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PARANOID CONDITIONS AND PARANOIA

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PARANOID CONDITIONS AND PARANOIA

Norman A. Cameron

The term “paranoia” was coined in ancient Greece, no one knows when; it appears in the works attributed to Hippocrates as a word already in current use. It was probably used to mean what the lay public and the legal profession call “insanity.” After disappearing from the literature and occasionally reappearing for centuries, it was revived in the eighteenth and nineteenth centuries to designate a number of different severe mental disorders. For a time, in the nineteenth century, it covered delusional and delirious syndromes, a confusion easy to understand when one realizes that the French, who then led the field, employ the term *“délire”* for both delirium and delusion.

Toward the end of the century, Kraepelin began his renowned work on classification, which mushroomed through successive editions until it became the standard text for most of Europe. In his 1915 edition of a four-volume work, he devoted more than seventy pages to detailed descriptions of a variety of paranoic forms, some of which merged gradually into his descriptions of dementia praecox and some into manic-depressive psychoses. He followed Kahlbaum in recommending also the term “paraphrenia.” Even Bleuler, when he wrote his compendious monograph on what he called the

group of schizophrenias, could not break away from Kraepelin's classification with its multitudinous subdivisions. This is in marked contrast to the situation today when paranoid conditions and paranoia appear only sporadically as separate entities in the current literature.

An independent new spirit entered medical psychology when Freud formulated paranoia as a neuro-psychosis of defense in 1896, and followed up with a series of papers that ultimately established paranoid conditions and paranoia as psychodynamic phenomena with an ontogenetic development. He depicted this as a gradual weakening of defenses against self-reproaches, which were projected, but returned to consciousness in a delusional form, ascribed now to other persons and not to the self. His novel concept of *projection* and his interpretations of delusions as attempts at self-cure, as reconstructions of external reality to embrace the distortions of inner reality also, have dominated psychiatry ever since.

Freud's formulation of paranoia as the result of a failure to maintain homosexual wishes under repression has given rise to considerable controversy, still not wholly resolved, to which I shall return later. There is a widespread misconception to the effect that Freud based this hypothesis upon his famous analysis of the autobiography of the talented jurist, Daniel Paul Schreber. Actually, Freud had arrived at this formulation much earlier; his paper on the Schreber case gave him the opportunity to enunciate and

document his theory.

During the past decades, *paranoia* has been reserved for a rare syndrome in which an elaborate delusional system becomes firmly rooted in a person's thinking, while the rest of his personality may remain relatively well-preserved. The much more numerous paranoia-like clinical syndromes, which shade over into schizophrenia or depression, are designated *paranoid states* or *paranoid conditions.* A growing contemporary trend treats paranoid conditions as variants of schizophrenia or of depression. The revised official classification still retains the older distinctions, but with outspoken evidence of uncertainty as to their validity.

Official Classification

The revised edition of the official manual prepared by a committee of the American Psychiatric Association defines *paranoid states* as psychotic disorders in which the essential abnormality is a delusion, usually persecutory or grandiose. Whatever disturbances in mood, behavior, and thinking occur, including hallucinations, are said to derive from the basic delusion. A proviso is added that most authorities today question whether paranoid states are distinct clinical entities, whether they are not just variants of schizophrenia or paranoid personality.

Paranoia is defined as an exceedingly rare condition in which an

intricate, complex, elaborate delusional system develops logically out of some misinterpretation of an actual event. The patient often believes that he possesses unique and superior ability. His condition, in spite of a chronic course or a static balance, appears not to interfere with the rest of his thinking and general personality.

Involutional paranoid state (involutional paraphrenia) refers to delusion formation with onset in the involutional period. It is to be distinguished from schizophrenia by an absence of conspicuous thought disorders. The whole concept of involutional psychoses loses much of its usefulness when it is recommended, as in a recent article, that *any* psychosis appearing at age forty be considered involutional.

Paranoid personality is listed separately among personality disorders that are not psychotic. It consists of deeply ingrained maladaptive behavioral patterns usually recognizable at adolescence or earlier. It is characterized by hypersensitivity, rigidity, unwarranted suspiciousness, jealousy, excessive self-importance, envy, and a tendency to blame others and ascribe evil motives to them. Interpersonal relationships are maintained with difficulty.

Paranoid Conditions

Since paranoia is only a rare and extreme form of *paranoid condition,* we shall focus upon the far more common paranoid conditions, and give a nod to

history by adding a brief statement about *classical paranoia* toward the end. It should be clearly understood from the start that pure paranoid conditions, with no sign of schizophrenia, no taint of depression or manic grandiosity and aggression, no evidence of neurotic defense, are rarely if ever found. This is obviously true of all forms of classification of human experience and behavior; none of the classes excludes traces, or even major contaminations, of the symptoms of other disorders. Most of what we shall be describing—the defensive organization, ego adaptations, the half-real, half-imaginary pseudo-community reconstructions, the paranoid behavior—will be found entering into paranoid trends in all psychoses, including brain disorders, in some neuroses, and in more than a single personality disorder. Nonetheless, we cannot get along without some form of classification, for the sake of communication with colleagues, teaching students, and clarifying certain basic issues. It is only necessary to guard against taking our artificial groupings too literally or resisting change when they prove contrary to clinical experience.

Incidence

The incidence of paranoid conditions, within the meaning of DSM-II, the revised official classification of 1968, is generally believed to be high in the population. Unfortunately, there is no reliable way to estimate the actual incidence for a number of reasons. For one thing, clinical and incidental

observation suggests that paranoid trends are widely distributed; yet only a fraction of mildly and moderately paranoid persons ever seek help. Usually, paranoid trends are uncovered in the course of medical, paramedical, psychological, and legal situations, or in personal encounter, almost by accident.

I have emphasized elsewhere in some detail the attitudes of belief, disbelief, trust and suspicion, expectation and apprehension, that are integral components of everyone's daily mood and thought. It is normal and essential to proceed with our everyday life by utilizing perceptions that reveal only fragments of objects, the beginnings of action and bits of conversation, inferences as to another's intent, and, as a rule, only a sketchy knowledge of his background. Such incompleteness of input leaves large areas of potential uncertainty. At times, it places a strain upon confidence and credibility and it may set the stage even in normal people for a haunting suspicion that something evil may be afoot. It is not really a great jump from suspicion and mistrust to a transitory paranoid fear. This happens on a large scale in disaster and threats of extinction.

Defenses such as *projection* and *denial*, whose exaggerated use is basic to paranoid delusions, are also a part of normal ego defenses and adaptations, from infancy to old age. It is largely a question of the degree to which such maneuvers become dominant and pervasive, of the ease of regression under

stress, and the readiness of any given person to correct his misinterpretations through further communication, mutual exchange, trust, and consensual validation. And even these criteria are not infallible. Irrational beliefs that resist corrective emotional experience and contradict the evidence are common in many treasured human institutions. We are witnessing today in our own culture a striking rise in mysticism among the highly educated, as well as among those less well equipped to think logically. But to call all such widespread and expanding unwarranted credulity *paranoid* would be to reduce an already overworked concept to mere nonsense.

A further impediment to accurate estimates of the incidence of paranoid conditions is that even definitely paranoid persons rarely recognize their delusions as pathological. Thus, in every community there are chronically suspicious individuals, who understand neither the motives of others nor their own, who cannot really trust anyone enough to confide freely and ask for help. The reaction of the common man to suspicious, wary “loners” is seldom one to encourage frankness and trust. Besides all this, even psychotic paranoid persons may be in better contact with their personal surroundings and appear more competent than equally disturbed depressive and schizophrenic persons. Pinderhughes has contributed original contributions to the presence of much paranoid violence among both pathological and “normal” persons in our contemporary culture.

Heredity

In spite of great advances in the fields of genetics, twin studies, perinatal stress, individual differences at birth, and longitudinal studies, there is still no conclusive evidence to refute Miller's classical review of four hundred hospitalized patients, which included all psychotic persons with marked paranoid trends. He could unearth clear evidence of paranoid illness among the ancestors of only eight patients, or 2 percent. Only forty-four, or 11 percent, were direct descendants of ancestors who had suffered from "nervous or mental illness" of any description. On the other hand, observations of neonates and young infants reveal wide differences in sensitivity to external stimulation and internal stress, and a wide range in tension, restlessness, and quiescence. There is no doubt that such individual differences may conceivably be linked to later hypersensitivities in adult life.' We have the right to speculate that the more sensitive and tense infants might react later in life, or even throughout life, more maladaptively than average under the impact of life stresses. But for the present these are speculations, conceivable but not demonstrated preludes to adult paranoid developments. Ongoing intensive studies of infancy, and the continuance of longitudinal research, may someday throw much needed light upon our problems.

Sex and Marital Status

What data we have in this area come from perusal of hospital records also. Tyhurst reported an actual lack of reliable evidence concerning sex distribution of paranoid conditions. Kolb asserts that an abnormally high percentage of psychotic paranoid persons has never married. He attributes this to their basically homosexual orientation and chronic hostility, which make them unacceptable partners.

Age

Paranoid psychoses occur more frequently in adulthood than during adolescence or post-adolescence. There are special sources of anxiety, frustration, conflict, and personal insecurity during the fifth decade and later. Waning youth and attractiveness in a youth-oriented culture are no light matters, neither is a decrease in vigor and flexibility of adaptation, progressive deafness, or diminished acuity of sight and other senses. Age brings with it an inevitable accumulation of disappointments; opportunities for new ventures usually fall off sharply in the elderly. Thus, a person with compensated life-long paranoid trends may grow less and less able to cope with such losses. He may react to ordinary neglect and social isolation with frank delusions of persecution, jealousy, and sometimes with compensatory delusions of grandeur.

Social Milieu

There is nothing to indicate valid differences in the incidence of paranoid conditions among different socioeconomic groups. We may speculate that, even before middle life and old age, an adult with an unstable or inflexible personality organization, and with poor interpersonal relations, must face special difficulties as his achievements fall farther and farther short of expectation and desire. This is especially true of the underprivileged who are being studied today more extensively in psychiatry than ever before. A dissatisfied, insecure, neglected person at any socioeconomic level is likely—if he does not simply give up—to redouble his efforts, try aggressively to meet challenges, overcome obstacles, and prove himself. He may also spur himself on in his sex life, or seek new and untried sources of gratification. If his efforts in any human endeavor fail, the temptation to look outside himself for explanations may be irresistible. Then his habitual denial and projection may lead him to construct delusions that seem to provide explanations and protect him from having to acknowledge painful, humiliating defeat.

A basically paranoid person who becomes disheartened, and feels moved to submit to failure, risks the revival of primitive fears for his own bodily intactness and his psychological integrity, which may have lain dormant within him for decades. The world around him will then seem full of threat. At this point, it is most useful to focus our attention upon by far the commonest form of paranoid conditions, upon the development of persecutory delusions.

Persecutory Paranoid Development

Personality Background

What characteristics in the premorbid personality of persons who develop delusions of persecutions must we look for, and how do these operate in precipitating such disasters? A simple answer is impossible. The potentially paranoid person, before frank illness, may have been utilizing any one or any combination of a variety of ego defenses and adaptations. The search for simplistic cause-and-effect cannot succeed; we have to think in terms of complex matrices out of which persecutory convictions may emerge. Until a great deal more is known about the origins of these matrices, we must content ourselves with noting certain characteristics that seem to emerge with considerable regularity from the background of vulnerable individuals.

To begin with, persons who develop persistent, pervasive paranoid delusions have always been tense, insecure, and fearful, operating at high levels of general anxiety, which is often discharged as over-activity, aggression, or chronic anger. They easily become suspicious and distrustful under ordinary living conditions, have difficulty in confiding, and when they do confide, they expect to be betrayed. What genuinely close and reciprocal relationships they have are limited to a very few individuals; and even such ties may not survive an interpersonal crisis. What past histories can be obtained reveal almost life-long tendencies toward secretiveness,

seclusiveness, and solitary rumination. These may be hidden behind a brittle facade of superficial give-and-take.

The world in which such a person lives is dangerous; he must always be on the lookout for attack. He finds people unpredictable and untrustworthy, because he is relatively incapable of taking the role of other persons and viewing things from their different perspectives. This concept is derived from George

Herbert Mead's *generalized other.* The paranoid person, who needs more than an ordinary degree of understanding of others' motives, because he is so fearful and uneasy, has developed next to none. Therefore, he is easily exposed to surprise and suffers hurts and humiliations which more socially adept people foresee, discount, or ignore. He is often relatively incompetent in everyday situations of co-operative, competitive, and complementary relationships. He lives with endless tensions over mutual misunderstandings and misinterpretations; he is plagued by ideas of *self-reference.*

Mild, harmless ideas of self-reference are familiar to everyone. An occasional mistake in assuming that a critical remark or a compliment is meant for oneself, when actually it is not, lies within everyone's range, no matter how revealing it sometimes is. Persons with well-compensated paranoid trends may be especially prone to self-reference without being in

danger of psychosis. It is only when, in the face of exceptional stress, their self-reference focuses upon a particular theme, or singles out certain individuals who seem banded together, that a threat of decompensation looms.

The apparent *self-sufficiency* that many aggressive or pseudo-autonomous paranoids exhibit is a screen that hides their weakness. They are actually always over-concerned about what others think and feel in relation to them, and less able than the average to satisfy their need to know. When stress increases their need, without increasing their ability to meet it, they tend to increase vigilance and look for signs that confirm their suspicions. This in turn heightens general anxiety, reduces still further a less than normal trust, and stimulates *basic distrust.*

It has frequently been pointed out that persecutory paranoid persons are fundamentally hostile. Their organization includes major fixations at sadistic levels, a preponderance of disowning projective aggression, and an ease of ego-regression. The aggressiveness is rarely aimless; it is almost always *reaction-sensitive.* The paranoid’s special sensitivities correspond to some of his outstanding weaknesses—his fears, frustrations, guilt, or ego-alien impulses. In short, each paranoid has an exceptional readiness to overreact with counteraggression to whatever he personally misconceives as a threat to his vulnerable *security system.* He may unconsciously fear bodily

attack or the loss of something vital to him—the residual of his early unresolved castration fears.

Premorbid Personality Stresses

It is well established that *denial* and *projection* occur most often at completely unconscious levels, so that a paranoid person is entirely unaware of exactly what he is defending against and what he is doing. His misfortune is that he unwittingly creates around him an atmosphere of uneasiness and resentment, which makes others avoid his company and actually increases his social isolation. He feels more and more misunderstood and threatened, unwanted, unloved, and discriminated against; yet, his multiple frustrations push him continually to overcome the hostility gathering around him, and this, too, is experienced by others as stepped-up aggression.

To offset his gnawing sense of being constantly misunderstood, he develops further ego defenses and adaptations in an attempt to strengthen his position vis-a-vis other persons. This is often accomplished at the cost of increasing his characteristic rigidity. It is easy to see why anyone who must rigidly defend his vulnerable personality organization should have to be insistent upon his opinions as the only possible interpretations, unable to allow the possibility of uncertainties or contradictions into his established ways of thinking. The alternative would be to invite an already potential

disorganization. Without in the least realizing it consciously, he is staving off a threat, however dimly felt, of precipitating a disastrous experience that might lead to eventual decompensation. He is the little boy holding his fingers of primitive defenses in the dike, to protect himself from being overwhelmed by the dammed-up waters of his repressed urges and fears.

What paranoid persons rarely recognize is that their own hostile aggression nurtures the very hostility that they correctly perceive in their human surroundings. As Pinderhughes has pointed out in several recent studies, the paranoid unknowingly *stimulates violence* in others by his own unconscious urges to defensive violence. When he can no longer otherwise guard against his threats of personal failure, inferiority, temptation, or misdeed, he is forced to call in such secondary defenses as rationalization, misunderstanding, and distortions of recall—as indeed *normal persons* also do under comparable circumstances—but with far greater single-mindedness and determination. It is essential for every therapist to remind himself that all paranoid maneuvers are not products of personal malice, but reactions to intolerable pressures of urgent necessity—the necessity to preserve and shore up an unstable personality structure, to discharge excessive libidinal and aggressive impulses which the person cannot channel or control by any other means.

It must be said that most paranoids do not fail. Fortune smiles on some,

while others show creativity in evolving effective compensatory adaptations. The more fortunate succeed in discharging their intolerable energies in socially acceptable action, or in marketable fantasies—as we often witness in literary creations and the arts—or in setting up self-protective systems of reaction formation that withstand their life stresses. Many succeed in ridding themselves constantly of otherwise inadmissible impulses by entering upon crusades, for example, against socially condemned forms of sexuality, against the hostile encroachment of oppressors, against cruelty, depravity, and crime. Many are able to line themselves up beside normal persons in promoting the constructive uses of brotherly love.

We are here concerned, of course, with the paranoids who fail. Among these, three characteristics are outstanding: (1) An extreme sensitivity to certain unconscious trends in others, with a remarkable insensitivity to similar trends in themselves; (2) a marked tendency to self-reference, and an incapacity for correcting their false self-reference by empirical, objective reality-testing; and (3) the already mentioned severe defects in reciprocal role representation, by which ordinary people manage to view things from others' perspectives. It must not be forgotten that there is nearly always a core of truth in paranoid accusations; and this alone accounts for the defensive resentment and hostility which they arouse in normal persons, a resentment toward someone who is unintentionally stirring up their own unconscious guilt. This all sounds very intricate and complex; but it is really

only the description of common interactions between unrecognized trends in paranoids and corresponding unrecognized trends in normal persons. Familiarity with such patterns makes them readily intelligible.

Precipitating Factors

The single most general factor in precipitating paranoid attacks is stimulation, internal or external, to a traumatic discharge of hostile and erotic impulses when frustration provokes intolerable over-excitation. The upsurge of impulse may result from the loss, or threats of loss, of major sources of gratification. It may come as an over-compensatory reaction to the dangers of a person’s unrecognized passive wishes or fears of impotence, or as a vigorous defense against temptation. In this regard, the paranoid is often exceptionally vulnerable to ego disruption from his own superego assaults, and once more these may be experienced consciously or unconsciously as a sudden increased sense of guilt. The concept of unconscious guilt is easiest to demonstrate in dreams, where the guilt that is ignored completely during the day comes out clearly in accusations against the self, which are represented in the dream as stemming from others.

Paradoxically, both rivalry and isolation can be dangerous for a potential paranoid even in the presence of success. Close competitive situations not only stimulate an oversensitive person to hostile

counteraggression, they also harbor homoerotic temptation in everyday contests as to who shall dominate and who shall submit. Similar threats arise, even in the absence of competition, when a vulnerable person is thrown into close quarters with like-sexed individuals for long periods of time.

Increased isolation can have comparable effects for different reasons. Isolation leaves a person at the mercy of his private daydreams, without the safeguard of countervailing external contacts, without the corrective effects that the talk and action of others normally provide. Experimental work in sensory deprivation with normal subjects, and recent extensive studies of dreams and daydreams, have brought such factors into new prominence.

Internal stresses can become unbearable when a paranoid person suffers humiliation in actual failure or feels belittled by public setback. He has habitually relied for narcissistic support upon extravagant hopes and imaginings to offset a hidden pervasive sense of inadequacy. Again, the overreactions are not simply the product of thwarted ambition and wounded pride; they arise out of serious threats to an ego integrity that is in fragile balance.

Hypochondriacal anxieties are common in preparanoid personalities. These often express an unconscious suspicion of bodily defect, fears of damage, and vulnerabilities, that have personal symbolic meanings. Accident

and physical illness, including intoxication and brain damage, can have similar results, especially when they involve helplessness, dependence, and a somewhat infantile position.

In this section, we have considered mainly external reality situations and influences. This does not mean that paranoid conditions are produced by rivalry, erotic temptation, actual failure and defeat, or sudden close contact, or social isolation, or even solely by major losses in security and gratification. These are often the precipitating factors. They tip the balance of a chronically unstable personality organization, one dependent upon primitive defenses, defective in interpersonal reality-testing, hypersensitive to unconscious processes in others, and burdened by irresistible pressures to deny, project, and form pseudo-communities. Nonetheless, these precipitating factors are both dynamically and clinically crucial, since they start off a paranoid development that may lead to decompensation.

Onset

The earliest phase of a psychotic paranoid attack may be quite indistinguishable from the ordinary fluctuations of a hypersensitive person's life. It may be only in retrospect that one can say when the habitual suspiciousness, blaming others, and self-reference blossom as outright delusion. Even the most abrupt onset is often analogous to sudden cardiac

decompensation. Outwardly, a person seems to be functioning well; and then decompensation comes without warning. The precipitating stress is sometimes proportionately severe and suddenly applied; sometimes, the new stress is only the last straw.

Early Phases

In most psychotic paranoid developments there is a prodromal phase in which interest is withdrawn from real interpersonal events. Preoccupation ensues and partial ego regression. But even while preoccupied and still regressing in some respects, the patient begins making his first step toward a reconstruction ("restitution"), toward regaining contact with his social environment, but now on a *delusional basis.* In the initial steps, a paranoid may be aware only of feelings of estrangement and puzzlement. Things have changed for him inexplicably; and he tries to understand what is happening. He scrutinizes his surroundings uneasily, engages in solitary observations, and looks for hidden meanings. He watches the little things people do and say, their glances and gestures, their frowns, smiles, and laughter. He listens to conversations, asks leading questions, and ponders over it all like a detective.

Finding a Focus: Preliminary Crystallizations

If the situation is too unstructured, too anxiety-laden, the paranoid is

driven irresistibly to form hypotheses, as normals do in unintelligible situations. But, here, paranoid defects in valid reality-testing and in tolerating uncertainty trip him up. He cannot turn to someone else confidently; and he cannot just give up his projected fears and retrace his path. His projection and regression are necessary components of his whole defensive maneuver against being overwhelmed by a disintegrating hostility. Thus, while he goes on projecting, he moves toward a reconstructed “reality” that incorporates his pathological urges, his defenses, his inner misinterpretations and adaptations, with whatever he can accept of his external surroundings.

Final Crystallization: The Paranoid Pseudo-Community

Up to this point the projections, although by no means random, have still lacked a fixed focus—a specifically recognizable danger coming from a particular source. It remains now for the patient to conceptualize the dangerous “others” as a unified group with some definite plot, of which he is center. This he achieves by organizing a well-structured pseudo-community, with all his projections and misinterpretations operating intelligibly within it.

The paranoid pseudo-community is an imaginary organization; but it includes some real persons with real functions, as well as persons whom the patient misidentifies, and some wholly imagined persons who serve to complete and justify the complex imaginary community of conspirators. All these real,

misidentified, and imagined persons seem united for the express purpose of acting aggressively toward the paranoid, who is the focus of everything. The pseudo-community often seems well-coordinated, with specific plans, like the fictional gangs in mystery stories. Pseudo-communities are not limited to paranoid psychoses; they have been described in psychotic depressions and in schizophrenia.

Once formed, the pseudo-community may move irresistibly along drive-determined vectors, picking up momentum as it goes. Real happenings are distorted and remolded to feed the ongoing process; vague and trivial incidents are endowed with significance; contrary winds of evidence are transformed into components of the rising delusional tempest. Because of the overinclusion of so much environmental material, the patient's attempts to come to grips with his seeming predicament are doomed to failure. The pseudo-community is closely related to the concept of *overinclusion,* originally formulated by this writer to describe cognitive processes in schizophrenia, but since then found valid for other psychotic confusions.

Many paranoids do not carry their delusional systems over into overt action. Some remain chronically fixed at a pseudo-community level in an otherwise passive state; and some are able to replace at least part of the unrealistic reconstruction, their delusion, with more realistic components. The rare few go on to elaborate a classical paranoia.

Paranoid Action

In many, perhaps most psychotic paranoids, action amounts to no more than a morose, resentful, suspicious, or hostile attitude toward the world, behind which delusional convictions of being badly treated or maligned are concealed. Occasional phases of openly hostile accusation or threat may appear from time to time. But if a paranoid acts out publicly his aggression, which to him seems justified and completely reasonable, he is usually met by some social sanction. To the patient any counteraggression seems the final confirmation of his delusional expectation of hostile attack. Thus, in the end, he unintentionally *brings about* a social reality situation that corresponds to his psychotic, angry, frightened reconstruction. An excerpt from a case will serve here as an illustration.

Charles G., an unmarried man of forty-nine, was persuaded to enter the clinic on a voluntary basis, after admitting suicidal plans to avoid being kidnapped and tortured to death. He was polite and superficially co-operative, but basically distrustful and uncommunicative. He had been living in idleness on a private income, when he suddenly got into a situation where he felt cheated. He became enraged and threatened to assault the man he accused. After thinking this over alone, he went into a panic because he "realized" that the man he had threatened might have gangster protection. Under cover of darkness, he fled in his car to relatives he had in the West. As

he drove west, across country, he became quickly convinced that he was being followed, and that even the police were in on the imagined plot. He slept in the back of his car under a pile of clothing to avoid detection. Arriving at last at his relatives' home, he was found to have made preparations for suicide, including writing a farewell note.

His childhood had given Charles no adequate basis for developing basic trust. After his mother's death, when he was a small child, his father did not remarry, but boarded his children in the homes of various relatives or friends, moving them about the country as his work moved him, and often putting each in a separate home. Charles often lived with strangers, separated from his siblings, and shifted somewhere else without advance warning. He had no chance to develop meaningful relations with anyone; and, as children often do, he blamed himself for his plight that seemed to him evidence that he was guilty of something.

Charles continued this pattern of life as an adult, leading a solitary life as a realtor, shifting his place of employment, developing no friendships, and confiding in no one. In telling his story at the clinic, it was striking how he slipped from probable fact to palpable inference in constructing chains of pseudo-logic, which satisfied his need for certainty, even while it frightened him. In the clinic, he even repeated his life pattern by declining to confide—while saying that he had something he wanted to tell someone—and by

finding grounds for suspicion in other patients, the staff, and some visitors. One day, he went into another panic after a visitor whom he himself had invited by telephone had gone. He suddenly “realized” that the man was a gangster in disguise; he made an impulsive suicidal attempt, and then demanded transfer at once to a Veterans’ Hospital. There we lost track of him. (See Ref. 16 in Bibliography for a more detailed account of this case.)

With such a life history, which denied him even ordinary opportunities for affectionate acceptance and interchange, the wonder is not that he developed a paranoid psychosis at forty-nine, but rather that he had managed reasonably well for so many decades on such meager resources. It was the same cluster of personality defects that faulted his life and defeated him and us in attempts at therapy—his utter loneliness, his sweeping distrust, his unsupported inferences in terms of life-long fears and guilt, and his incapacity for sharing in anyone else’s perspective, once he had reached his frightening conclusions.

Other Psychotic Paranoid Reactions

Delusional Jealousy

As Freud pointed out half a century ago even normal jealousy is by no means rational; it is neither under conscious control nor proportional to the

situation in external shared reality. Its constituents are: grief over loss or threats of loss of love; hostility toward both a love-object and a rival; and a narcissistic injury which painfully lowers self-esteem. Jealousy becomes delusional when it shows the characteristics already described for delusions of persecution, i.e., when it leads to excessive projection, regression, and a renewed contact with external reality achieved through distortions. Here, too, unfounded beliefs become fixed, contradictory evidence is scorned or ignored, and the most trivial or irrelevant incident is mistaken for confirming validation. The jealous paranoid watches vigilantly for signs that he is right and misinterprets minimal signs of unconscious attitudes in others (the "core" of truth), while remaining blind to his own corresponding unconscious trends. The primitive ego defenses of denial and projection are as striking as they are in persecutory delusions. A brief case excerpt will illustrate delusional jealousy.

Peter J., a lawyer, became convinced that he had been duped by his wife and her obstetrician, both of whom belonged to a dark-skinned minority. His jealousy was aroused by her praise of her obstetrician and by her seeming pleased at going for frequent check-ups. The newborn baby was also dark-skinned; and when the obstetrician sent Peter an unexpectedly small bill for the delivery, he was certain that the baby was not his own.

The childhood background of this man makes his delusional jealousy

intelligible, though no less pathological. His parents were passionately devoted to appearances, conformity, and status, but not to affection for their son. He married into an immigrant family against their violent objections, and despite his own dislike for his wife's family and friends. His own disdain made him feel like an outsider from the start. During his wife's pregnancy, he augmented his own anxiety and sense of wrongdoing by having an extramarital affair. His experiences reinforced his suspicions of his wife's "infidelity," a clear case of projection of his own guilt. His delusion seemed to justify his own unfaithfulness; it was a new construction of reality which ascribed his own infidelity to his innocent wife.

In therapy, Peter was able to work through some of the background of his paranoid jealousy and, although he retained a small residue of suspicion, he gained enough insight and objectivity to make a recurrence unlikely. One interesting development was his spontaneous recognition that he had identified with his wife in the obstetrical situation and secretly envied her. He laughed this off after he had revealed it; and since he was seeking only ameliorative therapy, there was no need to explore his identification or his envy. Freud's original accounts emphasized unconscious homoerotic fantasies in the background of both delusions of jealousy and of persecution.

Erotic Delusions

In erotic delusions, a person, usually a woman, believes that she is beloved sexually by a man who, for some unknown reason, does not make an open avowal of love, but does give little signs of his affection. Passive men sometimes have a corresponding erotic delusion. The supposed lover is often a public figure—in politics, on stage or lecture platform, in the movies or on television. Since such deluded persons sometimes pester the object of their affections with letters, pay them visits, or demand a public avowal, they may drive their target to seek police intervention.

The love involved may be narcissistic self-love projected in fantasy and ascribed to the target person. It may be a defensive maneuver, as Freud maintained, which substitutes a delusional heterosexual attachment for denied unconscious homosexual wishes. Fenichel wrote that the sex of the imaginary lover was unimportant in borderline erotic delusional men. These sense vaguely an imminent object loss, and cling frantically to at least some love-object. Many persons with erotic delusions experience pleasure from their imagined predicament; but some feel “persecuted by love” and protest indignantly.

Paranoid. Grandiosity

Grandiose delusions are met less frequently than those of persecution; but when they do occur, they are usually more intractable than any others.

Manifest grandiose delusions range in complexity from relatively simple convictions that one is enormously talented, attractive, or inspired, all the way to intricately systematized beliefs that one is about to revolutionize the life of man, as a prophet, reformer, scientist, or great inventor. Many such delusions are stable, persistent, and even well-organized. Occasionally, a grandiose delusional person is able to play a significant part in some realistic social, artistic, or scientific movement; and in rare instances, he initiates and carries through reforms. Delusions of grandeur are attempts to recapture lost object relationships. Their higher incidence among severe, rather than mild, paranoid conditions, points to the greater denial of consensual reality demanded. It is no surprise that they are common in classical paranoia.

Classical Paranoia

The rare classical paranoia represents only the ultimate in elaborate systematization and fixity of delusional reconstruction. Some persons with such severe paranoia may still be able to conduct their own affairs in spite of harboring an intricate, complex, unmodifiable delusional system, without disorganizing or desocializing. The delusions seem more or less isolated from the rest of the personality organization in such cases, almost like a foreign body reaction, leaving large areas of thinking and action free to operate normally. One of the most extraordinary examples of this was the case of Schreber, whose behavior and conversation were almost without exception

outwardly normal for several years, even though at the same time he maintained incredible delusions.

What has already been said of persecutory, erotic, and grandiose delusions applies to classical paranoia. It is generally regarded as untreatable. However, if one avoids the trap of equating treatability with complete recovery, there is no reason to conclude in advance that no amelioration is possible, even though the delusions remain fixed. There is no reason why psychiatrists and psychologists should make such an equation when medicine and surgery have long ago discarded it. The healing arts have as their goal the improvement of a person's life, and the relief of unnecessary suffering, and no more.

Folie à Deux

More than a century ago, Baillarger reported the admission on the same day of two relatives with the same delusions. The term later adopted, *folie à deux,* has led to a needless multiplication of terms, such as *folie à trois, folie à cing,* and even *folie à douze*. The typical setup is that of a dominant delusional person who induces a parallel delusional development in a dependent one. If the two are separated, the dependent one recovers quickly, but not the dominant one. A majority exhibit persecutory paranoid delusions.

In his classical case reports, Gralnick points out the preponderance of

persons living in intimate contact, and lists the frequency of each relationship in 103 cases. He ascribes the greater susceptibility of women to their being obliged to play a somewhat restricted, submissive role. Sex role differences may also be invoked.

Psychodynamics and Early Childhood

What are the psychodynamics of paranoid conditions, and what congenital and early childhood experiences predispose a person to become seriously paranoid? Since paranoid thinking is almost universal, and appears even when defective communication occurs in normal people, no simple cause-and-effect relationship can be invoked. There are interesting possibilities in the results of direct observation of neonates; they reveal striking differences in sensitivities to environmental stimulation, and in relative tolerance for delays in satisfying such simple needs as nourishment, warmth, and general comfort.

Is the hypersensitive neonate more vulnerable than others to later stress? Probably so, but we really do not know for sure. Some hypersensitive infants remain consistently hypersensitive and some do not; some placid newborns become hypersensitive later. One must always remember that enormous internal physiological readjustments follow birth, and we have very little idea as to what these portend. Is there a genetic factor involved?

Undoubtedly, but here also the vicissitudes of embryonic and fetal development, the process of birth and of perinatal stresses, form an extremely complex matrix. A great deal more is known today than twenty years ago, but not yet enough for final conclusions to be drawn.

The early handling of infants presents such a multitude of potentialities in itself that it may be decades before we can be sure how much weight to give any infant's experiences during the first few weeks or months. The reports of the many who observe infants directly, and such speculations as, for example, Melanie Klein's contention that every infant passes through an early paranoid and a later depressive "position," are still as tentative as the genetic conclusions repeating a very old tradition that people are "just born that way." We must always bear in mind that each approach to the thorny question of the infantile origins of paranoid disorders is also a quest for certainty by students of behavior, experience, and genetics. It is easy to be seduced by an elegant hypothesis and by impressive accumulations of data; but there is no justification in 1973 for dogmatic assertions. For even if we knew far more than we now do about genetic loading, perinatal stress, and the patterns of child-rearing and mothering, we would still be a long way from being able to link such data with paranoid development twenty or thirty years later.

As for the psychodynamics of paranoid development, these, too, must

depend at least to some extent upon the innate biology of the individual infant, upon the early defensive and adaptive maneuvers he develops, upon his success in forming a symbiotic unit with his mother, and his success in dissolving the symbiosis to become a more or less autonomous individual. No professional person conversant with the current status of these factors is likely to ignore any one of them. (This writer has discussed these problems in some detail elsewhere, and has set forth the probable, but still speculative, background of persons especially vulnerable to paranoid development. These accounts are obviously too long to be included here. Although they make every effort to present a coherent picture in terms of contemporary knowledge, they remain in part hypothetical, since our knowledge is uncertain and there are many gaps.)

The probable origins of paranoid conditions, both ontogenetic and biosocial, have already been indicated in the case illustrations sketched in this chapter, and they are representative of the direct clinical observations to others, as the citations imply. Whether these can be considered universal is a question that only the future can answer. As others have found, in addition to this writer, some of the most "typical" paranoid delusions appear in classical manic-depressive, schizophrenic, and organic brain damage syndromes. One must learn to avoid dogmatic assertion and remain receptive to the ongoing changes in theoretical orientations that point toward a different future.

In addition to the current literature already cited, a recent treatise by Swanson et al. deserves mention. It gives a partial history of the paranoid concept, takes a position on the basic nature of the paranoid person, and gives summary accounts of problems arising in the paranoid's family and community, and of the importance of paranoid trends in government, industry, law, and religion. An extensive bibliography is usefully arranged by topic. (A special chapter on international political attitudes might be added after the startling and welcomed reversal of Chinese-American relations has been assayed.)

The chief weaknesses of this treatise are the attempt to cover too much in too short a space, and a relative neglect of dynamics. For example, the authors seem to discount Freud's fundamental contributions on grounds that he was inexperienced in working with psychotics, although he explicitly stated that he had had considerable contact in this area. They call attention clearly, as does Pinderhughes, to the enormous potential dangers of having paranoid personalities in positions of power, dangers that have been realized in our own time and throughout history.

A major controversy, that exemplifies dominant interpretations of the whole paranoid concept during the past two or three decades, centers around Freud's insistence that paranoid conditions grow out of failures in ego defense against previously repressed homosexual wishes. This claim has

never been disproved. It is significant for today's situation that Freud himself published convincing evidence of prevalent procreative fantasies and beliefs in small children at the same time that he wrote his famous critique of the Schreber case. It is these two seemingly opposed revelations—actually, not mutually exclusive—that continue as dominant themes up to the present. Arguments over whether to place Schreber's diagnosis in the official box marked "paranoid state" or in the more popular one labeled "paranoid schizophrenia" are immaterial, since what we are considering is the paranoid modes of thought and feeling, in whatever combination they occur.

Theories and Observations Since Freud: Homosexual Origins

In the mainstream of professional concern, homosexual origins have received the most support. Only a few examples, out of hundreds, will be cited here. The whole situation is currently complicated by a longstanding conviction that paranoid delusions are nearly always components of schizophrenia, and the more recent emphasis upon their presence in mania and depressions. During the 1940s, a number of variations appeared on the homosexual theme. There were then, and still are, occasional publications with opposed findings, as, for example, that male paranoids tend more to homosexual delusions (even when overtly homosexual), whereas females believe themselves accused of being prostitutes. Knight stressed intense homosexual love that needed hatred to counteract it, while Bak emphasized

delusional masochism, against which the paranoid tried vainly to defend himself.

Klein postulated normal infant sadism, and referred predisposition to paranoia to arrested development beyond a phase in which a terrifying superego reigned. Segal has written a lucid introduction to Klein's work. Jaffe and Frosch have further advanced the homosexual hypothesis. The doubt cast upon this interpretation by reports of overt homosexuals being paranoid has been countered by a claim that overt and repressed impulses can operate at the same time in the same person.

More recently, hatred has again been highlighted in paranoid developments, notably by Pinderhughes, and Carr et al. The important researches of Baumeyer, Katan, and Carr, et al. have spelled out the actual sadistic treatment that Schreber experienced at his own famous father's hands, which is clearly represented in his distorted delusions. Freud knew nothing of all of this. Niederland researches continue and promise future enrichment. Two especially significant new findings are: (1) that Schreber's older brother was also a jurist, was also named Daniel, and committed suicide in the face of success, just as the younger Daniel was engulfed by psychosis in the face of his success; and (2) that Schreber's mother was of great importance in his life, although this possibility seems to have been neglected even by Freud. Obviously, the whole issue of homosexuality in paranoia needs

overhauling, in spite of abundant clinical evidence of feminine homosexual attitudes in Schreber's illness.

Procreation Fantasies and Deep Regression

Although Freud urged everyone to go to the original autobiography of Schreber, his advice was followed only in exceptional instances, for example, by Katan and Niederland. Since its translation into English in 1955, interest has rapidly increased in its restudy. The translators, MacAlpine and Hunter, have been criticized for being unsympathetic to Freud. Be that as it may, their comments in their Introduction and Discussion included with the translation raise valuable questions, which deserve, at least, not to be ignored. For example, they state: "Neither in theory nor in therapy is projection of and conflict over unconscious homosexuality as firmly established as the cause of paranoid illness ... as is generally believed and stated." And: "Schreber fell ill when a wish-fantasy that he could, would or should have children became pathogenic. Simultaneously he became doubtful of his own sex."

They seem to be implying that Schreber's paranoia arose from his repressed infantile procreation fantasies. If one rereads Schreber's *Memoirs,* there is plenty of evidence for such fantasies in the fusion of God, Flechsig, and Schreber père, as well as strong hints that not only the older brother but Schreber's mother also played leading roles in the delusional systems. It is

ironic that Freud’s delightful contributions to infantile procreation fantasies, especially in the “Little Hans” case, should now be used to refute his other interpretation. Actually, the two approaches supplement each other. Katan has recently tried an integration, with clarity and restraint, in which he designates paranoia as a special form of schizophrenia. It is safe to conclude that, whatever the controversies, paranoid thinking will always be with us, because it is a variant of normal experiences.

Individual Psychotherapy of Paranoid Conditions and Paranoia

An immediate goal in the treatment of paranoid persons, including paranoia, is reduction of anxiety and development of trust. This is not easy to achieve, since the patient is highly suspicious of everyone, and cannot be won over by words of reassurance or advice. The therapist must be relaxed, and neither inquisitive nor indifferent; he must keep his distance and not be dismayed by apparent lack of progress or even the prospect of ultimate failure. He needs to practice suspended judgment as much as his patient does. Whatever reassurance and emotional support he gives must be only in an unfeigned attitude of respect, acceptance, and concern, never expressed in words and never encroaching upon the paranoid’s excessive need for privacy and concealment. It is essential to keep in mind that paranoid delusions may be indispensable protective devices, security operations that keep a patient in some effective contact with his surroundings, and allow him to reconstruct

his conceptions of his social environment while providing a tolerable harmony with his conscious and unconscious inner desires, fears, hates, and hope. To attack delusions may be to precipitate an immediate sweeping regression into panic or an undifferentiated state.

Niederland has recently suggested touching upon the ambulatory paranoid's distrust of his therapist from the start, and continuing to explore it throughout treatment. This must be done, of course, with circumspection and as unobtrusively as possible, to avoid giving the slightest impression of blaming the patient, which he will always be over-ready to infer because of his pathological unconscious hostility and his superego projections. The paranoid is exquisitely sensitive to traces of unconscious aggression in others, to any hint of interference in his affairs, and to threatened restrictions of his liberty of thought, feeling, and action, which he experiences as intentional humiliation. Only the therapist who has learned to walk on eggs with comfort, skill, and self-assurance should treat seriously paranoid persons, unless he does so under the supervision of someone experienced in this area of treatment.

This writer has suggested that in all paranoid psychoses there is an active nucleus of neurotic conflict which in itself helps keep the patient from deeper regression. The therapist who is reasonably comfortable in the presence of psychosis can approach neurotic components with techniques

usually employed in working with neurotics. This general approach has received further support in the recent literature.

If the general tension of a paranoid subsides, communication markedly improves, and he becomes able to express underlying fears, anger, and a sense of being ostracized. What Freud said about “deep interpretation” in the therapy of psychoses is as true today as when he wrote it. A psychotic is often able to interpret unconscious meanings more immediately and significantly than his therapist can. Such special insight may be a gift; but it is an expensive one and usually a misfortune. Obviously, therapy of paranoid persons involves something quite different from even the most intelligent common sense. It demands therapist attitudes unique in the patient’s life experience—completely non-judgmental ones which avoid both premature agreement and unwanted explanation, as well as intolerable contradiction. There is always a core of truth in every delusion; and therapists must never forget it.

There is no exclusive technique for the treatment of paranoia. Some therapists succeed with a naturally warm, kindly, but not too familiar and never condescending approach. A paranoid patient may be superior in mental ability and achievement to his therapist; and even when the opposite is true, he has had experiences that may be richer than his therapist’s, as well as different. One might as well be condescending to his own dreams—which many naive normal persons are—as to the daytime delusions of a patient.

Other therapists enter into the paranoid delusions deliberately, but with caution, and with a clear understanding that they do not accept the patient's paranoid beliefs as social fact. Some therapists keep rigorously out of delusional systems without making an open issue of acceptance or rejection.

This writer favors an interested, attentive, relaxed, and unaffected attitude, with an unfeigned air of detachment and suspended judgment. This avoids stimulating suspicions and fears by avoiding any hint of intrusion or overt friendliness that might be mistaken for intimacy. Suspended judgment is essential, since a therapist cannot know how much of what he hears is social fact and how much fantasy. Many paranoid complaints are justified, and the most fantastic things happen in real life, as one quickly learns. If a therapist's feelings are genuine, any patient will feel this at nonverbal and unconscious levels; if they are false, he will readily sense deceit behind the most clever mask of feigned friendliness and fair words.

There is no difference of opinion about the necessity for scrupulous but not cruel honesty, for respect, truthfulness, and steadfastness. What the patient needs is not merely a chance to talk and "ventilate" his feelings; he needs to break out of his isolation, and share his fright, anger, and resentments with someone who does not take sides or pretend to know everything. The therapist must become what one of my own patients called "a new point of reference," a person who gives the patient the chance to catch

glimpses of his own personal world from another's perspective. An indispensable therapeutic goal is that of replacing a pervasive, uneasy suspicion and mistrust with a specific confidence, which then forms a new base for further explorations by the patient. One must always remember that it is not the delusion that calls for therapy, but the frightened person; sometimes, a paranoid regains effective social health without entirely giving up his delusional beliefs. This is as real a recovery as that of a diabetic who learns to regulate his life independently without ever losing his original vulnerability to diabetes.

Progress in paranoid conditions must always be guarded. The most important limiting factors are the basic ego-adaptive and -defensive organization, its potentialities for flexibility and change, and its capacity for forming new ego and superego identifications. There are wide differences among paranoid persons in these dimensions, which must be recognized and dealt with as therapy progresses. It is fortunate that today attention is focused upon the human setting in which the patient lives, or if he has been hospitalized, the setting to which he will return. It is here that the social worker is the most significant person, not the psychiatrist, the psychologist, or the nurse. As an expert in community attitudes and resources, he can make the difference between success and failure, as individual psychotherapy tapers off and terminates. His therapy deals as much with the community as with the recovered or recovering patient. He must understand the patient's

internal dynamics, his group and general social behavior, the structure of the mini-community of his immediate associates, and the total effective environment to which an ex-patient must adapt himself, without losing his individuality and identity.

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