Are There Delusions Specific for Paranoid Disorders vs. Schizophrenia?
by Kenneth S. Kendler

Abstract

DSM-III proposes that only persecutory delusions and delusions of jealousy can occur in paranoid disorders, all other types of delusions in the absence of an affective syndrome being indicative of schizophrenia. The scant empirical evidence relevant to this issue suggests that the type of delusion on admission is not predictive of outcome in patients with paranoid psychosis. These findings raise questions about the validity of the distinction drawn in DSM-III between types of delusions.

The types of delusions that can occur in paranoid psychoses have been a subject of some debate in psychiatry. Kraepelin (1976) listed the following types of delusions as occurring in paranoia: persecutory, grandiose, erotic, religious, jealousy, and possibly hypochondriacal. DSM-II (American Psychiatric Association 1968) states that the delusions in paranoid states are "...generally persecutory or grandiose" (p. 37). The latest draft (1/79) of DSM-III (American Psychiatric Association, in preparation) lists only persecutory delusions or delusions of jealousy as occurring in paranoid disorders. The presence of any other kind of delusion without persecutory or jealous content meets, according to DSM-III, the symptomatic criteria for schizophrenic or schizophreniform disorders.

Empirical data, though scanty, do exist relevant to the question of what types of delusions may be specific to paranoid disorders as opposed to schizophrenia. The data come from two Norwegian followup studies. The first, conducted by Nils Retterstol (1970), consisted of personal followup at 5 or more years after index admission of over 250 patients diagnosed as either schizophrenia or paranoid psychoses. Specifically excluded from the sample were delusional affective illness and acute confusional psychoses. Although the term "reactive" is applied to the paranoid psychotics, this does not mean that the psychoses were brief. Forty-one percent of Retterstol's paranoid psychotics had been psychotic for over 6 months before admission, and only 22 percent were psychotic for less than 1 month. The second study, conducted by a series of investigators working at the Gaustad Hospital, was on all functional psychoses, again with a followup at a minimum of 5 years after index admission. One of the diagnostic entities investigated was "reactive paranoid psychosis."

Noreik (1970), in describing the project, specifically states that the reactive psychoses category was largely used as a diagnosis of exclusion, that is, to label any psychotic patient who was neither schizophrenic nor manic-depressive.

Results

The relevant data from three studies are presented in table 1. The studies of both Holmboe and Astrup (1957) and Noreik (1970) come from the Gaustad Hospital. Retterstol's cohort, as well as that of Holmboe and Astrup, contains a mixed population of paranoid psychotics and schizophrenics. Noreik's cohort

Reprint requests should be sent to Dr. Kendler at Department of Psychiatry, Veterans Administration Medical Center, 130 W. Kingsbridge Rd., Bronx, N.Y. 10468.
### Table 1. Clinical outcome as a function of type of delusion

<table>
<thead>
<tr>
<th>Author</th>
<th>Patient cohort</th>
<th>Variable measured</th>
<th>Type of delusion on admission (%)</th>
<th>Entire sample</th>
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</thead>
<tbody>
<tr>
<td>Retterstol (1970)</td>
<td>206 patients with paranoid reactive psychosis and 84 patients with schizophrenia</td>
<td>Percent favorable clinical course on minimum 5-year followup&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Persecution 60 71 Jealousy 53 Hypochondria 36&lt;sup&gt;2&lt;/sup&gt; Gran- deur 73 Sexual 76 Self-reference 64</td>
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<tr>
<td>Holmboe and Astrup (1957)</td>
<td>255 patients with acute schizophrenia and schizophreniform psychosis including 52 with paranoid psychoses.</td>
<td>Percent of patients who did not demonstrate schizophrenic defect on 5-year followup</td>
<td>Persecution 59 Jealousy 33&lt;sup&gt;2&lt;/sup&gt; Hypochondria 76&lt;sup&gt;1&lt;/sup&gt; Gran- deur 56 Sexual 64 Self-reference 50 En- tire sample 54</td>
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<tr>
<td>Noreik (1970)</td>
<td>279 patients all discharged with diagnosis of reactive paranoid psychosis</td>
<td>Percent verified on followup as reactive paranoid psychosis. All other patients developed schizophrenia</td>
<td>Persecution 43 Jealousy 27 Hypochondria 54 Gran- deur 50 Sexual 45 Self-reference 47 Entire sample 45</td>
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<sup>1</sup> The remainder of patients had an unfavorable clinical course. Clinical course was correlated highly with diagnostic outcome (92 percent with unfavorable and 8 percent with favorable clinical course diagnosed schizophrenic).

<sup>2</sup> Different from mean group outcome (by $\chi^2$ at $p < .10$).

<sup>3</sup> Different from mean group outcome (by $\chi^2$ at $p < .05$).
consists of patients who were all discharged as paranoid psychotics. On followup, over half were found to have developed schizophrenia. The hypothesis tested in these three studies is that if certain delusions are specific for paranoid psychosis, they ought to predict nonschizophrenic outcome. Furthermore, if certain delusions are specific for schizophrenia, they ought to predict schizophrenic outcome. In Retterstol's (1970) study, this hypothesis rests on the assumption, amply supported by his data, that schizophrenia has a poorer outcome than paranoid psychosis.

As can be seen in table 1, no agreement across studies was found that a given type of delusion could predict a schizophrenic or nonschizophrenic outcome. The one statistically significant result (by $\chi^2$, $p < .05$), which easily could have occurred by chance, is contrary to what DSM-III would predict.

**Discussion**

No clear difference emerges in the data presented here between those types of delusions regarded by DSM-III as specific for paranoid disorders vs. those regarded as specific for schizophrenia in predicting schizophrenic or nonschizophrenic outcome in paranoid psychotics and schizophrenics. These results do not support the validity of the distinction proposed in DSM-III between delusions of persecution and jealousy, on the one hand, and all other nonbizarre, non-Schneiderian delusions, on the other (e.g., hypochondriacal, grandiose, religious, and sexual). These data must be regarded as in need of replication and extension.

The data here reviewed have a further implication. In suggesting that no type of delusion is specific for paranoid psychoses, these results further weaken the logic of using the confusing term “paranoid” to describe this group of psychoses. These data suggest that it is the tendency toward the formation of any kind of delusion in the absence of schizophrenic, affective, or organic illness that is specific for these disorders. The term “delusional disorder” as proposed by Winokur (1977) appears to describe more accurately and with less possibility for confusion the essential psychopathology of these patients.

**References**


**The Author**

Kenneth S. Kendler, M.D., is at the Department of Psychiatry, Veterans Administration Medical Center, 130 Kingsbridge Rd., Bronx, N.Y.