The Concept of Paranoid States and the Significance of Transient Disorganization During Special Management

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ABSTRACT

17 cases diagnosed as paranoid states were submitted to intensive therapy, in a special milieu, aiming at disruption of the delusional system rather than concealing the symptoms. It was found that the residual apathy is relatively inversely proportionate to the transient disorganization met with during the course of treatment. This might give support for the view that functional psychoses are but one continuum with different presentations at different stages. It also recommended considering the structural pathology in making the treatment plan and evaluation of the results.

INTRODUCTION

Paranoia as a medical term was used two thousand years ago by the Greek to mean something equivalent to the lay term 'insanity'. Since then the term is still confusing and ambiguous. In the 18th century it was used as a class name for both delirious and delusional state (Freedman & kaplan, 1967). This confusion still holds in the French literature where the word 'delire' means both delirium and delusion (Ey **et al.** 1967). The English trend describes paranoid reactions or states under various clinical categories: schizophrenia, depression, personality maldevelopment and lastly due to organic brain disease (Fish, 1968). This wide scope may denote that such a concept is too wide to serve any independent clinical entity.

In recent nosological disciplines it is noticed that the term paranoid state is getting to include more and more 'symptom complex' entities. The Egyptian classification (DMP-I, 1979) has adopted the term paranoid states to describe both acute and subacute transient states as well as chronic fixed delusional, hallucinatory or imaginative states. The former

are nearer to the term paranoid reactions used by the Anglo-Saxonian schools, while the latter is nearer to the concept of delire chronique (Ey et al. 1967) used by the French school. The difference between both groups is so significant in both treatment and prognosis that it has to raise doubts about the justification of their inclusion under one main category. In the ICD-9 (1977) the paranoid state category expanded, compared to ICD-8 (1967) and DSM-II (1968), to include different varieties such as : paranoid state simple, paranoia, paraphrenia and induced insanity. It excludes, however, acute paranoid reaction which is placed under the main category "Other Non-Organic Psychoses". In the DSM-III (1978) the main category is paranoid psychosis while the subcategories include paranoia, paranoid states and shared paranoid disorder. Paranoid state, however, as described in this manual is nearer to paranoid reaction : "the onset is usually relatively sudden, and the condition rarely becomes chronic."

The first author (Rakhawy, 1979) puts paranoid states on a paranoid scale starting from normal and ending by true paranoia (paranoia vera). According to his view the term paranoid state is only justified when the delusional system is active along with the conceptual system in the same matrix of consciousness where the delusional system* functions as a splint avoiding personality disorganization.

From a dynamic point of view, Freud (1955) described a case of paranoia as being the product of a defense machanism against impending eruption of homosexual trends. Kolb (1968) postulates it to be a defense against homosexuality in males and heterosexuality in females. Guntrip (1968), following Fairbairn, considers that paranoid mechanisms are defenses against regression to the objectless state (schizoid position).

We can come to conclude that 'paranoid state' is still ambiguous term.

(*) Hallucinations and images being considered as delusions from a structural point of view.

overinclusive and rather illusive. Waiting for further delineation and subcategorization, the whole structural organization is to be investigated. Our approach here is to try to see such organization through the how of the resolution of certain paranoid states putting in consideration its possible relation to schizophrenic disorganization. The hypothesis is based on the assumption that if paranoid state represent a compromized personality splinted by some delusional system, it is liable to disorganize if reorganization is aimed at through intensive therapy. This therapeutic manoeuvre is quite different than simply attacking the delusions to hide them at the expense of other positive personality aspects.

MATERIAL AND METHOD

Seventeen cases of paranoid states were admitted to hospital and submitted to intensive treatment including high doses of phenothiazines (thioridazine 600-1200 mg / day, perphenazine enantheate 100 mg ampoules bi-weekly and chlorpormazine 500-2000 mg/day). Moreover, electroshock (unilateral) was used either every other day or daily varying from 8 to 12 sessions. All patients were made to attend group therapy sessions three times weekly, utilizing mainly the evolutionary group therapy technique (Rakhawy, 1978; Hamdi 1979). The milieu was adopting the idea that psychosis is a language and that any malorganization is possibly correctable.

The patients were thirteen males and four females. Their ages ranged from sixteen to fifty two with an average of thirty one years. The period of stay ranged from six days to seventy two days with an average of twenty two days. Two psychiatrists independently recorded the symptomatic variations during and after the course of treatment in addition to the report of a senior psychiatrist leading the group therapy in the hospital. Special notice is given to the manifestations of disorganization.

The degree of disorganization was measured according to the following criteria :

1. Grade I (+): perplexity, vagueness and depersonalization (Impending disorganization).
2. Grade II (++): Lack of abstraction, lability of affect, hesitancy and moderate degree of incongruity.
3. Grade III (+++): Marked formal thought disorder, loss of self-limits, regressive behaviour, incontinence incoherence up to word salad (disintegration).

Assessment of the results were judged by two main dimensions :

1. The disappearance of delusional system and whether this is a result of hiding to appear under stress (e.g. Group pressure) or actual disappearance referring to resolution or assimilation.
2. The degree of emotional response as judged by the intuitive empathy of the assessors as well as the active productivity in work and warmth of social relations. Grading of apathy was also considered according to a previously established scale (**Rakhawy et al**)

RESULTS

Results are summed up in table (1). Five patients out of seventeen (29%) did not show any disorganization. The rest showed various grades of disorganization which lasted for a period ranging from few hours (cases No. 10 & 16) up to one month (cases No. 4 & 5). This disorganization followed E.C.T. in most cases (8 cases out of 12). Two cases were disorganized one day after admission before introducing any physical treatment or drug therapy (No. 4 & 15). Cases No. 3, 9 & 13 showed disorganization after the first E.C.T., cases No. 5 & 14 after the second shock, case No. 7 after the thrid, case No. 12 after the 4th and case No. 10 after the tenth. The last two cases (16 & 17) were disorganized after intensive interaction and "group pressure" in group therapy.

In all cases the disorganization went parallel to the disruption of the delusional system.

TABLE I

Showing the Time of Onset, Degree and Duration of Resulting Disorganization and the Final Outcome after its Subsidence.

Case No.	Time of appearance of symptoms of disorganiz.	Duration of disorganiz.	Grade of disorganiz.	Results	
				Delusions	Apathy(*)
1	—	—	—	No	++
2	—	—	—	Hidden	++
3	After the 1st. E.C.T.	Two weeks	+++	Hidden	+
4	One day after admission before treatment	One month	++	Hidden	±
5	After 2nd E.C.T.	One month	+++	Shakeable	++
6	—	—	—	Present	++
7	After 3rd E.C.T. one week after admission	9 days	+++	Present	No apathy
8	—	—	—	Present	+
9	After 1st E.C.T. 2 days after admission	1 day	++	No	No apathy
10	After 10th E.C.T.	Few hours	+	Shakeable	±
11	—	—	—	Hidden	No apathy
12	After 4th E.C.T. 10 days after admission	One week	+++	No	No apathy
13	After the 1st E.C.T. 2 days after admission	1 day	++	Shakeable	+
14	After the 2nd E.C.T. 3 days after admission	One week	+++	No	No apathy
15	One day after admission before treatment	Two weeks	++	No	±
16	During group therapy	Few hours	+	Hidden	+
17	During group therapy	3 days	++	Hidden	±

(*) ± minimal + moderate ++ severe.

The grade of disorganization was varying from perplexity up to loss of self-limits and complete regression with urine and stool incontinence.

As shown in the table, most cases who did not develop manifest disorganization did not show definite structural alteration, as the delusions either persisted (in two cases), just hidden (in two cases) or disappeared in the last one. As regards apathy, three cases were considered severely apathetic (++), one case moderately apathetic (+) while the last was not apathetic at all. This can be compared with the group which developed various grades of disorganization; where four cases showed complete disappearance of delusions, another four had succeeded to hide their delusions (appearing only under group pressure), three had shakeable delusions and the last case had its delusional system as fixed as before.

As regards apathy, it disappeared in 4 cases, was minimal (±) in another 4 cases, moderate in 3 cases (+) and severe in one (++).

DISCUSSION

While the minority of cases (29%) did not show frank disorganization, most of them (71%) showed variable degrees of schizophrenia-like disorganization. This would support the possibility that paranoid states are but defenses against disorganization and regression. It was quite interesting to have this disorganization just on admission (in cases 4 & 15) as if the patient drops his internal psychological defense (delusional system) once he perceived an alternative concrete protection (the hospital).

The therapeutic outcome of those who did not show any degree of disorganization shows that four patients (out of five) remained deluded but the delusions were either overt or consciously hidden to appear only under stress. In general, the group that developed disorganization showed a higher incidence of dissolution of the delusional system rather than its mere disappearance away from the surface, with minimal residual or no apathy. In cases No. 7, 12 & 14 who developed severe and lengthy disor-

ganization, the delusions were dissolved and no apathy was encountered for months.

These results may denote that when such intensive therapy succeeds to disrupt the integrity of the paranoid system, it shakes the whole compromise keeping the different personality compartments together. In other words, the disruption could not be restricted to the delusional compartment alone. If one admits partly that in established paranoid state "delusions are incorporated in the personality of the deluded", as the DMP-I (1979) puts it, one can grasp the must of disorganization if a real restructuring is aimed at. However, what happened in our trial is parallel to the sequence of events expected over a longer period of time in the 'normal' evolution of psychosis towards schizophrenic illness. Ey et al (1967) described four stages under the general term of "delire chronique evolution systematique", the last stage being an occasional state of mental deterioration over a period of years.

Dynamically speaking, since the delusional system is cathected with emotions, it is expected that when this system of delusion is disrupted, a quantum of energy is liberated either to invest the object in real relatedness or to involve mainly the ego (predominantly the regressed ego) resulting in certain variant of personality disorders. Until this shift occurs (from the delusional system to either the object or the self) there would be expected to have the energy in a state of fluidity, ego paralysed to function and disorganization liable to occur. This picture being transient, though still schizophrenia-like, the stable outcome excludes schizophrenia as the diagnosis of such outcome. Such transient picture is not far from the French syndrome called "Bouffée Delirante".

The striking observation was that the incidence and degree of disorganization is inversely proportionate to the degree of residual apathy. Although such degree did not amount to be considered as a residual scar justifying the diagnosis of schizophrenia, it is significant in stimulating revision of the criteria of assessment of the improvement of such cases. One can suggest that in a special milieu, temporary and controllable disor-

ganization could be favourable (particularly illustrated in cases No. 12 and 14).

The results also open the dossier of the functional psychoses as one process with different clinical presentations. Kubie (1969) states that "there is but one illness which begins as a process and ends in the long-run as a state of integrity on lower level". Our findings also suggest that descriptive diagnosis is but a cross-section at one stage or another of this continuum.

Thus, in paranoid states, like many other equivalent pathological compromises, the 'how' of resolution should be considered as important as, or even more important than, getting rid of the overt symptoms.

This approach concentrates on introducing the structural pathology of the personality as an essential independant variable side by side with both symptomatology and longitudinal psychopathology.

REFERENCES

American Psychiatric Association (1968) *Diagnostic and Statistical Manual of Mental Disorders* Second Edition (DSM-II). Washington, D.C.: American Psychiatric Association.

———— (1978) *Diagnostic and Statistical Manual of Mental Disorders*. Third Edition (DSM-III) (Draft). Washington, D.C. : American Psychiatric Association.

Egyptian Psychiatric Association (1979) *The Diagnostic Manual of Psychiatric Disorders* (DMP-I). Cairo: Egyptian Psychiatric Association.

Ey., H., Bernard, P. and Brisset, C. (1967) *Manuel De psychiatric*. Paris : Masson.

Fish, F. (1968) *An Outline of Psychiatry for Students and Practitioners*. Bristol : John Wright & Sons Ltd.

Freedman, A. and Kaplan, H. (1967) (eds.) *Comprehensive Textbook of Psychiatry*. Baltimore : The Williams & Wilkins Co.

Freud, S. (1955) Some neurotic mechanisms in Jealousy, Paranoia and Homosexuality. *In Standard Freud* Vol. 18.

Guntrip, H. (1968) *Schizoid phenomenon, Object Relations and the Self.* London : The Hogarth Press.

Hamdi, E. (1979) *Group psychotherapy : An Egyptian Approach* Cairo : Dar El-Ghad.

Kolb, L.C. (1968) *Noyes Modern Clinical psychiatry* 7th ed. Philadelphia : Saunders.

Kubie, L.S. (1971) Multiple fallacies in the concept of schizophrenia. In Doucet, P., and Laurin, C. (eds.), *problems of psychosis.* Montreal: Excerpta Medica.

Rakhawy, Y.T. (1978) *An Introduction to Group psychotherapy.* Cairo : Dar El-Ghad (In Arabic).

——— (1979) *A Study in Psychopathology.* Cairo: Dar El-Ghad (In Arabic).

Rakhawy, Y.T., Abdel Kader, M., Gawad, M.S. Abdel Aziz, T. and Soliman Kawther; Difficulties in assessment of apathy (Unpublished document).

World Health Organization (1968) *Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death.* 8th Edition (ICD-8). Geneva : WHO.

——— (1977) *Manual of the Inernational Statistical Classification of Diseases, Injuries and Causes of Death.* 9th Edition, (ICD-9). Geneva : WHO.

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الملـــــوجز

مفهوم « حالات البارانويا » وأهمية التفسخ المؤقت اثناء العلاج الخاص :

أجرى هذا البحث على سبعة عشر حالة من حالات البارانويا عولجت بالعلاج المكثف فى وسط خاص بهدف تمزيق المنظومة الضـــلالية أكثر من اخفاء الأعراض الظاهرة ، وقد وجد أن تبلد الشعور المتبقى بعد العـــلاج يتناسب عكسيا مع التفسخ المؤقت الذى طرأ على بعض الحالات أثناء سياق العلاج ، وقد دعم ذلك الرأى القائل بأن الذهانات الوظيفية ليست الا متصلا واحدا يظهر فى أشكال مختلفة فى الأطوار المختلفة ، كما أوصى بالأخذ فى الاعتبار التركيب الباثولوجى كمتغير اضافى يساعد فى توجيه العـــلاج وتقويم النتائج ٠

ABSTRAIT

Le concept de délire chronique* et le sens de la désintégration momentanée de la personalité au cours d'un traitement spécial

17 cas, diagnostiqués de délire chronique, ont subis une thérapie intensive, dans un milieu spécial, dans le but de rompre le système de délire, plutôt que de calmer les symptoms.

Il a été trouvé que l'apathy résiduelle est inversement proportionnelle à la désintégration momentanée de la personalité produite durant le cours du traitement.

Ceci pourrait donner appui à la vue que les psychoses fonctionnelles ne sont qu'une entité continue, avec différentes présentations à différentes étapes.

On recommande aussi la considération de la pathology structurale dans la préparation du plan de traitement et l'évaluation des résultats.

(*) Le terme diagnostic "délire chronique" est employé ici suivant le concept anglais "Paranoid state" c'est-à-dire excluant la schizophrenie Paranoide.

The Life Setting in Which Mental Illness Occurs *

By R. H. Rahe

ABSTRACT

The use of recent life change measurement in the lives of persons developing mental disorders parallels the measurement of risk factors by epidemiologists to understand disease distribution. A significant association between recent life change build-up and illness symptomatology has been documented repeatedly. Proposed mechanisms explaining this association are 1) lowered bodily resistance and resultant precipitation of illness symptomatology, and 2) direct and formative influence on subsequent symptom formation. For schizophrenia and most physical illnesses, the precipitation mechanism appears the most likely one. However, for depression and neurotic disorder, both mechanisms may be operative. Future advances in the area of life change and illness awaits the development of measures of persons' stress tolerance characteristics—such as social support systems, psychological defenses, coping capabilities, and illness behaviour tendencies.

Studies of life setting and its association with the onset of psychological illness can perhaps best be understood from the perspective of epidemiology. That is, epidemiologists studying a number of physical diseases, such as coronary heart diseases (CHD), label environmental factors reliably associated with disease onset as risk factors. As recent genetic studies find serum cholesterol minimally influenced by genetic factors it likely represents an environmental risk factor (Christian **et al.**, 1976). Persons' serum cholesterol levels can serve to identify those at high risk (about twice the average) for future development of CHD (The Pooling Project, 1978). However, even though serum cholesterol is a reliable risk factor for this disease, pathophysiological mechanisms linking risk factor to CHD are far from clear. Disconcertingly, hypotheses regarding such mechanisms shift from time to time.

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* The view presented in this paper is that of the author. No endorsement by the Department of the Navy has been given or should be inferred.