and motivations which the delusions imply, and consequent socially maladaptive behaviors. Paranoia thus defined was seen to be the core disorder in a spectrum of disorders which share its essential features but also have unique essential features; these disorders include shared (induced) paranoia, acute paranoia, and paraphrenia (see Table 1).

This spectrum in turn was seen as being set within a continuum which ranges from normal perceptions and behaviors to globally psychotic ones, all of which show varying frequencies, intensities, and durations of paranoid characteristics, although nonparanoid characteristics may be more typical of them. Thus, paranoid tendencies may be found in normal individuals but usually do not survive contact with reality; suspicions approaching but not quite reaching delusional levels are typical of paranoid personality and paranoid personality disorder; and at the
If we have learned that the facts should not be confused with the truth, it is because we know that it is only by understanding the complexity of contexts that we can make sense of facts. We have a surfeit of facts. What we do not have, and most of us in the quiet of our nights know it, is an overarching conception of contexts into which we can put these facts and, having done so, the truth then stands a chance of emerging.

--S. B. Sarason
The Lack of an Overarching Conception in Psychology (1989)
far end of the continuum, the delusions found in paranoid schizophrenia are often bizarre and accompanied by hallucinations and other schizophrenic characteristics, while organic delusional syndrome has known organic origins and is globally psychotic.

Finally, in the reconceptualization of paranoia presented in the preceding chapter, the kinds of delusions, emotions/motivations, and behaviors described as essential features of the disorder were shown to characterize large groups or entire societies of people under certain circumstances, which may include the leadership of a charismatic but paranoid person, especially during a critical time in the society; it was therefore proposed that societal paranoid disorder, or societal paranoia, be recognized as a subtype of shared (induced) paranoid disorder, the other subtype being the long-recognized folie a deux or familial subtype.

However, the conceptualization of any mental disorder is not only of academic interest, but serves to provide guidelines for understanding and treating human beings who are suffering from the disorder; and human beings are complex entities of whom any particular mental syndrome is only one aspect. Therefore this reconceptualization of paranoia and related disorders, which has been used as a basis for various proposed changes in the official diagnostic manual, must be further carried out if it is to
provide for the holistic understanding of persons suffering from these disorders; and such understanding includes awareness of various factors both commonly and differentially at work in the development, precipitation, and maintenance of such disorders, and of the expression of these disorders in both covert and overt behaviors.

The further reconceptualization of paranoia and related disorders to be presented in this chapter, then, will view them not as entities in themselves, but in context, as patterns of maladaptive covert and overt behaviors engaged in by persons who have been predisposed to engage in such behaviors by interactive external and internal factors in their development and present situation, and the ways in which they have perceived them and reacted to them; these behaviors in turn will be seen as affecting the person, the present situation, the person's future development, and the environment. This reconceptualization will be represented in a series of person-oriented models for behavior in general, for paranoia, and for other paranoid disorders, including societal paranoid disorder, or societal paranoia, as earlier proposed for inclusion in the official classification system.

The consideration of various factors in the development, precipitation, and maintenance of these disorders has prompted recognition of the contributions of various specific approaches to their understanding; these
include psychodynamic, behavioral, cognitive, biological, sociological, and cross-cultural approaches, and they have been integrated into the model for paranoia. Also, the viewing of the disorders as patterns of maladaptive behavior has prompted the integration of a stress-coping paradigm into all of the models for the disorders.

This person-oriented extension of the reconceptualization of paranoia and related disorders may be expected, then, not only to increase understanding of the disorders in terms of both their similar and differential development, as well as their precipitation and maintenance, but to point to more avenues for treatment, prevention, and research than may be indicated by a diagnostic disorder-oriented approach, since the latter is necessarily chiefly concerned with current symptomatology. These two approaches, however, are essentially complementary rather than oppositional, and this chapter extends the reconceptualization of paranoia and related disorders.

Before further discussion of this extension of the reconceptualization of paranoia and related disorders, it should be noted that it is in line with developments in general scientific theory as well as in psychological theory. As discussed in Chapter I, the need for a more comprehensive approach than is generally in current use in
the scientific study of phenomena was placed in large historical perspective by Lincoln and Guba (1985). They proposed the use of "naturalistic inquiry" as opposed to the traditional and dominant method of scientific research, charging that the latter tends to present reality as simple, tangible, and fragmented, whereas the experience of reality is multiple, constructed, and holistic. They further observed that although investigators using the latter method are usually considered to be objective, it is impossible to separate the knower and the known, or the values of investigators from their investigation; and while causality is usually depicted as unidirectional, it is actually multidirectional and simultaneous.

It should also be noted that specific criticisms of assumptions in the DSM system began to appear long before Lincoln and Guba's publication, although they may not have been couched in terms of general scientific theory. Such criticisms have come from all quarters, including the psychiatric or psychodynamic community: Cameron (1959), for example, criticized the official classification of psychiatric illnesses as separate and distinct, in contrast to "the nonconformities that living patients always exhibit" (p. 508); and Szasz (1974) went so far as to call the basic assumption of the existence of mental illness a "myth." On the other hand, behaviorists and especially those engaged in behavioral assessment have tended to
ignore the official classification system in their concern with the observation and modification of specific behaviors; this is indicated by the late publication of the first behavioral model for paranoia (Haynes, 1986). And humanistic psychologists (e.g., Mahrer, 1978) have rejected psychiatric categories outright as having little or no correspondence to reality. Finally, descriptions of madness by persons so diagnosed, such as those by Beers (1908) and those anthologized by Porter (1987), reveal the glaring inadequacies of psychiatric classification for defining or describing mental disorders.

Modifications and extensions of the official classification system have been proposed from time to time, as well as alternate systems such as behavioral assessment. Mahrer (1970) edited a volume of such proposals for the classification of personality, including Cattell's factor analytic system, Eysenck's dimensional system, and Mahrer's system based on motivations for needing psychiatric hospitalization. Lorr (1986) proposed that categorical and dimensional approaches be combined, by adding a quantitative set of measurements to the criteria for the major syndromes; each patient could then be described by a diagnostic group and a standardized syndrome profile. And DeNelsky and Boat (1986) proposed a model for diagnosis and treatment based on coping skills rather than symptoms or pathologies.
None of these proposals, however, has been put to general use, nor is soon likely to be, especially in view of the fact that both official records of treatment, including those used for third-party payments, and the psychological/psychiatric literature in general are based on the \textit{DSM} classification system. With possibly the sole exception of Lorr's proposal—which seems to involve the development of more and better assessment instruments than exist at present—these proposals if put into effect might well result in the loss of far more information than would be gained. Furthermore, with the exception of Mahrer's and of DeNelsky and Boat's proposals, they are no more concerned with a holistic understanding of the mentally disordered person than is the official diagnostic system. Even the Mahrer and the DeNelsy and Boat proposals, however, would apparently exist apart from the \textit{DSM} system rather than be integrated with it; and with all its faults, that system must be recognized as one that must be dealt with in theory-building, research, and practice.

The \textit{DSM} system, in fact, has persisted for good reason: It represents many clinical observations and opinions brought together—however ill-fitting they may be—over many years. Continual modification of it according to new theory and new information, rather than abandonment of it, appears to be not only inevitable but invaluable. At the same time, the development of new
theory and the gathering of new information must not only be related to but go beyond the DSM system, to both supplement and reshape it; and particularly in light of developments in general scientific theory as described earlier, an appropriate direction for such theory-building and research appears to be toward providing a holistic view of mentally disordered persons, and of integrating various approaches to the understanding of such persons and of the disorders which they experience. As described earlier, then, this is the direction to be taken in this chapter in regard to paranoia and related disorders.

Along with efforts to radically modify, significantly extend, or entirely replace the official classification system for mental disorders, efforts to achieve a holistic view of human behavior, and to integrate insights and information on human behavior from various viewpoints, are not new in the modern history of psychopathology. Indeed, some major events in this history may be defined in terms of such efforts, as in the founding of humanistic psychology in 1964 to be a "third force" in psychology and psychiatry, using a more general approach than psychoanalysis or behaviorism, and the publication of Dollard and Miller's (1950) attempted reconciliation of the latter two approaches. Recent efforts, as noted in Chapter I, include Staats' (1983) analysis of the problems of
integrating approaches and areas in psychology, and the
subsequent founding of the Society for Studying Unity
Issues in Psychology.

There have also been very recent efforts to integrate
approaches to the understanding of paranoid disorders.
These include Aktar's (1990) incorporation of DSM
descriptive features and developmental information into a
psychoanalytical view of paranoid personality disorder, and
Houseman's recommendation for psychiatric nurses in
particular that they take a "biopsychosocial perspective"
of paranoid persons (sic--not "patients").

Much of the current understanding of human behavior,
and of personality and personality disorders in particular,
was disseminated as part of social learning theory, or
social behaviorism (Staats, (1983). As developed and
independently published by Staats, Bandura, and Mischel,
and based in part on work done decades earlier by Rotter
and others, this approach views human beings as active
agents, particularly through their cognitive processes, in
determining the effects of the environment on their
behavior; therefore behavior is not only learned, but it is
learned more often through observation than through
experience; and further, human beings, their behavior, and
the environment all interact with each other. Thus,
personality is viewed not merely in the traditional way as
a complex of traits with generalized effects on behavior,
but as characteristic ways of behaving in response to situations and the ways in which they are perceived.

Mischel (1973) observed, in fact, that while personality traits may be consistently expressed in intellective behaviors, and in various other kinds of behaviors in similar situations, they are not expressed consistently across various kinds of situations; further, situations are varyingly perceived by individuals in terms of the individuals' competencies or previous learning about such situations, their encoding and categorizing of the situations, their expectancies of rewards or punishments for their behavior in the situations, the values they place on the situational stimuli, and the plans or rules they have for their own behaviors in specific situations. As Michel's main focus was on the integration or interaction of personal, behavioral, and situational variables, he referred to his theory as an interactional model of personality; and while it served as a general model, it could be used to account for individual differences. Like other social learning theory or indeed any much discussed psychological theory, it has been much criticized, but it has also been generative (e.g., Rychman, 1982).

An Interactional Model of Human Behavior

Marsella (1984) described an interactional model for all behavior, whether normal or abnormal, that he and his
co-workers had used since 1967 in a series of
cross-cultural studies, that they had modified in subsequent
studies, and that had been adapted by various other
psychologists. This model is depicted in Figure 2.

As an introduction to the description of his model,
Marsella noted that the most critical current problems in
psychopathology are conceptual in nature, and that the
conceptualization of a disorder directs and also limits the
understanding and treatment of the disorder. He then
proposed a model that takes into account both the external
or environmental and cultural forces in a person's life,
and the internal or biological and psychological forces,
and that shows the person as the product of these but also
greater than the sum of these; it also depicts both the
forces and the person as constantly interacting with each
other. The person is also depicted as being in constant
interaction with the situation; and behavior is defined as
ongoing adjustment in this interaction, and as affecting in
turn both the person and the situation.

Marsella noted that interactional models of behavior
represent a major paradigmatic orientation for psychology
and the other behavioral sciences--an orientation which had
only recently gained popularity although it could be traced
to Galileo's notion of causality as the result of
interdependencies between an object and its surroundings;
this was in contrast to the Aristotelian notion of
Figure 2. An interactional model of human behavior.

causality as a simple linear relationship. Marsella also traced the interactional orientation through German philosophy and psychology, including the work of Wilhelm Wundt and the Gestaltists, and Kurt Lewin, who had been profoundly influenced by them and who developed the first interactional system in psychology, called topological or field theory as analogous to field theory in physics. Marsella also noted that others who had advanced interactional theories included Fritz Perls and Andreas Angyal, the latter of whom invented the term "biosphere" to describe the person and the environment as a unit, and Henry Murray, who had been influenced by Adolf Meyer's psychobiological approach to psychopathology. It was Mischel's work, however, influenced by Bandura's, that had focused attention on the interactional paradigm.

Although Marsella's general interactional model of human behavior, as depicted in Figure 2, may be applied to both normal and abnormal behavior, it was based on a conception of psychopathology as resulting from interactions between stresses and resources on biological, psychological, and sociological levels of functioning. This conception was given empirical support in several studies by Marsella and his co-workers, in which they assessed particular stresses and resources, and found through multivariate data analysis that distinct patterns of psychopathology were related to particular interactions.
between these stresses and resources. The person was viewed as a coping response system, the situation as a source of stresses, and the interactions between them as a stress state; psychopathology was viewed as a way of adapting to stress states.

The stresses assessed in these studies were specified as including the amount of frustration, conflict, and tension associated with major areas of functioning, such as marriage, child-rearing, housing, employment, interpersonal relations, and nutrition. They were measured along the classic parameters of frequency, intensity, and duration, and along others such as controllability and predictability. Resources included biological supports such as health, strength, energy, and endurance; psychological or cognitive supports such as the use of defense mechanisms, stress inoculation techniques, and philosophies of life as found in religion, self-directed behavior, projection, and optimistic fatalism; and social supports as found in families, friendships, and social welfare networks and support systems. Stress states were positioned on the three polarities of system overload-underload, positive-negative perception of the experience, and high arousal-low arousal.

In addition, Marsella proposed that psychopathological behaviors be evaluated not in terms of symptoms per se but in terms of quantitative and qualitative attributes of
responses to various situations, with these responses
classified according to the functional systems in which
they occurred. These systems would include the somatic,
sensory, perceptual, motor, affective, cognitive,
interpersonal, and self systems. Quantitative attributes
would include response activation (present or absent),
rates, duration, and latency; and qualitative attributes
would include appropriateness, inconsistency,
interpenetration, perseveration, interruption,
fragmentation, incongruence, conflict, and relationship to
antecedents.

Finally, Marsella described his interactional model of
human behavior as one on which both more theoretical and
empirical work needed to be done. Nevertheless, it has
proven to be a master model indeed, capable of modification
and variation, but comprehensive in its view of human
behavior, given the assumptions that abnormal behavior is
continuous with normal behavior, that behavior may be
defined in terms of stress-coping interactions, and that
the major variables affecting behavior are external
environmental, internal, or specific situational factors.

A modification of this model will be proposed which
integrates its basic dimensions with stress-coping theory
in an alternate way, reinterprets some aspects of the
model, and from which more specific models will be derived
for paranoia, for the differential diagnosis of disorders
on the paranoid spectrum and the paranoid continuum, and particularly for the proposed new category of societal paranoia.

The Coping Evolution Continuum

As part of his discussion of the general interactional model of human behavior, Marsella (1984) defined stressors as "any event/object/process which elicits a state of change in an organismic system" (p. 242), and described coping as including "all of the biological, psychological, or sociological aspects of human functioning that mediate stressors" (p. 245). In other words, the emphasis was on stress, and coping was described in terms of supports. Within the next few years, however, Marsella and Scheuer (1987) developed a concept of human behavior that emphasized coping, and viewed coping as a process which occurred in several stages.

This view of coping was initiated by findings in a study using a coping behaviors checklist (Scheuer, 1988) to determine differences between anhedonic and nonanhedonic students in responding to a hypothetical academic event that could be expected to be highly stressful. The checklist had been rationally derived from other checklists, scales, and discussions of assessment techniques in the coping literature, and the behaviors had been arranged in a time sequence from immediate reflexive
ones, such as increased heart rate, to reflective ones, such as planning how to deal with any similar event in the future; and they fell generally into two large categories, those of defensive and of directly active coping behaviors. When the checklist was subjected to a Kuder-Richardson test for internal consistency, a score of .93 was obtained, indicating that a single concept was being measured.

A continuum of coping behaviors was then hypothesized by Marsella and Scheuer, and was seen as corresponding to both individual human and evolutionary development, as shown in Figure 3. In the 1988 publication in which the model of the coping continuum was presented, the definition of coping was still given in terms of the "utilization of biological, psychological, and social resources" for "controlling, mastering, and preventing" stress, but the purpose of such management was seen as "the promotion of human growth and development." This definition of coping is due for further revision, but particularly in combination with the model of the coping continuum (which, of course, may also be revised), it has important implications for the interactional model of human behavior: It suggests the nature and specification of particular behaviors as related to the motivation for them, and as measurable along the dimensions Marsella suggested.
Figure 3. The coping evolution continuum.

It should be noted that Marsella's (1984) observation that interactional models of behavior represent a major paradigmatic orientation for psychology and the other behavioral sciences is at least as true for stress-coping models. The earliest reference to stress as a concept appears to have been in the work of Wolff and his colleagues at Cornell in the 1950s (Marsella, 1984); and ever since the development of the concept as an overarching one by Hans Selye (1956), a physician, it has been widely employed in medicine, psychology, and various other disciplines, as well as in the popular press. Selye defined stress in terms of the wear and tear of life on the human organism; and he posited a "general adaptation syndrome" which describes the stages in which human beings respond to stress as alarm, resistance, and, when resistance fails, exhaustion and ultimately death. This model was developed out of a concern with disease and deterioration, and their impact on human beings.

A more optimistic view of the human condition was then developed in the concept of coping. Perhaps the earliest reference to coping in the literature was in a discussion of the coping functions of the ego mechanism by Theodore Kroeber (1963), the anthropologist. However, the concept of coping as part of the resistance to stress was developed by Richard Lazarus (1966), a psychologist, who had spent the previous decade investigating stress as defined by
Lazarus. To his stress-coping model he and a co-worker have since added appraisal as a mediator (Lazarus & Folkman, 1984); this is in keeping with the general recognition in psychology of cognitive processes as mediators between experience and behavior.

As in the case of stress, a huge literature has accumulated around the concept of coping: By frequency of references, coping ranks in the top 20% of the more than 4,000 topics listed in Psychological Abstracts, and it is commonly linked in publications with the concept of stress. Also like the concept of stress, it appears with great frequency in the popular press. While most of the publications employing either or both of the concepts has been concerned with their application to specific disorders or problems faced by human beings, other publications have continued to address basic issues in regard to these concepts. An example of this which was discussed earlier, and which illustrates the general applicability of stress-coping theory, is DeNelsky and Boat's (1986) coping skills model for diagnosis and treatment, proposed by them as an alternative to the DSM system.

As another example, and one which is important for empirical research, Kanner, Coyne, Schaefer, and Lazarus (1980) developed a "Daily Hassles" scale to measure minor stresses, and suggested that this scale offers a better way of assessing stress than do scales which measure major life
events—and that, in fact, the stress of major events is likely to be expressed in small daily stresses.

A third example, which is particularly pertinent to interactional models of human behavior, is Waterhouse's (1984) presidential address to the Australian Psychological Society; in this he discussed his views of stress, coping, and vulnerability in relation to the growing field of behavioral medicine or health psychology, and urged that researchers keep in mind the likelihood of multiple rather than single determiners, interacting variables, inner stimuli and responses, unconscious nonrational determiners, and various theoretical orientations.

It is not surprising that stress-coping and interactional models of human behavior have both developed during the latter half of the 20th century; they represent the efforts of human beings to understand themselves and their environment during a time marked by both cataclysmic events and unprecedented advances in scientific knowledge ranging from the biological to the astronomical and including communication. And the same desire for the widest possible perspective on human behavior that led to the development of both of these major paradigmatic approaches has also led to efforts to relate them to each other. Such efforts are exemplified by Marsella's general interactional model of human behavior, first used in 1967
An Interactional Stress-Coping Model of Behavior

The interactional stress-coping model of behavior shown in Figure 4 combines the Marsella (1984) general interaction model for human behavior with the Marsella and Scheuer (1987) model of the coping continuum. It differs from Marsella's original model primarily in that stress and coping behaviors are actually located in the model as diagrammed rather than only referred to in the discussion of the model as being generally present; this also results in a somewhat different interpretation of elements and relationships in the model.

Thus, while in the original model behavior was depicted as the product of the person and the situation, in this model the stressful nature of a situation or an event is stated, and this is indicated as impacting on the person who actually performs the behaviors. As in the original model, however, the person is depicted as having been shaped by earlier interactional factors on which he or she has also had an impact; the person's behaviors, therefore, are prompted not only by the situation or the event but by previous perceptions and responses to them, or, in other terms, by a personal history of learning.
Figure 4. An interactional stress-coping model of behavior.

One effect of indicating that behaviors are actually performed by the person as affected by a particular event or situation, rather than as being equally attributable to both the person and the situation, is that this makes the modified model a less deterministic one than the original model appears to be—although, of course, the original need not be so interpreted. In other words, the new form of the old model makes room for consideration of the age-old basic question of the existence and nature of the will and responsibility, which still dogs the decisions of forensic psychologists though it appears to have been abandoned by most other psychologists.

The modified model also differs from the original in regard to the description of behavior(s). The range of behavior in the original model was given as normal to abnormal, while in this model, in keeping with the more recently developed concept of the coping continuum, behaviors are seen as ranging from maladaptive through increasingly adaptive behaviors, or, more specifically, from random behaviors, through reflexive and defensive behaviors, and finally to direct coping behaviors and mastery.

It should be noted, however, that there is no exact correspondence of the maladaptive-adaptive range with the range of behaviors on the coping continuum. Random behaviors may accidentally be either maladaptive or
adaptive; reflexive behaviors such as the activation of the autonomic nervous system may be generally adaptive, but will be maladaptive particularly if they are prolonged and if the organism is approaching what Selye described as exhaustion; defensive behaviors may be adaptive if they are sufficient for withstanding the stressors, or if they are preliminary to directly coping with the stressors, but they will be maladaptive if they are insufficient or represent a persistent state; however, direct coping behaviors, and, obviously, behaviors leading to mastery, are more likely to be adaptive than maladaptive. In other words, though there is no exact correspondence, there is a general correspondence between the maladaptive-adaptive range and the range of behaviors on the coping continuum.

It should also be noted, as the model suggests, that the continuum of coping behaviors represents variation over time; these behaviors in response to a stressful event or situation are likely to be successive, although not invariably so; and the performance of them will not only directly affect the person and the immediate situation or event, as the original model indicated, but ultimately the larger environment and the unique biology and psychology of the person.

Finally, it should be noted that the unit in the model representing the specific event/situation-person-behaviors relationship may be seen not only in sequence to the
developmental factors-person relationship, but as representing innumerable instances of the ways in which such factors actually impact on persons and their behaviors and are in turn impacted by them during development; these instances may include the "daily hassles and uplifts" specified by Kanner, Coyne, Schaefer, and Lazarus (1980). That is, from the time of conception onward, until the time at which the event or situation specified in the model is under consideration, the person has been affected by, and has increasingly affected, not only the general nature of environmental, biological, and sociological factors, but the multitudinous stressful events and situations in which such factors are expressed, and which are inevitably a part of birth, growth, and life-long development.

In the application of this model for treatment, prevention, and research, the specification of events and situations would obviously depend on the particular case; but, as Marsella (1984) indicated, the major areas of functioning in the distressed person's life should be considered, and stressful events or situations in each should be specified and individually as well as collectively assessed for the frequency, intensity, duration, and other characteristics of the stress experienced by the person. These areas included family and
other interpersonal relationships, housing, nutrition, and employment.

Consideration of the areas in which the person functions offers an opportunity to integrate an additional theory into this model and so increase its comprehensiveness. Bronfenbrenner's (1979) theory of the ecology of human development includes a conceptualization of that ecology as organized in microsystems (primarily the family unit), mesosystems (neighborhood, school, work, and social life), macrosystems (subcultures or cultures), and exosystems (systems which do not directly involve the person). In the application of an interactional model of human behavior, events or situations occurring in any of these systems should be considered as possible sources of stress for the person. And, of course, events or situations occurring in any components of the systems not mentioned by Bronfenbrenner, such as religious and political organizations, should also be considered as possible sources of stress.

It must be remembered, however, that these systems not only give rise to stressful events and situations, but they also provide mechanisms for attempting to cope with stress; and these may be adaptive or maladaptive. Such mechanisms can be specified among the behaviors which the distressed person performs. These might include, depending on the nature of the stressful event or situation, protecting or
increasing one's physical well-being as opposed to excessive eating, drinking, drug use, or driving at illegal speeds; cognitively tempering negative perceptions and emotions, as opposed to losing control of one's temper; deciding to tackle the problem instead of giving up on it, putting up with it, and/or engaging in unrelated activities; using rational methods of problem-solving as opposed to wishful thinking, complaining, or ruminating; calling on family and other social support systems as opposed to withdrawing from them; recalling subcultural or cultural devices for addressing stressful events or situations, ranging from prayers to jokes, as opposed to rejecting such devices; planning ways to prevent or better manage similar events or situations in the future, rather than forgetting about them; and eventually contributing in some way to the solution of related problems faced by other people as opposed to ignoring them.

Each of these mechanisms for attempting to cope with stress, as well as other mechanisms, can be broken down into more specific behaviors; and any of the behaviors can be evaluated in terms of dimensions such as those suggested by Marsella (1982).

The factors seen as contributing to the development of the person, for better or worse, in the original interactional model of human behavior can also be specified. Physical environmental factors to be
considered include climate, terrain, the presence or absence of bodies of water, the nature of plant and animal life, and unusual features of the landscape or unusual natural events such as earthquakes, tidal waves, and destructive storms, as well as such culturally-linked physical features as open space and wooded areas, farmlands and fishing grounds, industrial and residential areas, business districts and public buildings, traffic, air quality and odors, and noise levels.

Cultural environmental factors include foods, beverages, clothing, housing and furnishings, and means of transportation and communication that are characteristic of the culture, as well as the native language of the culture, its history and literature, arts and crafts, music and dance, theater and sports, its philosophical and religious beliefs and practices, its medical, legal, educational, military, and socioeconomic systems, its social strata and customs, and its attitudes toward and interactions with other cultures.

Biological factors include genetic patterns and mutations; prenatal, perinatal, and postnatal conditions and events; gender, pigmentation, body type, and facial features; the rate and extent of physical development; the levels and balances of hormones, enzymes, and neurotransmitters, especially as related to states of arousal or activity; the acuity of sensation and
perception; illnesses, injuries, disabilities and compensation for them, and the general present condition of health, strength, endurance, and coordination.

Psychological factors include previous learning and present behavioral, cognitive, emotional, and motivational characteristics, and the nature of relationships with other people, as well as the desire and ability to make personal and situational changes.

All of these factors, like the behaviors listed earlier, can be further specified and assessed. A more difficult problem is the assessment of their interactions; however, some of these interactions can be determined by advanced multivariate statistical techniques. Meanwhile, the specification of such factors in an interactional model should be helpful in intervention and research on problems involving stress and attempts to cope with it.

Stress-coping problems may be seen as including those which have been or may be classified as paranoid; the interactional stress-coping model of behavior may therefore be applied to these particular problems for the better understanding, treatment and prevention, and further investigation of them. These applications of the master model also serve to integrate previous theory and research on paranoid disorders into the reconceptualization of them.
An Integrative Model of Paranoia

The application of the interactional stress-coping model of behavior to paranoia resulted in the model of paranoia which is shown in Figure 5. This model indicates that particular environmental, cultural, biological, and psychological factors may influence an individual to respond to events or situations perceived as stressful with covert or overt behaviors that may be classified as paranoid, according to the historically derived definition of paranoia presented earlier in this dissertation.

According to this definition, which was not only derived from historical descriptions, such as those summarized in Table 1, but was also extracted from the DSM-III-R (1987) description of delusional disorder, paranoia is a disorder characterized by persistent nonbizarre delusions of persecutory, grandiose, or other self-referential content, which are not due to other mental or organic disorders. Social and marital functioning may be impaired, while nondelusional intellectual and occupational functioning may be satisfactory. Excessively self-defensive or aggressive and violent behaviors related to the delusions may occur.

It should be noted that official definitions of paranoid disorders, as summarized in Table 4, have been basically concerned with covert behaviors and particularly with delusions, while this definition, in consonance with
Biological Factors: Hypersensitive/chronically aroused nervous system (Psychobiologic Model)

Psychological Factors: Shame, anxiety, projection (Psychodynamic Model)
External attribution, aversive learning, social isolation (Behavioral Model)
Biased information processing (Cognitive Model)

Environmental Factors: Hostile/threatening physical and cultural environments (Sociological Model)

Cultural Factors: Mistrust and suspiciousness as common cultural or subcultural attitudes; potential for violence (Cross-Cultural Models)

Event or Situation: Specific threat or harm to well-being or esteem

Covert Behaviors: Delusions of self-importance (Erotomanic Type, Grandiose Type), deception (Jealous Type), persecution (Persecutory Type) and other deliberate threat or harm; defensive in function (Psychiatric Model)

Overt Behaviors: Excessively defensive or aggressive attempts to cope with the stressful event or situation: Social withdrawal, demands for recognition, physical attack, litigation (Coping Continuum)

Figure 5. An integrative model of paranoia. (See Figure 4 and Table 2.)
this model, recognizes overt behaviors as equally important. Further, both covert and overt paranoid behaviors are seen in this model as representing attempts to cope with events or situations that are perceived as highly stressful by persons who are, inherently or through experience, extremely sensitive to them.

Thus, the covert behaviors that mark paranoia are seen as delusions that indicate extreme notions of self-importance, such as are displayed in the erotomanic and grandiose types of paranoia or delusional disorder; delusions of being deceived, such as are found in the jealous type; and delusions of being persecuted or otherwise threatened or harmed such as are found in the persecutory and possibly other types of the disorder. They may further be seen as defensive—and indeed have been since Freud (1911) so described them—as they serve to protect the person's sense of security and self-esteem and to defend against attacks on them, although the cost may be loss of contact with reality.

Overt behaviors that mark paranoia are seen as being excessively defensive or aggressive attempts to cope with stressful events or situations such as the characteristic social withdrawal and isolation of paranoid persons which both contribute to and represent ways of dealing with social and marital difficulties, and various aggressive
behaviors which are mentioned in descriptions of types of delusional disorder in DSM-III-R (1987).

The latter include the pursuit or harassment of public figures by persons with erotomanic delusions, who may be seen as attempting to cope with a lack of recognition by important persons, or with specific instances of rejection; the leadership of religious cults by persons with grandiose delusions, whose attempts to acquire, increase, and maintain authority may be seen as attempts to cope with a lack of recognition which they consider their due, or to cope with threats to such authority once it has been acquired; physical attacks on spouses or lovers by persons with jealous delusions, who may be seen as attempting to cope with deception and betrayal by punishing those "proven" to be guilty, usually by certain events or situations which offer only the flimsiest of circumstantial evidence; and legal actions undertaken by persons with persecutory delusions, who may be seen as attempting to cope with great wrongs which they believe they have suffered in specific events and situations, regardless of a lack of evidence or evidence to the contrary.

This view of paranoid behaviors as representing attempts to cope with stressful events or situations, or people involved in them, contributes the element of motivation to the understanding of paranoia, while the official diagnostic view is limited to simply describing
such behaviors. Although the inferring of motivation may be avoided in diagnosis as controversial and not amenable to verification, motivation as described in terms of coping is inherent in the description of the behaviors, and does not necessarily imply etiology, although it may suggest it. For example, the pursuit of public figures to the point of harassment which has been observed in persons with erotomantic delusions is by definition motivated by a lack of recognition of those persons on the part of the public figures; and actual rejection of such persons by the public figures whom they pursue has often been observed to intensify the pursuit. At the same time, the desire for recognition by important persons and the refusal to accept rejection makes the pursuit more understandable than if it were simply described as harassment, and it also suggests that the pursuing persons received inadequate attention from important persons early in their lives--i.e., their parents or other caregivers. This possible motivation for the maladaptive behavior at an etiological level, however, is one to be investigated rather than simply inferred.

In fact, as is made clear by the interactional model of behavior from which this model of paranoia is derived, no single influence can account for human behavior--nor, indeed, can any combination of influences, as is indicated by the emphasis on the person as an active agent in the interactional stress-coping model of behavior. The
likelihood of multiple factors as contributing to the
development of any particular kind of behavior, in fact,
became rather startlingly evident as this model of paranoia
was developed from the master model: The major models of
paranoia in the literature, as described earlier in this
dissertation, fell neatly into place under the major
factors proposed in the master model as contributing to the
development of any behavior.

Thus, the shame, anxiety, and projection pointed to by
the psychodynamic model, the external attribution, aversive
learning, and social isolation suggested by the behavioral
model, and the biased information processing demonstrated
in the cognitive model, may all be seen as possible
psychological factors in the development of paranoia.
Furthermore, they may be seen as consonant with each other.

Likewise, other internal factors such as the
hypersensitive or chronically aroused nervous system
posited in the psychobiologic model, and external factors
such as the hostile or threatening environments described
in the sociological model, or the attitudes of mistrust or
suspiciousness and the possible violence alluded to the
cross-cultural model, may be seen as biological,
environmental, and cultural factors favoring the
development of paranoia.

The proposed master model of paranoia, therefore, sees
the models developed from major viewpoints of
psychopathology not as contradictory of each other, but as complementary, each valid from its respective viewpoint and contributing to a holistic view of the disorder. In addition, this master model includes the psychiatric model of paranoia in its delineation of the covert behaviors in which the disorder is expressed, and provides motivation for all the covert and overt behaviors described by couching them in stress and coping theory. This model has therefore been identified as an integrative model of paranoia.

Empirical support for the relating of distinct patterns of psychopathology to particular sources of stress, as mentioned earlier in this chapter, may be found in a series of cross-cultural studies by Marsella and his co-workers. In a study of urban Filipino men, Marsella, Escudero, and Gordon (1971) found among symptom patterns those characteristic of depression, anxiety, psychosomatic disorders, and paranoid disorders. Paranoid fear in particular was found to be present, as revealed in the endorsement of statements that other people were plotting against or trying to harm the respondents, or that the respondents were experiencing physical symptoms of fear. Although no specific stressors leading to such fear were identified, the fear was speculatively related to generally high levels of fear and interpersonal suspicions in
Philippine culture at that time; these were seen as being derived from traditional folklore and from Roman Catholic positions that viewed the world as a dangerous place, as well as from actual high rates of crime and its explosive nature in the country. Other possible contributions to the paranoid fear were seen as being a lack of individual independence among the respondents and consequent fears of social rejection, and concern the respondents may have had about their own potential for hostility.

It must be pointed out, however, that the population in this study was a normal one, and no effort was made to find patterns of symptoms from which diagnoses of mental disorders could be made. Nevertheless, this study offers support for the proposed model of paranoia, which is based in part on a continuum view of paranoid disorders.

The integrative model of paranoia as described has obvious implications for research and intervention. It suggests the need for identification of and research on very specific factors which appear to contribute to the development of paranoia; such specific factors are suggested by the major factors, and by their components as listed in the foregoing interactional stress-coping model of behavior. For example, specific physical environmental factors might include features of weather, terrain, housing, or traffic that make almost constant caution
advisable; specific cultural environmental factors might include a frightening folklore and a high crime rate; specific biological factors might include an acute sensorium, inherited or developed as favoring survival in a physically hostile environment; and specific psychological factors might include experiences of having been targeted for or having actually experienced severe or repeated harm, leading to expectations of further malicious treatment.

As in the application of the interactional model of human behavior, such specific factors should be assessed according to at least the frequency, intensity, duration, controllability, and predictability of their occurrence; and, as this model of paranoia also suggests, their interaction should be investigated. Their relative potency, as reflecting the potency of the major factors which they represent in the development of paranoia, should also be assessed. In addition, there should be an effort to identify developmental stages during which both the major and the specific factors might be most influential.

This model of paranoia also suggests that events and situations which appear to precipitate paranoid behaviors should also be identified, along with their emotional and motivational content; and they should be evaluated particularly for the degree of stress which they evoke in
the person, and its relationship to earlier experiences.

The person's repertory of coping behaviors, both covert and overt, should also be identified, as well as their awareness of the possible consequences of employing various behaviors.

The presence or absence of these various factors, events or situations, experiences of stress, and particular coping repertories in the lives of persons who have exhibited paranoid behaviors, and also in the lives of persons who have not done so, would not only serve to validate or invalidate the model but, if the model is validated, to indicate areas for intervention in both paranoid persons and in persons at risk for the development of paranoia—which, according to the paranoid continuum, includes normal individuals. As a general example, it indicates the importance of providing individuals with physically safe and culturally accepting environments, of being sensitive to their particular sensitivities, and of fostering positive experiences and successful ways of coping with stress.

The integrative model of paranoia as presented, then, accounts for and relates to each other the major models of paranoia to be found in the literature, which reflect the major psychobiosocio approaches to the understanding of human behavior—the psychodynamic, behavioral, cognitive,
psychobiological, sociological, and cross-cultural approaches; and it also leaves room for the recognition of the human will in determining behavior. Finally, it integrates the psychiatric and stress-coping approaches to the diagnosis of psychopathology and of this particular disorder; and it serves as a point of departure for treatment, prevention, and further research.

Perhaps most important of all, it provides a testable framework for the understanding and alteration of a highly problematic kind of human behavior, within which many revisions and future developments can be accommodated.

A Model for the Differential Diagnosis of Disorders in the Paranoid Continuum

Just as the major models of paranoia in the literature fell into place when the interactional stress-coping model of behavior was applied to the disorder, producing a master model of paranoia which included and related the previous ones, so a consideration of this model as related to possible models of other disorders in the paranoid continuum revealed their relationships in terms of differential diagnosis; this is in line with the view of paranoia as the core or defining disorder in the paranoid spectrum and therefore the paranoid continuum, as earlier discussed. A model for this differential diagnosis is shown in Figure 6.
SOCIETAL PARANOIA (proposed subtype of Shared Paranoia)

Culture
Mistrust and suspiciousness as common cultural or subcultural attitudes; potential for violence

Event or Situation
Specific threat or harm to well-being or esteem

Behaviors
Delusions of reference involving threat or harm; defensive or aggressive attempts to cope with the stressful event or situation

PARAPHRAGENIA
PARANOID SCHIZOPHRENIA
ORGANIC DELUSIONAL SYNDROME

Biological Factors
Mild to severe CNS dysfunction beyond hypersensitivity and chronic arousal; aberrant perceptions

Psychological Factors
Shame, anxiety, projection; external attribution, aversive learning, and social isolation; biased information processing

SHARED (INDUCED) PARANOIA
Controlling influence of primary paranoid person to share delusions and participate in defensive or aggressive behaviors

PARANOID PERSONALITY DISORDER
PARANOID PERSONALITY DISORDER
Slight to strong suspicions that stop short of delusions of being threatened or demeaned; habitual defensive behaviors, such as avoidance; some aggressive behaviors

Event or 51 tuat Ion SHARED (IF'DUCED) PARAJIOIA
Specific threat or Control ling Influence of harm to well-being to Person(s) primary paranoid person or esteem to share delusions and participate In defensive or aggressive behaviors

Person(s)

Figure 6. A model for differential diagnosis of disorders in the paranoid continuum. (See Figure 5.)
Thus, acute paranoia, as suggested by its sudden development, short duration, and absence of chronic sequelae, appears to depend more on external or physical and cultural environmental factors than on the internal or biological and psychological factors which appear to be active in the development of paranoia and other paranoid disorders, although some predisposition to even an acute form of the disorder may be assumed. Indeed, as discussed earlier, DSM-III (1980) described the disorder as one that may be found in individuals who have experienced drastic changes in their environment, such as immigrants, prisoners of war, military inductees, and persons leaving home for the first time. Such persons may be expected not only to perceive the new environment as hostile or threatening, but to be met with mistrust or suspiciousness in the culture in which they are perceived as strangers; and, indeed, violence may be directed against them.

Likewise, societal paranoia, as proposed, depends to a large extent on environmental factors, and may involve competition with other societies for physical space and resources. More importantly, and by definition, it involves cultural or subcultural characteristics such as mistrust or suspiciousness, and a potential for violence. These characteristics might be exemplified in an excessive use of locks, the widespread possession of firearms, or xenophobic laws, regulations, and unofficial practices. As
in the case of other paranoid disorders, the development of societal paranoia depends on predisposition or temperament; this in turn is at least partly dependent on historical learning, acquired in dealing with other groups of people representing other cultures or subcultures.

While societal paranoia differs from other paranoid disorders in regard to the primacy of cultural factors in its development, it is also a shared or induced disorder, and may best be classified under that original category. It differs from the description of the original category primarily in the number of people who may be involved, and in their relationship to each other. The original category may then be identified as a familial type of shared or induced paranoid disorder, and societal paranoia may be identified as another subtype. This classification of societal paranoia seems appropriate also because the most virulent form of it appears to be induced by a paranoid charismatic leader, just as the familial subtype of the disorder is induced by a primary paranoid person.

It is interesting to note that the proposed category of societal paranoia fills what otherwise would be a gap in the model, identifying a form of paranoia in which cultural factors predominate.

On the other hand, the accumulation of evidence has led to a general assumption that the development of paraphrenia
and paranoid schizophrenia, along with other disorders with schizophrenic components, is may be basically dependent on biological factors; and organic delusional syndrome is by definition almost entirely dependent on such factors--although psychological, environmental, and cultural factors are also influential in the development, precipitation, expression, and outcome of these disorders. It should be noted that any biological determinents of paraphrenia, paranoid schizophrenia, and organic delusional syndrome are of a different kind and of greater severity than the hypersensitivity and chronic arousal which mark paranoia and other paranoid disorders, and involve aberrant perceptions rather than simply misinterpretations of incoming information.

Paranoia, in contrast to the disorders which have been primarily influenced by environmental or biological factors, has traditionally been perceived as a basically or even exclusively psychological disorder, developed as the result of inner conflict, prejudicial learning experiences, or persistently wrong-headed thinking. This explains its traditional position as the primary disorder in a particular class of mental disorders. However, from a holistic point of view, the presence of biological, environmental, and cultural factors with reciprocal influence cannot be doubted.
Shared or induced paranoid disorder also by definition differs from paranoia and other paranoid disorders in that more than one person is involved in the disorder, with the affected persons usually influenced in the development of paranoid delusions and the performance of overtly paranoid behaviors by a primary paranoid person. However, it may be assumed that the affected persons were predisposed by various environmental and innate factors to accept rather than reject or even question such delusions and excessively defensive or aggressive behaviors—in other words, they were predisposed toward developing paranoia under certain circumstances. It must be noted, however, that the category of shared or induced paranoia subsumes individual cases of paranoia, usually limited to persons in a family or similar group, and also paranoia as evidenced by a larger number of people with a common culture or subculture. It is the bringing together of such people in a particular power structure that seems to characterize shared or induced paranoia.

Paranoid personality and paranoid personality disorder differ from each other and from the previously described disorders in the intensity rather than the kind of covert and overt behaviors which characterize them. Thus, suspicions of being threatened or demeaned by others stop short of delusions that the threats and demeaning practices are actually occurring; and overt behaviors tend to be
avoidant or otherwise defensive rather than aggressive, although aggressive behaviors which are usually well within a normal range may occur.

The application of the interactional stress-coping model of behavior to the disorders of the paranoid spectrum and the paranoid continuum which have appeared in the DSM or ICD series, then, shows that they represent distinct types in a related series of disorders. They are related by the kinds of factors which have fostered their development, the kinds of events or situations which precipitated them, and the kinds of covert and overt behaviors by which they are diagnosed; and they appear to differ from each other largely by the comparative potency of the kinds of factors which influenced their development.

It may be noted that these previously or currently recognized types of disorders have been seen as related to environmental, biological, and psychological factors, although no specific disorder has been related to cultural factors. However, the new category of societal paranoia, as proposed in this dissertation, can indeed be seen as heavily influenced by factors such as the pervasive mistrust or suspiciousness which may characterize some cultures much of the time and may characterize any culture at particular times, and by the potential for violence which is inherent in such characteristics.
This model for the differential diagnosis of paranoid disorders, then, seems to support the validity of types of the disorders which have either been dropped from or never included in the DSM series, with acute paranoia representing the former—along with shared paranoia as included in the paranoid category rather than assigned to a residual one—and with paraphrenia and societal paranoia representing the latter. In doing so, this model supports the notion of a paranoid spectrum and a paranoid continuum, and should prove useful in the understanding of all these disorders, with consequent implications for intervention and research as most usefully directed toward particular areas of concern in regard to particular disorders.

A Model of Societal Paranoia

A model for societal paranoia, the proposed new category which was discussed in detail earlier, is shown in Figure 7. As in the case of the preceding models, when the interactional stress-coping model of behavior was applied to the concept of this disorder and the accumulated evidence for its existence, various factors seen as contributing to its development, precipitation, and expression fell into place and could be seen as related to each other, and could also be seen as paralleling the development of previously recognized types of paranoid disorders.
Figure 7. A model of societal paranoia.

(See Figure 5.)
Thus, in regard to the physical environment, a basic factor in the development of paranoia on a societal level, though neglected in the relevant literature, is seen as being a competition for space and resources, inevitably accompanied by hostility and threats; and factors in the cultural environment are seen as being paranoid attitudes and behaviors, including suspiciousness and violence, which are sanctioned either popularly or officially when they serve the purposes of society. Factors in the temperament or general nature of a society, which may be seen as corresponding to biological factors in individuals, include hypersensitivity to certain issues, a usual relatively high state of arousal, and erroneous perceptions of other societies. Psychological factors include a deep-seated need for pride in the society, a history of aversive relations with other societies in which certain behaviors involving them were learned, and insufficient, inaccurate, or otherwise biased information about issues of concern.

Events or situations which precipitate paranoid behaviors are seen as those which threaten or actually damage the security or prestige of the society, and they may be intensely influenced by paranoid leadership, to which a society experiencing distress is particularly vulnerable, as the earlier discussion of the proposed category made clear.
Societal behaviors seen as paranoid include the aggrandizement of the society by its members and the vilification of other societies, to a degree which is out of touch with reality and which may include the obsessive blaming of the leaders of other societies and the justification or near-adoration of the society's own leaders. Paranoid societal behaviors also include, even more unhappily, defensive and aggressive behaviors which are destructive to the resources of the society and its members as well as to opposing societies. These last behaviors, in fact, offer a supreme example of the circular effect of paranoid behaviors on the original environment and culture in which they arose, as well as on the temperament and psychological functioning of the society itself.

The utility of a model of societal paranoia such as this must be obvious for understanding, evaluating, and guiding the behaviors of large groups of people, and might be particularly useful for persons involved in such groups who are not entirely comfortable with their involvement. While it seems to suggest particular applicability to nations, it could also be applied to much smaller organizations, as was pointed out in the earlier proposal for the new category. The model also invites further research for its validation and implications.
This chapter, then, has developed the reconceptualization of paranoia and paranoid disorders beyond suggested changes in the DSM series, though consonant with them, and into models which, it is hoped, make the reconceptualization clear and useful for those concerned with this major but neglected group of disorders.
Summary and Discussion

The Need for a Reconceptualization of Paranoia

Preliminary to the presentation of a reconceptualization of paranoia and its applications for research, classification, and intervention, the need for such a reconceptualization was discussed. This need was seen as apparent in DSM-III-R, in which the concept of paranoia and other paranoid disorders was abandoned in favor of the concept of a single delusional disorder, although paranoid personality and paranoid schizophrenia were retained as other types of disorders. It was noted that the concept of paranoia continues to exist elsewhere in the psychological literature, in other professional literatures including those of political science and anthropology, and in general usage.

The need for a reconceptualization of paranoia and related disorders was also discussed in regard to the challenge of naturalistic inquiry (Lincoln & Guba, 1985) to the traditional scientific method, which assumes that phenomena can be reliably described by data which are
simple, tangible, and fragmented, and that such data are objectively obtained—although the phenomena are experienced as multiple, constructed, holistic, and inseparable from the viewpoints of the persons who experience them. Naturalistic inquiry seems especially challenging to severely reductionist conceptions of phenomena, such as the concept of delusional disorder in DSM-III-R, which is based on a single psychological feature; this has increased the perceived need for reconceptualizing paranoia and related disorders as complex phenomena experienced by human beings.

Finally, this perceived need was discussed in regard to the negative impact of paranoia on society. Although traditionally described as a rare disorder, and receiving far less attention than schizophrenia and mood disorders, paranoia has been diagnosed in clinical and other reports as affecting cult leaders, Presidential assassins, and major political figures themselves, including Adolf Hitler; it has been implicated in witch-hunts, in the forty-five years of the "cold war" between the U.S. and the U.S.S.R., and, at the other end of the social structure, in fatal traffic accidents and in domestic abuse and violence. A reconceptualization of paranoia that recognizes its social significance, and indicates directions for intervention, seems long overdue.
An Overview of the Concept of Paranoia

History. An overview of the vicissitudes of the concept of paranoia was then presented. This included a history of the concept, beginning with the invention of the word by the ancient Greeks, who, contrary to the usual interpretation, did not use it only as a general word for madness but also with the connotation of wrong thinking, as different from mania, melancholia, and other kinds of madness.

It was also noted in the history that the approach to madness in Biblical times and cultures was a moral one, taken in terms of sin rather than psychopathology; this approach was extended through the Dark and Middle Ages and well into the Renaissance.

With the beginnings of the modern scientific approach to psychopathology in the mid-18th century, however, paranoia was resurrected as a term for madness in general. It was Heinroth, Kahibaum, and particularly Kraepelin and Freud at the end of the 19th century, who used it to identify a specific disorder of the intellect; and the delusional disorder described in DSM-III-R is taken from part of Kraepelin's description of paranoia--which he kept revising throughout his lifetime. Indeed, the description and concept of paranoia have been in continual revision by various investigators ever since; paranoia has been seen as a form of schizophrenia, a type of masked depression, a
normal adaptive behavior, and a useless construct (see Table 1). But no matter how thrashed over, it has survived in both professional and popular thinking.

Models. Following the history of the concept of paranoia, models of the disorder derived from major theoretical approaches were reviewed. These included (a) the psychiatric and particularly Kraepellean model in the four editions of the DSM (1952, 1968, 1980, 1987), each of which presented revised nomenclature and different types of paranoid disorders; (b) the psychodynamic model, which emphasizes the role played in paranoia by the projection of unacceptable impulses, as first described by Freud (1962/1911) in regard to the case of Schreber, and still supported (e.g., Meissner, 1981), although the impulses are no longer considered to be necessarily homosexual; (c) the behavioral model developed by Haynes (1986), which describes paranoia as behavior originally learned in early aversive family interactions, including external attribution, and maintained by social isolation; (d) the cognitive model used for a computer simulation of paranoia by Colby (1975) and consonant with Magaro's (1981) hypotheses about one-sided information processing; (e) the psychobiologic model developed by Marinello (1989), which defines paranoia as the maintenance of the normal physiological emergency state; and (f) the sociological model of Mirowsky and Ross (1983), which describes paranoia
as alienation from society that has been extended into a sense of persecution. (See Table 2.) It was also noted that other models of paranoia exist or are being developed in the literature, which are derived from less prominent orientations to psychopathology; these include cross-cultural models.

**Issues.** Unresolved issues found in the literature on paranoia were then reviewed, particularly as related to the conceptualization of the disorder. These included the following: (a) the classification of paranoia (delusional disorder) and paranoid disorders, including nomenclature used, and types and subtypes recognized; (b) the relationship of paranoid personality disorder, which does not feature delusions, to disorders in which delusions are essential features; (c) the relationship of paranoid schizophrenia to the paranoid disorders, as it has traditionally been classified as a type of schizophrenia but differs significantly from other types; (d) the diagnosis and differential diagnosis of paranoia (delusional disorder) and related disorders, and of these and other categories of disorders; (e) the assessment of paranoid disorders and their characteristics; (f) the epidemiology of paranoia (delusional disorder), particularly its presumed rare occurrence; (g) the etiology of paranoia, including genetic and physiological correlates or the absence of them; (h) the course and probable outcome
of paranoia and related disorders; and (1) the treatment of paranoia and its effectiveness or ineffectiveness, and suggestions for the prevention of the disorder.

A Reconceptualization of Paranoia

A reconceptualization of paranoia was then proposed, in conjunction with possible applications to the classification of paranoia and related disorders in the DSM series.

In this reconceptualization, paranoia is seen as an historically widely recognized disorder, and the core disorder in a spectrum of paranoid disorders, distinct from schizophrenia and depression. The paranoid spectrum includes types previously described in the literature and a new subtype, societal paranoia, proposed in this dissertation. The paranoid spectrum is further seen as being on a continuum with normal-range paranoid tendencies at one end, and globally psychotic delusional disorders at the other (see Figure 1).

The definition of paranoia offered was derived from descriptions in the literature of the disorder, including the description of delusional disorder in DSM-III-R:

Paranoia is a mental disorder characterized by the presence of persistent nonbizarre delusions of persecutory, grandiose, or other self-referential content, which are not due to other mental or organic disorders. Social and
marital functioning may be impaired, while nondelusional intellectual and occupational functioning may be satisfactory. Excessively self-defensive or aggressive and violent behaviors related to the delusions may occur.

However, it was emphasized that as a definition of delusional disorder, this was abstracted from the total description of the disorder and its types, and that only one essential feature is required for diagnosis—the presence of persistent nonbizarre delusions, regardless of content. Nevertheless, the types are listed (alphabetically) by content: Erotomanic, grandiose, jealous, persecutory, and somatic; and all but possibly the last of these seem to be clearly related to the self-defense or positive self-esteem of affected persons. In other words, the delusions appear to be marked not only by their intensity and duration, but by the defensiveness and self-aggrandizement that have traditionally been called paranoid. Including the general nature of the delusions as part of the essential feature of the disorder would seem important in diagnosis and treatment; and it supports the proposed change in the name of delusional disorder to paranoia—particularly since delusions are prominent in other disorders.

It was further suggested that the DSM description of paranoia explicitly include the dimensions of overt behavior referred to in the abstracted definition; these
are, in fact, what are likely to bring the delusional person to professional attention, rather than the delusions themselves, and they may have highly significant effects on society.

It was then shown that other disorders which exhibit paranoid delusions or overt paranoid behaviors, perhaps in addition to other prominent features, can be defined as part of the paranoid spectrum or the paranoid continuum with reference to their departure from the enlarged definition of paranoia. Thus, paranoid personality and paranoid personality disorder feature tendencies toward delusions, such as suspicions of varying intensity, rather than actual delusions; shared (induced) paranoia features other person(s) participating in the primary case of paranoia; acute paranoia differs from classic paranoia in the duration of the paranoid delusions and overt behaviors; paraphrenia and paranoid schizophrenia are characterized by varying schizophrenic-like as well as paranoid features; and organic delusional syndrome is distinguished from paranoia by the presence of known organic etiological factors. (See Table 4.)

The paranoid spectrum was described as including only those disorders in which delusions are the most prominent features—i.e., shared (induced), acute, and "simple" paranoia, and paraphrenia; paranoid personality and paranoid personality disorder, which are not delusional,
and paranoid schizophrenia, which features bizarre delusions and hallucinations, have traditionally been excluded from the DSM paranoid spectrum, but are seen in this reconceptualization as part of a paranoid continuum. Organic delusional syndrome, usually referred to only in differential diagnosis, is also seen as on the continuum.

This holistic reconceptualization of paranoia and other paranoid disorders, then, involving not only delusions but overt behaviors and emotional/motivational components of the disorders, provides a means for relating the otherwise isolated concept of delusional disorder to paranoid personality disorder and to paranoid schizophrenia—relationships and nomenclature which are referred to as problematical in DSM-III-R. It also provides a means for restoring the previously recognized syndromes of shared (induced) paranoid disorder, acute paranoia, and paraphrenia to an official place in the diagnostic manual, and thereby additionally provides official references for the literature on these disorders. Further, it provides a means for relating clinically significant paranoid behaviors to behaviors within the normal range and to globally psychotic delusional behaviors. Finally, it provides an organized basis for the diagnosis and differential diagnosis of paranoia and related disorders, for their assessment by means other than the diagnostic manual, for investigating the prevalence and other demographic
variables of the various disorders of interest, for conducting longitudinal studies, and, as noted above, for treatment and prevention.

Research suggested by this reconceptualization, and its application in intervention, would in turn be useful in validating or modifying the reconceptualization. Recommendations for specific research problems will therefore be discussed at the end of this chapter.

Contingent Changes in the DSM Classification of Paranoia and Related Disorders

It was recalled that the DSM classification of paranoid (delusional) disorders has changed with every edition, and currently differs from the classification in ICD-9 (1989) (see Table 3). Further changes are likely to be made in future editions, contingent upon developments in theory and research. Specific changes contingent upon the reconceptualization of paranoia and related disorders presented in this dissertation, and intended in part to reconcile varying observations presented in the other diagnostic manuals, were proposed for consideration. They include the following:

1. Restoring the DSM-III-R categorical name Delusional (Paranoid) Disorder to Paranoid Disorders.

This would revert to former DSM, present ICD-9, and other professional and general usage. Presumably set in
the manual between schizophrenia and mood disorders, as is delusional disorder, it would be recognized as one of the three major groups of psychoses, distinct from the other two. The name would indicate that paranoia is the identifying concept among several disorders, and that delusions are the most prominent feature; the retention of the term "delusional" would also provide a useful link with DSM-III-R.

In the general introduction to this group of disorders, it would be helpful to observe that paranoid behaviors of insignificant frequency, intensity, or duration may occur within the normal range of behaviors, and that extreme paranoid behaviors are among the prominent features of disorders not classified with this group--i.e., paranoid personality disorder, paranoid schizophrenia, and organic delusional syndrome.

2.Naming paranoia as the primary and defining disorder among other paranoid disorders, using the definition derived from historical descriptions of the disorder, which may also be abstracted from the DSM-III-R description of delusional disorder. For continuity in the DSM series, paranoia may parenthetically be called delusional disorder.

Paranoia would thus be defined as a mental disorder characterized by persistent nonbizarre delusions of persecutory, grandiose, or other self-referential content, which are not due to other mental or organic disorders.
Social and marital functioning may be impaired, while nondelusional intellectual and occupational functioning may be satisfactory. Excessively self-defense or aggressive and violent behaviors related to the delusions may occur.

3. Noting that erotomania as a subtype of paranoia is a misnomer: according to DSM-III-R, it is most often characterized not by erotic or sexual delusions but by idealized romantic delusions.

Nevertheless, the long use of the name in the literature of this subtype would make a change in name unnecessarily complicating.

4. Either further justifying the inclusion of the somatic subtype of paranoia, or else deleting it from paranoia and classifying subtypes of it with body dysmorphic disorder or hypochondriasis, or other somatoform disorders—or else assigning them to residual categories.

In addition to including somatic features, these delusions differ from erotomaniac, grandiose, jealous, and persecutory subtypes in not being concerned with self-defense or self-esteem, and appear to be more associated with anxiety than with anger.

5. Deleting nonmalevolent delusions from the unspecified subtype, and including nonbizarre delusions of reference; and also providing for the inclusion of delusions that may exist in other cultures or be developing in our own.
The latter seems particularly important as recent research has indicated that delusional content varies with culture and over time (Mitchell & Vierkant, 1989); and contemporary convictions, such as those involving group supremacy, are not rare.

6. Reinstating shared paranoid disorder (DSM-III, 1980) or induced psychotic disorder (DSM-III-R) among the paranoid disorders.

This would indicate its definition as paranoia shared by two or more persons, having been induced in the second by the first. Additionally, it would provide links with both DSM-III and DSM-III-R, and with the recognition of paranoia as existing on societal levels.

7. Also reinstating acute paranoid disorder (DSM-III) among the paranoid disorders.

This would indicate its sudden onset and brief duration in association with major environmental stresses, and also its identification by the same covert and overt behaviors which mark paranoia, as well as its good prognosis.

8. Including paraphrenia among the paranoid disorders.

Paraphrenia, a syndrome in which relatively mild paranoid and schizophrenia-like features are both prominent, but which occurs later in life than either schizophrenia or paranoia, was recognized by Kraepelin (1896/1921), is identifiable with the paranoid state classification in DSM-I (1952) and the involutional
paranoid state classification in *DSM-II* (1965), has received considerable attention (e.g., Bridge & Wyatt, 1980), and is recognized in *ICD-9* (1989). Most recently, Munro (1982, 1987, 1989) has argued convincingly for its inclusion among paranoid disorders in the *DSM* series, noting that this syndrome does not fit into any other category.

9. Finally, introducing a new category into the paranoid disorders, societal paranoia, a form of paranoia in which large groups of persons or even nations participate, usually under the leadership of a charismatic paranoid person, overriding any internal dissent, sharing paranoid delusions, and performing or sanctioning paranoid behaviors based on those delusions.

Identifying this category would be important for the diagnosis and treatment of individuals involved in such groups, for the psychological and other professional study of such groups, and for the well-being of society as a whole.

This category could be the second of two subtypes of shared (induced) paranoia, the first being called familial paranoia and including *folie a deux* and paranoia shared by other intimate groups.

Overall, these proposed changes in the *DSM* classification of paranoia and related disorders, based on the proposed reconceptualization of paranoia and other
recent theory and research, were presented as an attempt to organize, incorporate, and extend, rather than simply supersede, information from the earlier DSM editions and other psychological literature.

The consequent avoidance of "temperocentricity" in classification and diagnosis would have general implications for the DSM series, as would the avoidance of ethnocentricity alluded to in the 5th proposed change, which refers to cross-cultural as well as temporal differences affecting diagnosis. More obvious general implications that the proposed changes would have for the DSM series may be seen in the inclusion of overt as well as covert behaviors as a necessary part of the essential features of disorders, and in the recognition of not only paranoia but perhaps other kinds of disorders as existing on the societal as well as the individual level.

Further Reconceptualization

The proposed reconceptualization of paranoia and related disorders was then discussed as having applications and implications beyond those described above in reference to classification in the DSM series. A series of models were created, based on the reconceptualization and other theory, especially Marsella's (1984), to help explain the development, precipitation, maintenance, and expression of paranoia and related disorders, to indicate both their
similarities and the points at which they depart from each other as well as from normal behavior, and to suggest appropriate points for intervention and research.

An interactional stress-coping model of behavior. A general model for understanding both covert and overt behaviors as attempts to cope with stress was created as a template from which a model for paranoid behaviors could be developed. This general model combined Marsella's (1982) interactional model of human behavior, and Marsella and Scheuer's model of the coping evolution continuum (1988).

The Marsella model of behavior (see Figure 2) depicts behavior, whether normal or abnormal, as resulting from the interaction of a person and a situation, and as also affecting both the person and the situation; the person has been shaped by the impact of both internal and external variables and their interactions, and the person has also affected these variables. This model, as has been noted, is consonant with the holistic approach of naturalistic inquiry to the investigation of phenomena; derived models consequently take a holistic approach.

The Marsella and Scheuer coping model (see Figure 3) views coping behavior as on a continuum from random behavior, through reflexive and defensive behaviors, to mastery; the progression in coping is associated with progression from negative to positive states of being.
Our patients are sick not merely in an abstract mind, but by actually living in ways that put their minds and the entire organism and its activity in jeopardy, and we are now free to see how this happens—since we study the biography and life history, the resources of adaptation and of shaping the life to success or failure.

--Adolf Meyer

*The Contributions of Psychiatry to the Understanding of Life Problems* (1921)
In the combined interactional stress-coping model of behavior (see Figure 4), it is the stressful nature of situations or specific events which elicit the behaviors of concern from the person. These behaviors represent automatic, defensive, or direct attempts on the part of the person to cope with the stressors, and are classified along the coping continuum as proceeding from maladaptive to adaptive, and as varying over time. These behaviors in turn affect the person and the immediate situation or event, and ultimately the external and internal variables which have shaped and continue to shape the person.

**An integrative model of paranoia.** A holistic model of paranoia was then developed from the general interactional stress-coping model of behavior; other models of paranoia derived from major theoretical approaches (see Table 2) fortuitously and neatly fit into this model, making it a highly integrative one (see Figure 5).

Thus, the integrative model identifies external factors that may predispose a person to paranoia as including hostile or threatening environments, described in a sociological health model (Mirowsky, 1985), and negative cultural attitudes and overt behaviors, suggested by cross-cultural models (Torrey, 1981). Internal factors cited in the integrative model as predisposing to paranoia include biological factors, particularly chronic nervous...
system malfunction or arousal, described in psychobiologic models (Pavlov, 1934; Marinello, 1989), and various psychological factors such as projection, aversive learning, and selective information processing, discussed respectively in psychodynamic models (Freud, 1896-1933/1962; Meissner, 1981), a behavioral model (Haynes, 1986), and cognitive models (Colby, 1975; Magaro, 1981).

The integrative model of paranoia proposes that precipitating factors are specific threats or damage to the person's security or esteem, to which the person is highly sensitive due to physiological factors and/or earlier experiences. The resultant covert and overt behaviors, on which the diagnosis of paranoia rests in the reconceptualization, are described in the model as including delusions, as derived from the psychiatric model of delusional disorder (DSM-III-R), and maladaptive defensive or aggressive attempts to cope with the stressful precipitating events or situations.

The mechanism for the maintenance of paranoia is indicated in the proposed model by the reciprocal impact of the person's delusions and excessive defensiveness or aggressiveness on the person's own distressed condition, on the events or situations that evoked the behaviors, and on environmental, cultural, biological, and psychological factors that predisposed the person to paranoia in the
first place. In other words, paranoia becomes a self-reinforcing system, unless intervention is accomplished at some point.

Appropriate points for intervention are suggested by this model, however: It appears possible that the effects of hostility in the environment or in the culture could be reduced by supportive attitudes and actions on the part of those dealing with the paranoid person, if not by ameliorating environmental and cultural conditions; chronic arousal could be reduced by increasing the person's ability to enjoy pleasurable activities; and psychotherapy could be directed toward recognizing projection, learning positive behaviors for personal interaction, and widening the person's range of attention, decision-making, and reality testing. Such interventions are, in fact, commonly used to treat other disorders; the integrative model of paranoia indicates the various points at which particular problems may exist for paranoid persons, and at which therapeutic techniques might be most effectively applied. Various specific treatments for paranoid disorders have been equivocally successful; a multi-targeted or holistic approach to diagnosis and treatment therefore seems indicated.

The holistic integrative model of paranoia, then, takes the reconceptualization of paranoia beyond classification to intervention.
A model for differential diagnosis of disorders in the paranoid continuum. A model was then developed to show the similarities and differences among paranoia and related disorders, in accordance with the reconceptualization of paranoia as the core or defining disorder in a spectrum of disorders, which are distinct from schizophrenia and mood disorders, and which are on a continuum with normal paranoid tendencies at one end and globally psychotic delusional disorders at the other (see Figure 1).

The components of the paranoid spectrum and the paranoid continuum were discussed earlier in some detail, particularly in regard to the application of the reconceptualization of paranoia to DSM classification. When these disorders were superimposed, according to their most salient features, on the holistic integrative model of paranoia, the fit—as in the case of relating other models of paranoia to the holistic model—was remarkable (see Figure 6).

Thus, acute paranoia may be seen as differing from "simple" paranoia primarily in regard to the heavy contribution of current or recent environmental factors (Mirowsky, 1985); biological or organic factors have been suspected or identified as contributing to paraphrenia (Bridge & Wyatt, 1980), paranoid schizophrenia (e.g., Magaro & Page, 1983), and organic delusional syndrome (DSM-III-R, 1987); shared (induced) paranoia obviously
differs from other paranoid disorders in the number of persons involved; and paranoid personality and paranoid personality disorder differ from each other (Turkat & Banks, 1987) and from related disorders (Millon, 1983) in the intensity rather than the nature of covert and overt behaviors: suspicions do not proceed to delusions, and overt behaviors are not as extreme.

Furthermore, the area with which no previously identified paranoid disorder can be strongly associated is that of the cultural environment; and this vacancy can neatly be filled by societal paranoia, the new category proposed in this dissertation.

It should be noted that this model serves not only to differentiate among paranoia and related disorders, but to support the concepts of a paranoid spectrum and a paranoid continuum, and the proposed holistic approach to psychopathology.

A model of societal paranoia. Finally, a model for the proposed new category of societal paranoia was developed (see Figure 7); it was based, like the model for differential diagnosis, on the holistic integrative model of paranoia. As a subtype of shared (induced) paranoia, societal paranoia has as its most salient feature the involvement of persons other than the primary paranoid person in delusional and excessively defensive or aggressive behaviors. It differs from the earlier
recognized shared paranoid disorder (DSM-III, 1980) and induced psychotic disorder (DSM-III-R, 1987) in the large numbers of persons who may be involved, ranging from street gangs to nations; in the former edition of the manual, the disorder was essentially limited to folie a deux, and in the latter to family members numbering up to 12. Such intimate group or familial paranoia may be considered the first subtype of shared (induced) paranoia.

Differences between the model of societal paranoia and the basic model of individual paranoia are those which have to do with the numbers of persons involved; the model of societal paranoia was designed to be parallel to that of individual paranoia, and the parallels were not difficult to find, in the literature of political science (e.g., Hofstadter, 1965) as well as psychology (e.g., Silverstein, 1989), and, of course, in the contemporary public media.

Thus, the unit for diagnosis and intervention in societal paranoia is not the person but the society with paranoid ideation; physical environmental factors which predispose societal groups to paranoid behaviors include competition for space and resources; cultural factors include the sanctioning of paranoid attitudes and behaviors when the purposes of the society are served by such sanctioning; innate factors are described not as biological but temperamental in regard to a society, and include easy arousal; psychological features include a history of
aversive relationships with other societies; events or situations which evoke paranoid behaviors are seen as specific threats or damage to the society's security or prestige; and the paranoid behaviors include delusional conviction of the superiority of one's own society and the inferiority of others, and defensive or aggressive behaviors which ultimately are destructive to one's own society as well as to others.

Perhaps more than any other part of the reconceptualization of paranoia presented in this dissertation, societal paranoia could be profitably investigated, especially as applied to perhaps the most urgent problem facing our society, that of warmaking. Whether or not the model of societal paranoia can be validated, it forces us to question whether behaviors that are considered pathological on the personal level should be not only acceptable but praiseworthy on a societal level. And, in regard to general psychological theory, it forces us to reconsider the meaning of normality, and whether, to return to the principles of naturalistic inquiry, investigation can indeed be value-free.

In sum, then, this dissertation has addressed the need for a reconceptualization of paranoia, traced the history of the concept, described the major models and issues to be found in the pertinent literature, and presented a
reconceptualization of the disorder with suggestions for consequent changes in DSM classification, a holistic integrative model of the disorder particularly useful for intervention, and derived models for differential diagnosis and for the investigation of a proposed new category, societal paranoia.

Recommendations for Further Investigation

This dissertation is intended as a source for a series of hypotheses about paranoia and related disorders which no doubt will take many years to investigate, but the investigation of which should be very much worthwhile in such a neglected, disputed, but significant field. The dissertation will therefore end with an open-ended list of specific questions for research in regard to the issues in the literature on paranoia, which were discussed earlier, and the reconceptualization of paranoia, which has been the primary topic.

The following list of questions is by no means exhaustive, but it is intended to be basic, and could give rise to more specific questions for research. The questions are arranged in related clusters.

1. Delusions as defining criteria. Does delusional disorder in fact exist in terms of its strict definition—that is, as a disorder of which the only essential feature is the presence of persistent nonbizarre
Research related to psychopathology is an active ingredient of psychology, anthropology, physiology, genetics, and many other disciplines. All mental health professionals are strongly affected in their practice by their conceptualization and knowledge of advances in psychopathology.

--G. L. Klerman

*Historical Perspectives on Contemporary Schools of Psychopathology* (1986)
delusions in the absence of other organic or mental disorders?

In clinical populations, how were cases so diagnosed brought to official attention? Was maladaptive behavior a condition for referral and diagnosis? If so, should not such behavior be considered to be a second essential feature?

In both normal and clinical populations, what is the association of persistent nonbizarre delusions, or a tendency toward them, and various kinds of maladaptive behavior? To what extent does maladaptive behavior differentiate clinical from normal populations who have delusional experiences? (The answer to this last question should have implications far beyond the specific topic.)

Finally, does the primary concern with delusions, seen in the new name and basic description of this category, hamper the recognition of paranoid behaviors by clinicians, and downplay the importance of such behaviors to society?

2. Behavioral characteristics. To what extent does the maladaptive behavior of delusional persons include (a) impaired social functioning, (b) impaired marital functioning, (c) excessive self-defense, (d) aggression, (e) violence, and (f) other maladaptive behavior. (The last should be specified, and may include behaviors that seriously affect only the delusional persons themselves.
Any significant findings should be mentioned in the official description.

3. Delusional dimensions. Is emotional intensity not only an important dimension of delusions, but perhaps basic to their development? What kinds of emotions are involved?

4. Delusional content. What proportions of persistent nonbizarre delusions are (a) erotomanic, (b) grandiose, (c) jealous, (d) persecutory, (e) somatic, (f) mixed, and (g) of other specific content, such as being doomed to disaster? If almost all persistent nonbizarre delusions fall into the first six categories, as DSM-III-R implies, and especially if "other" delusions exhibit the same concerns, the self-referential nature of the delusions should be added to their basic description. If significant numbers of delusions fall into subtypes in the last category, these should also be noted in the official description and be investigated.

5. Delusions and hallucinations. Are delusions in fact on a continuum with hallucinations as Zigler and Levine (1983) proposed, and have delusional adults experienced hallucinations during early developmental periods, or do hallucinations early in life predispose to delusions later in life? If so, the official description of delusional disorders and paranoid schizophrenia should include this information.
6. **Common denominators of paranoid delusions.** Do most paranoid delusions involve self-defense and self-esteem? False attribution (projection)? If so, this should be noted in the description. If so except in the case of the somatic type of delusions, should this type then be assigned to another disorder? If a significant number of delusions do not involve self-defense and self-esteem, what other functions might the delusions serve? (The last question need not be answered in the official classification system, but seems to be an important question for research and treatment.)

7. **Delusions in the paranoid spectrum.** To what extent are persistent nonbizarre delusions of self-reference, and related maladaptive behaviors, found in the various disorders which have been proposed as being part of the paranoid spectrum? These include (a) induced psychotic disorder (DSM-III-R), (b) acute paranoid reaction (ICD-9), and (c) paraphrenia (ICD-9).

8. **Delusions in related disorders.** To what extent are persistent nonbizarre delusions of reference, and related maladaptive behaviors, found in other disorders proposed as being part of a paranoid continuum? These include (a) paranoid personality disorder (DSM-III-R), (b) paranoid schizophrenia (DSM-III-R), and (c) organic delusional syndrome (DSM-III-R).
9. Delusions in nonparanoid disorders. To what extent are delusions, and related maladaptive behaviors, found in disorders outside the paranoid spectrum, particularly schizophrenia, schizoaffective disorder, and mood disorders; and how do they differ from delusions within the spectrum in regard to frequency, intensity, duration, and both substantive and emotional content?

10. Common denominators in nonparanoid delusions. Are the delusions and related maladaptive behaviors found in disorders outside the paranoid spectrum also concerned with self-defense and self-esteem, and how do they differ from paranoid disorders in this regard? Can the differences be at least partly explained by the ways in which persons respond to challenges?

11. Epidemiology of paranoid disorders. What is the prevalence of delusional disorder and other disorders in the paranoid spectrum? What are the correlations with age of onset, sex, mental disorders of family members, divorce, socioeconomic status, urban dwelling, and other demographic variables? With abuse and other psychological variables?

12. Paranoid characteristics in normal populations. What is the prevalence of paranoid personality vs. paranoid personality disorder in normal populations (Turkat & Banks, 1987)? What are the significant differences between them, and how are they related over time?
13. **Paranoid characteristics and physical problems.**
What physical problems have been diagnosed in persons with paranoid disorders or persons with subclinical levels of paranoid characteristics? Are these persons at particular risk for cardiovascular or other diseases?

What are the major physiological correlates of such persons?

14. **Paranoid characteristics and neurological problems.** What neurological or neuropsychological problems have been diagnosed in persons with paranoid disorders or with subclinical levels of paranoid characteristics? Do their WAIS-R scores show significant left-brain/right-brain differences, and do a significant number of persons with such differences show abnormal levels of paranoid characteristics? Can such differences in WISC-R scores indicate the vulnerability of children to paranoid disorders later in life?

What perceptual problems may exist in paranoid disorders, and to what extent may they be neurologically, as opposed to cognitively, based?

15. **Etiology of paranoid disorders.** To what extent have persons with paranoid disorders experienced, as members of micro-, meso-, macro-, or exosystems, (a) hostile or threatening physical environments; (b) mistrust and suspiciousness directed toward them; (c) hypersensitive or easily aroused nervous systems; (d) excessive shaming or
other aversive training; (e) a tendency toward "one track" thinking; or (f) specific threats or damage to their sense of security or esteem, immediately preceding the onset or exacerbation of their disorders? How do persons with these disorders compare with control groups on these measures? How do they compare with persons with other kinds of disorders?

16. Course and prognosis. What are the abilities and skills that enable paranoid persons to function reasonably well in society or to return to it after brief hospitalization, and how can these be enhanced? How can enduring paranoid characteristics be ameliorated or turned to benign purposes? How can the paranoid experience be so used?

17. Treatment and prevention. What are the implications of the possible contributing factors listed above for the treatment and prevention of the disorders of the paranoid spectrum? To what extent have various treatments already been found to be effective in these disorders, and how can this information be incorporated into new approaches? What preventive factors seem to have been at work in the lives of persons who experienced any of the possible contributing factors listed above, but who did not develop paranoid disorders?

18. Delusions in nonWestern cultures. Do delusions of the types listed in DSM-III-R exist in other cultures? Are
other kinds of delusions prominent in other cultures? Which are associated with excessively defensive or aggressive behaviors?

19. Societal paranoia. Do historical, recent, or present wars, as analyzed by historians and political scientists, fit the model of societal paranoia? How good is the fit? Does the model fit sociological theories of group violence, of racism, or of other sociological problems? What techniques can be used or developed for intervention on a societal level?

20. The relationship of societal and individual psychopathology. What is the correspondence between factors in the development of paranoid disorders and techniques used to gain popular support for wars, to recruit members for cults, or to convince individuals for other purposes that they have been seriously wronged or threatened and must gain a superior position? What techniques used by political prisoners to avoid brainwashing, or developed by therapists for the return to society of former cult members, might be useful in the treatment of paranoid disorders? How can manipulation be distinguished from the dissemination of information and education, and how can vulnerable persons learn to make the distinction?

What other overlapping areas between societal problems and individual psychopathology can be discerned, studied,
and addressed, in order to promote the well-being of societies and individuals?

A basic need in proceeding with research on these and other questions, as noted earlier, is the development of instruments for the assessment of paranoia (delusional disorder) and related disorders. There is also a basic need for large-scale general surveys using these instruments, particularly because of the presumed rarity of the core disorder. And it would be endlessly helpful in future investigations if the next DSM edition returned to the original nomenclature of paranoia and paranoid disorders, if for no other reason than that the double nomenclature required to refer to both historical and current literature is very cumbersome indeed to use. More importantly, and contrary to the intent of those responsible for providing it, the new nomenclature is complicating rather than clarifying, or at least has been found so in the writing of this dissertation; and, as discussed above, the exclusive reference to delusions in the name and basic description of this disorder may be misleading and even obstructive to further research and intervention.

In any case, as stated at the beginning of this dissertation, there appears to have been a need for a review of the history of the concept of paranoia, a survey
of models of the disorder, and an identification of issues in regard to it and related disorders. All of these were seen as necessary preliminaries to a reconceptualization of paranoia and related disorders in terms of DSM classification, and a further reconceptualization, consonant with new theoretical developments in the investigation of phenomena, in terms of a master model to be used in research and intervention.

It is hoped that this dissertation has approximated these goals, and that the provision of a coherent and comprehensive conceptual basis for the understanding of paranoid disorders, whatever the weaknesses of that basis may be, will serve to support further work in a much neglected but highly significant area of psychopathology.

Finally, it should be noted that the proposed reconceptualization of paranoia and related disorders has general implications for psychology and psychopathology. In regard to psychological studies, it has endeavored to show the value of theoretical studies which seek to relate accumulated masses of data; this is in contrast to the view that premium or even exclusive value should be placed on the accumulation of masses of data. At the same time, the utility of theoretical studies as points of departure for future data-gathering has been pointed out.
In regard to psychopathology, this reconceptualization of paranoia and related disorders has raised concerns about the present official diagnostic system, including the following: (a) The appropriateness of a reductionist as opposed to a comprehensive approach to mental disorders; (b) the emphasis on intellective and emotional symptoms, to the neglect of behaviors that actually bring persons to clinical attention; (c) the lack of reference to behavioral motivation or the function of disorders that would seem essential to the understanding and treatment of them; and (d) the assumption that psychopathology exists only on individual and not societal levels, and that it is to be defined in terms of deviance from the norms of specific groups, rather than from across-group value systems.

It is proposed, rather, that mental disorders are to be studied and treated as complex phenomena requiring a holistic consideration of the persons experiencing them; that such persons are identified primarily on the basis of their overt behaviors rather than their inner experiences, and these behaviors should therefore be an essential part of diagnosis; that such behaviors may be seen as the attempts of the persons to cope with severe or prolonged stress; that pathological ideation, emotion, and behavior may characterize large groups and even nations as well as individuals, and are in need of recognition and intervention; and that there are ultimate human
values—such as those expressed in the Preamble to the *Ethical Principles of Psychologists* (1981)—which should inform our attempts to identify, investigate, treat, and prevent mental disorders.
Appendix A

DISMANTLING OF PARANOIA AND PARANOID DISORDERS
(Index of DSM-III-R Diagnoses and Selected Diagnostic Terms,

Paranoia. See Delusional (paranoid) disorder 199(202)

Paranoid disorder. See Delusional (paranoid) disorder 199(202)

Acute. See Psychotic disorder not otherwise specified 211

Atypical. See Psychotic disorder not otherwise specified 211

Shared. See Induced psychotic disorder 210(211)

Paranoid personality disorder 337(339)

Paranoid type, Schizophrenia 197(197)
Appendix B

DELUSIONAL (PARANOID) DISORDER


297.10 DELUSIONAL (PARANOID) DISORDER

The essential feature of this disorder is the presence of a persistent, nonbizarre delusion that is not due to any other mental disorder, such as Schizophrenia, Schizophreniform Disorder, or a Mood Disorder. The diagnosis is made only when it cannot be established that an organic factor initiated and maintained the disturbance.

Apart from the delusion or its ramifications, behavior is not obviously odd or bizarre. Auditory or visual hallucinations, if present, are not prominent. This category was called Paranoid Disorder in DSM-III. However, since delusions are the primary symptom of this disorder and the term paranoid has multiple other meanings, which can cause confusion, the term Delusional Disorder is used in this manual.

Current evidence from demographic, family, and follow-up studies suggests that Delusional Disorder is probably distinct from both Schizophrenia and Mood
Disorders. The differentiation of Delusional Disorder from severe Paranoid Personality Disorder is less clear.

**TYPES AND ASSOCIATED FEATURES.** The following delusionary themes are commonly seen in Delusional Disorder: erotomanic, grandiose, jealous, persecutory, and somatic. The type of Delusional Disorder is based on the predominant delusional theme. Cases presenting with more than one delusional theme are frequent.

**Erotomanic Type.** The central theme of an erotic delusion is that one is loved by another. The delusion usually concerns idealized romantic love and spiritual union rather than sexual attraction. The person about whom this conviction is held is usually of higher status, such as a famous person or a superior at work, and may even be a complete stranger. Efforts to contact the object of the delusion, through telephone calls, letters, gifts, visits, and even surveillance and stalking are common, though occasionally the person keeps the delusion secret.

Whereas in clinical samples most of the cases are female, in forensic samples most are male. Some people with
this disorder, particularly males, come into conflict with
the law in their efforts to pursue the object of their
delusion, or in a misguided effort to "rescue" him or her
from some imagined danger. The prevalence of erotic
delusions is such as to be a significant source of
harassment to public figures.

**Grandiose Type.** Grandiose delusions usually take the
form of the person's being convinced that he or she
possesses some great, but unrecognized talent or insight,
or has made some important discovery, which he or she may
take to various government agencies (e.g., the Federal
Bureau of Investigation or the U.S. Patent Office). Less
common is the delusion that one has a special relationship
with a prominent person, such as being the daughter of a
movie star or an advisor to the president, or that one is
the prominent person, in which case the actual person, if
alive, is regarded as an imposter. Grandiose delusions may
have a religious content, and people with these delusions
can become leaders of religious cults.

**Jealous Type.** When delusions of jealousy are present, a
person is convinced, without due cause, that his or her
spouse or lover is unfaithful. Small bits of "evidence,"
such as disarrayed clothing or spots on the sheets, may be
collected and used to justify the delusion. Almost
invariably the person with the delusion confronts his or her spouse or lover and may take extraordinary steps to intervene in the imagined infidelity. These attempts may include restricting the autonomy of the spouse or lover by insisting that he or she never leave the house unaccompanied, secretly following the spouse or lover, or investigating the other "lover." The person with the delusion may physically attack the spouse or lover and, more rarely, the other "lover."

**Persecutory Type.** This is the most common type. The persecutory delusion may be simple or elaborate, and usually involves a single theme or series of connected themes, such as being conspired against, cheated, spied upon, followed, poisoned or drugged, maliciously maligned, harassed, or obstructed in the pursuit of long-term goals. Small slights may be exaggerated and become the focus of a delusional system. In certain cases the focus of the delusion is some injustice that must be remedied by legal action ("querulous paranoia"), and the affected person often engages in repeated attempts to obtain satisfaction by appeal to the courts and other government agencies. People with persecutory delusions are often resentful and angry, and may resort to violence against those whom they believe are hurting them.
Somatic Type. Somatic delusions occur in several forms. Most common are convictions that the person emits a foul odor from his or her skin, mouth, rectum, or vagina; that he or she has an infestation of insects on or in the skin; that he or she has an internal parasite; that certain parts of his or her body are, contrary to all evidence, misshapen and ugly; or that certain parts of his or her body (e.g., the large intestine) are not functioning. People with somatic delusions usually consult nonpsychiatric physicians for treatment of their perceived somatic conditions.

AGE AT ONSET. The age at onset of Delusional Disorder is generally middle or late adult life, but can be at a younger age. In most studies average age at onset has been found to be between 40 and 55.

COURSE. The course is quite variable. In certain cases, especially of the persecutory type, the disorder is chronic. However, even in such cases, waxing and waning of concern with the delusion are common. In other cases, full periods or remission may be followed by subsequent relapses. In yet other cases, the disorder remits within a few months, often without subsequent relapse.
Impairment. Impairment in daily functioning is rare. Intellectual and occupational functioning are usually satisfactory, even when the disorder is chronic. Social and marital functioning, on the other hand, are often impaired. A common characteristic of people with Delusional Disorder is the apparent normality of their behavior and appearance when their delusional ideas are not being discussed or acted upon.

Complications. No information.

Predisposing Factors. Immigration, emigration, deafness, and other severe stresses may predispose to the development of Delusional Disorder. There is some evidence that low socioeconomic status also increases the risk of developing this disorder. People with Paranoid, Schizoid, or Avoidant Personality Disorder may also be more likely to develop Delusional Disorder.

Prevalence. Delusional disorder is relatively uncommon. The best estimation for the population prevalence of the disorder is around 0.03%, which, because of its late age at onset, suggests a lifetime morbidity risk of between 0.05% and 0.1%.
SEX RATIO. Delusional Disorder is apparently slightly more common in females than males.

FAMILIAL PATTERN. No information is available regarding the familial pattern of Delusional Disorder itself. However, there is limited evidence that cases of Avoidant and Paranoid Personality Disorders may be especially common among first-degree biologic relatives of people with Delusional Disorder.

DIFFERENTIAL DIAGNOSIS. The diagnosis is made only when it cannot be established that an organic factor initiated and maintained the disturbance. ORGANIC MENTAL DISORDERS often present with symptoms that suggest Delusional Disorder. In particular, in the early phase of a DEMENTIA, there may be simple persecutory delusions. ORGANIC DELUSIONAL SYNDROMES, such as those due to amphetamines or a brain tumor, may cross-sectionally be identical in symptomatology to Delusional Disorder. (See also discussion of etiological factors of Organic Delusional Syndrome, p. 110.)

In SCHIZOPHRENIA, PARANOID TYPE, or SCHIZOPHRENIFORM DISORDER, there are certain symptoms, such as prominent hallucinations and bizarre delusions (e.g., delusions of control, or of thought broadcasting, thought withdrawal, or thought insertion), that are not present in Delusional
Disorder. Although delusions that others are attempting to control the person's behavior are common in both Delusional Disorder and Schizophrenia, the experience of being controlled by alien forces suggests Schizophrenia or Schizophreniform Disorder. Compared with Schizophrenia, Delusional Disorder usually produces less impairment in occupational and social functioning.

The differential diagnosis with Mood Disorders with Psychotic Features can be difficult, as the psychotic features associated with Mood Disorders most commonly involve nonbizarre delusions, and prominent hallucinations are unusual. Therefore, the differential diagnosis depends on the temporal relationship of the mood disturbance and the delusions. In a Mood Disorder with Psychotic Features, the onset of the mood disturbance usually precedes the appearance of psychotic symptoms and is present after their remission. Furthermore, in Mood Disorders, the mood symptoms are usually severe. Although depressive symptoms are common in Delusional Disorder, they occur after the onset of the delusions, are usually mild in nature, and often remit while the delusional symptoms persist.

Specifically, if the total duration of all mood disturbances has been brief relative to the total duration of the delusional disturbance, then the mood disturbance is considered to be an associate feature of a Delusional Disorder, and no additional diagnosis of a Mood Disorder is
given. However, if the total duration of all mood syndromes has not been brief relative to the duration of the delusional disturbance, then a diagnosis of a Mood Disorder with Psychotic Features or Psychotic Disorder NOS must be considered. If the delusions are present only during the episodes of mood disturbance, then a diagnosis of either Bipolar Disorder with Psychotic Features or Major Depression with Psychotic Features should be made. If the nonbizarre delusions persist in the absence of any mood disturbance, then diagnoses of both Psychotic Disorder NOS and Mood Disorder NOS are made. An example of this would be a person with a five-year history a fixed persecutory delusion who for most of that time had also had recurrent depressive episodes.

BODY DYSMORPHIC DISORDER involves a preoccupation with some imagined defect in appearance, but, unlike in Delusional Disorder, Somatic Type, the belief is not of delusional intensity, i.e., the person can acknowledge the possibility that he or she may be exaggerating the extent of the defect or that there may be no defect at all.

In PARANOID PERSONALITY DISORDER there may be paranoid ideation or pathologic jealousy, but there are no delusions. Whenever a person with a Delusional Disorder has a preexisting Personality Disorder, including Paranoid Personality Disorder, the Personality Disorder should be listed on Axis II, followed by "Premorbid" in parentheses.
A diagnosis of a PSYCHOTIC DISORDER NOS is made if the duration of nonbizarre delusions is less than a month and there is no apparent psychosocial stressor (as in Brief Reactive Psychosis).

**DIAGNOSTIC CRITERIA FOR 297.10 DELUSIONAL DISORDER**

A. Nonbizarre delusion(s) (i.e., involving situations that occur in real life, such as being followed, poisoned, infected, loved at a distance, having a disease, being deceived by one's spouse or lover) of at least one month's duration.

B. Auditory or visual hallucinations, if present, are not prominent [as defined in Schizophrenia, A(1)(b)].

C. Apart from the delusion(s) or its ramifications, behavior is not obviously odd or bizarre.

D. If a Major Depressive or Manic Syndrome has been present during the delusional disturbance, the total duration of all episodes of the mood syndrome has been brief relative to the total duration of the delusional disturbance.
E. Has never met criterion A for Schizophrenia, and it cannot be established that an organic factor initiated and maintained the disturbance.

SPECIFY TYPE: The following types are based on the predominant delusional theme. If no single delusional theme predominates, specify as UNSPECIFIED TYPE.

EROTOMANIC TYPE
Delusional Disorder in which the predominant theme of the delusion(s) is that a person, usually of higher status, is in love with the subject.

GRANDIOSE TYPE
Delusional Disorder in which the predominant theme of the delusion(s) is one of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person.

JEALOUS TYPE
Delusional Disorder in which the predominant theme of the delusion(s) is that one's sexual partner is unfaithful.
PERSECUTORY TYPE
Delusional Disorder in which the predominant theme of the delusion(s) is that one (or someone to whom one is close) is being malevolently treated in some way. People with this type of Delusional Disorder may repeatedly take their complaints of being mistreated to legal authorities.

SOMATIC TYPE
Delusional Disorder in which the predominant theme of the delusion(s) is that the person has some physical defect, disorder, or disease.

UNSPECIFIED TYPE
Delusional Disorder that does not fit any of the previous categories, e.g., persecutory and grandiose themes without a predominance of either; delusions of reference without malevolent content.
Appendix C

DISORDERS FORMERLY CLASSIFIED AS PARANOID
(Psychotic Disorders Not Elsewhere Classified,

298.80 BRIEF REACTIVE PSYCHOSIS

The essential feature of this disorder is sudden onset of psychotic symptoms of at least a few hours', but no more than one month's, duration, with eventual full return to premorbid level of functioning. The psychotic symptoms appear shortly after one or more events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in that person's culture. The precipitating event(s) may be any major stress, such as the loss of a loved one or the psychological trauma of combat. Invariably there is emotional turmoil, manifested by rapid shifts from one intense affect to another, or overwhelming perplexity or confusion, which the person may acknowledge, or which can be judged from the way he or she responds to questions and requests.

To avoid misdiagnosis when a more pervasive disorder is actually involved, Brief Reactive Psychosis should not be
diagnosed if any of the prodromal symptoms of Schizophrenia were present before onset of the disturbance or if the person had Schizotypal Personality Disorder. In addition, the diagnosis is not made if the disturbance is due to a Psychotic Mood Disorder or if an organic factor initiated and maintained the disturbance.

ASSOCIATED FEATURES. Behavior may be bizarre and may include peculiar postures, outlandish dress, screaming, or muteness. Suicidal or aggressive behavior may also be present. Speech may include inarticulate gibberish or repetition of nonsensical phrases. Affect is often inappropriate. Transient hallucinations or delusions are common. Silly or obviously confabulated answers may be given to factual questions. Disorientation and impairment in recent memory often occur.

AGE AT ONSET. The disorder usually appears in adolescence or early adulthood.

COURSE. The psychotic symptoms generally subside in a day or two. By definition, this diagnosis is not applicable if the psychotic symptoms persist for more than one month. Transient secondary effects, such as loss of self-esteem and mild depression, may persist beyond the one month, but
there is eventually full return to the premorbid level of functioning.

**IMPAIRMENT.** Supervision may be required to ensure that nutritional and hygienic needs are met and that the person is protected from the consequences of poor judgment, cognitive impairment, or acting on the basis of delusions.

**PREDISPOSING FACTORS.** Preexisting psychopathology may predispose to the development of this disorder. People with Paranoid, Histrionic, Narcissistic, Schizotypal, or Borderline Personality Disorder are thought to be particularly vulnerable to its development. By definition, situations involving major stress predispose to development of this disorder.

**COMPICATIONS, PREVALENCE, SEX RATIO, AND FAMILIAL PATTERN.** No information.

**DIFFERENTIAL DIAGNOSIS.** The diagnosis is made only when it cannot be established that an organic factor initiated and maintained the disturbance. Organic Mental Disorders, particularly DELIRIUM, ORGANIC DELUSIONAL SYNDROME, or INTOXICATION, can be distinguished from this disorder only on the basis of historical or laboratory information that
indicates a known organic factor. (See also discussion of etiologic factors of Organic Delusional Syndrome, p. 110).

Although by definition this diagnosis is not made if the psychotic symptoms persist for more than one month, the diagnosis can be made soon after the onset of the disturbance, without waiting for the expected recovery. In such instances the diagnosis should be qualified as "provisional." If the disturbance continues beyond one month, the diagnosis should be changed to either SCHIZOPHRENIFORM DISORDER, DELUSIONAL DISORDER, MOOD DISORDER, or PSYCHOTIC DISORDER NOS.

MANIC AND MAJOR DEPRESSIVE EPISODES may follow a major psychosocial stressor. The diagnosis of a Manic or Major Depressive Episode preempts the diagnosis of Brief Reactive Psychosis, and should be made when the relevant criteria are met, whether or not the condition is associated with a psychosocial stressor.

People with a PERSONALITY DISORDER may, under stress, develop Brief Reactive Psychosis, in which case both diagnoses should be made.

An episode of FACTITIOUS DISORDER WITH PSYCHOLOGICAL SYMPTOMS may have apparently psychotic symptoms and may also be precipitated by a psychosocial stressor, but in such cases there is evidence that the symptoms are intentionally produced.
When Malingering presents with apparently psychotic symptoms, there is usually evidence that the illness was feigned for an understandable goal.

**Diagnostic Criteria for 298.80 Brief Reactive Psychosis**

A. Presence of at least one of the following symptoms indicating impaired reality testing (not culturally sanctioned):

1. Incoherence or marked loosening of associations
2. Delusions
3. Hallucinations
4. Catatonic or disorganized behavior

B. Emotional turmoil, i.e., rapid shifts from one intense affect to another, or overwhelming perplexity or confusion.

C. Appearance of the symptoms in A and B shortly after, and apparently in response to, one or more events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the person's culture.

D. Absence of the prodromal symptoms of Schizophrenia, and failure to meet the criteria for Schizotypal Personality Disorder before the onset of the disturbance.
E. Duration of an episode of the disturbance of from a few hours to one month, with eventual full return to premorbid level of functioning. (When the diagnosis must be made without waiting for the expected recovery, it should be qualified as "provisional.")

F. Not due to a Psychotic Mood Disorder (i.e., no full mood syndrome is present), and it cannot be established that an organic factor initiated and maintained the disturbance.
297.30  INDUCED PSYCHOTIC DISORDER

The essential feature of this disorder is a delusional system that develops in a second person as a result of a close relationship with another person (the primary case) who already has a psychotic disorder with prominent delusions. The same delusions are at least partly shared by both persons. This diagnosis is not made in people who present evidence of a psychotic disorder (or the prodromal symptoms of Schizophrenia) immediately before onset of the delusion.

The content of the delusion is within the realm of possibility, and often is based on common past experiences of the two people. Occasionally, bizarre delusions may be induced. Usually the primary person with the psychotic disorder is the dominant one in the relationship and gradually imposes his or her delusional system on the more passive and initially healthy second person. These people have usually lived together for a long time, and are isolated from contact with other people.

ASSOCIATED FEATURES. If the relationship with the primary person who has the psychotic disorder is interrupted, usually the delusional beliefs in the second person will diminish or disappear. Although most commonly seen in relationships of only two people (known as Folie a deux), cases have been reported involving up to twelve
people in a family. People with this disorder rarely seek treatment, and secondary cases are usually brought to light when the primary person receives treatment.

AGE AT ONSET. Variable.

COURSE. The course is usually chronic in that this disorder occurs almost invariably in relationships that are longstanding and resistant to being altered by external forces.

IMPAIRMENT. Impairment is generally less severe than for Delusional Disorder or Schizophrenia, as often only a portion of the primary person's delusional system is adopted.

PREVALENCE. Rare.

SEX RATIO. More common among females.

COMPLICATIONS AND FAMILIAL PATTERN. No information.

DIFFERENTIAL DIAGNOSIS. In DELUSIONAL DISORDER, SCHIZOPHRENIA, and SCHIZOAFFECTIVE DISORDER, there is either no close relationship with a dominant person who has a psychotic disorder or, if such a person, the
psychotic symptoms (or prodromal symptoms, in the case of Schizophrenia) precede the onset of any shared delusions.

**DIAGNOSTIC CRITERIA FOR 297.30 INDUCED PSYCHOTIC DISORDER**

A. A delusion develops (in a second person) in the context of a close relationship with another person, or persons, with an already established delusion (the primary case).

B. The delusion in the second person is similar in content to that in the primary case.

C. Immediately before onset of the induced delusion, the second person did not have a psychotic disorder or the prodromal symptoms of Schizophrenia.
298.90 PSYCHOTIC DISORDER NOT OTHERWISE SPECIFIED
(ATYPICAL PSYCHOSIS)
Disorders in which there are psychotic symptoms (delusions, hallucinations, incoherence, marked loosening of associations, catatonic excitement or stupor, or grossly disorganized behavior) that do not meet the criteria for any other nonorganic psychotic disorder. This category should also be used for psychoses about which there is inadequate information to make a specific diagnosis. (This is preferable to "Diagnosis Deferred," and can be changed if more information becomes available.) This diagnosis is made only when it cannot be established that an organic factor initiated and maintained the disturbance.

Examples:

(1) psychoses with unusual features, e.g., persistent auditory hallucinations as the only disturbance

(2) postpartum psychoses that do not meet the criteria for an Organic Mental Disorder, psychotic Mood Disorder, or any other psychotic disorder

(3) psychoses with confusing clinical features that make a more specific diagnosis impossible
301.00 PARANOID PERSONALITY DISORDER

The essential feature of this disorder is a pervasive and unwarranted tendency, beginning by early adulthood and present in a variety of contexts, to interpret the actions of people as deliberately demeaning or threatening.

Almost invariably there is a general expectation of being exploited or harmed by others in some way. Frequently a person with this disorder will question, without justification, the loyalty or trustworthiness of friends or associates. Often the person is pathologically jealous, questioning without justification the fidelity of his or her spouse or sexual partner.

Confronted with a new situation, the person may read hidden demeaning or threatening meanings into benign remarks or events, e.g., suspect that a bank has deliberately made a mistake in his account. Often these people are easily slighted and quick to act with anger or counterattack; they may bear grudges for a long time, and
never forgive slights, insults, or injuries. They are reluctant to confide in others because of a fear that the information will be used against them. People with this disorder are typically hypervigilant and take precautions against any perceived threat. They tend to avoid blame even when it is warranted. They are often viewed by others as guarded, secretive, devious, and scheming.

When people with this disorder find themselves in a new situation, they intensely and narrowly search for confirmation of their expectations, with no appreciation of the total context. Their final conclusion is usually precisely what they expected in the first place. Often, they have transient ideas of reference, e.g., that others are taking special notice of them, or saying vulgar things about them.

ASSOCIATED FEATURES. People with this disorder are usually argumentative and exaggerate difficulties, "making mountains out of molehills." They often find it difficult to relax, usually appear tense, and have a tendency to counterattack when they perceive any threat. Though they are critical of others, and often litigious, they have great difficulty accepting criticism themselves.

The affectivity of these people is often restricted, and they may appear "cold" to others. They have no true sense of humor and are usually serious. They may pride
themselves on always being objective, rational, and unemotional. They usually lack passive, soft, sentimental, and tender feelings.

Occasionally, others see people with this disorder as keen observers who are energetic, ambitious, and capable; but more often they are viewed as hostile, stubborn, and defensive. They tend to be rigid and unwilling to compromise, and may generate uneasiness and fear in others. They often have an inordinate fear of losing their independence or the power to shape events according to their own wishes.

These people usually avoid intimacy except with those in whom they have absolute trust. They display an excessive need to be self-sufficient, to the point of egocentricity and exaggerated self-importance. They avoid participation in group activities unless they are in a dominant position.

People with Paranoid Personality Disorder are often interested in mechanical devices, electronics, and automation. They are generally uninterested in art or aesthetics. They are keenly aware of power and rank and of who is superior or inferior, and are often envious and jealous of those in positions of power. They disdain people they see as weak, soft, sickly, or defective.

During periods of extreme stress, people with this disorder may experience transient psychotic symptoms, but
they are usually of insufficient duration to warrant additional diagnosis.

**IMPAIRMENT.** Because people with Paranoid Personality Disorder generally realize that it is prudent to keep their unusual ideas to themselves, impairment tends to be minimal. However, occupational difficulties are common, especially in relating to authority figures or co-workers. In more severe cases, all relationships are grossly impaired.

**COMPLICATIONS.** The relationship of this disorder to Delusional Disorder and Schizophrenia, Paranoid Type, is unclear. Certain essential features of Paranoid Personality Disorder, such as suspiciousness and hypersensitivity, may predispose to the development of those other disorders, however.

**PREDISPOSING FACTORS.** No information.

**PREVALENCE.** Since people with this disorder rarely seek help for their personality problems or require hospitalization, the disorder seldom comes to clinical attention. Because of a tendency of some of them to be moralistic, grandiose, and extrapunitive, people with this
disorder may be overrepresented among leaders of cults and other fringe groups.

SEX RATIO. This order is more commonly diagnosed in men.

FAMILIAL PATTERN. No information.

DIFFERENTIAL DIAGNOSIS. In DELUSIONAL DISORDER and SCHIZOPHRENIA, PARANOID TYPE, there are persistent psychotic symptoms, such as delusions and hallucinations, that are never part of Paranoid Personality Disorder. However, these disorders may be superimposed on Paranoid Personality Disorder. ANTISOCIAL PERSONALITY DISORDER shares several features with Paranoid Personality Disorders, e.g., difficulty in forming and sustaining close relationships, and poor occupational performance; but except when the two disorders coexist, a lifelong history of antisocial behavior is not present in Paranoid Personality Disorder. People with SCHIZOID PERSONALITY DISORDER are often seen as strange and eccentric, cold and aloof, but do not have prominent paranoid ideation.
DIAGNOSTIC CRITERIA FOR 301.00 PARANOID PERSONALITY DISORDER

A. A pervasive and unwarranted tendency, beginning by early adulthood and present in a variety of contexts, to interpret the actions of people as deliberately demeaning or threatening, as indicated by at least four of the following:

(1) expects, without sufficient basis, to be exploited or harmed by others
(2) questions, without justification, the loyalty or trustworthiness of friends or associates
(3) reads hidden demeaning or threatening meanings into benign remarks or events, e.g., suspects that a neighbor put out trash early to annoy him
(4) bears grudges or is unforgiving of insults or lights
(5) is reluctant to confide in others because of unwarranted fear that the information will be used against him or her
(6) is easily slighted and quick to react with anger or to counterattack
(7) questions, without justification, fidelity of spouse or sexual partner
B. Occurrence not exclusively during the course of Schizophrenia or a Delusional Disorder.
Appendix E

SCHIZOPHRENIA, PARANOID TYPE


295.3x PARANOID TYPE

The essential feature of this type of Schizophrenia is preoccupation with one or more systematized delusions or with frequent auditory hallucinations related to a single theme. In addition, symptoms characteristic of the Disorganized and Catatonic Types, such as incoherence, flat or grossly inappropriate affect, catatonic behavior, or grossly disorganized behavior, are absent. When all exacerbations of the disorder meet the criteria for Paranoid Type, the clinician should specify Stable Type.

Associated features include unfocused anxiety, anger, argumentativeness, and violence. Often a stilted, formal quality or extreme intensity in interpersonal interactions is noted.

The impairment in functioning may be minimal if the delusional material is not acted upon. Onset tends to be later in life than the other types, and the distinguishing characteristics may be more stable over time. Some evidence
suggests that the prognosis for the Paranoid Type, particularly with regard to occupational functioning and capacity for independent living, may be considerably better than for other types of Schizophrenia.

**DIAGNOSTIC CRITERIA FOR 295.3x PARANOID TYPE**

A type of Schizophrenia in which there are:

A. Preoccupation with one or more systematized delusions or with frequent auditory hallucinations related to a single theme.

B. None of the following: incoherence, marked loosening of associations, flat or grossly inappropriate affect, catatonic behavior, grossly disorganized behavior.

**SPECIFY STABLE TYPE if criteria A and B have been met during all past and present active phases of the illness.**
ORGANIC DELUSIONAL SYNDROME

The essential feature of this syndrome is prominent delusions that are due to a specific organic factor. The diagnosis is not made if the delusions occur in the context of a reduced ability to maintain and shift attention to external stimuli, as in Delirium.

The nature of the delusions is variable and depends, to some extent, on the etiology. Persecutory delusions are the most common type. Amphetamine use may cause a highly organized paranoid delusional state indistinguishable from the active phase of Schizophrenia. Some people with cerebral lesions develop the delusion that a limb of their body is missing.

In Organic Delusional Syndrome, hallucinations may be present, but are usually not prominent. When prominent hallucinations coexist with prominent delusions, both Organic Delusional Syndrome and Organic Hallucinosis may be diagnosed.
ASSOCIATED FEATURES. Mild cognitive impairment is often observed. As in Schizophrenia, almost any symptom may occur as an associated feature. The person may appear perplexed, disheveled, or eccentrically dressed. Speech may be rambling or incoherent. Abnormalities of psychomotor activity may occur, with either hyperactivity (pacing, rocking), or apathetic immobility. Ritualistic, stereotyped behavior, sometimes associated with magical thinking, may also be observed. A dysphoric mood is common.

IMPAIRMENT. Impairment in social and occupational functioning is usually severe.

COMPLICATIONS. The person may harm himself or herself or others while reacting to delusions.

ETIOLOGICAL FACTORS. These are diverse. A number of substances—e.g., amphetamines, cannabis, and hallucinogens—may cause this syndrome. Some people with temporal lobe epilepsy have an interictal Organic Delusional Syndrome that is almost indistinguishable from Schizophrenia. A paranoid Organic Delusional Syndrome has been described in some cases of Huntington's chorea. Certain cerebral lesions, particularly of the right hemisphere, may result in this syndrome.
DIFFERENTIAL DIAGNOSIS. NONORGANIC PSYCHOTIC DISORDERS such as SCHIZOPHRENIA or DELUSIONAL DISORDERS [sic] must be distinguished from Organic Delusional Syndrome.

Differentiation rests primarily on evidence, gathered from the history, physical examination, or laboratory tests, of a specific organic factor judged to be etiologically related to the delusions. The appearance of delusions de novo in a person over the age of 35 years, without a known history of Schizophrenia or Delusional Disorder should always alert the diagnostician to the possibility of an Organic Delusional Syndrome. On the other hand, the fact that a person has a previous history of nonorganic psychosis does not mean that one should neglect consideration of an Organic Delusional Syndrome, especially if there is concern about a possible organic factor (for example, the ingestion of a hallucinogen).

In ORGANIC HALLUCINOSIS, hallucinations are prominent. Delusions, if present, are related in content to the hallucinations. In ORGANIC MOOD SYNDROME, symptoms resembling those of Mood Disorders predominate. Delusions and hallucinations, if present, are related in content to the mood disturbance.
DIAGNOSTIC CRITERIA FOR ORGANIC DELUSIONAL SYNDROME

A. Prominent delusions.

B. There is evidence from the history, physical examination, or laboratory tests of a specific organic factor (or factors) judged to be etiologically related to the disturbance.

C. Not occurring exclusively during the course of delirium.
Appendix G

GLOSSARY OF TECHNICAL TERMS: DELUSION


DELUSION. A false personal belief based on incorrect inference about external reality and firmly sustained in spite of what almost everyone else believes and in spite of what constitutes incontrovertible and obvious proof of evidence to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture (i.e., it is not an article of religious faith).

When a false belief involves an extreme value judgment, it is regarded only as a delusion when the judgment is so extreme as to defy credibility. Example: If someone claims he or she is terrible and has disappointed his or her family, this is generally not regarded as a delusion even if an objective assessment of the situation would lead observers to think otherwise; but if someone claims he or she is the worst sinner in the world, this would generally be considered a delusional conviction. Similarly, a person judged by most people to be moderately underweight who asserts that he or she is fat would not be regarded as
A delusion should be distinguished from a hallucination, which is a sensory perception (although a hallucination may give rise to the delusion that the perception is true). A delusion is also to be distinguished from an overvalued idea, in which an unreasonable belief or idea is not as firmly held as is the case with a delusion.

Delusions are subdivided according to their content. Some of the more common types are listed below.

**Delusion of being controlled.** A delusion in which feelings, impulses, thought, or actions are experienced as not being one's own, as being imposed by some external force. This does not include the mere conviction that one is acting as an agent of God, has had a curse placed on him or her, is the victim of fate, or is not sufficiently assertive. The symptom should be judged present only when the subject experiences his or her will, thoughts, or feelings as operating under some external force. Examples: A man claimed that his words were not his own, but those of his father; a student believed that his actions were under the control of a yogi; a housewife believed that sexual feelings were being put into her body from without.
**Delusion, bizarre.** A false belief that involves a phenomenon that the person's culture would regard as totally implausible. Example: A man believed that when his adenoids had been removed in childhood, a box had been inserted into his head, and that wires had been placed on his head so that the voice he heard was that of the governor.

**Delusion, grandiose.** A delusion whose content involves an exaggerated sense of one's importance, power, knowledge, or identity. It may have a religious, somatic, or other theme.

**Delusion, mood-congruent.** See mood-congruent psychotic features.

**Delusion, mood-incongruent.** See mood-incongruent psychotic features.

**Delusion, nihilistic.** A delusion involving the theme of nonexistence of the self or part of the self, others, or the world. Examples: "The world is finished"; "I no longer have a brain"; "There is no need to eat, because I have no insides." A somatic delusion may also be a nihilistic
Delusion if the emphasis is on nonexistence of the body or part of the body.

**Delusion, persecutory.** A delusion in which the central theme is that a person or group is being attacked, harassed, cheated, persecuted, or conspired against. Usually the subject or someone or some group or institution close to him or her is singled out as the object of the persecution.

It is recommended that the term *paranoid delusion* not be used, because the meanings are multiple, confusing, and contradictory. It has often been employed to refer to both persecutory and grandiose delusions because of their presence in the Paranoid Type of Schizophrenia.

**Delusion of poverty.** A delusion that the person is, or will be, bereft of all, or virtually all, material possessions.

**Delusion of reference.** A delusion whose theme is that events, objects, or other people in the person's immediate environment have a particular and unusual significance, usually of a negative or perjorative nature. This differs from an idea of reference, in which the false belief is not as firmly held as in a delusion. If the delusion of reference involves a persecutory theme, then a delusion of
persecution is present as well. Examples: A woman was convinced that programs on the radio were directed especially to her; when recipes were broadcast, it was to tell her to prepare wholesome food for her child and stop feeding her candy; when dance music was broadcast, it was to tell her to stop what she was doing and start dancing, and perhaps even to resume ballet lessons. A patient noted that the room number of his therapist's office was the same as the number of the hospital room in which his father died and believed that this meant there was a plot to kill him.

**Delusion, somatic.** A delusion whose main content pertains to the functioning of one's body. Examples: One's brain is rotting; one is pregnant despite being postmenopausal.

Extreme value judgments about the body may, under certain circumstances, also be considered somatic delusions. Example: A person insists that his nose is grossly misshapen despite lack of confirmation of this by observers.

Hypochondriacal delusions are also somatic delusions when they involve specific changes in the functioning or structure of the body rather than merely an insistent belief that one has a disease.
**Delusion, systematized.** A single delusion with multiple elaborations or a group of delusions that are all related by the person to a single event or theme. Example: A man who failed his bar examination developed the delusion that this occurred because of a conspiracy involving the university and the bar association. He then attributed all other difficulties in his social and occupational life to this continuing conspiracy.
Appendix H

ANNOTATED COMPARATIVE LISTING OF DSM-III
AND DSM-III-R: PARANOID DISORDERS


PARANOID DISORDERS DELUSIONAL (PARANOID) DISORDER

DSM-III required either persecutory delusions or
delusions of jealousy in making a diagnosis of a Paranoic
Disorder. In DSM-III-R the disorder is defined more broadly
in terms of delusional themes, but more narrowly in the
requirement of a duration of at least one month, both in
accordance with traditional concepts of the disorder.
Because the ordinary English meaning of the term "paranoid"
suggests only suspiciousness, the more nosologically
descriptive term "Delusional Disorder" is used for this
category.

Paranoia Delusional (paranoid) disorder

Specify type: erotomanic
grandiose
jealous
Shared paranoid disorder  Induced psychotic disorder

This disorder may involve delusions without a paranoid content, hence the change in terminology. In addition, the term "induced" more accurately describes the essence of the disorder.

Acute paranoid disorder

In DSM-III-R such cases are subsumed under Psychotic Disorders Not Elsewhere Classified.

Atypical paranoid disorder
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