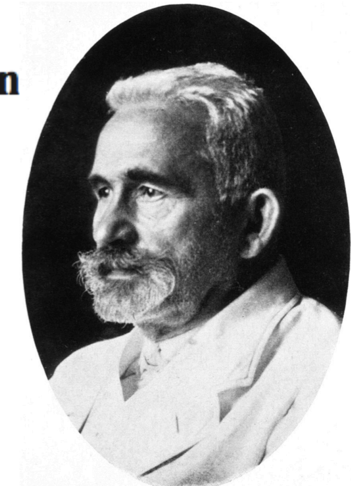
The Clinical Features of Paranoia in the 20th Century and Their Representation Diagnostic Criteria From DSM-III Through DSM-5



….On the other hand, there is doubtless a group of cases where a *lasting, unshakable system of delusions* clearly recognizable from the beginning, gradually developing, while *presence of mind* and the *order of the train of thought are completely conserved*. It is for these forms which I want to reserve the name of paranoia.

(Kraepelin pp. 325–326)

Kendler et al. Schizophrenia Bulletin 43: 332–343, 2017

	Kraepelin 1899,[1] 1904,*[23] and 1909[24]**
Disorder	Paranoia
Country	Germany
Systematized delusions	Lasting, unshakable system of delusions. Delusions are logically assimilated. Often see gradual spreading of delusions to incorporate more and more people.
Minimal hallucinations	Only in rare cases
Chronic course of illness	Development of disease takes a very slow course. Often at a standstill for many years.
Prominent ideas of reference	Prominent. Real perceptions are understood in a prejudiced way. A stain on a dress, a whole in the boot and not usual consequences but striking facts whose origin is only to be explained by hostile machinations.
Minimal affective deterioration	Presence of mind conserved. Excellent conservation of reason. In the course of decades, a slowly increasing debility often evident accompanied by a gradually progressing system of delusions. Lack emotional dullness seen in dementia praecox.
Lack of insight	Always lacking. Objections to delusions are typically cleverly refuted.
Non-bizarre delusions	The content of delusions show, in morbidly developed form, a remarkable agreement with those fears, wishes, and hopes, which even in normal individuals proceed from the feeling of uncertainty and the endeavor after happiness**
Intact cognitive processes	Order of train of thought preserved.
Lack of mood abnormality	Striking disturbances in the emotional deportment of the patient are wanting throughout. The patient is in neither morbidly cheerful nor gloomy mood.*
Delusional memory	Falsification of memory is common. In examining the past experiences, the patient's eyes are open, prior details now suddenly appear to him of major importance.
Actions and behaviors appropriate aside from areas of delusional beliefs	Typically, calm, reasonable, preserve an orderly attitude capable of satisfactory mental activity. Actions and behaviors may be free of disorder for a long time. But over time, preoccupation with delusional beliefs often increase and govern more and more of their life.
Delusional themes	Persecutory and grandiose themes typically predominate but erotomanic and querulous forms also occur.

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a false, irrational belief that is highly developed and organized, with multiple elaborations that are coherent, consistent, and logically related.

American Psychological Association

Kendler et al. Schizophrenia Bulletin 43: 332–343, 2017

Disturbo delirante 297.1 (F22)

Criteri diagnostici

A. La presenza di uno (o più) deliri con una durata di 1 mese o più.

B. Il Criterio A per la schizofrenia non è mai stato soddisfatto.

Nota: Le allucinazioni, se presenti, non sono preminenti e sono correlate al tema delirante (per es., la sensazione di essere infestato da insetti associata ai deliri di infestazione).

C. Il funzionamento, a parte l'impatto del/dei delirio/i o delle sue ramificazioni, non risulta compromesso in modo marcato, e il comportamento non è chiaramente bizzarro o stravagante.

D. Se si sono verificati episodi maniacali o depressivi maggiori, questi sono stati brevi rispetto alla durata dei periodi deliranti.

E. Il disturbo non è attribuibile agli effetti fisiologici di una sostanza o a un'altra condizione medica e non è meglio spiegato da un altro disturbo mentale, come il disturbo di dismorfismo corporeo o il disturbo ossessivo-compulsivo.

Specificare quale:

Tipo erotomanico: Questo sottotipo si applica quando il tema centrale del delirio è che un'altra persona sia innamorata dell'individuo.

Tipo di grandezza: Questo sottotipo si applica quando il tema centrale del delirio è la convinzione di avere qualche grande (ma non riconosciuta) dote o intuizione oppure di aver fatto qualche importante scoperta.

Tipo di gelosia: Questo sottotipo si applica quando il tema centrale del delirio dell'individuo è che il proprio coniuge o amante sia infedele.

Tipo di persecuzione: Questo sottotipo si applica quando il tema centrale del delirio comporta la convinzione dell'individuo di essere oggetto di una cospirazione, ingannato, spiato, seguito, avvelenato oppure drogato, dolosamente calunniato, molestato, oppure ostacolato nel perseguimento di obiettivi a lungo termine.

Tipo somatico: Questo sottotipo si applica quando il tema centrale del delirio coinvolge le funzioni o le sensazioni corporee.

Tipo misto: Questo sottotipo si applica quando non predomina nessun tema delirante.

Tipo senza specificazione: Questo sottotipo si applica quando la convinzione delirante dominante non può essere chiaramente determinata oppure non viene descritta nei tipi specifici (per es., deliri di riferimento senza una componente persecutoria o di grandezza preminente).

Table 1. Therapeutic approach to patients suffering from delusions.

Issues	Purpose	Recommendation
(1) Introductory remarks	To engage with patients	Summarize the steps the interview will take
(2) How to respond to a patient's delusions	To establish alliance and help with diagnosis and treatment	When possible, avoid commenting on the factual basis of a delusion
(3) Establishing trust	To build a foundation for working together	Show genuine interest in the patient's story
(4) Empathizing with feelings	To consolidate the therapeutic alliance	Show appreciation of the patient's distress
(5) Working together	To create a shared goal for therapy	Focus on distress tolerance and coping skills, not on the delusion itself
(6) Importance of form over content	To identify cognitive biases	Help the patient recognize and alter modes of thinking
(7) Psychological purposes served by delusion	To understand what is gained by a delusion	Help patient recognize the role played by the delusion
(8) Fixity of delusion	To establish possibilities for distraction	Use distraction techniques when needed and teach them to family members
	To monitor safety	Carefully assess potential for self-harm and aggression

Gonzalez-Rodruguez et al. *Int. J. Environ. Res. Public Health* 2020, *17*, 4583

Disturbo schizoaffettivo

Criteri diagnostici

A. Un periodo ininterrotto di malattia durante il quale è presente un episodio dell'umore maggiore (depressivo maggiore o maniacale) in concomitanza con il Criterio A della schizofrenia.

   Nota: L'episodio depressivo maggiore deve comprendere il Criterio A1: umore depresso.

B. Deliri o allucinazioni per 2 settimane o più in assenza di un episodio dell'umore maggiore (depressivo o maniacale) durante la durata lifetime della malattia.

C. I sintomi che soddisfano i criteri per un episodio dell'umore maggiore sono presenti per la maggior parte della durata totale dei periodi attivi e residui della malattia.

D. Il disturbo non è attribuibile agli effetti di una sostanza (per es., una sostanza di abuso, un farmaco) o a un'altra condizione medica.

Concepts of psychoses

Kraepelinian dichotomy; from 19thC

(Kraepelin; Bleuler; Schneider)

Zone of rarity

SZ

BP

Way obsolete

SAD; 1933 (Kasanin)

Zone of rarity

SZ

SAD

BP

Obsolete

Psychotic ← Severity of Sx → Mood

Kasanin's original concept of schizoaffective disorder (1933): delimitation of benign psychotic disturbances with a remitting course from schizophrenic disorders with chronic course

Continuum; 1986 (Crow)

SZ

SAD

BP

Psychotic ← Severity of Sx → Mood

One disease

[P+L (1978); C+O (2005); L+H (2006); Maier (2007)]

Mood disorder

BP very psychotic (formally SZ)

BP moderate psychotic (formally SAD)

classic BP nonpsychotic

Psychotic ← Severity of Sx → Mood

Lake & Hurwiz 2007

Differenti criteri (espressione di diversa visione del disturbo schizoaffettivo)

TABLE 1 **DSM-IV TR and ICD-10 diagnostic criteria for SAD**

	Diagnostic Criteria				
	Affective	**Schizophrenic**	**Duration**	**Simultaneity**	**Additional**
DSM-IV	Major depressive, manic, or mixed episode	Meeting Criterion A for schizophrenia (presence of ≥2 delusions, hallucinations, disorganized speech, behavioral disturbances, or negative symptoms)	Major depressive episode 2 weeks; mixed or manic 1 week Psychotic symptoms 1 month to meet Criterion A for schizophrenia	During the same period of the illness	Delusions or hallucinations for ≥2 weeks without prominent mood symptoms Mood symptoms as a substantial portion of the total illness duration
ICD-10	Prominent manic, depressive, or mixed symptoms	One, preferably 2 of (a)-(d) symptoms for schizophrenia*	Mania ≥1 week; depression ≥2 weeks	Simultaneous, or at least within a few days of each other	

* Symptoms include (a) thought echo, thought insertion or withdrawal, or thought broadcasting; (b) delusions of control, influence or passivity, clearly referred to body or limb movements or specific thoughts, actions, or sensations; delusional perception; (c) hallucinatory voices giving a running commentary on the patient's behavior, or discussing him between themselves, or other types of hallucinatory voices coming from some part of the body; (d) persistent delusions of other kinds that are culturally inappropriate and completely impossible (eg, being able to control the weather, being in communication with aliens from another world).

Source: References 3,5

cross-sectional approach instead of longitudinal perspective

6A21 Schizoaffective disorder

Parent

Schizophrenia or other primary psychotic disorders

Show all ancestors

Description

Schizoaffective disorder is an episodic disorder in which the diagnostic requirements of schizophrenia and a manic, mixed, or moderate or severe depressive episode are met within the same episode of illness, either simultaneously or within a few days of each other. Prominent symptoms of schizophrenia (e.g. delusions, hallucinations, disorganization in the form of thought, experiences of influence, passivity and control) are accompanied by typical symptoms of a depressive episode (e.g. depressed mood, loss of interest, reduced energy), a manic episode (e.g., elevated mood, increase in the quality and speed of physical and mental activity) or a mixed episode. Psychomotor disturbances, including catatonia, may be present. Symptoms must have persisted for at least one month. The symptoms are not a manifestation of another health condition (e.g., a brain tumor) and are not due to the effect of a substance or medication on the central nervous system (e.g., corticosteroids), including withdrawal (e.g., alcohol withdrawal).

Postcoordination

Add detail to **Schizoaffective disorder**

Has manifestation *(use additional code, if desired .)*

6A25	Symptomatic manifestations of primary psychotic disorders
6A25.0	Positive symptoms in primary psychotic disorders
6A25.1	Negative symptoms in primary psychotic disorders
6A25.2	Depressive symptoms in primary psychotic disorders
6A25.3	Manic symptoms in primary psychotic disorders
6A25.4	Psychomotor symptoms in primary psychotic disorders
6A25.5	Cognitive symptoms in primary psychotic disorders

ICD-11

International Classification of Diseases for Mortality and Morbidity Statistics

Eleventh Revision

Differenti criteri comportano diverso outcome a lungo termine

Diagnostic criteria		outcome
ICD-11	Affective and psychotic symptoms: 1. Develop together 2. Are equally prominent 3. Occur within the same episode	More favorable than schizophrenia, similar to that of affective disorders
DSM-5	Temporal dissociation of affective and psychotic symptoms	Unfavorable, resembling (or even worse) that of schizophrenia

DISTURBO SCHIZOAFFETTIVO: EPIDEMIOLOGIA

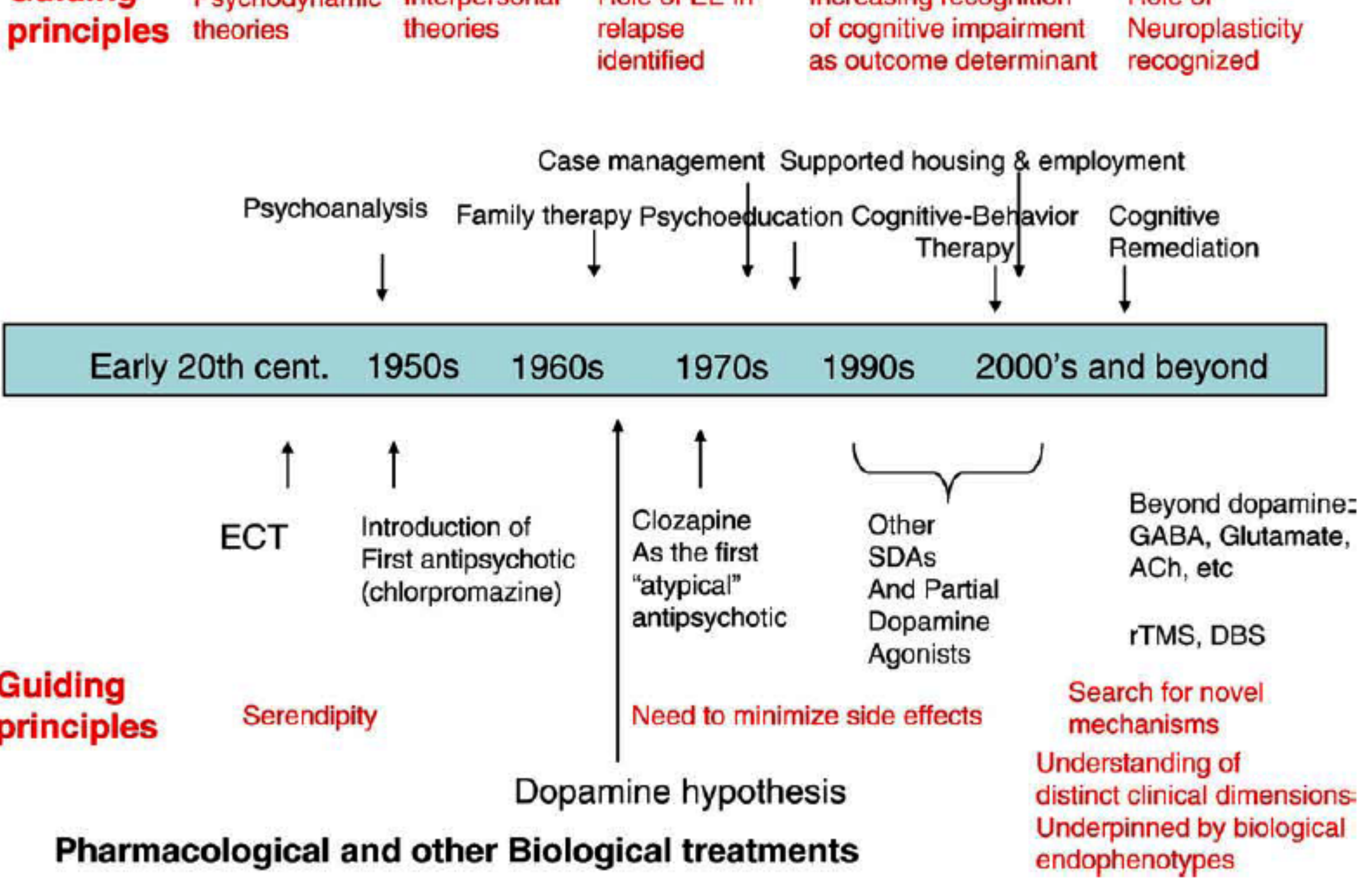
Incidenza: maggiore nel sesso femminile

Prevalenza: 0.3%

Età di esordio: prima età adulta

I parenti di primo grado dei pazienti hanno aumentato rischio di ammalare per Disturbo Schizoaffettivo, Schizofrenia e Disturbi Bipolari

Trattamento della Schizofrenia



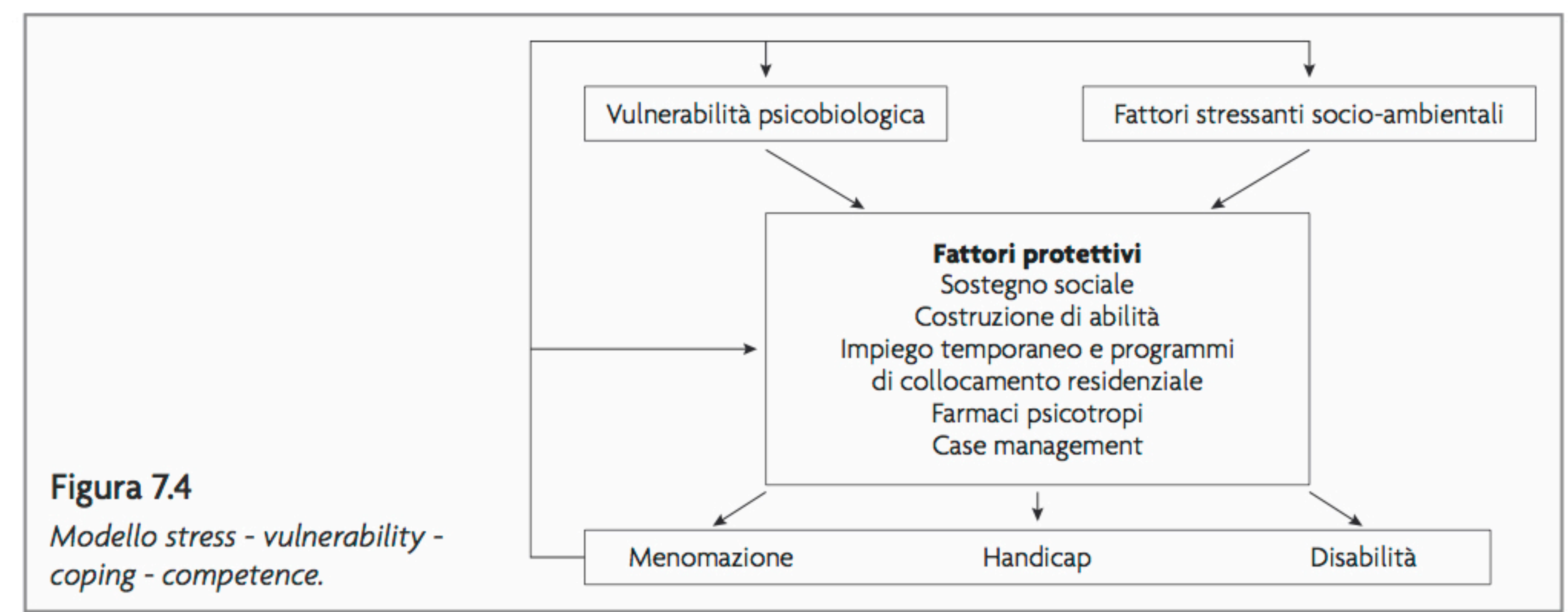


Figura 7.4

Modello stress - vulnerability - coping - competence.

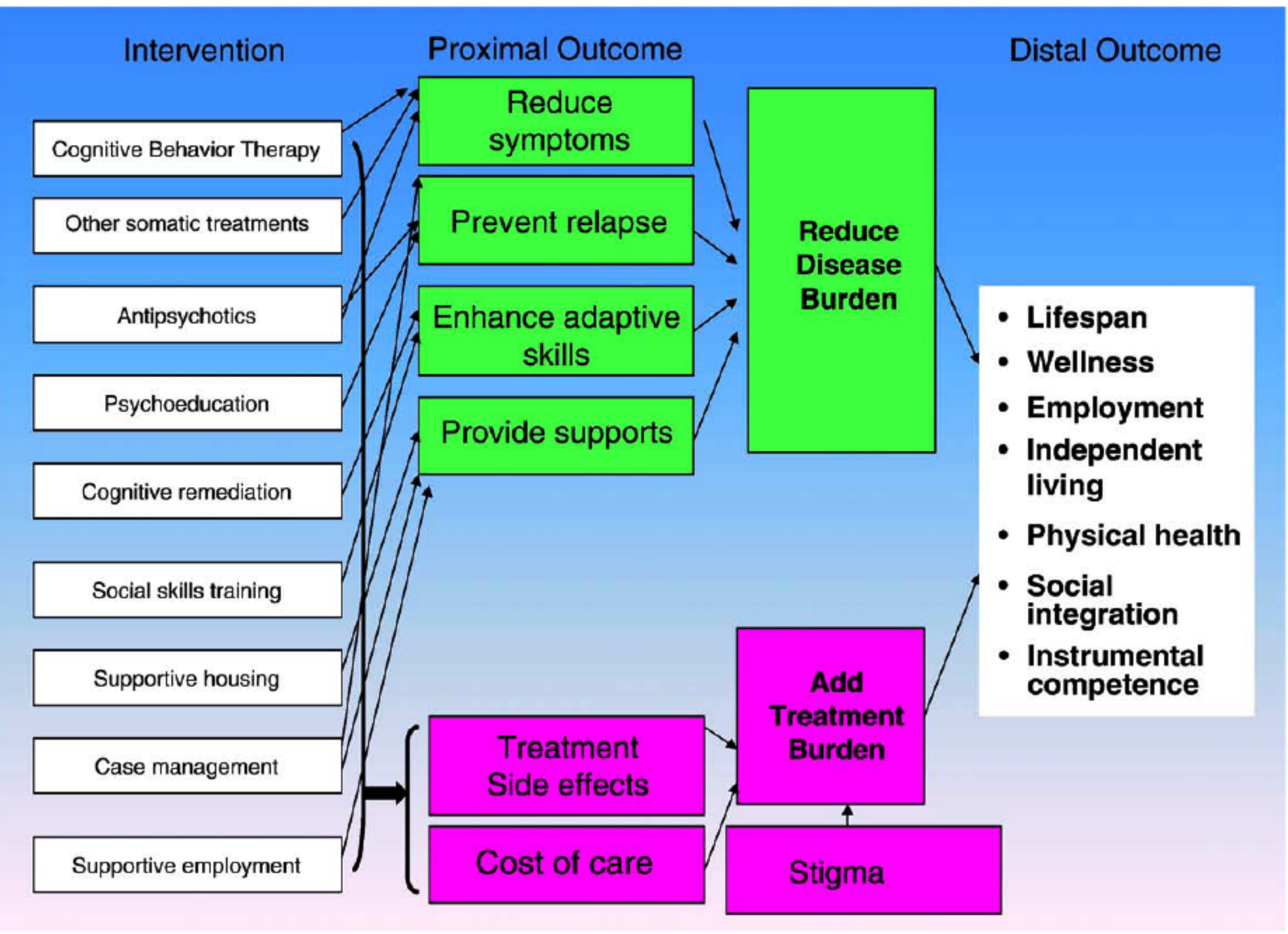
Esempi di disabilità causate da menomazioni sintomatiche e cognitive che comportano un handicap significativo in pazienti schizofrenici.

Difficoltà nel tollerare un lavoro
Nel seguire le istruzioni
Nel cooperare con i colleghi e i superiori
Nel problem solving
Nel mantenere la concentrazione
Nell'abilità di accettare le critiche
Di chiedere aiuto

Trattamento della Schizofrenia: interventi psicosociali

Psychotherapeutic interventions in schizophrenia: effect sizes.

Treatment modality	Most commonly reported outcome variable	Effect size (Hedge's g)
Social skills training	Skill acquisition	.76–1.43
	Community functioning	.51
Psychoeducation	Relapse (2 years)	.17–.56
Cognitive Behavior Therapy (CBT)	Positive symptoms	.35–.65
Cognitive remediation	Cognitive functioning	.11–.98
	Social functioning	.36–.51


Intervention
Proximal Outcome
Distal Outcome
Cognitive Behavior Therapy
Other somatic treatments
Antipsychotics
Psychoeducation
Cognitive remediation
Social skills training
Supportive housing
Case management
Supportive employment
Reduce symptoms
Prevent relapse
Enhance adaptive skills
Provide supports
Reduce Disease Burden
Treatment Side effects
Cost of care
Add Treatment Burden
Stigma
• Lifespan
• Wellness
• Employment
• Independent living
• Physical health
• Social integration
• Instrumental competence