Case report

What's happened to paraphrenia? A case-report and review of the literature

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Abstract. Paraphrenia is a chronic psychotic disorder similar to paranoid schizophrenia, but with a better-preserved affect and relation and a much less personality deterioration. It was firstly systematically described by Kraepelin in 1913 in order to define a group of psychotic patients who exhibited characteristic symptoms of dementia praecox, but with minimal disturbances of emotion and volition, and marked delusions. After the publication of the Mayer-Gross's report in 1921, the view to differentiate paraphrenia from schizophrenia was considered to be unfounded and the term "paraphrenia" was not included in the current DSM-IV-TR diagnostic criteria. Consequently, now this disorder is infrequently diagnosed. However, several authors suggest that the concept of paraphrenia has not lost its usefulness. It seems to be that some psychiatrists recognize the illness, but labelled it as "atypical psychosis", "schizoaffective disorder", "delusional disorder" or "psychotic disorder not otherwise specified" for the lack of a better diagnostic category. Very few systematic studies on paraphrenia have been carried out in the past 70 years. Aim of this article is to describe a case of chronic delusional psychosis who meets the Ravindran's modern diagnostic criteria for "paraphrenia redefined", suggesting that it is possible to define and recognize the illness if the practitioners are induced to use a viable diagnostic entity. Further research would benefit paraphrenic and schizophrenic patients. (www.actabiomedica.it)

Key words: Paraphrenia, paranoid schizophrenia, delusional disorder, atypical psychosis, psychotic disorder not otherwise specified

Background

> *«...The most beautiful sensation is the dark side of life. The man who is unable to feel amazement or surprise, is so to speak as "died". His eyes are dull and extinguished» (Einstein A.: Relativity, the special and general theory [1916]) (1).*

The term "Paraphrenia" was introduced by Kahlbaum [1863] (2) within his classification of dementia insanities related to transitional periods of life. He used it specifically to refer to dementia disorders with a typical first adulthood onset, previously called by Morel [1857] as "Dementia Praecox" (3).

Some years later, in the eight edition of his "Textbook of Psychiatry", Kraepelin [1913] (4) resumed the term "Paraphrenia" to describe «...the uncertain psychotic group between paranoia and paranoid dementia», in which a much less personality deterioration and a better-preserved affect and relation were typically present.

Nowadays, paraphrenia is relatively infrequently diagnosed and is not listed in the current ICD and DSM series (5, 6), though it continues to create significant problems in the clinical practice (7). However, some psychiatrists still seem to recognize this illness but label it as "atypical psychosis", "schizoaffec-

tive disorder" or "psychotic disorder not otherwise specified" for the lack of a better diagnostic category (8). These vague diagnostic entities do not lend themselves well to research and do not lead to reliable epidemiological data (such as the real prevalence rate of paraphrenia) (9).

Omitted from the DSM-III-R [1987] (10), the American Psychiatric Association (APA) stated that paraphrenia would remain excluded until further research was carried out and would in the meantime be subsumed under schizophrenia (11). Consequently, paraphrenia remained absent from the DSM-IV [1994] (12) and the DSM-IV-TR [2000] (6), but this decision, according to Munro [1991] (13), was only served to worsen the "overinclusiveness" of the schizophrenia category and to discourage original research on paraphrenia. Therefore, for a better clinical and nosographical comprehension, Ravindran et al. [1999] (14) have recently hypothesized that paraphrenia should lie in a central position (as a specific diagnostic category) on a single "paranoid spectrum" between delusional disorder and paranoid schizophrenia.

Few systematic studies on paraphrenia in the past 70 years have been carried out, except for on "late-onset paraphrenia", a controversial diagnosis whose links with conventional paraphrenia are still uncertain (15). Late paraphrenia was firstly described by Roth (16) in 1955 as a chronic psychotic disorder of old age, characterized by a hallucinatory-paranoid state which seemed to appear more frequently in females with sensorial deficits and social isolation. Roth essentially held Kraepelin's view that no marked decrease in the basic personality level occurred in paraphrenia in contrast with schizophrenia, although cases reported by Kraepelin were not necessarily restricted to the elderly (17, 18).

In this article, the authors describe a case of paraphrenia in order to suggest the nosographical importance of the Kraepelin's concept and to advocate its return to a diagnostic canon. The mean clinical benefits to consider the diagnostic autonomy of paraphrenia could be (A) to reduce the "overinclusiveness" of the schizophrenia category and (B) to decrease the frequent bias to classify it within poorly reliable diagnostic entities (such as "atypical psychosis", "schizoaffective disorder" or "psychotic disorder not otherwise specified") (19).

a) Paraphrenia: the concept

In the eight edition of his "Textbook of Psychiatry", Kraepelin [1913] (4) presented a chapter entitled "Die Endogenen Verblodungen", in which he discussed two different forms of chronic psychotic disorder, namely "Dementia Praecox" and "Paraphrenia". It was logical that the concept of paraphrenia was born during the process in order to define demenitia praecox like a distinct entity (in which the main symptoms were the disturbances of emotion and volition) (20). Therefore, Kraepelin proposed the term "Paraphrenia" to define an uncertain group of chronic psychoses characterized by a vivid and (more or less) systematized delusional system (with or without hallucinations), but without disturbances of emotion and volition. According to him, these psychopathological features typically indicated that the inner structure of mental life remained sufficiently intact. He believed that paraphrenia was associated with paranoid dementia and paranoia, but it did not show the classical personality deterioration of schizophrenia and the full clinical features of delusional disorder ideation. In paraphrenic patients, personality decay was minimal and emotional relation was well-retained, but in spite of its relatively benign features, paraphrenia was as chronic as schizophrenic and delusional disorders (21). As well as paranoia, paraphrenia was separated from dementia praecox and was considered as a specific and independent psychotic illness (22).

Kraepelin observed that recovery did not occur in many paraphrenics. Nowadays a slight evidence to suggest that paraphrenia only occurs in one-tenth of inpatient psychiatric population is present (23). This result does not tell us if the disorder is relatively uncommon or if its generally more benign features enable more sufferers to remain outside hospital (7).

Following the Kraepelin's view and the concept of "Imaginative Psychosis" (proposed by Dupré and Logre in 1911) (24), the French traditional psychiatry identified at least six main psychopathological features of the paraphrenic syndrome (25):

1) *Delusions with dream-like imaginary and megalomaniac characteristics*. In paraphrenia, persecutory and expansive delusional themes were typically fanciful, paradoxical, but were organized each other into a coherent unitary system (26). The agreement of patients to delusional ideation was firm and strong, but not as complete as in paranoia (27).

2) *Paralogical thought dominance*. Paraphrenic ideation typically used symbolism and magic formulas, drawing to universal archetypes, infant myths and collective representations of primitives (26).

3) *Bipolarity phenomenon*. The paraphrenic patient was attracted to the imaginary pole of his delusional world, but he could easily deviate from it to return to the real world (27).

4) *Integrity of relation with reality*. In contrast with paralogical thought and the absurdity of his delusional world, the paraphrenic patient kept for a long time a well-retained interpersonal functioning and a correct adjustment with the real world (28). His pragmatic abilities (i.e. school performance, working activity, social behavior) remained (more or less) preserved, as such as his intellectual and mnemonic faculties.

5) *Vivid and changeable hallucinations* (mainly auditory and visual, with typically scenic features) (29). Confabulation (as a luxuriant and fanciful memory production) was often prevalent on hallucinations in increasing delusional themes (30).

6) *Mental state integrity* (although hypnotic or like-dream subconfusional phases were not unusual and were accompanied with visual hallucinations or imaginary delusions which established "prolific moments" for daytime delusional ideation) (31).

Kraepelin also described four different subtypes of paraphrenia, namely "paraphrenia systematica", "paraphrenia expansiva", "paraphrenia confabulans" and "paraphrenia phantastica".

The *paraphrenia systematica* was the main group of paraphrenia. Its clinical onset was more frequently insidious. Delusions of reference and persecution gradually appeared over the course of several years, often accompanied by auditory hallucinations, ideas of passivity and mental influence with somatic and thought control. After some years, during which persecutory delusions gradually developed, delusional themes of grandeur also appeared. It was possible that patients had delusions of grandeur at the beginning of the disorder (32). Delusions of remembrance ("pseudo-memories") with typical confabulations and memory delusional interpretations were commonly observed. In this paraphrenic subgroup, mood was more frequently depressive at the onset of the disorder, but subsequently it became euphoric or dysphoric as a result of the evolution of delusional ideation (33). The male-to-female ratio was 3:2, with a higher proportion of males (60%). Although this paraphrenic subtype more often occurred between the ages of 30 and 50 years, Kraepelin suggested that it could occur in patients under 25 or over 50 yrs of age (34).

According to Kraepelin, the *paraphrenia expansiva* affected a relatively small group of paraphrenic patients. It was characterized by delusions of grandeur (rich in the variety of their contents) and was persistently accompanied by an exuberant megalomania with exalted (or irritable) feelings and severe excitement. Several patients had also vivid visual hallucinations. Although this paraphrenic subtype began between the ages of 30 and 50 years in about three-fourths of patients, a case with onset at 64 years was described by Kraepelin. All cases reported by Kraepelin were females. Kraepelin suggested a close relationship between this paraphrenic subgroup and manic-depressive psychosis (35).

The *paraphrenia confabulans* affected only a minority of paraphrenic patients. Its distinctive psychopathological feature was the presence of "pseudo-memories" (the delusions of remembrance). Its clinical onset was more frequently insidious and patients gradually showed delusions of persecution and grandeur, which confirmed their false extraordinary past experiences and confabulations (34). In this paraphrenic subgroup, mood was more often expansive (or irritable) and was commonly accompanied by logorrhea, accelerated ideation and hyperactivity. The cases reported by Kraepelin were between 20 and 60 years of age, with an approximately equal sex ratio.

The *paraphrenia phantastica* was characterized by a greatly fanciful and changeable delusional content, with a typically eccentric and incoherent structure. Kraepelin attempted to differentiate this subtype from paraphrenia systematica, in the respect that

delusions in the latter had a propensity to be systematized, while those in the former rapidly and frequently changed (36). Delusions of persecution, mental influence, somatic passivity and grandeur, visual and auditory hallucinations, confabulation, and neologism were commonly observed in this paraphrenic subtype. Mood was more often depressive, but it could become expansive as a result of megalomaniac ideation. The cases reported by Kraepelin were between 20 and 50 years of age. The proportion of males ranged from 60% to 70%. Kraepelin suggested the close relationship of this paraphrenic subtype with the paranoid type of dementia praecox, because of a higher proportion of personality deterioration (35).

b) From Mayer-Gross to DSM-IV-TR: the decline of paraphrenia concept

Mayer-Gross [1921] (37) studied outcomes of 78 patients who had been diagnosed by Kraepelin as having paraphrenia. Some of them were observed for more than 10 years. Table 1 summarizes his findings.

According to Mayer-Gross, 45 of the Kraepelin's cases showed symptoms of *paraphrenia systematica*. Fourteen out of those 45 cases gradually progressed to schizophrenia (with the development of catatonic features, personality deterioration, and the typical schizophrenic disturbances of volition), five cases to paranoia, two to paranoid psychopathy, three to manic-depressive illness, and two to organic senile psychosis. Two cases were unclassifiable. Therefore, seventeen out of the 45 cases retained the original diagnosis of paraphrenia systematica.

Thirteen out of the 78 cases reported by Kraepelin were diagnosed as having *paraphrenia expansiva*. Five out of those 13 cases were diagnosed with schizophrenia during the course of the clinical observation. One case was found to have organic senile psychosis and one case had manic-depressive illness, while a diagnosis could not be made for one case because of too brief observation period. In the remaining five cases, the original diagnosis of paraphrenia expansiva was retained.

Eleven out of the 78 cases reported by Kraepelin were diagnosed as having *paraphrenia confabulans*. Five out of those 11 cases were diagnosed with schizophrenia after clinical observations lasting for 1 to 12 years. The remaining six paraphrenic cases kept the original diagnosis of paraphrenia confabulans.

Nine out of the 78 cases reported by Kraepelin were diagnosed with *paraphrenia phantastica*. Eight out of those 9 cases gradually progressed to schizophrenia. In the one remaining case, the observation period of only three months was too brief for an accurate diagnosis.

In summary, 28 out of the 78 cases retained the diagnosis of paraphrenia according to the description of Kraepelin, but the remaining 50 cases changed their clinical pictures over the observation period. Thirty-two cases were reclassified as having dementia praecox. Therefore, Mayer-Gross concluded that a majority of paraphrenia deteriorated to dementia praecox (more than one-half of Kraepelin's personal cases), a small group of patients belonged to endogenous paranoid psychosis without severe disturbances of volition (paranoia) and only a few to manic-depressive illness.

Since the publication of Mayer-Gross's report, the view to differentiate paraphrenia from schizophrenia was considered to be unfounded and discussions on paraphrenia waned both in Europe and in the USA (38). Nowadays, paraphrenia was excluded by the current ICD and DSM series (13). Therefore,

Table 1. Outcome of Kraepelin's paraphrenic psychoses (Mayer-Gross, 1921) (37)

Subtype	Kraepelin's diagnosis	Final diagnosis		
		Schizophrenia	Paraphrenia	Others
Paraphrenia systematica	45	14	17	14
Paraphrenia expansiva	13	5	5	3
Paraphrenia confabulans	11	5	6	0
Paraphrenia phantastica	9	8	0	1
Total	78	32	28	18

if patients with paraphrenic disorder are diagnosed according to DSM-IV-TR diagnostic criteria [2000] (6), they may be diagnosed with "schizophrenia", "delusional disorder", "schizoaffective disorder" or "psychotic disorder not otherwise specified". According to ICD-10 [1992] (5), paraphrenia is to be included under the "delusional disorder" ("paranoia"), although this is somewhat controversial (39).

However, 28 (35.9%) out of 78 cases that were diagnosed with paraphrenia by Kraepelin retained the same diagnosis. Moreover, it is noteworthy that 17 (37.8 %) out of 45 cases of paraphrenia systematica kept the same diagnosis throughout. Therefore, the question whether paraphrenia has to be considered as a distinct diagnostic entity from schizophrenia (as it happened in Kraepelin's time) remains till today an essential problem concerning the classification of psychotic disorders (7, 14). Bridge and Wyatt [1980] (40) concluded their review on paraphrenia as follows: «...the evidence leads to the conclusion that paranoid states are not rare and the diagnosis of paraphrenia has a real clinical utility».

c) Paraphrenia redefined

In 1991, Munro (13) proposed a continuum of psychotic disorders (the "paranoid spectrum") ranging from delusional disorder (paranoia) to paraphrenia, and to paranoid schizophrenia. He recognized paraphrenia as a distinct clinical entity for patients who showed psychotic disorders in the paranoid spectrum, but kept affective warmth and lacked thought deterioration and grossly disorganized behavior. Referring to the literature, Munro observed the following tendency in the patients in his paranoid spectrum: «...approximately the 10% of patients with delusional disorders or paraphrenia will show a "shift to the right" deteriorating to schizophrenia or (especially in older individuals) to degenerative senile dementia».

Some years later, Ravindran et al. [1991] (14) suggested that in the clinical practice cases of "paranoid disorder" which did not present the well-encapsulated delusional system of paranoia and yet did not appear as profoundly thought- and personality-disturbed as in paranoid schizophrenia were frequently found. The authors hypothesized that «...the kraepelinian paraphrenia would be an acceptable diagnosis for these cases, if it could be showed that they form a coherent nosographical group», and proposed a description of paraphrenia in modern terms (table 2).

Ravindran et al. carried out an experimental study in order to determine whether cases that matched their diagnostic criteria for paraphrenia could be identified in the clinical practice, defining a recognizable diagnostic entity, and could be distinguished from other schizophrenia-like disorders. Patients were clinically screened by means of a standard comprehensive interview schedule administered by a psychiatric nurse. Patients with psychotic symptoms were then interviewed by a psychiatrist and, if symptoms were "atypical", were administered the "Paraphrenia Project Questionnaire" (PPQ). "Atypical" meant that the patient did not meet DSM-IV criteria for schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder or brief psychotic disorder.

Thirty-three cases matched the modern criteria for paraphrenia after all other patients with schizophrenia-like disorders had been examined and discarded, readily confirming the starting hypothesis of Ravindran and colleagues. Their filtering method with consecutive interview and questionnaire was useful to identify cases that were positively diagnosed with paraphrenia and to distinguish those patients from delusional disorder and paranoid schizophrenia.

Table 2. Diagnostic criteria for "Paraphrenia" redefined by Ravindran et al. [1999] (14)

A delusional disorder of at least "6 months" duration, characterized by the following:

1. Preoccupation with one or more semisystematized delusions often accompanied by auditory hallucinations. These delusions are not encapsulated from the rest of the personality as in delusional disorder.
2. Affect is notably well-preserved and appropriate. Even in acute phases, there is an ability to maintain rapport with the interviewer.
3. None of the following: intellectual deterioration, visual hallucinations, incoherence, flat or grossly inappropriate affect, or grossly disorganized behavior at the times other than during the acute episode.
4. Disturbance of behavior is understandable in relation to the content of delusions and hallucinations.
5. The patient only partially meets DSM-IV Criterion A for schizophrenia. No significant organic brain disorder.

Although all of these cases had been previously diagnosed as other than paraphrenia (usually delusional disorder, paranoid schizophrenia, schizoaffective disorder or depressive major disorder with psychotic symptoms), the authors concluded that «...given adequate criteria such as provided here, any competent diagnostician can recognize a case of paraphrenia».

Ravindran et al. also identified several explicit clinical features which allowed to consider paraphrenia (according to Kraepelin's view) as a distinct psychotic disorder with a specific nosographical autonomy, differentiating it from delusional disorder (paranoia) and paranoid schizophrenia (both as defined in the DSM-IV).

a) *Age of onset*. Although traditionally the onset of paraphrenia was thought to be middle or old age (41), this disorder did not seem predominantly to occur in elderly subjects. In the study carried out by Ravindran et al., about one-third of cases began before the age of 30 years and more than 80% before the age of 49 years.

b) *Sex ratio*. Although uncertain, the paraphrenic disorder seemed to be more common in females (42). Ravindran et al. observed that 24 (72.7%) out of their cases were women and only 9 (27.3%) were males.

c) Predisposing and risk factors. Sensory impairment, social isolation, migrant status and other significant stressful events (such as discriminating, humiliating and threatening experiences during earlier life, expulsion from home or illegitimate birth) seemed to play a part (43, 44). It was also possible (though evidence was uncertain) that premorbid paranoid or schizoid personality disorders more commonly occurred with paraphrenia than by chance (45). Poor education, celibacy, lower-than-normal marital status rates had been frequently mentioned, possibly indicating abnormal personality traits (46, 47).

d) *Familial pattern*. According to Ravindran et al., a low frequency of schizophrenia in families of paraphrenic patients was present, suggesting that a little or no genetic link between the two psychotic disorders exists.

e) *Course*. Paraphrenia seemed to be a chronic illness, ameliorated (but not cured) through pharmacological treatment (48). Like paranoid schizophrenia, it appeared to respond to antipsychotic treatment (49). Ravindran et al. suggested that short-term treatment results in paraphrenic disorder seemed better than were usual in paranoid schizophrenia. According to them, the administration of antipsychotic drugs generally showed a return to good personality functioning, good behavioral control, better reality testing, more normal thinking and well-preserved affect. Behavioral therapy also could reduce the degree of delusional preoccupations, but psychotherapy was not of primary value (50).

f) *Outcome*. According to Ravindran et al., clinical outcome was often satisfactory, sometimes with a surprisingly complete return to near-normal, sometimes with an encapsulation of delusional ideation. However, treatment compliance was not always good and relapse seemed to be quite common (51). Ravindran et al. showed that 66% of their paraphrenic patients had previously not complied with treatment and that at the time of discharge from hospital for the current episode, 50% of them had significant lack of insight, more than 40% still had recognizable delusions and 25% retained marked residual symptoms of illness. Therefore, paraphrenia appeared to be chronic and also a paranoid disorder, in which (although intellectual faculties were generally unimpaired) daily living, working activity, social functioning and quality of life were likely to deteriorate during exacerbations (52). Some paraphrenic cases also appeared to deteriorate to schizophrenia and in elderly patients dementia could sometimes supervene (53). In the study carried out by Ravindran et al., several patients showed a certain degree of personality and interpersonal incompetence (more than one-half lived alone and were single, separated or divorced).

g) *Associated features*. According to Ravindran et al., paraphrenia was frequently associated with distress and agitation. Irrational behavior could also appear since delusions and hallucinations became more vivid and judgement lessened. However, in spite of the bad reputation of paranoid illnesses, less than one-third of their cases had made threats or behaved aggressively in the current episode.

h) *Differential diagnoses*. Until the study of Ravindran et al. was carried out, paraphrenic patients were usually diagnosed with various nosographical

entities (mainly delusional disorder, paranoid schizophrenia, schizoaffective disorder, major depressive disorder with delusions, bipolar disorder with delusions, dementia, severe obsessive-compulsive disorder with near-bizarre features and rituals, severe paranoid, schizoid or schizotypal personality disorder) (54). According to Ravindran et al., these diagnoses were approximations and previous clinicians were at least placing the patients within the paranoid spectrum.

Some years ago, Sarrò [2005] (23) supported the view of paraphrenia like a distinct psychotic illness, suggesting to consider it as a transitional form of paranoid disorder within the more systematized delusion of paranoia and the more disorganized delusion of schizophrenia. According to Sarrò, the main psychopathological feature of paraphrenia was the peculiar expression ("frondosa") of its delusional ideation, which was typically vivid, polymorph and changeable, and usually produced a "biographical breaking" in spite of the "health" past of the patient. Paraphrenics showed a replacement of their historical biography (based on real life-events) with another biography (more mythological, symbolic and utopian), which, mixed with residual aspects of their previous "health" life, handed on common archetypes of the history of humanity (such as the eternal fight between Good and Evil). Within this expansive grandiosity, it was not uncommon that paraphrenics gradually elaborated a "neogenealogy", in which they stayed at the top of their delusional cosmology, boasting of famous kinship or divine rebirth and metamorphosis ("palyngenesia").

Pereyra [1967] (55) suggested that this peculiar expression of paraphrenic delusional world distinguished paraphrenia both from paranoia and paranoid schizophrenia. According to him, paranoia delusions were restricted on concrete themes, around which patients built a well-systematized and internal coherent delusional system, deducing on it with irreducible certainty. On the contrary, paraphrenic patients extemporized at the moment and resolved irremediable gaps between their delusions and reality by imaging or with a magic reasoning, although in other areas of their cognition they maintained themselves firmly anchored to normal rules of the logic and to real experiences of external world. Finally, in paranoid schizophrenia, delusions were more disorganized than in paraphrenia, lacked the typical grandiosity of paraphrenic disorder and were characterized by a traumatic and afflicted "nihilism". Moreover, in schizophrenia a long-term personality deterioration and a progressive decline in affective, social and working functioning were more frequently present.

Case report

Mark (the name is unreal) was a 28-year-old male patient. First-born of three brothers, he lost his father at the age of 9 years, who suddenly died while working on an electric cable. His mother was described as emotionally unstable, impulsive and aggressive. She used to beat him as a punishment practice, so he decided to go to live alone at the age of 25 years. Familial antecedents were negative for mental disorders.

Mark attended the compulsory education with poor results and was not able to hold high-school degree. Since the age of 16 years, he had various working experiences (as plumber, storekeeper, and metal-worker in different local industries). In the last five years, he was regularly working as porter in a packing company which sent kitchen units.

The patient came to the Outpatient Psychiatric Service in Guastalla (Reggio Emilia Mental Health Department) in January 2008. At admission, he was anxious and depressed, having great difficulty in falling asleep. He reported to be troubled and "obsessed" by a significant life-event happened to him three months before: a self-masturbation while he was having a shower in the Municipal swimming pool. Mark was frightened because of the suspicion to have been watched by a fellow worker and by children who were attending swimming courses. This event was greatly stressful for him, triggering a marked anxiety state. He became doubtful about his sexual orientation and had the suspicion that his fellow workers had been learnt about the masturbation. He reported that they were sure of his presumed homosexuality and derided him on the workplace, teasing and speaking ill of him to the employer.

One month later the admission, the patient began to show delusions of remembrance ("pseudo-memories"). While he was listening on the radio to a song played by Vasco Rossi (a popular Italian singer), Mark was greatly shocked because this song seemed perfectly to describe his personality. He became more agitated and reported that in the last summer, while he was on holiday in Sicily, he met a man very similar to Vasco Rossi. They both stopped to speak for several minutes and Mark told the man some episodes of his childhood, specifically when he had been raped by a neighbour drug abuser (Albert) while he was singing in a public garden. Albert forced him to have an oral sex intercourse and threatened to kill him if he had confided to his parents all about it. The patient reported that he proposed to Albert the same song which Vasco Rossi subsequently would have used to record his popular hit. Until January 2008, Mark had no history of mental disorders and did not ever remember anything about his presumed infant abuse and his summer meeting with Vasco Rossi. He told to have understood the real meaning of his masturbation in the shower of the Municipal swimming pool: «...the abuse has been to blame. That's why I do not control my sexual drives».

In April 2008, Mark met a young girl (Mary) in a disco. He told her his story and reported that she was very interested about his ability to write songs, and that she promised to help him in getting contacts with popular singers of the show-business. The patient said that after the meeting with Mary, he began to receive many phone-calls by persons who defined themselves as "Vatican psychologists". According to Mark, they seemed to be interested to him and his story. However, no one of these calls was saved and demonstrated by Mark. In that period, his mood became hyperthimic. Although he slept only 3-4 hours at night, he was hyperactive and began to practice painting and to write songs, waiting for a "great revelation" which the Pope would have formulated the next 15th of August. The patient reported that this great revelation was that he was Jesus Christ: «...the Redeemer who would have led the world to the salvation».

In April 2008, sodium valproate (1 g/die) and risperidone (4 mg/die) were administered and Mark's clinical picture gradually improved within the following 6-8 weeks. Delusions of grandeur, delusions of reference and persecutory ideation disappeared, as such as agitation, insomnia and hyperactivity. His mood returned to be euthimic and the patient became able to formulate correct judgements about the summer meeting with Vasco Rossi and his mystic and persecutory delusions. However, nowadays "pseudo-memories" about his childhood still persist. During the observation period, the patient showed no personality deterioration and maintained a well-preserved cognitive, working and social functioning. No disturbance of volition, alcohol or drug abuse, mental disorder due to general medical conditions and organic brain damage were observed. EEG, neurological and neuroimaging examination (CT, MRI) were also normal.

Discussion

The case reported in this article was affected by a chronic psychotic disorder with a marked, vivid, quite systematized and changeable delusional system, which was composed by a combination of delusions of reference, delusions of persecution and (subsequently) delusions of grandeur, mystic delusions and delusions of remembrance ("pseudo-memories"). His mood was initially agitated and depressed, but then became hyperthimic and expansive. After the drug administration (sodium valproate and risperidone), his clinical picture gradually improved within the following 6-8 weeks. Delusions of reference and persecution, mystic delusions and delusions of grandeur disappeared. His mood returned to be euthimic, but few pseudo-memories still persisted. During the observation period, the patient showed no personality deterioration and maintained a well-preserved cognitive, working and social functioning. No disturbance of volition was also observed.

According to DSM-IV-TR (SCID-I) (56), the patient met diagnostic criteria for "psychotic disorder not otherwise specified". "Paranoid schizophrenia", "schizophreniform disorder", "schizoaffective disorder", "delusional disorder", "brief psychotic disorder" were excluded, as such as mood disorders with psychotic symptoms, severe paranoid, schizoid or schizo-

typal personality disorders, severe obsessive-compulsive disorder with near-bizarre ideation and rituals, drug-induced psychotic disorder, dementia or other psychotic disorders due to general medical conditions or organic brain damage. On DSM-IV-TR axis II (SCID-II) (57), the patient met diagnostic criteria for "paranoid" personality disorder. MMPI-II (58) was also administered and showed highly significant T scores on "paranoia" (Pa) and "psychopathic deviation" (Pd) scales.

According to Ravindran et al. (14), the patient met their modern diagnostic criteria for "paraphrenia redefined" (table II). He resulted to be affected by a delusional disorder of at least 6 months duration, characterized by the following features: (1) preoccupation with semisystematized delusions, which were not encapsulated from the rest of the personality as in delusional disorder; (2) affect remained quite preserved and appropriate (even in acute phases, there was an ability to maintain rapport with the interviewer); (3) no intellectual deterioration, auditory and visual hallucinations, incoherence, flat or grossly inappropriate affect, or grossly disorganized behavior were observed at the times other than during the acute episode; (4) disturbance of behavior was understandable in relationship with the content of the delusions; (5) the patient only partially met DSM-IV-TR Criterion A for schizophrenia and no significant organic brain disorder was also described.

With reference to other clinical features proposed by Ravindran et al. in order to consider paraphrenia as a distinct psychotic disorder with a specific nosographical autonomy, the case reported in this article seems to support the following results:

a) although traditionally the onset of paraphrenia was thought to be middle or old age, the disorder does not seem to occur exclusively in elderly subjects. In several paraphrenic patients, it appears to begin before the age of 30 years;

b) poor education, celibacy and other infant stressful events (such as parental aggressiveness) seem to play a part as predisposing or risk factors for the development of paraphrenia, as such as premorbid paranoid personality disorder;

c) familial psychiatric antecedents are negative for mental disorders (suggesting that there is a little or no genetic link between paraphrenia and schizophrenia);

d) paraphrenia seems to be a chronic paranoid disorder, ameliorated (but not cured) by pharmacological treatment. However, it appears to have a good response to antipsychotic medications with a gradual return to good personality functioning, good behavioral control, better reality testing, more normal thinking and well-preserved affect;

e) paraphrenia clinical outcome is quite often satisfactory (intellectual functioning, daily living, working activity and social relation are generally unimpaired), sometimes with an encapsulation of delusional ideation and pseudo-memories;

f) paraphrenia is frequently associated with distress and agitation, but rarely shows irrational or aggressive behaviors.

According to Pereyra (55), the case reported in this article seems to confirm the peculiar expression of paraphrenic delusional world, which distinguishes paraphrenia both from the more systematized delusions of paranoia and the more disorganized delusions of schizophrenia. Finally, according to Sarrò (23), this case-report seems to suggest that the main psychopathological feature of paraphrenia is the peculiar expression ("frondosa") of its delusional ideation, which is typically vivid, polymorph and changeable, and usually produces a "biographical breaking" in spite of the "health" past of the patient. Paraphrenic patients appear to show a replacement of their historical biography (based on real life events) with another biography (more symbolic and mythological), which, mixed with residual aspects of their infant pseudo-memories, hands on common archetypes of the history of humanity (such as the eternal fight between Good and Evil, a divine rebirth or metamorphosis).

Conclusions

Apart from a small literature on "late-onset paraphrenia", whose links with paraphrenia as a whole are unclear (13), few systematical studies on paraphrenia in the past half-century or more are available. This article reports the case of another type of "paranoid

disorder", which does not fit into the DSM-IV-TR delusional category and which is not schizophrenic, but yet often diagnosed as "psychotic disorder not otherwise specified" for the lack of a specific diagnostic niche. Nowadays, several authors (14, 23, 55) suggest that the concept of paraphrenia has not lost its usefulness. It appears that some psychiatrists recognize the illness, but label it as "atypical psychosis", "schizoaffective disorder", "delusional disorder" or "psychotic disorder not otherwise specified" for the absence of a better diagnostic category.

In summary, we propose that paraphrenia («...the uncertain group» described by Kraepelin in 1913) (4) can be a recognizable and viable diagnostic disorder, and that practitioners (bent on accurate diagnosis) should be able to designate it as such. This suggestion would enhance research and clinical care in the field of paraphrenia. Removing a subgroup from the heterogeneous categories we call schizophrenia and delusional disorder would also make research on paraphrenia more straightforward.

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