PARANOID PSYCHOSES

A PROPOSED ADDITION TO SOUTHARD'S MAJOR PSYCHOTIC GROUPS

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The grouping of the mental disease entities into eleven primary categories, as proposed by Southard (1), is highly satisfactory from a pragmatic standpoint. It is very palpably superior to any more detailed subdivision, from the viewpoint of both student and teacher; easier for the one to present and define; easier for the other to grasp and correlate. It serves, moreover, as a neat and facile diagnostic index in which practically every psychiatric entity may be quickly placed.

From the standpoint of the practical psychiatrist, however, one possible alteration may be suggested, which would, without altering the principle of major categories, or that of diagnosis by orderly exclusion, materially augment the practical value of the Southard nosology. This is the insertion of a twelfth group, to be number IX, embracing paranoid psychoses, and possibly labelled paranoicopsychoses, or paranoidoses, which should include all idiopathic psychoses characterized by paranoid symptoms, including "paranoid dementia præcox."

That such a group is amply justified by clinical findings, in both a quantitative and qualitative sense, is not difficult of demonstration.

First of all it should be pointed out that in all of the eleven major groups of Southard's classification, there occur paranoid forms, or paranoid colorings. With these we are here not at all concerned. Thus we may exclude, a priori, such representative examples as the following:

In Group I, the neurosyphilis group, syphilitic paranoia should certainly remain. In Group II, the hypophrenias, the paranoid state dependent upon hypophrenic judgment defect are certainly properly retained. Similarly in Group III, the epileptics, with their proverbial ego-centricity and frequent paranoicism. Group IV, the drug

psychoses, contains the beautiful examples of drug-paranoias, *e. g.*, alcoholic Eifersuchtswahn, to mention only the most conspicuous.

The psychoses with focal brain disease (Group V) may be accompanied by striking paranoid symptoms, as was shown in a case reported by the writer (24), and Schuster has demonstrated the association of paranoid symptoms with variously situated brain tumors. Similarly, paranoid delusions with psychoses associated with somatic disease (Group VI) are frequently seen, and were conspicuous in the recent influenza epidemic (25). Of the gerio-psychoses (Group VII), senile paranoia or paranoid senile dementia is common enough. Group VIII, paranoid forms of the Schizophrenias, are discussed below. The cyclothymic psychoses (Group IX) are frequently strongly colored by paranoid trends, as are also the psychoneuroses (Group X). The paranoid constituents of Group XI, the psychopathies, etc., are discussed below.

But with all these we have here nothing to do. There remain yet many forms in which the elaboration of paranoid elements forms the characteristic and determining feature, and for which we have no satisfactory explanation.

In the first place, those two psychiatric cousins, paranoia (Kraepelin) and paraphrenia, are at present completely divorced in Southard's scheme, and the one added to the schizophrenic group, while the other is relegated of necessity to the group (XI) of psychopathies and miscellaneous psychoses. Waiving for the present the question as to the deserts of these diseases from the standpoint of basal symptoms in abnormal psychology, and as to the justifiability of losing so frequent and so characteristic a psychosis as paranoia in a group of miscellanies, or so dubiously schizophrenic a disease as paraphrenia in a group characterized by that phenomenon, we pass on to other closely allied forms.

Above all stand a group of "Unclassified paranoid psychoses" or "Unclassified paranoic states." The great frequency with which this diagnosis is made in a rapidly turning psychiatric clinic is surely a most striking fact. To those whose associations are stimulated by statistics, it will emphasize this fact to know that according to Pollock's census of the New York state hospitals in July, 1917, there were therein:

"Psychoneurosis	150
"General Paresis	1,325
"Manic depressive insanity	2,408
"PARANOIC CONDITIONS AND PARANOIAS	1,642
" (or 4.7 per cent. of the total number of insane, 35,000 +)."	

Add to this, possibly,

"Allied to dementia præcox, 1,233."

These cases, as they are seen at the Boston Psychopathic Hospital, for example, Dr. Southard's own institution, do not correspond to classical paranoia, neither to paraphrenia, nor by any means to paranoid schizophrenia (*dementia præcox*). Indeed, a certain large proportion of them fall in a group which surely merits special study. I refer to those cases of psychosis developing in the later years, often soon after the menopause, and characterized by persecutory delusions or persecutory (*sic!*) phonemata, or both—but always without demonstrable damage to the personality, or evident schizophrenia.

The writer falls in strongly with the view of Seelert (2), who in a study of "paranoid psychoses in advanced years" concludes that these more or less uniform cases probably comprise a distinct and unnamed syndrome, which is "probably an individual reaction of an endogenous sort to a chronic, slowly progressive, organic cerebral process."

Perhaps they should even be considered in the light of a new entity—but be that as it may, it is without the province of this paper. That they exist is not to be doubted, and as demonstrated they occur in surprising numbers. And as the Southard grouping now stands, these more or less uniform cases of committable psychoses of striking stamp must be crushed into the composite group of psychopathies, with committable and noncommittable entities of divers sorts.

Add to this list, then, those quasi-normal persons of paranoid personality—the querulants, litigants, cranks, et al. These persons, as borderline cases, might be grouped with great pragmatic advantage in an order of paranoid psychoses, and regarded as definitely psychotic, rather than merely (!) psychopathic—even though they be not committable.

Again, one recalls those rather hazy and infrequent entities, insisted upon by one or another European psychiatrist, and clung to tenaciously by this or that American devotee. Here, to list but a few, one would include: Wernicke's (3) *Hallucinoze*, Kraepelin's (4) *Eifersuchtswahn* (non-alcoholic), Kraepelin's (4) *Beeinträchtigungswahn*, Ziehen's (5) *hallucinatory paranoia*, French writers' (6) *delire paranoïaque* and *delire systematisé*, Sander's (7) *original paranoia*, Kleist's (8) *involutional paranoia*, Westphal's (9) *acute paranoia*, *periodic paranoia*, Laseque's (10) *folie de persecuteurs persecutés*, Falret's (?) (11) *folie lucide*, *raisonnante*, French (13) *delire systematisé*, Magnan's (12) *delire chronique à évolution systematique*, Regis' (13) *psychose systematisée progressive*, Se-

rieux's (14) *delire d'interpretation*, *delire de revendication*, Dupre's (15) *delire d'imagination*, Neisser's (16) *confabulatory paranoia*. (Among these, of course, one must allow for many synonyms.)

Finally, I propose the possible advantage of a separation of the so-called "paranoid form of dementia præcox," or "dementia paranoides" or "schizophrenia paranoides" from the main group representing schistic psychoses, and its identification with this new group of paranoid psychoses.

I shall not recall here the historical development of the presently composed dementia præcox, nor more than mention the doubts expressed by Seglas (21), Serieux, Bleuler (22), and even Kraepelin, as to whether this form would eventually stand affirmed as identical in essential nature with hebephrenia and catatonia.

The word "paranoid" seems to have been coined by Kraepelin to describe cases resembling but distinct from paranoia. This term, in turn, was introduced by Snell (17) and Griesinger (18), and originally meant merely "delusions." Kraepelin gives Kahlbaum (19), and then Krafft-Ebing and Mendel the credit for substituting the word for the older conception of *Verruechtheit*. Later, under the influence of Ziehen (5) et al., it came to include hallucinations and was finally whipped into the stereotyped, standardized form now recognized by Kraepelin.

The derivative word "paranoid" has never been rigidly enough delimited. Following Kraepelin, because of his influence in promulgating the term, it probably should be restricted to symptoms of the nature of "delusions and hallucinations of a persecutory bearing, and rapid development, be they changing, dissociated or fully developed" (4).

The writer would propose a more generic definition for the reason that the above does not sufficiently succinctly include the very closely allied symptoms of delusions of reference, delusions of influence, etc.

Southard (20) has divided delusions into two classes—those expressing a degenerate wish and those expressing a degenerate hypothesis. I have elsewhere (23) proposed that the idea is perhaps more readily grasped if the conception of direction is introduced, and the delusions termed afferent and efferent, with respect to the ego and its environment, or ego-centripetal and ego-centrifugal. Thus, the ego-centripetal delusions, or erroneous ideas conceived as originating from without the limits of reasonable possibilities, represent delusions of persecution, influence, reference, molestation, etc.—or expressions of degenerate hypotheses. I have

also suggested that hallucinations might be similarly regarded. Now it appears that this type of delusions and hallucinations is precisely what is intimated in general in the current use of the word "paranoid." At any rate it would be of immense pragmatic value in the teaching of psychiatry and hence in mental hygiene, if we would make some such specific definition of so important a term. The proposed limitation of "paranoid" symptoms to afferent or ego-centripetal delusions or hallucinations (or both) and with or without systematization, grandiosity, etc., has certain inherent commendations.

Accepting, however, for the present, Kraepelin's ill-defined conception of paranoid, it appears that his "paranoid dementia præcox" is precisely this symptomatology plus the factor of progress to a terminal dementia. As a matter of fact, however, we do not know that any considerable proportion of what we are calling paranoid dementia præcox actually does progress to a terminal dementia. This is a matter which will soon be conclusively demonstrated either in the affirmative or negative, now that the Kraepelin conception is growing to an age beyond that of the average state hospital case.

We do know, even at present, that at least some of these cases show no demonstrable evidence of dementia even after years of observation. Southard's insistence on the extirpation of the term "dementia præcox" as of pragmatic value in mental hygiene is then here directly to the point. It were better to give these cases the benefit of a doubt than to condemn them to a pessimistic diagnosis of implied hopelessness. Every psychiatrist must be occasionally overwhelmed with the utter lack of similarity in the cross-section view of cases of so-called "paranoid" and "catatonic" schizophrenia. If, then, the terminal, and supposedly criterion state is in doubt we are the more justified in at least a tentative divorce. This is in addition to and without reference to the historical arguments in favor thereof.

CONCLUSION

But whether or not this group be included, perhaps now the point is self-supporting—that there are paranoid states, *i.e.*, psychoses characterized by afferent type of delusions, which are not well placed in Southard's otherwise efficient and practical major group nosology. These, it is proposed, might be bunched as a twelfth group—the paranoicopsychoses, or paranoidoses, possibly to stand ninth in the list, and to include those mental disease forms, characterized by paranoid (*i.e.*, afferent) delusions, with or without

hallucinations, not otherwise provided for in this inclusive classification. Herein would fall such currently recognized entities as paranoia, paraphrenia (and Magnan's disease), paranoid personalities (to be considered before the more generic and more tenuous psychopathy group), together with the unclassified paranoid states, the unclassified paranoid psychoses, numerous entities described by various European psychiatrists listed above; and finally, with probable pragmatic benefit, the paranoid form of schizophrenia.

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