Paul Sérieux (1864–1947)

Paul Sérieux was born in Paris. His father came from Alsace-Lorraine and his mother was English. He was attracted to psychiatry from the beginning of his medical career and was a pupil of Gaétan Magnan, one of the most influential of late 19th century French psychiatrists. He travelled widely in Germany, Italy and Switzerland and was a keen advocate of Kraepelin's ideas on dementia praecox at a time when French psychiatrists were antipathetic to them. Like other French psychiatrists whose articles are translated in this volume, he was interested in forensic psychiatry. He also wrote on the historical aspects of his subject, arguing, against established opinion, that the French Revolution had disrupted the rights of the insane and made their plight worse.

The monograph which he wrote with Joseph Capgras is a masterpiece of clinical observation combined with theoretical interpretation. The bulk of this study is translated here. More than many of the other so-called 'atypical psychoses' it deserves to be seriously considered in many cases of what are loosely termed paranoid illnesses.

Joseph Capgras (1873–1950)

Joseph Capgras was born in Central France and studied medicine in Toulouse. His cousin, who was a doctor, steered him towards psychiatry. He worked in several mental hospitals around Paris, and was then appointed to the staff of St Anne's Hospital in Paris, one of the most important psychiatric hospitals in France, where he remained until his retirement.

In addition to the present article, he is celebrated for giving a description of the syndrome which now bears his name – the Capgras Syndrome or the illusion of doubles. He was much honoured in his life-time and was an outstanding clinician and teacher.

Misinterpretative delusional states

P. Sérieux and J. Capgras (1909)
(*Les Folies Raisonnantes: le Délire d'Interprétation*, pp. 5–43. Paris: Baillière)

Introduction

A category of 'systematised delusional states', equivalent to the term 'paranoia' in other countries, has long been recognised in France. These can be acute or chronic, primary or secondary, and can occur with or without intellectual impairment. They are characterised in the main by organised groups of more or less coherent delusions relating to fantastic or absurd themes, which appear genuine to the subject. They are subdivided according to content into delusional states of persecution, grandeur, jealousy, mysticism, eroticism or hypochondria. Nowadays, however, we cannot establish the autonomy of a psychosis on the basis of delusional content alone. It is necessary to study the particular grouping of the symptoms and the full evolution of the morbid condition. As far as possible, we should try to take account of their causes and their development in the light of current psychiatric knowledge. Consequently, 'systematised delusional states' constitute no more than a morbid state which can occur at the beginning or during the course of a variety of mental illnesses.

Acute or secondary delusional states are certainly not discrete entities. The delusions are polymorphous and lack organisation; they are accompanied by excitement, depression or confusion and both their onset and termination are rapid. They may appear in the course of dementia, delirium of infective or toxic origin, certain personality disorders, affective psychosis or dementia praecox.

Chronic systematised delusional states can, however, be subdivided into two groups. The first comprises those acquired psychoses which profoundly alter the mental functions of a subject and lead sooner or later to dementia. The second group contains constitutionally determined psychoses, exaggerations of the personality which remains essentially intact. They do not lead to intellectual impairment. It is this second group which we intend to subdivide, and to identify within it a discrete nosological entity which we shall call *chronic psychosis based on delusional misinterpretation* or, in brief, *misinterpretative delusional states* by reason of their most salient feature. There are other important characteristics but, unlike the systematised psychoses which progress

to dementia and originate from a disorder of perception, the states which we are considering here are almost exclusively based on delusional misinterpretation. Hallucinations, when they occur, are episodic and play almost no part in their development.

Before we outline the characteristics of this condition, we should define what we mean by delusional misinterpretation. This is a form of false reasoning, having as its point of departure a real perception, something that really happened. By virtue of its emotional associations, it then, aided by erroneous inductions or deductions, takes on an intense personal significance for the subject.

Delusional misinterpretation should be distinguished from an hallucination, which is a perception without an object, and from an illusion, which is a perception corresponding inadequately with its object. A mystic who sees the Holy Virgin appearing to him in the dark is experiencing an hallucination. Don Quixote, when he takes windmills for giants, is the victim of an illusion. We restrict the term 'illusion' to an error of the senses, although others have regarded 'misinterpretations' as 'mental illusions'. One should also beware of mistaking a misinterpretation for an hallucination; one patient, for example, claimed to have heard certain insulting words, but in the case of a misinterpretation words of some sort had actually been uttered.

Delusional misinterpretation should also be distinguished from a delusional idea, which is a false concept created out of many constituents, or at least not deduced from an observed fact. To quote Régis: 'The first is an exact point of departure, whereas the second is erroneous in its entirety; a delusional misinterpretation is to a delusional idea rather as an illusion is to an hallucination'.

It is not so easy to separate a delusional misinterpretation from a false interpretation or error. Several writers have produced useful lists of differentiating features, but none of these is entirely reliable. An error has been considered rectifiable, a delusional misinterpretation incorrigible. An error is usually isolated, circumscribed; a delusional misinterpretation tends to become diffuse and associated with analogous ideas to form a system. An error has not the self as its object; a delusional misinterpretation has, and is characterised by its markedly egocentric nature. An error does not usually have repercussions for the behaviour of a subject and often remains theoretical; a delusional misinterpretation tends to be acted on, and to orient and dominate behaviour. An error is made by a normal brain and a normal personality; a delusional misinterpretation appears on a pathological background. It is not true, moreover, that delusional misinterpretations are always recognised as absurd and unacceptable by sane people; some of them are more reasonable than many errors, and have been taken up by sensible and intelligent people.

Such affectively determined judgements are common to a variety of psychoses, and also occur in states of heightened passion; a slight emotional upset or a troublesome idea may serve to provoke them. For this reason one cannot regard the presence of delusional misinterpretations alone as a diagnostic criterion for a particular morbid entity.

We define a *misinterpretative delusional state* as: *a chronic systematised psychosis characterised by: (1) multiple and organised delusional misinterpretations; (2) the absence or infrequency of contingent hallucinations; (3) the preservation of clear consciousness and other psychological functions; (4) the progressive extension of the misinterpretations; and (5) a chronic unremitting course without a terminal dementia.* It is a functional psychosis whose origin is to be found, not in the action of a toxic agent, but in a psychopathological predisposition arising out of an anomalous development of those cerebral association areas which subserve judgement, critical sense and emotion. Essentially it is a congenital degenerative malformation.

The misinterpretative delusional state is one of the psychopathological conditions which are artificially grouped under the heading of *'folies raisonnantes'*, i.e. insanity based on faulty reasoning. Except for their 'partial delusions', subjects with this disorder retain their mental capacities and preserve their mental energy, often with remarkable skill when it comes to discussing and defending their beliefs. They hardly deserve to be called insane in the strict sense of the term because they remain in touch with their surroundings and retain the appearance of normality. Some never become psychiatric patients but only draw attention to themselves by their eccentricity. Most of them are admitted to hospital, however, not because of their ideas, but because their violent and impulsive nature renders them dangerous to other people. If one gets to know them or reads their letters or memoirs, one realises that none of their ideas is entirely unreasonable. If anything, one is struck by the logic of their opinions, the normal train of associations and the accuracy of their memory, as well as by their lively curiosity and their intact, sometimes penetrating, intelligence. One can find no evidence of active hallucinations, depression, confusion or loss of emotional responsivity. Detailed and repeated examination may be necessary to elicit the morbid ideas.

Some patients put forward quite plausible, even legitimate, complaints. A woman may accuse her husband of immoral behaviour: he

has deceived her, is trying to poison her, has squandered her money and confines her to the house. A man may complain of injustice by his superiors, hostility from his colleagues and insinuations and malevolent allusions by those around him. Someone of humble birth may try to prove their connection with a titled family.

Some patients seem only to make false judgements; everything that happens is viewed from a special angle; everything is made to fit one fixed idea which is based on a false premise. Their delusional concepts remain reasonable given this first faulty step, and there is no general impairment of logical thinking.

Other patients, no different from the former in any essential respect, present their arguments in a more peculiar way. Their view of the world, although retaining an appearance of logic, becomes more and more bizarre. It soon becomes apparent that their ideas are fuelled by pathological imagination. One such patient, for example, took another inmate for a spy; nurses were police in disguise; and he soon concluded that he was surrounded by agents provocateurs in the pay of his enemies. He maintained that for a long time he had been plagued by a multitude of vexations. People were following him, whistling at him, brushing against him and spitting on him; they were making menacing gestures; they would scratch his face or touch his hands, and a woman had lifted up her skirt in front of him. During the night, doors and windows would be opened and shut to keep him awake. Various complicated obstacles were put in his path to cripple him. Why did people hang around in groups in front of a newspaper kiosk? Was it to keep him from reading certain things? He knew that newspapers were full of allusions to him, barely disguised by means of pseudonyms. His own picture appeared in the newspapers, and announcements were made about him. He was famous, he had been honoured in certain circles, a minister had taken notice of him and a woman from the nobility had looked at him with a maternal air; he must be of noble birth himself. One tries to reason with him on these matters in vain; he claims to have ample evidence to support his case.

Clinical conditions resembling our concept of misinterpretative delusional states have been noted by several French authors. Some have placed the condition along with systematised hallucinatory states, on the grounds that there is a perceptual disorder. Other psychiatrists have regarded cases with aggressive outbursts and persistent claims of injustice as representing a form of paranoia. Others have attributed clear-cut cases of what we are describing to a certain kind of personality disorder.

In our view, however, misinterpretative delusional states deserve a distinct place amongst the large group of personality disorders. They are also radically different from delusional states based on hallucinations. As for regarding them as a form of paranoia, this is an inadequate formulation because paranoia is such a heterogeneous collection of quite separate conditions . . .

In this study we shall restrict ourselves to subjects whose mental state highlights what we regard as the crucial feature of misinterpretative delusional states, namely, the pathological nature of their reasoning . . . In this way we hope to justify the autonomous position that we are claiming for these states in psychiatric classification.

Symptoms of misinterpretative delusional states

The condition is characterised by the presence of two sorts of apparently contradictory phenomena . . . On the one hand, there are positive symptoms, which owe their development to delusional misinterpretations and ideas. On the other hand, there are negative symptoms: integrity of intellectual functioning, and the absence or rare occurrence of hallucinations . . .

Delusional ideas

On cursory examination the delusional ideas appear to constitute the principal symptom, particularly the fantastic themes of their content.

Usually there are ideas of persecution or grandeur, alone, together or in sequence. Ideas of jealousy, mysticism and eroticism are frequent. Less common are hypochondriacal ideas, and occasionally there are ideas of self-accusation. The least frequent of all are ideas of possession. One never sees nihilistic ideas.

The content is of little account in understanding the nature of their delusions. What is important, and common to them all, is the way the patients defend their inventions with the help of arguments derived from reality. Although this is sometimes done in a fanciful way, most of their reasoning draws on the ordinary, the possible and the reasonable: teasing, prejudice, theft, poisoning. They never refer to supernatural powers.

The way in which these ideas coalesce into a system is very variable. It is sometimes rapid, sometimes slow; the system can be precise and incorrigible, or rudimentary and with an element of doubt; it can be poorly formulated or exceedingly complex. If the system is loosely held together, it can disturb the subject by raising numerous doubts. In

some cases, it is less a question of delusional conviction than of delusional doubt; unreasonable facts are treated as possible rather than certain.

These delusional ideas are often kept secret by the patient. This is so common that one can almost regard it as a symptom. The patient so distrusts those around him that he only intimates his true thoughts by allusion and innuendo. Usually when he is first admitted to hospital he is excited and garrulous, but soon settles down to become virtually mute. This attitude poses a number of problems for the doctor. One woman kept her delusion of grandeur secret for a year, and it only emerged in her writings. A paranoid patient of Séglas and Barbé kept his delusion to himself for five years. This pattern is particularly frequent in delusions of grandeur. Sometimes these are kept hidden because the patient is aware of how unreasonable it must seem; a megalomaniac, who finally admitted that she was the sister-in-law of the King of England, added: 'I didn't talk about it because I would have been thought mad; it's so ridiculous'.

Delusional misinterpretations

Such patients do not invent what happens to them; the events are not merely figments of their imagination or fabrications of a pathological mind. The process which leads to delusions involves the distortion, dressing up and amplification of real events; the delusion is therefore more or less exclusively based on phenomena which really occurred in the outside world or in their internal world of feelings. A glance, a smile, a gesture, the cries or songs of children, a neighbour's coughing, the whispering of passers-by, a piece of paper found in the street, or an open door can all be the pretext for their misinterpretations.

The more insignificant it seems to others, the more it stands out to these patients. Where others see only coincidences, they uncover a secret truth. This ability to pick up hidden allusions, to understand insinuations and double meanings, and to interpret symbols only serves to confirm to the patient his superiority in these matters: 'I understand', he will tell us, 'things which no one else does'.

Two of Régis' patients illustrate this point very well. One said that: 'Because fate has bequeathed to me such a penetrating insight and made me always want to look beneath the surface of things I feel as if I should live alone and away from the world'. The other described how she would construct an entire sequence of events from only one fact, and how certain expressions in her conversation seemed to her as if she had guessed what she was going to say. She felt that she could predict

the flow of an argument from the outset. She felt the need to offer explanations to her companions on all sorts of subjects and then interpret what followed in a certain way.

If an explanation does not spring to mind the patient will interpret this itself as significant. People, they mention, are trying to muddle them or make them lose their sense of direction. They must keep a wary eye open for such traps. Sometimes this tendency to see symbols everywhere spreads to involve their own language and behaviour. They resort to ambiguous phrases and express their thoughts in puns and riddles. A paranoid patient who had just shot someone left in front of his victim's house *'un morceau de cerceau'* [a piece of a child's hoop – untranslatable alliteration – Tr.].

Their skill in these matters appears boundless. We shall now examine the two principal ways in which misinterpretations are established, consolidated and amplified. The first we shall call *exogenous misinterpretations* – based on things which have occurred in the external world. The second – *endogenous misinterpretations* – originate from internal sensations, functional disturbances of the brain or altered states of consciousness.

Exogenous misinterpretations

Here everyday happenings are the source of most misinterpretations. A jostling in the street is a sign of impending attack. A stain on the patient's clothes is taken as a grave offence on his person. If his trousers, shoes or tie become torn or damaged this is part of a plot. If someone fails to shake their hand or does so without warmth it is an intentional slight. A dustcart passing along the street signifies malign intent. Nothing escapes their ingenuity. What do these sheets hanging out mean? Or those red curtains in the windows? Or marks on their photographs discovered after a lengthy inspection? If someone tells them about a cataract operation they are trying to suggest that they are blind to the infidelity of their partner. They are asked if the river in their home town has plenty of fish in it; this is an insinuation that they are a 'maquerau' [mackerel but also colloquially a ponce – Tr.]. Why was the son of that civil servant given the *Malade Imaginaire* to read when his father was about to take sick leave? Why do their colleagues tap their canes in that way? One woman concluded that her husband was about to leave her because she received a letter with two five centimes stamps on it instead of one of ten centimes. Another saw some shiny shoes in a shop window which he took to mean that he was a homosexual. Yet another had a special meaning for each colour: pink meant that she was

going to kill a 'baby'; white stood for her lover, Mr Blan . . . [blanc = white, Tr.] . . .

The behaviour, gestures and facial expressions of those around them play a considerable role in their misinterpretations. 'Why,' asked one patient, 'do people keep touching their eyes unless it is to tell me that I am blind? And whenever I look at the expression on Mrs A's face and particularly the way she places her finger near her nose to make a pattern as if opening a bottle of wine I wonder whose unsuspecting but nevertheless malign accomplice she is. Can it be chance or is Mrs B looking at me all the time, staring at me across the room, following my every move, and yet all the time pretending to be busy with something else?' The same patient would interpret crossed arms as meaning that her child was still alive. If people scratched their forehead it was an allusion to Mr X; if they touched their neck the gesture referred to Mr Y. The drumming of fingers on the table indicated something else. One, two or three coughs had their separate meanings, all to do with scenes from her childhood. A patient of Deny and Camus learnt by heart a book in which a particular meaning was attached to everyday objects: a needle stood for injury, an umbrella for protection, a broom for change, etc. She then made up her own symbolic language.

It is usually the most trivial incidents which lead to the most extraordinary conclusions. For example, a young woman received several glances from an actress and concluded that she was her daughter. Certain erotic delusional states are entirely based on the supposed significance of facial expression; this fact is, of course, used to good effect by playwrights and poets . . .

Sometimes the source of misinterpretations lies in important events: domestic tragedies, bereavements, unpleasant incidents. Subjects attribute the death of a parent to poisoning or to criminal activity. Some patients use national or international events as their starting point: their letters to ministers and sovereigns have decisive influence on diplomatic affairs; on their advice Russia and Japan have signed a peace treaty; their help allowed the King of England to accomplish certain missions; their money has financed several business ventures. A patient of Joffroy is interesting from this point of view. His delusional system had for a number of years been solely concerned with contemporary events: wars, catastrophes, affairs of state, sensational trials. The Dreyfus affair, the Boer War, the Russo-Japanese War, the relationship between Church and State and ministerial crises all parodied his own petty quarrels on a grand scale.

The most important symbol of all for these patients is language. They

may see a personal reference in things which they hear in the street; 'Fire', 'Idiot', 'Charenton-Vincennes'. Joffroy regarded as particularly striking their habit of prefacing statements with the phrase: 'Someone told me.' Nothing annoys them more and makes them lose faith in their doctor more quickly than if they think that what they claim to have heard is taken for an hallucination.

A single innocuous phrase can give rise to the most outrageous suspicions. One patient, on being shown a portrait of a king, was told that she must surely know who it was, and concluded that it was her true father. Another heard a woman in the street saying to her child, 'Your hair looks smart', and took this to refer to his own condition . . . When out walking with his fiancée he overheard two remarks made by another couple: 'She's not for you' and 'Fashionable and enticing'. He interpreted these as comments on his engagement . . .

Sometimes the expressions that they hear take on a symbolic meaning, and they construct arguments out of the interplay and punning of these. The word 'cock' signifies pride, 'pear' an imbecile and 'rice' means that someone is laughing at them [riz = rice, rire = laugh, Tr.] . . .

Misinterpretations based on puns are often constructed from proper names. An intelligent woman believed falsely that her daughter Marie had been raped. She encountered a nurse in the hospital by the name of Marie Potin, which she took as an allusion to the rumours she had been accused of spreading about her daughter [potins – gossip, Tr.] . . .

Written material is also a potent source of misinterpretations. A particular turn of phrase, the style of the handwriting, an underlined word, spelling mistakes, punctuation or the form of the signature can all evoke suspicion. One patient told us: 'My son finished writing his name with a "u" not an "n". He has never written like that before'. Another patient thought that she recognised two styles of writing on the envelope. Another considered one of the full stops too heavy, and concluded that this negated what had been a friendly greeting.

Newspapers furnish some of the best material for such misinterpretations. Patients discover articles about themselves or messages addressed to them in the correspondence columns. There are pictures of their enemies under a false name. One patient took a picture of the King and Queen of Italy for his wife and her supposed lover . . .

Some see a complicated pattern of codes, riddles and 'interesting hieroglyphics' in newspapers or letters. They analyse, comment and translate what they see as hidden formulae. They do this in a way

reminiscent of code-makers who hide certain words and leave only those which they want to form their message . . . One patient underlined the following letters in a phrase from her mother's letter: 'Tu oublies toi même' producing 'Tue-toi' [You forget yourself – kill yourself, Tr.].

Some patients go to the length of maintaining that an edition of the newspaper has been specially printed for them. 'In June 1900', wrote a patient of Legrain, 'although a regular subscriber to the newspaper Matin, I suddenly received a number of issues of this containing articles which told me quite clearly that I was the emperor of Germany. I then went to the offices of the newspaper to look up the same issues, but I could not find those articles in them. From this I concluded that an extra edition had been printed especially for me'.

Endogenous misinterpretations

(a) *Misinterpretations based on an underlying organic state.* To the numerous provoking causes emanating from the external world we also have to add *internal sensations*. The term 'somatic introspection' used by other authors is usually the expression of a misinterpretative delusional state.

A patient's deductions may arise not from any morbid trouble in his surroundings but from a detailed examination of the workings of his body. He considers certain somatic observations to be pathological simply because he has not noticed them before. Physiological phenomena, such as fatigue or an erection, serve as the point of departure of his misinterpretations. One of our paranoid subjects blamed the doctor for 'pricking feelings' and 'disordered movement' which he felt in his limbs; if, after reading his newspaper, he felt tired, this was because he was hypnotised; his wet dreams were evidence that he was being made to ingest substances without his knowledge. A woman explained her feelings of sexual arousal as the influence of some foreign and occult agent; she accused various people of having a distant effect on her genital organs.

Some patients regard poison as the cause of their condition, when it is in fact neurasthenia, tuberculosis, indigestion or colitis. During a bout of gastritis one patient believed that she had swallowed some arsenic. Another related the following experience: 'At night I am woken up by an indefinable sensation, like the rush of some fluid which relentlessly floods into my forehead, my temples and my brain; next, I feel torturing bursts of pain and buzzing in my ears. It is like molten lead or quicklime surging through my veins. It is worse after meals and in the morning, and at this time I feel as if unbelievably cruel acts are being performed'. Muscular spasms, twitches and cramps are attributed to electric currents, and insomnia, profound sleep or sleepiness after meals to drugs. During an attack of tonsillitis one patient wrote: 'I am at this moment the victim of violent changes in my throat and tonsils. Whenever I comb my hair, someone makes it all fall out. The barber scratched my face four times this morning: he is trying to make me look old; my hair is already grey like an old man; they're trying to soften my teeth to prevent me chewing properly; my blood is getting thin and I'm getting eczema as a result of all these foul things being done to me. It is only because of my personal hygiene and the strength of my constitution that I keep control of my physical and intellectual powers'.

Women may explain their menstrual problems and menopausal changes in terms of intervention by their enemies. One of our patients attributed her hot flushes to jets of fluid being played on her: 'Someone is wrinkling my skin, turning it yellow, making my cheeks hollow and pricking my eyes' . . .

(b) *Misinterpretations based on an altered mental state.* Certain altered states of consciousness and certain functional disorders can exacerbate misinterpretations. Some patients are surprised to find themselves assailed by unaccustomed thoughts or see a connection between these thoughts and events occurring at the same time. One patient was thinking of Marshal Biron, a traitor who was born in his part of the country, when at the same moment his brother walked in: he concluded that his brother had betrayed him and was his wife's lover. 'How', he then said, 'could I give an account of my whole life to my wife as if she were a confessor? It's strange. I feel as if I am being driven mad.' Another patient surprised himself by making extraordinary confessions to his parents. He felt that by such a means he was being forced to reveal his soul. Some seek, in similar ways, to understand certain feelings. If surprised to find that they have no affection for their mother, for example, they conclude that they are not a real son . . .

It is not only emotion, fatigue or nervous exhaustion which can give rise to misinterpretations. One of our patients remarked that each time he came before a magistrate he lost all his capacity for thought, would stammer and was unable to give an account of himself. He wondered what had been done to him to produce such a state. Another patient could not understand why he was so fainthearted; someone must have projected rays on to him to make him feel afraid . . .

In other cases, acute delusional states or depression supervene in the

course of their condition and are interpreted as episodes of madness due to poisoning or certain suggestions.

Some patients go so far as to misinterpret previous occasions when their delusional state was particularly active.

Finally, some delusional ideas borrow their content from dreams. A patient with the mystical variety of the condition justified his preoccupation with certain themes by the nocturnal terrors he had experienced as a child. A German woman, named Katzian, had the revelation that she was not a member of the family of that name; she saw in a dream her father in prison, with a dog, a symbol of fidelity, on his right, and a cat, a symbol of faithlessness, on his left; she concluded that she was a false *'Katzian'* (*Katz* – cat in German) . . .

Nature and formulation of the delusional ideas

Contemporary psychiatry attaches no nosological value to the nature of the delusional ideas or to the behaviour which arises from them.

The nature of delusional ideas varies, even within the same type of psychosis, according to individual factors which make up a person's psychological orientation: personality, intellectual level, inclinations, habits, education and the vicissitudes of life. All these intervene to steer the predisposed individual towards ideas of grandeur, persecution, mysticism or eroticism.

Accessory influences such as the type of schooling, cultural background, beliefs, occupation and above all social milieu also play a part. More than other psychiatric conditions, misinterpretative delusional states derive most of their content from real events – economic facts, political struggles, and scientific and industrial advances. The concerns of our patients reflect the epoch in which they live; the devils and witches which tormented paranoid subjects in the Middle Ages have given way in our day to Jesuits, Freemasons and policemen. Some people have a mentality akin to those who have lived in an earlier epoch, and they, and others who take an interest in the occult sciences, may exhibit a mixed picture of modern and medieval preoccupations.

The reactions of patients in response to their misinterpretations can also be formulated in terms of their personality . . . Apathetic and impulsive individuals may interpret an event in the same way, but react to it in opposite ways, by flight or aggression respectively. Some paranoid subjects are resigned to their fate, others fight it . . .

The predominance of a particular category of ideas gives each patient a distinctive pattern to his condition. Seven types of misinterpretative

delusional states can be distinguished: persecutory, megalomanic, jealous, erotic, mystical, hypochondriacal and self-accusatory. It is exceptional to encounter any of these in a pure form, as usually two ideas become associated in the mind of a patient through either their contrasting or their similar qualities, and a crowd of further ideas produces a heterogenous collection of themes. The most frequent combination is that of grandiose and persecutory ideas. Sometimes one of the pair remains in embryonic form: for example, a persecuted individual with a streak of vanity will explain the miseries which he is undergoing in terms of the envy which brings out his grandiosity; or an ambitious person will complain of hostility from certain people. Often the two associated themes are equal in intensity and the misinterpretations serve to satisfy fear and pride to an equal degree. The idea of jealousy is rarely found on its own; it usually derives from a sense of persecution. An erotic delution can be combined with one of jealousy and persecution. The mystical subject, usually afflicted by a special form of megalomania, often feels persecuted. The hypochondriacal notion is commonly episodic and has its origin in ideas about persecution. Self-accusatory ideas are ordinarily a special form of persecution . . .