

The puzzling symptom of paranoia: a response

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Summary

In a clinical setting where early diagnosis and intervention is necessary, the reliability of paranoia as a manifestation of psychosis in a series of cases has come under justifiable scrutiny by the authors. However, in so doing, due consideration must be

given to factors such as the significance that could be attached to retrospective diagnoses, adolescent prodromal conditions, the diagnostic criteria for Asperger syndrome and personality and cultural factors, making the task of the psychiatrist rather complex.

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Commentary

The authors have given an excellent review of a range of manifestations of paranoia. In a diagnostic criteria bound world of psychiatry, it is timely to remind the readers that paranoia could exist from the normal to very abnormal. When 19th century psychiatrists such as Kraepelin described persecutory delusions in paranoia or dementia praecox, they described features that they observed in antipsychotic naïve, chronically ill, institutionalized patients. These delusions had lasted many years and were substantive. When these pioneers described the delusions and hallucinations as characteristic of paranoia or dementia praecox, the psychosis was well established and the phenomenology was an attempt to understand an existing psychosis. That gave such phenomenology high reliability and validity in their diagnoses at the time. Unfortunately such a facility of long term view is not available to modern day clinicians. They see patients who express psychotic symptoms, the previous night and the clinicians are expected to reach a diagnosis and commence treatment. The authors make this point with regard to a 15 year old who talks about a toxic fume, where it should not be considered a persecutory delusion.

There is a current body of research that supports the authors' contention. It is worth quoting two important studies in this context. McGee et al showed that auditory hallucinations were present in 8% of children in the community and only one third of them had a DSM III diagnosis (1). In another remarkable study of experiences of auditory hallucinations in children in the community, Escher et al, showed that at the end of a three year follow up period, in 60% the voices had discontinued (2). Authors of this study stress the need to take into consideration the context of auditory hallucinations in children, before concluding that they are pathological.

While agreeing with the authors in their task of attempting to clarify the phenomenology of paranoia, I have some issues with the basis on which they have done so. The review of previous diagnoses in this series is retrospective. Psychiatric presentations could well change over months if not years. It is also well

known that both affective disorders and abnormal personality disorders can throw up transient psychotic symptoms that are often difficult to elicit in retrospect. If the original clinician observed the simple criteria laid down in ICD 10 or DSM IV, the clinician revising such diagnosis must pay close attention to the original psychosis.

Further the originally diagnosed psychotic disorder may remain under control for several months once medication is discontinued. To ensure that such a situation does not arise, the authors could have followed up these patients for possible recurrence of original symptoms.

Prodrome in adolescence is the other condition that the authors could have considered. These prodromes can be extremely difficult to diagnose and the only way to get a handle on them is to study the genetic and stress factors and follow them up. A high percentage of them turn out to have bipolar disorder but a significant percentage would suffer from schizophrenia.

I also would have liked to see more details of how Asperger syndrome was diagnosed, for they must have fulfilled the criteria laid down in ICD 10 or DSM IV. The vast majority of adolescents with Asperger syndrome are normal adolescents who do not fulfill criteria for psychosis but are socially awkward and having odd interests.

Though authors state that we should have an appreciation of the paranoia spectrum and the need to study the patients' cultural and personality characteristics, the authors themselves do not give us the grounds on which the diagnoses were changed and new diagnoses adopted. A significant psychotic break down in the past has to be studied over and over before we come to post hoc conclusions, using retrospective accounts from patients or family members.

In the study by McGee, it was found that 40% of children with auditory hallucinations went on to develop a major psychosis (1). Poulten et al showed that psychotic symptoms at age 11 years predicted a very high risk of developing a major psychosis at the age of 26 years

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(odds ratio 16.4) (3). All this clearly shows that the task of the psychiatrist is not an easy one. Any review of the first diagnosis has to be done with due consideration of the context in which it occurred, the personality factors as well as the known risks reported in the literature.

Declaration of interest

None

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