A STUDY OF PARANOID ILLNESS IN PRIVATE PRACTICE

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SYNOPSIS

A study was made of 51 patients suffering from paranoid illness seen and treated by the author in a private psychiatric clinic. This group of patients comprises 25% of the patients suffering from functional psychoses seen in the clinic. In this paper the author tries to clarify the confusion concerning the concept and diagnosis of paranoid illness.

Comparing the data obtained with the control consisting of patients suffering from schizophrenia (Chia, 1970), the age of onset of paranoid illness was found to be older than that of schizophrenia, and in the ethnic distribution, the incidence of the Indian/Pakistani/Sikh/Ceylonese group was much greater.

The clinical feature of the patients were analysed. The cultural background of the patients was revealed and an attempt was made to show the pathoplastic effect it had on the symptomatology of the illness. From the analysis of the clinical features the patients were, on the whole, found to be very disturbed mentally but because of their suspicious attitude, persecutory delusions and lack of insight, were not receptive to accept medical help and treatment. Phenothiazine and Haloperidol were drugs of choice in the management of this condition. Often Electro-convulsive-therapy was indicated and had to be given.

Follow-up study showed that with regular medication and supervision the prognosis for the patients was good. Without regular treatment the chance of relapses was high. With no treatment at all, the patients often caused much hardship to their relatives, and occasionally would be of danger not only to others but to themselves.

INTRODUCTION

In this paper the author will try to present the clinical features and outcome of paranoid illness seen in a private psychiatric clinic and the problems in their management. Surprisingly few studies have been done on paranoid illness (Retterstol, 1968; Herbert and Jacobson, 1967) and as in other psychiatric syndrome the problems of making a distinction between normal and pathological reaction, the classification and the problems of follow-up of the patients make such a study difficult. Since most of the patients in this study are suffering from paranoid schizophrenia, it is felt that a short review of the concept of schizophrenia and paranoid illness will be necessary to clarify the confusion in the diagnosis of the conditions.

Kraepelin, 1896, first brought together various mental syndromes—hebephrenia, catatonia and paranoid psychoses—that he concluded were manifestation of a single disease process, since they had in common the following feature—a progression towards a state of personality deterioration or dementia. To this disease, he gave the name of 'Dementia Praecox'. Bleuler in 1911 coined the term 'Schizophrenia' which included a wider range of the illness than Kraepelin's 'Dementia Praecox' and he believed that the outcome of the illness was not necessarily one of deterioration. Bleuler also gave paranoid schizophrenia a definite and important place in his, 'The Group of Schizophrenias'.

Kraepelin (1911 and 1921) trying to obtain a clearer clinical differentiation of paranoid illness suggested a grouping which included paranoia, paraphrenia and paranoid schizophrenia. Paranoia may be defined as a paranoid illness of insidious onset characterised by well-systematized, persecutory delusion with little or no intellectual deterioration and, where the personality is well-preserved. According to Fish (1962), inspite all criticisms there was no doubt that 'Paranoia' was a clinical entity.

The Committee on nomenclature and statistics of the American Psychiatric Association (1952) stated that 'paranoia' was an extremely rare condition. However, according to Myre Sim (1968), this was only so because 'Paranoia' was rarely seen by psychiatrists and rarely admitted to hospital. 'Paraphrenia' was described by Kraepelin as a state intermediate between 'paranoia' and paranoid schizophrenia and without the characteristic dementia of the latter. In 1921, Mayer in his study concluded that paraphrenia

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was not a disease entity which could be sharply separated from schizophrenia. In practice, it is often difficult and at times impossible to draw a clear line between them and in this study 'Paraphrenia' is regarded as equivalent to paranoid schizophrenia.

Diagnosed under the term 'paranoid reaction' (Henderson and Gillespie, 1969) are patients whose delusions of persecutions can be explained in terms of the patients' background and their immediate stressful situation. This condition can also be distinguished from schizophrenia by an absence of hallucinations and other symptoms of schizophrenia. Paranoid reaction usually recovers with time, environment re-adjustment and treatment.

In considering paranoid illness one has also to consider premorbid personality. Kretschmer's description of a 'hypersensitive person with strong tendencies to self-reverence' and Cameron's 'hypersensitive and a social person' are those who would develop paranoid illness. In such a person the illness fluctuates in severity, may be recurrent or remain quiescent for long periods.

Definition

In this paper the term paranoid illness was used to cover all patients in which paranoid symptoms were the presenting and main features of the illness. These were subdivided into paranoid reaction, paranoid personality with paranoid reaction and paranoid schizophrenia. Paranoid symptoms occuring as secondary features to other organic psychoses and, drug and alcoholic intoxication and addiction were excluded.

MATERIALS OF STUDY

The materials of the study consisted of all the patients suffering from paranoid illness according to the above definition, seen in a private psychiatric clinic during the years 1968 to 1970. Paranoid illness was found to constitute about 25% of functional psychosis seen in the clinic.

A comparison of the age of onset of the patients suffering from paranoid illness and schizophrenia (Chia, 1970) would be apparent from Table I. As observed from the table—49% of the patients suffering from paranoid illnesses had their onset of illness after the age of 30 compared with 29% of patients suffering from schizophrenia.

It was interesting to note that in the ethnic distribution of the patients, as shown in Table II, the Indian/Pakistani/Sikh/Ceylonese group was markedly over-represented and the Malay group was not at all represented.

TABLE I

AGE AND SEX

Age of Onset of Illness	No. of Male Patients	No. of Female Patients	Total No. of Patients	%	Control %
13 - 14	—	—	—	—	1
15 - 19	—	5	5	9·8	29
20 - 29	9	12	21	41·2	41
30 - 39	5	7	12	23·5	22
40 - 49	4	1	5	9·8	6
Over 50	6	2	8	15·7	1
TOTAL	24	27	51	100·0	100

A comparison of age of onset of paranoid illness and schizophrenic illness (Chia, 1970).

TABLE II

ETHNIC DISTRIBUTION

Ethnic Group	% of Patients with Paranoid Illness	% of Singapore Population	% of Schizophrenic Patients
Chinese	78·4	74·2	80·0
Malays	—	14·6	3·0
Indian/Pakistani/ Sikh/Ceylonese	19·6	8·1	10·0
Others	2·0	3·1	7·0
TOTAL %	100·0	100·0	100·0

A breakdown of the ethnic grouping of patients suffering from paranoid illness compared with the mid-1968 Singapore population and with schizophrenic patients.

TABLE III

MARITAL STATUS

Marital Status	No. of Married Patients	No. of Single Patients	No. of Widowed Patients	No. of Divorced Patients
Male	8	18	1	—
Female	20	1	2	1
TOTAL	28	19	3	1

A breakdown of marital status of the patients.

From Table III, for male patients—18 were single and 8 were married. Among the female patients, the reverse was noticed—20 patients were married and only 1 patient was single. The educational level of the patients was shown in Table IV.

TABLE IV

EDUCATIONAL LEVEL

Category	Educational Level	Patients No.	Patients %	% of Schizophrenic Patients
1	University	4	7·8	5
2	Pre-U 1 and 2, College	11	21·6	19
3	Secondary 1-4	17	33·3	37
4	Primary 1-6	6	11·8	27
5	No formal education	13	25·5	12

A comparison of educational level of patients suffering from paranoid illness and schizophrenia.

Clinical Features

Paranoid delusion is defined as a false persecutory belief that cannot be corrected by argument or logic and is not appropriate with the patient's educational or cultural background.

Singapore is a multi-cultural society with a predominantly Chinese population and after the many years of intermingling among the various races, the superstitions and pagan-beliefs of the different races are accepted by many of the population. Beliefs in evil-spirits, charms and black-magic are common and often the help of fortune-teller, bomoh or gods through the temple-mediums are sought to find the explanations of and to obtain help for one's misfortune and ailments. A common belief that mental illness, with its psychological symptoms is being caused by evil-spirits, or by charms or black-magic applied by neighbours or enemies is frequently held. With such a unique background it would be interesting to see the pathoplastic effect of the cultures on the symptomatology of paranoid illness in Singapore.

In the analysis of the paranoid delusions of the patients, it was interesting to note that 23 patients believed that they were persecuted by their neighbours. 14 patients believed that their own members of the family were against them. Others were persecuted by: police and government-agents (6 cases); people of other races (5 cases); colleagues (9 cases); foreign agents and gangsters (4 cases); friends (3 cases); the attending doctors (3 cases) and temple medium (1 case). In one unusual case the patient was under the false belief that she was being persecuted by a goldfish thus resulting in her gourging the eyes of the poor fish.

Methods of persecution varied. The most common method was by black-magic (12 cases) which was understandable considering our cultural background. Other methods were: scolding (8 cases); poison (6 cases); murder and beating (4 cases each); threatening and investigating (2 cases each). Other less common methods were: being swindled, being experimented on, career being wrecked, brain being burnt, baby being taken away, soul being taken away, being fed with faeces, and bombs being planted on patient's premises. Many of the patients also had ideas of reference and believed that others were secretly talking about, watching, following, laughing at or persecuting them.

Except for one patient who was indifferent, the reactions of the patients were, on the whole, intense and in a few patients dangerous. 5 patients hid inside their houses and did not leave their homes. 3 shifted houses but to no avail because the persecutors followed them. 6 patients reported the affairs to the police. 3 patients were of danger to others—setting fire to neighbours' houses (2 cases) and stabbing the mother (1 case).

15 patients were very depressed and 13 patients were very agitated. 10 patients had ideas of suicide, one attempted suicide (jumping out of the balcony from a 3rd floor flat to escape from persecutors) and one committed suicide by jumping down from a 8th floor flat.

Other Symptoms

Hallucinations in the form of persecutory voices were common and present in 14 patients. Visual (6 cases) and olfactory (3 cases) hallucinations were less common.

Other symptoms were: thought disorder (5 cases); hypochondriacal complaints (4 cases); pathological jealousy (1 case) and abnormal behaviour (11 cases) unrelated to the paranoid delusions.

Management

In the management of patients suffering from paranoid state a lot of patience, tact, understanding and complete honesty was required to gain their trust and their co-operation. However, it would be realized that inspite of all the patience and persuasion, some patients would remain unreasonable and resent any suggestion of help, treatment and hospital care. When they were of danger to themselves and to others, and had no insight to the situation or into their illness, com-

pulsory admissions to the mental hospital would be necessary but not easy. Often police were involved, but, occasionally the help of relatives or friends was employed to force and send the patients to hospital. The author had helped to send 9 such patients to the hospital. Three other patients were sent by the relatives themselves.

Sometimes the relatives were reluctant to send the patients to hospital. The threatening, noisy, suspicious and disturbing behaviour of the patients would cause them much fear and hardship. In such cases the author sometimes found liquid Serenace (Haloperidol) useful to sedate and improve the patients' mental condition. This drug, because of its tasteless quality, could be administered by the relatives to the food or drinks of the patients without their knowledge.

Some patients (18 cases) being less disturbed or more submissive were persuaded to accept treatment and help. However, it was difficult to make them take continuous medication which was necessary to prevent relapses. The co-operation of the relatives would be most essential in helping them.

Finally, there were the patients who appealed for help and wanted to be protected from their persecutors. The response to treatment for them was often very satisfactory and the prognosis was usually good.

Phenothiazine and Haloperidol were the drugs of choice in the treatment of these patients. In 13 of the patients Electro-convulsive-therapy was given.

Follow-Up

An attempt was made to follow-up all the patients studied to assess their outcome with and without treatment. At the time of the study, 18 patients were still being followed-up by the author and 6 were being followed-up by the doctors in Woodbridge Hospital. A further 18 patients were contacted. Their mental states were then re-assessed by the author and the interim history of their illness was obtained. The outcome of 9 patients was unknown because of problems in tracing them. When contact was not possible the period between the first and last attendances for psychiatric advice and treatment was considered as the length of follow-up.

In this study, it was possible to reveal the clinical progress and outcome of 38 patients over a period of six months to three years from the time of their initial visit to the clinic. Among this group of patients, 10 were still receiving regular treatment and follow-up by the author; 16 patients were irregular in their follow-up and medication; and 12 patients had stopped medication completely.

TABLE V

	No. of Patients with Regular Treatment and Follow-up	No. of Patients with Irregular Treatment and Follow-up	No. of Patients with No Further Treatment and Follow-up
Recovered without relapse	8	—	3
Recovered with 1 relapse	1	6	2
Recovered with 2 relapses	—	7	—
Recovered with 3 relapses	—	1	—
Recovered with many relapses	—	1	—
Persistent psychiatric disorder	1	1	7
TOTAL	10	16	12

From Table V, it would be observed that of the patients who had regular treatment and follow-up, only 1 patient had one further relapse and only one remained persistently mentally unwell. With irregular treatment the chances of further relapses were high. Without treatment the majority of the patients remained chronic. The 3 patients who recovered without any further treatment were finally all diagnosed as suffering from paranoid reaction.

At the time of study, on the basis of the outcome of the illness and on verification and bringing to light all the data of the patients, a final diagnosis was made of the patients as shown in Table VI.

TABLE VI

Final Diagnoses	No. of Patients
Paranoid schizophrenia	42
Paranoid reaction	5
Personality disorder with paranoid reaction	4
TOTAL	51

A final psychiatric diagnostic breakdown.

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