2017

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Schizophrenia Bulletin vol. 43 no. 2 pp. 332–343, 2017
doi:10.1093/schbul/sbw161
Advance Access publication December 21, 2016

The Clinical Features of Paranoia in the 20th Century and Their Representation in Diagnostic Criteria From DSM-III Through DSM-5

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This review traces, through psychiatric textbooks, the history of the Kraepelinian concept of paranoia in the 20th century and then relates the common reported symptoms and signs to the diagnostic criteria for paranoia/delusional disorder in DSM-III through DSM-5. Clinical descriptions of paranoia appearing in 10 textbooks, published 1899 to 1970, revealed 11 prominent symptoms and signs reported by 5 or more authors. Three symptoms (systematized delusions, minimal hallucinations, and prominent ideas of reference) and 2 signs (chronic course and minimal affective deterioration) were reported by 8 or 9 of the authors. Four textbook authors rejected the Kraepelinian concept of paranoia. A weak relationship was seen between the frequency with which the clinical features were reported and the likelihood of their inclusion in modern DSM manuals. Indeed, the diagnostic criteria for paranoia/delusional disorder shifted substantially from DSM-III to DSM-5. The modern operationalized criteria for paranoia/delusional disorder do not well reflect the symptoms and signs frequently reported by historical experts. In contrast to results of similar reviews for depression, schizophrenia and mania, the clinical construct of paranoia/delusional disorder has been somewhat unstable in Western Psychiatry since the turn of the 20th century as reflected in both textbooks and the DSM editions.

Key words: paranoia/history/Kraepelin/DSM/delusional disorder/psychiatric nosology

Introduction

In his key sixth edition (where he explicated for the first time the major features of his nosologic system)[1,2] published in 1899, Kraepelin begins his discussion of paranoia with an extensive review of the complex history of this diagnostic category in 19th century psychiatry. During that time, paranoia was commonly used as a broad category for delusional insanities not accompanied by marked agitation and/or expansive moods (then called mania), or retardation and/or depressed mood (then called melancholia).[3] He next writes (italics in original):

> These, briefly, are the considerations which make me assume a fundamentally different attitude with respect to the question of paranoia. I consider only those cases of disease identical which, apart from differences in degree and particular incidents, have the same result in general [and the same] … essential characteristics of the disease – the fundamental incurability [and], the permanent occurrence of delusions…. Of the great number of chronic cases which are usually grouped with paranoia, those where the delusions are attended with clear signs of mental debility, in my view, also need separate consideration. In these cases, we observe that the delusions rapidly take quite fantastic forms …. On the other hand, there is doubtless a group of cases where a *lasting, unshakable system of delusions* clearly recognizable from the beginning, gradually developing, while *presence of mind* and the *order of the train of thought are completely conserved*. It is for these forms which I want to reserve the name of paranoia. (Kraepelin[2] pp. 325–326)

Kraepelin's concept of paranoia was not universally accepted in the Anglophonic world. In his presidential address to the British Medico-Psychological Association in 1904, Percy Smith provided a detailed review of the concept of paranoia that concluded with 2 major criticisms of Kraepelin's viewpoint.[4] First, he felt there were acute cases of paranoia which Kraepelin's system arbitrarily excluded. Second, and more importantly, he wrote

> I think that Kraepelin's action in removing a large group of cases in which terminal weak-mindedness occurs from the domain of paranoia to that of dementia praecox is open to question. (Percy Smith[4] p. 632)

The variegated story of the diagnostic category of paranoia in the 19th and 20th centuries,[3,5,6] its emergence as a major (but little-recognized) category in Kraepelin's nosology,[7] and its relationship with the diagnosis of paranoia in DSM-III, and Delusional Disorder in DSM-III-R through DSM-5,[8,9] have all been examined previously. My approach here is complementary to these prior efforts.

This is the fourth in a series of papers that have previously treated, in a parallel way, the history of the categories of depression,[10] schizophrenia,[11] and mania.[12] As in past efforts, I have located and reviewed clinical descriptions of paranoia found in textbooks between ~1900–1970 that adopt a broadly Kraepelinian diagnostic perspective. I organize and present the key signs and symptoms described in these sources, and rank them by frequency. I then evaluate the relationship between them and the symptomatic criteria for paranoia or delusional disorder in the major modern US diagnostic systems from DSM-III[13] through DSM-5.[14] As will become clear, Kraepelin's category of paranoia was less universally accepted in the 20th century than were those of dementia praecox/schizophrenia, mania or depression, and its representation in criteria from DSM-III[13] onward more variable.

Methods

I identified textbooks of Psychiatry or Psychological Medicine published from ~1900 to 1970 and written or translated into English from 3 major sources: Amazon.com, the National Library of Medicine, and forgottenbooks.com. As in earlier projects on depression, schizophrenia and mania, textbooks were rejected from consideration if they did not adopt a broadly Kraepelinian diagnostic perspective. However, I found 4 texts that adopted Kraepelin's views on other major diagnostic categories, but not on paranoia[15–18] and include them given their historical importance. I began sampling texts at 1900 as this was the time at which Kraepelin's view of paranoia has been articulated. I used 1970 as a cut-off because that would antedate the development of the first major operationalized diagnostic criteria set for paranoia in DSM-III.[13] No paranoia-like diagnostic category was included in the first 2 US operationalized criteria sets—the Feighner[19] or the Research Diagnostic Criteria.[20]

As in any such review, a number of decisions were necessary. Some textbooks contained a single section providing a clinical description of paranoia. However, several texts had a chapter covering a broad set of syndromes—such as "Paranoia and Paranoid Reaction Types",[21] or "Paraphrenia and Paranoia".[22] In total, I was able to review 10 textbooks published from 1899 to 1970: from the United States (4), United Kingdom (3), Germany (1), Switzerland (1), and France (1). I reviewed the texts in historical order, creating categories for signs and symptoms as I progressed. After going through all the texts one time, developing and scoring the categories, I went back a second time to key texts to insure the consistent application of my approach. In table 1, I included, when possible, short quotes from the text and typically dispensed for convenience with quotation marks and with the … spacing if I deleted words or phrases for brevity's sake. Finally, I never accepted symptoms or signs contained only in case reports.

Results

Authors Broadly Accepting the Kraepelinian Concept of Paranoia

The results of this review of 10 primary textbooks are summarized in table 1 which lists the 12 symptoms and signs of paranoia in the order of the frequency with which they were reported. No symptom or sign was reported by all 10 authors but 4 were described by all but one: systematized delusions, minimal hallucinations, chronic course of illness, and prominent ideas of reference. Systematization of the delusions were described in a variety of ways including that the delusions were "logically assimilated," "internally coherent," "logically interconnected with no inner contradictions," and "coherent—logical development upon false premises." Hallucinations were described as not present at all or "only in rare cases." However, one of the authors, Muncie,[32] while otherwise accepting the Kraepelinian framework for paranoia, disagreed—stating "there may develop hallucinatory corroboration of the dominant delusional idea." Course of illness was most typically described as chronic, often with an insidious onset and slow extension of the delusional system to an increasing number of areas of life. Several authors commented that their affected patients often moved in the hope of leaving their persecutors behind, but noted that the delusions eventually "spread" to their new environment. Many authors commented extensively—with detailed examples—on the prominent ideas of reference in which a widening variety of "neutral" environmental events were interpreted in the context of the expanding delusional system.

Three signs and symptoms were described by 7 or 8 of the 10 authors: minimal affective deterioration, lack of insight and non-bizarre delusions. A number of authors contrasted the lack of deterioration seen in paranoia compared to what is commonly observed in dementia praecox/schizophrenia. Several noted the high level of inter-personal and business skills that could be preserved for many years in those suffering from paranoia. While lack of insight was implied by virtually all authors, it was only commented upon specifically by 7 of them. Regarding the content of the delusions, some authors recorded how similar they were to common "fears, wishes, and hopes," and others that inquiry was sometimes needed to be sure that the fears they were describing were not in fact true. More commonly, authors just commented that the delusions were not (often in contrast to those commonly seen in dementia praecox/schizophrenia) absurd, grotesque or bizarre.

Table 1. Clinical Features of Paranoia as Recorded by 10 Textbook Authors From ~1900 to 1970 Who Broadly Accepted the Kraepelinian Construct

	Kraepelin 1899,[1] 1904,*[23] and 1909[24]**	De Fursac 1905[25]	Buckley 1920[26]
Disorder	Paranoia	Reasoning Insanity (Kraepelin's Paranoia)	Paranoia
Country	Germany	France	United States
Systematized delusions	Lasting, unshakable system of delusions. Delusions are logically assimilated. Often see gradual spreading of delusions to incorporate more and more people.	Immutability of the delusion. Apparent logic of the delusional system.	Systematized, chronic, internally coherent.
Minimal hallucinations	Only in rare cases	Absence or extreme rarity of hallucinations.	Perception for the most part is unaffected. True hallucinations do not take a part in the clinical picture.
Chronic course of illness	Development of disease takes a very slow course. Often at a standstill for many years.	As soon as the fixed idea is formed, the disease develops rapidly.	Gradual development in a progressive manner by evolution of a system of fixed ideas.
Prominent ideas of reference	Prominent. Real perceptions are understood in a prejudiced way. A stain on a dress, a whole in the boot and not usual consequences but striking facts whose origin is only to be explained by hostile machinations.	Numerous false interpretations. Delusional interpretations become more and more numerous until finally the fixed idea appears around which the whole delusional system is then built up.	Ordinary sounds of the street interpreted as efforts to annoy him. Accidental glance of a passer-by contains a look of scorn. A whistle or a cough is an insult.
Minimal affective deterioration	Presence of mind conserved. Excellent conservation of reason. In the course of decades, a slowly increasing debility often evident accompanied by a gradually progressing system of delusions. Lack emotional dullness seen in dementia praecox.	Absence of intellectual enfeeblement regardless of length of time that the disease has lasted.	No evidence of marked mental impairment. May be mentally brilliant and retain for years a remarkable lucidity in regard to matters outside their delusional system. Preservation of personality. No major disturbance of volition.
Lack of insight	Always lacking. Objections to delusions are typically cleverly refuted.	Absolute faith in delusions.	Delusional beliefs fixed.
Non-bizarre delusions	The content of delusions show, in morbidly developed form, a remarkable agreement with those fears, wishes, and hopes, which even in normal individuals proceed from the feeling of uncertainty and the endeavor after happiness**	Delusions can appear very probable and careful examination of their possible verity is sometimes needed.	
Intact cognitive processes	Order of train of thought preserved.		Without apparent involvement of the process of coherent thought.
Lack of mood abnormality	Striking disturbances in the emotional deportment of the patient are wanting throughout. The patient is in neither morbidly cheerful nor gloomy mood.*		May be depressed, irritated in early stages. If persecutory delusions, outbursts of anger common. If grandiose, often self-satisfied.
Delusional memory	Falsification of memory is common. In examining the past experiences, the patient's eyes are open, prior details now suddenly appear to him of major importance.		Delusional falsification of memory often occurs.
Actions and behaviors appropriate aside from areas of delusional beliefs	Typically, calm, reasonable, preserve an orderly attitude capable of satisfactory mental activity. Actions and behaviors may be free of disorder for a long time. But over time, preoccupation with delusional beliefs often increase and govern more and more of their life.		
Delusional themes	Persecutory and grandiose themes typically predominate but erotomanic and querulous forms also occur.	In addition to paranoid themes, litigious, hypochondriacal, amorous and jealous themes may occur.	Grandiose and persecutory most common. Religious, querulent, and erotic themes also occur.

Table 1. Continued

	Bleuler 1924[27]	Yellowlees 1932[28]	Noyes 1936[29]
Disorder	Paranoia	Paranoia (Discussed Within a Section Entitled "Paranoid States")	Paranoia
Country	Switzerland	United Kingdom	United States
Systematized delusions	A delusional system logically interconnected with no inner contradictions.	Systematized, fixed, elaborate	Delusions are fixed and logically elaborated.
Minimal hallucinations	Hallucinations are nearly always lacking.	Absent	Prominent hallucinations rarely if ever occur.
Chronic course of illness	Always chronic. Typically see a cancer-like extension of the delusion to ever widening areas and domination of the personality. Periods of stronger delusional preoccupation alternate with quieter phases. Improvement often appears with age.	Long and chronic course	Typically, chronic.
Prominent ideas of reference	Extensive. While it would seem that these were illusions, when investigated carefully, patient's perceptions were correct but were transformed into referential ideas.	Prominent. Chance meetings, accidents, signs, words and the trivial occurrences of every day are all interpreted by the patient as having some special reference to himself.	Are extensive with incidents repeatedly misinterpreted.
Minimal affective deterioration	The affectivity appears on direct observation to be primarily normal.	Tendency toward mental enfeeblement is negligible.	
Lack of insight	No insight	Delusions fixed	Delusions are fixed
Non-bizarre delusions		Logical, never grotesque	Content rarely bizarre.
Intact cognitive processes	Outside of the delusional system, his logic and train of ideas are sound.		
Lack of mood abnormality	A range of moods are seen but can be understood as resulting from the content of the delusion.	Emotional reactions normal	
Delusional memory	Common—elaborate		Retrospective falsifications are common—unimportant incidents of the past are discovered to have marked significance.
Actions and behaviors appropriate aside from areas of delusional beliefs	Conduct is normal as far as it is not influenced by delusions.	Some are able to adapt themselves to society's demands are remain out of institutional care.	Conduct apt to remain in bounds prescribed by society.
Delusional themes	Persecution most common but grandiose, litigious, jealousy, hypochondriacal and erotic themes also occur.	Persecution most common, can develop into grandiosity	Paranoid most common, but grandiose and religious delusions also occur. Erotic forms are somewhat rarer.

Table 1. Continued

	Sadler 1936[30]	Gordon 1936[31]	Muncie 1939[32]
Disorder	True Paranoia	Paranoia	Paranoia
Country	United States	United Kingdom	United States
Systematized delusions	Systematized, persistent fixed idea. Delusional formation is coherent—logical development upon false premises. Often slowly expands.	Formation of a fixed and systematized delusional system around which the patient's life is carried out.	Systematized delusion formation—ramifications of the system may be very extensive. Beliefs carry great "affective charge."
Minimal hallucinations	Hallucinations do not occur in true paranoia.	No hallucinations.	At times there may develop hallucinatory corroboration of the dominant delusional idea.
Chronic course of illness	Insidious in their development.	Chronic.	
Prominent ideas of reference	Extensive ideas of reference.	Ideas of reference become a dominant factor.	Misinterpretation of actual experiences to support delusional beliefs.
Minimal affective deterioration	Complete preservation of personality with the exception of the delusional system. With passing of years no evidence of deterioration or dementia.	No deterioration. No degeneration of the cognitive element. Intellectually the patient remains as sound as ever. Can often conduct their life in the outside world reasonably well.	
Lack of insight		Not the slightest insight into his condition.	
Non-bizarre delusions	Delusions are not absurd.		A formally correct superstructure on a false foundation.
Intact cognitive processes	Reasons clearly and logically on everything not connected with his complex.	Business and general topics can be discussed sensibly and clearly.	Conduct and logical reasoning are maintained.
Lack of mood abnormality		Close association of the emotional life with the delusional system.	
Delusional memory	Tendency to look retrospectively over past life and to place delusional interpretations upon very ordinary events.		Misinterpretations of past events in line with delusional beliefs.
Actions and behaviors appropriate aside from areas of delusional beliefs	General conduct—thinking, talking and social activities—to all practical purposes fairly normal.		
Delusional themes	Persecutory, grandiose, erotic, hypochondriacal and querulous	Primary delusion nearly always of a persecutory nature. But can be altered and exalted, amatory or querulous paranoia does occur.	Most common persecution but other themes common.

Table 1. Continued

	Slater 1970[22]	Summary out of 10
Disorder	Paranoia	
Country	United Kingdom	
Systematized delusions		9
Minimal hallucinations	No hallucinations	9
Chronic course of illness	Typically chronic but delusions can become "encapsulated" with minimal impact on functioning.	9
Prominent ideas of reference		9
Minimal affective deterioration	Personality deterioration is rare.	8
Lack of insight		7
Non-bizarre delusions	First rank symptoms rarely develop.	7
Intact cognitive processes		6
Lack of mood abnormality	Absence of primary affective disturbance	6
Delusional memory		6
Actions and behaviors appropriate aside from areas of delusional beliefs		5
Delusional themes	Persecution, jealousy, grandeur, somatic defect, bad smell.	Persecutory—10, Grandiose—8, Erotic 7, Litigious 6, Somatic 4, Jealousy 3, Religious 2, Olfactory—1

Note: For Kraepelin, all quotes are from the 1899 text except as noted from 1904 (*) and 1909 (**) text.

Four symptoms or signs were described by only 5 or 6 of our authors: intact cognitive processes, lack of mood abnormality, delusional memory, and appropriate actions and behaviors (aside from areas of delusional beliefs). In describing the thinking processes of patients with paranoia, these authors noted that the train of thought, its coherence, its logic, and its clarity were all maintained during the illness. The authors described a lack of a primary mood disturbance in several different ways. In particular, outside of their delusional content, affective disturbances were absent and their emotional reactions normal. However, several authors remarked that their delusions could cause a range of "secondary" mood changes, particularly irritability and anger with persecutory beliefs, and "self-satisfaction" with grandiose delusions.

Analogous to ideas of reference, when the delusions were confirmed by the repeated misinterpretation of events occurring around them, a number of authors noted that patients with paranoia often retrospectively misinterpreted their memories in the light of their delusional beliefs. For example, an old man met in the street as a child is now recognized as the King of Bavaria who recognized the patient as his legitimate heir. Five authors wrote that—aside from actions directly related to their delusions—patients suffering from paranoia typically behaved appropriately and would not, when seen from a distance, be judged mentally ill.

The final symptom described differed from the others in simply recording the delusional themes that the authors noted as occurring in paranoia. This list was diverse and varied substantially across authors. Persecutory delusions

Table 2. Diagnostic Criteria for Paranoia and Delusional Disorder from DSM-III Through DSM-5 and The Relationship of These Criteria to Symptoms and Signs Noted by Our Textbook Authors

		DSM-III	DSM-III-R	DSM-IV	DSM-V
	Number of Times Endorsed in Textbooks	Paranoia	Delusional (Paranoid) Disorder	Delusional Disorder	Delusional Disorder
Systematized delusions	9				
Minimal hallucinations	9	No prominent hallucinations	Hallucinations if present are not prominent.	*No hallucinations* with exception of tactile or olfactory if related to delusions.	Hallucinations if present are not prominent and are related to the delusional theme.
Chronic course of illness	9	Chronic and Stable Delusional system of at least 6 month's duration	At least 1 month's duration	At least 1 month's duration	At least 1 month's duration
Prominent ideas of reference	9				
Minimal affective deterioration	8	*No blunted flat or inappropriate affect*	*No flat or inappropriate affect*	*No negative symptoms (ie, affective flattening, alogia or avolition).*	*No negative symptoms (ie, diminished emotional expression or avolition).*
Lack of insight	7				
Non-bizarre delusions	7	No bizarre delusions	Nonbizarre delusions	Nonbizarre delusions	—
Intact cognitive processes	6	No incoherence or marked loosening of associations	*No incoherence or marked loosening of associations*	*No disorganized speech*	*No disorganized speech*
Lack of mood abnormality	6	Emotion appropriate to content of delusion. *Full depressive or manic syndrome not present, develops after the psychotic symptoms or is brief relative to duration of psychotic symptoms*	*Full depressive or manic syndrome not present, develops after the psychotic symptoms or is brief relative to duration of psychotic symptoms*	If mood episodes have occurred concurrently with delusions, their total duration has been brief relative to the duration of the delusional periods.	If manic of major depressive episodes have occurred these have been brief relative to the duration of the delusional periods.
Delusional memory	6				
Actions and behaviors appropriate aside from areas of delusional beliefs	5	Behavior appropriate to delusional content.	Aside from delusions, behavior is not odd or bizarre	Aside from delusions, behavior is not odd or bizarre	Aside from delusions, behavior is not odd or bizarre
Delusional themes		Persecutory only	Erotomanic, grandiose, jealous, persecutory or somatic	Erotomanic, grandiose, jealous, persecutory or somatic	Erotomanic, grandiose, jealous, persecutory or somatic

Note: Italics if criteria are not specifically listed under category but are ruled out because they are criteria for schizophrenia.

were recorded by all authors with the other themes, in declining frequency, being grandiose, erotic, litigious, somatic, jealousy, religious, and olfactory (ie, patient emitting an offensive smell).

Paranoia and Delusional Disorder—DSM-III to DSM-5

Table 2 summarizes the symptomatic diagnostic criteria for paranoia/delusional disorder in the 4 major US

Table 3. Clinical Features of Paranoia as Recorded by 2 Textbook Authors Who Rejected the Kraepelinian Construct

	Craig 1912[15]	Cole 1913[16]
Disorder	Chronic Delusional Insanity (Paranoia)	Paranoia (Systemized Delusional Insanity)
Country	United Kingdom	United Kingdom
Nature of delusions	Tendency to fixed systematized delusions, slowly woven and systematized.	Systematized.
Bizarreness of delusions?	Delusions of unseen agency (electricity, hypnotism) commonly occur. Others can read their thoughts. Can be quite fantastic—in describing the complicated apparatus that is used on them.	Many complain that their thoughts are read. Many explain their unusual sensations as due to mesmerism, electricity, magnetism or X-rays.
Level of affective deterioration	Slight vagaries of conduct are frequently all that can be detected. Emotions are not seriously disordered.	Modest. Some individuals can pass their entire lives in this condition and yet are able to follow their occupations.
Organization of thought	Reasoning power quite good for subjects unaffected by the delusions.	Talks rationally on ordinary topics outside his circumscribed sphere of insanity.
Course of illness	Slow and chronic. Does not typically lead to dementia although attention can become more and more absorbed in delusional ideas.	Insidious gradual onset. Only slight tendency to dementia.
Ideas of reference	Insane misinterpretation common. Sees hidden meanings and signs and hints everywhere.	Every little detail in the environment is closely entwined within the fabric of the patient's morbid imagination. He finds references to himself
Delusional memory		Ordinary events of their past are worked up to fit into their delusions.
Delusional themes	Persecution, grandiosity.	Exalted, persecutory, querulent, religious, amorous and hypochondriacal.
Origin of delusions		
Hallucinations	Presence of hallucinations are common, hearing and sight most frequently.	Sooner or later hallucinations of the senses are apt to develop. Often can hear the "telephonic voice of his accuser."
Insight		None
Actions and behavior	Generally well organized when not involving delusional beliefs.	Typically normal outside of areas of delusional belief.
Mood	No severe emotional disturbances as seen in mania and melancholia.	

operationalized systems that contained criteria for this syndrome. Two technical issues arose in describing these criteria. First, all of the DSM criteria sets contained one criterion that read something like "Criterion A for schizophrenia has never been met." So that meant we had 2 "levels" of criterion—those specifically written for paranoia/delusional disorder and the "rule outs" that derived from the schizophrenia criteria. To differentiate these, we put the latter in italics. Second, only in DSM-III were there separate criteria for a broader non-schizophrenic paranoid syndrome (termed Paranoid Disorder) and a narrower syndrome (termed Paranoia). We focus on the latter.

The criteria for paranoia/delusional disorder changed in 4 substantial ways from DSM-III to DSM-V. First, in DSM-III, delusional content was restricted to only persecutory delusions. The number of permitted delusional themes expanded considerably in DSM-III-R and remained stable thereafter. Second, the criteria for paranoia in DSM-III required a minimum of 6-month duration and the delusions were required to be "chronic and stable." Thereafter, no modifiers were used to describe the chronicity or stability of the delusions and the required minimum duration was reduced to 1 month. Third, in DSM-5 only, the requirement that the delusions be nonbizarre was dropped.[33,34] Fourth, in DSM-IV only, the criterion of "no prominent hallucinations" was dropped and a note added that tactile and olfactory hallucinations were permitted if consistent with the delusional theme. This provision was not present in DSM-5.

Table 2 also compares the symptoms and signs of paranoia derived from the textbook review to the criteria used for paranoia and delusional disorder from DSM-III to

DSM-5. Four comments are noteworthy. First, of the 4 symptoms and signs most commonly described by the authors, 2 of them—systematized delusions and prominent ideas of reference—were lacking from all relevant DSM editions. One of them—chronic course of illness—was moderately well captured by DSM-III, which required a chronic and stable delusional system of at least 6 month's duration. However, it was poorly assessed by subsequent editions of DSM which all required a minimal duration of 1 month. One—minimal hallucinations—is reasonably well captured with changing language (albeit permitting delusion-related olfactory and tactile hallucinations in DSM-IV) across the relevant DSM editions.

Second, of the 3 symptoms/signs reported by 7 or 8 of the authors, one of them—lack of affective deterioration—was present from DSM-III to DSM-5 as a result of criterion "Criteria A for schizophrenia has never been met" that is present in modified form in all these editions. A second one—lack of insight—was missing from all the relevant DSM manuals. The third—non-bizarre delusions—was present in DSM-III, III-R and IV, but not DSM-5.

Third, for the final 4 symptoms/signs described by 5 or 6 of the textbook authors, 3—intact cognitive processes, lack of mood abnormality, and appropriate actions and behaviors were covered well in all relevant DSM editions. By contrast, one of them—delusional memory—was not present in any of these editions.

Finally, DSM-III only permitted persecutory delusions for the diagnosis of paranoia. All the subsequent editions specified 5 possible delusional themes (Erotomanic, grandiose, jealous, persecutory, or somatic). Three themes that were not included in these criteria—litigious, religious and olfactory—were noted, albeit uncommonly, by our text authors.

While the DSM-III defined a syndrome rather close to Kraepelin's conception, with 3 major changes (shortening of minimum duration, elimination of requirement for stability of delusions, and dropping requirement for Nonbizarre delusions), by DSM-5 the syndrome of delusional disorder more closely resembled a broadly defined "paranoid state" than Kraepelinian paranoia.

Authors Rejecting the Kraepelinian Concept of Paranoia

A complete picture of the clinical history of paranoia in the 20th century through psychiatric texts would not be complete without a brief review of 4 textbooks I reviewed which rejected the Kraepelinian concept of paranoia. For 2 early British authors—Craig[15] and Cole[16]—this was not evident in their introductory comments. Rather, as their symptomatic descriptions were reviewed—as is clear from table 3—their concepts of paranoia diverged in 2 critical ways from Kraepelin's formulation. While they both described a syndrome characterized by a chronic course, dominated by systematized delusions without cognitive or affective deterioration, they both also described prominent auditory hallucinations and typically schizophrenia-like bizarre delusions. The third and fourth textbook authors Curran and Guttmann[17] and Mayer-Gross, Slater and Roth[18]—by contrast, concluded that Kraepelinian paranoia concept was a failed diagnostic construct. Curran and Guttmann, writing in 1945, concluded that paranoia is a "milder form of paranoid schizophrenia".[17] Mayer-Gross, Slater and Roth, in their 1954 textbook, wrote

> The effort to maintain paranoia as a distinct condition has failed…. Although it is doubtful whether a pure case ever existed, paranoia can serve as an ideal picture … [where] it is useful for orienting oneself in the difficult and multifarious field of paranoid psychoses…. If one rejects, as the authors do, any separation of the paranoid group of psychoses from the main body of schizophrenia… one if still left with the question why the symptom of delusion predominates in some patients… (Mayer-Gross et al[18] pp. 252–253)

Discussion

I have sought to trace, through psychiatric textbooks, the history of the clinical concept of paranoia in the 20th century and then relate these findings to the diagnostic criteria for paranoia—and the cognate category delusional disorder—in modern US operationalized diagnostic criteria. I reached 4 major conclusions which I review in turn.

First, there has been moderate but not uniform agreement in textbook authors across the 20th century about the nature of the diagnostic concept of paranoia. In line with its description by Kraepelin, the large majority of authors saw this as a chronic syndrome characterized by systematized non-bizarre delusions and prominent ideas of reference in the absence of hallucinations, affective or cognitive deterioration and major mood disturbance. Relatively good agreement across textbook authors was seen in the most important of these symptoms and signs.

Second, however, a minority opinion appeared among text authors which rejected the Kraepelinian concept of paranoia. This had no parallel in my reviews of the history of depression,[10] schizophrenia[11] and mania[12] over this same time period. In line with the comments of Percy Smith in 1904, two subsequent British textbook authors substantially expanded the diagnostic concept of paranoia so that it closely resembled what we would now call good-outcome paranoid schizophrenia and which Kraepelin late in his career termed paraphrenia.[35,36] Two other sets of authors, 41 and 50 years later, took this position further by arguing that paranoia did not exist as a viable separate psychiatric category from the broad spectrum of delusional forms of schizophrenia illness. Of note, in 1970, the surviving authors of one of these textbooks—Slater and Roth—reversed themselves, and considered paranoia a valid entity within the group of paranoid disorders.[22] Another prominent British textbook author—Henderson—who we could not use in this

review because he never provided a clear set of paranoia-specific symptoms and signs, at the end of an extensive historical review of the paranoid states concluded

> For what has been said, it is readily seen how difficult this whole field is, and how unwise it is to attempt to differentiate too closely between the paranoid schizophrenia, the paraphrenias and the paranoias. (Henderson and Gillespie[21] p. 335)

Third, the prominent symptoms and signs of paranoia recorded by the textbook authors did not map closely onto the DSM criteria for paranoia and delusional disorder. Indeed, the correspondence was worse than that seen in our parallel exercises for depression,[10] schizophrenia[11] and, especially, mania.[12] Most strikingly, 2 of our authors' most common symptoms—systematized delusions and prominent ideas of reference—were missing from all the relevant DSM manuals. Many of the other symptoms were included in the DSM criteria sets. However, the correspondence between the paranoia of the textbook authors and delusional disorder in DSM has decreased over time being highest in DSM-III and lowest in DSM-5. In particular, chronicity as a required criterion—defined as at least 6 months of illness—disappeared between DSM-III and DSM-III-R as did the need for nonbizarre delusions between DSM-IV and DSM-5. Indeed, delusional disorder in DSM-5—which could include cases of brief duration and/or presenting with hallucinations and bizarre delusions—departs substantially from Kraepelin's diagnostic concept of paranoia.

The change in the conceptual formation of delusional disorder across these DSM manuals was substantially greater than that seen for depression and mania and somewhat greater than that seen for schizophrenia.[10–12] If we were to compare paranoia/delusional disorder to the other 3 major psychotic and mood disorders articulated by Kraepelin, its instability was greater both over 20th century texts and within the recent DSM editions.

Fourth, although it could not be well captured by the above review of symptoms and signs, a number of textbook authors commented on the etiology of paranoia, understanding it more as a "personality development" rather than a disease. Here they are echoing Kraepelin's own views. While Kraepelin believed that dementia praecox was the result of an organic neurologic pathological process perhaps caused by autointoxication,[36] paranoia, by contrast, was

> … essentially a matter of abnormal development which takes place in persons of psychopathic disposition under the influences of the ordinary forces of life … we do not [here] have to do with a special disease process, but with a sort of "psychic malformation" … the root of [which] … is to be sought in a peculiar "paranoid" predisposition. [However] to produce [paranoia] … especially unfavorable external and internal conditions have to work in combination (Kraepelin[37] p. 187).

He echoed these views in his section on the causes of paranoia in his eighth edition where he wrote

> … a morbid process as the cause of paranoia cannot be found, [and instead] … we have to reckon with morbid preliminary conditions in the form of quite definite insufficiencies of the predisposition. (Kraepelin[24] p. 264)

One of the most pointed observations along these lines was made by Bleuler who wrote

> The delusional system of paranoiacs is a psychic formation that gives the appearance of a simple exaggeration of normal processes. The normal individual reacts in the same way but not continually so. Everybody has false references to oneself as well as insufficiency of logic as soon as he is in an affective state. The manifestation becomes pathological only because it cannot be corrected and especially because of the tendency to spread generally…. At any events it is not a direct result of any process in the brain or of a constitutional degeneration. (Bleuler[27] pp. 529–530)

Sadler puts this point more succinctly—that paranoia is "…not a disease but an outward manifestation of a deeper and underlying disorder of personality." (Sadler[30] p. 857)

It is of interest to examine, in the context of this discussion, the ICD-10 description of delusional disorder.[38] The ICD-10 requires delusions of at least 3 months duration and the absence of all classical schizophrenic symptoms (thought disorder, affective deterioration, prominent auditory hallucinations, and bizarre delusions). However transitory "voices" and olfactory or tactical hallucinations are permitted. The criteria specifically note that aside from "actions and attitudes directly related to the delusion," behavior, affect and cognition are normal. ICD-10's approach to delusional disorder is probably most similar to DSM-IV with the exception of a longer required duration. It bears a considerable albeit not complete resemblance to Kraepelin's concept of paranoia.

Limitations

This work should be interpreted in the context of 3 potential methodological limitations. First, I have not reviewed all major writings on paranoia in the Western Psychiatric tradition from ~1900–1970. I have surely under-sampled non-Anglophonic literature but have hopefully been able to obtain a broadly representative sample. Second, in starting the project, I was concerned that some texts might not be truly independent and just present, nearly verbatim, material from an earlier author. I found no such examples of this in the texts I reviewed.

Third, during the 20th century, psychiatric practice shifted from being largely asylum based to largely outpatient. Most of the patients with paranoia seen by our authors were in-patients. Some of the differences in symptoms and signs of paranoia/delusional disorder recorded

by our authors and those commonly seen today may arise from the differences in the patient populations.

Conclusions

Compared to Kraepelin's 3 major psychotic and mood diagnostic categories—depression, mania (both subtypes of his "manic-depressive insanity") and schizophrenia/dementia praecox—throughout the 20th and 21st centuries, paranoia has been a somewhat neglected step-child. From 1900 to 1970, Kraepelin's broad clinical and conceptual framework for the disorder was accepted by most textbook authors. But a significant minority rejected it at the same time as accepting his other major categories. While the diagnostic concepts of Kraepelin's views of depression, mania and schizophrenia were reasonably well reflected in the relevant DSM categories, this was less the case for paranoia. Indeed, the disassociation between Kraepelin's concept of paranoia and DSM delusional disorder has grown wider over time.

I would suggest, tentatively, 2 major reasons for this development. First, paranoia is a much rarer syndrome in clinical settings than is depression, mania or schizophrenia. Furthermore, it is a narrower syndrome covering less psychopathological "space." To use a geographical metaphor, if depression, mania or schizophrenia each represented continents, paranoia would be a modest-sized off-shore island. Largely for these reasons, it has attracted far less attention from researchers, pharmaceutical companies and nosologists. Second, more than his other great categories, Kraepelin's concept of paranoia is defined by what it is not. That is, the disorder has one key positive symptom—chronic delusions. But otherwise, it is largely defined by not having particular features of schizophrenia: bizarre delusions, hallucinations, cognitive disorganization, negative symptoms and psychosocial deterioration. Put another way, far more than schizophrenia, mania or depression, paranoia is a diagnosis of exclusion. Indeed, the main basis for the rejection of this category by the minority of the textbook authors is the unworkability of that exclusion—that among the broad spectrum of delusional syndromes, the dementia praecox-paranoia boundary articulated by Kraepelin in 1899 is not defensible.

In addition to an older literature,[8,39,40] a modest amount of research work continues to be done on paranoia/delusional disorder, a good proportion of which supports the validity of Kraepelin's distinction.[41–45] Whether and in what form paranoia will survive as a distinct clinical entity further into the 21st century will likely depend on the quality, quantity and overall results of these and similar investigations.

Acknowledgment

The author has declared that there are no conflicts of interest in relation to the subject of this study.

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