Paranoid Delusions vs. Paranoid Ideas vs. Overvalued Ideas

Delusions have been traditionally conceptualized as unshakable false beliefs that are held despite evidence to the contrary and despite the fact that there is no logical support for the beliefs. Delusions were thought by many to occur only in the setting of the schizophrenic process, or of certain cerebral disorders, such as in the course of some epilepsies. When delusions occurred in other mental illnesses, their origin and content could often be derived from the patient's situation, psychological difficulties, or prevailing abnormal mood. False beliefs of this kind were distinguished from true delusions by use of the term *delusional ideas*. McKenna (1984) made the distinction between *delusional ideas* and *overvalued ideas*, which are fixed and dominating convictions. These are sometimes seen in abnormal personalities, but are often seen in normal people whose lives are completely taken up by religious concepts, political ideas, or excessively idealistic beliefs. Being in love can also become an overvalued idea. Occasionally, these ideas are the precursors of delusional ideas.

DSM-IV-TR describes the concept of an over-valued idea as "an unreasonable and sustained belief that is maintained with less than delusional intensity (i.e. the person is able is to acknowledge the possibility that the belief may or may not be true). The belief is not of one that is ordinarily accepted by other members of the person's culture or sub-culture" (American Psychiatric Association, 1994). The definition is echoed by a number of American authors (Hollander, 1993; Kozak & Foa, 1994; Neziroglu, McKay, Yaryura-Tobias, & Stevens, 1999; Phillips & McElroy, 1993) who emphasise the *strength* of a belief as one of the key criterion for an over-valued idea. The term 'over-valued idea' has thus become a shorthand for *poor insight* in the middle of a continuum of obsessional doubts to delusional certainty. In this continuum patients at one end of the continuum with obsessional doubts are regarded as having *good insight* and those at other end of the spectrum with delusions have *no insight.* DSM-IV adds one other criterion: that the belief is abnormal compared to other members of the person's culture.

The older European concept of an over-valued idea is, however, broader and emphasizes a number of dimensions other than the strength of the belief and abnormality (Wernicke, 1900; Jaspers, 1959; Hamilton, 1974; McKenna, 1984). An over-valued idea was generally conceptualized by such authors as an isolated sustained belief, which are as follows:

- Is held *strongly,* with less than delusional intensity.
- Usually *preoccupies* the individual's mental life, compared to many delusions.
- Is *ego-syntonic,* compared to most obsessions. d. Often develops in an *abnormal personality.*
- Is usually *comprehensible* with knowledge of the individual's past experience and personality.
- The content is usually regarded as abnormal compared to the general population (but not bizarre as some delusions).

- Causes disturbed functioning or distress to the patient and others.
- Is associated with a *high degree of affect* (e.g. anxiety or anger when there is a threat to the loss of their goal or object of the belief).
- Compared to many delusions, is more likely to *lead to repeated action* which is considered as justified.
- Could progress to a delusion.
- Patients may not to seek help from mental health services but may be brought to the attention of the services by a concerned relative or another agency.
- Have some similarities to passionate religious or political convictions where the individual usually remains functional.

This does not mean that these criteria are a checklist for whether a belief is an over-valued idea or not. It describes how over-valued ideas were historically conceptualized and described by various European authors. It is therefore much broader than the more recent American definitions. An example of how an over-valued idea fits with the European description is in anorexia nervosa in which an underweight individual may believe she is too fat. Such patients may hold such beliefs with extreme tenacity but they are not considered delusional. This may however be the bias of a diagnostic system, which dictates that such beliefs cannot be delusional because anorexia nervosa is not a psychotic disorder. Such beliefs preoccupy the individual's mental life and can be described as ego-syntonic. Anorexia Nervosa often develops in an abnormal personality (especially obsessional, histrionic, and schizoid) (Smart, Beumont, & George, 1976), and is generally understandable with knowledge of the individual's past experience. The desire for slimness is not abnormal compared to the general population but the need for the degree of self-control is abnormal. There is a high degree of affect when the goals are threatened. Such beliefs cause impaired functioning with a high mortality and are a great distress to others. The belief is acted on repeatedly with further dieting and exercise to lose weight. A minority may progress to other delusions of schizophrenia (Hsu, Meltzer, & Crisp, 1981, 1983). Lastly it is the relatives of such patients who may force patients to seek help.

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