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Comments on the content of persecutory delusions: Does the definition need clarification?

Daniel Freeman*

Department of Psychology, Institute of Psychiatry, King's College London, University of London, UK

Philippa A. Garety

Department of Academic Clinical Psychology, GKT School of Medicine, King's College London, University of London, St. Thomas' Hospital, UK

Diagnostic criteria for subtypes of delusional beliefs based upon content have rarely been the subject of comment. In this article, several influential accounts of persecutory delusions are reviewed; differences and difficulties are noted, and their potential effect on cognitive psychological investigations discussed. One method of ensuring that researchers study similar phenomena is to use a more detailed definition than currently available, and therefore a new set of criteria is offered. Finally, related methodological problems in this emerging research area are highlighted. The issues discussed may stimulate further research on the content of delusional beliefs.

A key advantage cited for the single-symptom approach to psychosis is that it isolates single elements of psychopathology for study, thereby avoiding the problem of misclassification which has troubled diagnostic categories such as schizophrenia (Persons, 1986). In the last 10 years, researchers have increasingly adopted the single-symptom approach, and this has facilitated greater theoretical understanding of important phenomena, such as delusional beliefs (e.g. Bentall, Kinderman, & Kaney, 1994; Garety & Hemsley, 1994; Trower & Chadwick, 1995). In a recent article, the present authors reviewed the evidence for contemporary cognitive theories of delusional beliefs (Garety & Freeman, 1999). It was argued that research in this area now needs to focus upon detailed issues concerning changes in delusions over time, the multi-dimensional nature of delusions, and the differences between factors responsible for the formation, maintenance, and appraisal of delusions. This level of theoretical work, teasing out key cognitive processes, will require confidence that researchers are indeed isolating the same elements of psychopathology. The many conceptual difficulties in defining a delusion have been noted and have received attention elsewhere (e.g. Garety, 1985; Jones, 1999; Strauss, 1969). In this article the

* Requests for reprints should be addressed to Dr D. Freeman, Department of Psychology, Institute of Psychiatry, Denmark Hill, London SE5 8AF, UK (e-mail: D.Freeman@iop.kcl.ac.uk).

difficulties for the *subtypes* of delusional beliefs are highlighted with reference to persecutory delusions, the most frequently studied delusion subtype.

Definitions of persecutory delusions

The key early texts on schizophrenia and delusional beliefs contain descriptions of persecutory beliefs encountered in practice rather than detailed definitions, perhaps because of the perceived simplicity of classifying delusions by content. Two examples are shown in Table 1. As well as implicitly describing the nature of persecutory delusions (discussed in the next section), the clinical accounts illustrate that the subcultural context contributes to the content of delusional beliefs (e.g. the types of persecutor and persecution). That delusions can reflect the contemporary environment can also be seen in more recent descriptions of delusional beliefs such as the 'delusional dish syndrome' (Kidd, McGlip, Stark, & McKane, 1992), in which the appearance in the late 1980s of domestic satellite television dishes was observed to lead to their incorporation within delusional beliefs.

Table 1. Clinical accounts of persecutory delusions

The patient notices that he is looked at in a peculiar way, laughed at, scoffed at, that people are jeering at him, are spitting in front of him, the clergyman makes allusions to him in the sermon. He is grossly abused and threatened, his thoughts are influenced, he is surrounded by a 'spiteful revolution'. People spy on him; Jews, anarchists, spiritualists, persecute him, poison the atmosphere with poisonous powder, the beer with prussic acid, generate magic vapours and foul air, do not let him take a single good breath, try to wash him away with musk water. Kraepelin (1919)
The patient feels noticed, observed, put at a disadvantage, despised, ridiculed, poisoned, bewitched. He is persecuted by authorities or by the public prosecutor for crimes of which he is falsely accused by gangs, Jesuits, Freemasons etc. There are also delusions of physical persecution on the basis of bodily influences (false perceptions) and 'made' phenomena (passivity feelings), and querulant delusions about injustices, plots and treacherous manipulations.' Jaspers (1913/1963)

The drive from the 1970s onwards to diagnose schizophrenia more reliably led to the development of standardized instruments to assess the psychopathology and behaviour associated with psychiatric illness. Glossaries of definitions of symptoms were written. Table 2 contains three current definitions of persecutory delusions.

Are there difficulties with the definitions of persecutory delusions?

Unsurprisingly, there is broad agreement between the descriptions and definitions of persecutory delusions: individuals with persecutory delusions are concerned about others causing them physical, social, or psychological harm. It is likely that clinicians and clinical researchers will have been communicating about a broadly similar group

Table 2. Operational accounts of persecutory delusions

A delusion in which the central theme is that one (or someone to whom one is close) is being attacked, harassed, cheated, persecuted, or conspired against. DSM–IV (American Psychiatric Association, 1994)
Delusional belief that the self or people close to the self have been or might be assailed, tormented, cheated, persecuted or conspired against. Schedule for Affective Disorders and Schizophrenia (SADS) (Spitzer & Endicott, 1978) (extract from Winters & Neale, 1983)
Respondents believe that someone, or some organisation, or some force or power, is trying to harm them in some way; to damage their reputation, to cause them bodily injury, to drive them mad or to bring about their death. Schedules for Clinical Assessment in Neuropsychiatry/PSE-10 (WHO, 1992)

of individuals. However, on closer inspection there are discrepancies between the accounts, and points that require further comment, which could bear upon the study of underlying psychological processes. The issues to be highlighted are: what counts as persecution; persecutory intent; and the target, time frame, and severity of harm.

The first issue is the least complex, and concerns the potential inclusion in studies of participants with symptoms that are not directly persecutory. The clinical accounts in Table 1 both begin with a description of individuals with persecutory delusions feeling noticed or observed, and Kraepelin further notes that they believe that what is said may have coded meanings. These symptoms are all variants of delusions of reference. The clinical accounts also include examples of subjectively described thought disorder (e.g. thought insertion) and experiences of replacement of will by external forces (passivity phenomena). This wide-ranging conception of persecutory delusions is also illustrated in a more recent example taken from the *Comprehensive textbook of psychiatry*: 'Delusions of persecution, loosely known as paranoid delusions, include delusions of self-reference (ideas of reference), in which people take undue notice of or talk about the patient, and delusions of being influenced by outside forces or of being poisoned.' (Leon, Bowden, & Faber, 1989, p. 458). However, this conception of persecutory delusions is not consistent with the glossaries in Table 2. Although delusions of persecution are often closely linked to delusions of reference and anomalous experiences (i.e., persecutory delusions are often secondary elaborations of these experiences) there is a clear difference: only persecutory delusions concern harm. It is likely that the clinical accounts' wide-ranging conception of persecutory delusions has led to a number of research studies including individuals who believed that they were watched, or that their actions were controlled by others, but who did *not* believe that they were to be harmed. Therefore, individuals without directly persecutory symptoms may have been included in study groups. The use of the term paranoia has also contributed to the broadening of the symptoms included within comment and study of persecution. Paranoia has had multiple meanings (Manschreck, 1992). The term has been used to refer to ordinary

suspiciousness, to persecutory delusions, to delusions of persecution and delusions of reference, to persecutory and grandiose delusions, and to all types of delusions. Clearly, the direct study of persecutory delusions should only involve those individuals reporting beliefs concerning harm.

A report of harm, however, is not sufficient to conclude that a persecutory delusion is present: there is also the question of the persecutor's intent. There are individuals who report that harm is expected but who do not believe that the 'persecutor' means the action to cause distress. A patient may think that the harm is caused accidentally, or even that the perpetrator (mistakenly) means to be benevolent. There is ambiguity in whether such a belief would be included in the category of persecutory beliefs. However, we argue that an important element of persecution is that it must be believed that the persecutor *intends* their action to cause harm. For example, a potential participant in one of our studies was very distressed by the belief that his brother was deliberately cutting away parts of his brain. However, this person did not believe that this act was done maliciously; in fact, he thought his brother was trying to be helpful. This individual was not included in our study, because it was reasoned that the decision that a persecutory belief is present must not only be based upon the reporting of harm but also upon the believed intention of the perpetrator. Goldwert (1993) suggests that some individuals with the delusion that they are loved by someone who does not publicly acknowledge it view hospitalization as a 'benign conspiratorial persecution', in which the hospital tries to harden him or her so that they are worthy of the imagined lover. It is likely, as the issue is not made explicit in operational definitions, that researchers have sometimes neglected asking about the intention of the perpetrators, and therefore individuals have been included in studies when they did not believe that the perpetrators intended to harm them.

Apparent in the accounts is a discrepancy concerning the *target of threat*. The Schedule for Affective Disorders and Schizophrenia (SADS) and DSM–IV (American Psychiatric Association, 1994) allow for the harm to be targeted at individuals' relatives or friends only (see Table 2). The Present State Examination (PSE) guidelines do not. There is no data on the frequency of such a presentation. However, the target of threat may be an important variable that differentiates individuals: it is likely that believing oneself, rather than a significant other, to be the target of harm will produce a different experience. The PSE criteria, by concentrating on harm to the individual, is most consistent with the clinical accounts in Table 1.

There is also discrepancy in the accounts concerning the *timing of persecution*. The SADS criteria allow for individuals to believe either that harm is about to occur, or that it has occurred and will not happen again. Therefore, for example, the following two beliefs will both be counted as persecutory delusions: 'There is a conspiracy by my colleagues to make me look stupid so that I lose my job'; 'My colleagues deliberately made me look stupid so that I lost my job but now they have succeeded they are leaving me alone'. In contrast using the PSE criteria, only the former belief would be considered as persecutory, because there is the idea of future harm (i.e., of threat). This may be an important difference. Believing that harm will re-occur is likely to produce a different qualitative experience from believing that harm will not re-occur. Individuals with the former belief will feel more unsafe, and this is likely

to lead to changes in cognitive processing (e.g. stress-associated increases in psychotic processes, activation of anxiety-associated processes). A similar point can be made about delusions concerning current and ongoing harm (e.g. 'My persecutors are transmitting poison via a secret device in the wall and I am seriously attacked now'). Although such ongoing harm will be classified as persecutory by all the operational systems, it is probable that individuals with these beliefs will show differences in cognitive processing in comparison with individuals reporting past harm (or possibly even individuals reporting future threat). While some individuals do report concerns about previous perceived injustices, it is more helpful to view this as preoccupation with previous delusions, rather than to assume that they are identical to active persecutory beliefs concerning ongoing threat.

Finally, further comment is needed on the *nature of the persecution*. The clinical accounts in particular describe individuals who believe that they are the subject of extreme levels of harm, such as torture or poisoning. However, varying degrees of harm – from the mildly irritating (e.g. 'People are whistling to annoy me') to lethal (e.g. 'People are trying to kill me') – are reported by patients, and could all be viewed as persecution. It seems likely that some individuals have been excluded from studies because researchers (and the clinicians referring patients to researchers) have focused on high levels of threatened harm, or have concentrated upon physical forms of harm rather than social or psychological kinds. Moreover, low levels of persecution may have been eclipsed by other positive symptoms of psychosis.

Towards a more detailed definition of persecutory delusions

We have outlined a number of difficulties with existing definitions of persecutory delusions. Greater attention needs to be given to the concepts of harm and intent, and the target, time, and nature of persecution. The empirical significance of these factors is not known: one method to clarify the importance of the issues raised would be to study the influence of the variables of concern (e.g. the target of threat, the time orientation of threat, the nature of the threat, the intention of the persecutors). For example, there are a number of research questions concerning the nature of the threat. Are there differences in cognitive processes between individuals reporting physical threat and individuals reporting social or psychological threat? Does the severity of harm matter? If individuals reporting very low levels of harm (e.g. irritation) are found to differ from individuals reporting major harm (e.g. death), at what stage is a severity of threat threshold crossed? Interestingly, an additional benefit of the scrutiny of such variables may be a move towards greater study of the detailed content of delusions, as recommended recently by Birchwood (1999).

More simply, researchers could provide details of the content of participants' delusional beliefs with reference to the aspects discussed. Clearly it will also be useful to have a definition of the subtype of persecutory beliefs that addresses the issues raised in this paper. Therefore, in Table 3 a more detailed definition than currently available is offered.

Table 3. Criteria for a delusion to be classified as persecutory

Criteria A and B must be met:	
A.	The individual believes that harm is occurring, or is going to occur, to him or her
B.	The individual believes that the persecutor has the intention to cause harm
There are a number of points of clarification:	
I.	Harm concerns any action that leads to the individual experiencing distress
II.	Harm only to friends or relatives does *not* count as a persecutory belief, unless the persecutor also intends this to have a negative effect upon the individual
III.	The individual must believe that the persecutor at present or in the future will attempt to harm him or her
IV.	Delusions of reference do *not* count within the category of persecutory beliefs

Discussion

Clinical accounts, and definitions in diagnostic systems, have attempted to capture the rich variety of persecutory delusions: government plots and experiments, neighbourhood slander and deceit, evil spirits' acts of trickery and torture. While the dramatic clinical presentations may have contributed to such beliefs being the most experimentally studied of delusions, attention has been diverted from issues surrounding definition. We argue that there are some hitherto unconsidered difficulties in the assessment of persecutory delusions. Why is this issue of importance? Because it influences who is included and excluded from studies, and therefore may affect the results obtained. However, the extent of the problem is simply not known: many studies have not provided details of how the presence of a persecutory belief was decided, while the existing operation systems do not give attention to the issues discussed. To assist in resolving the problems, a more precise definition of persecutory delusions is offered. Provision of such criteria can be viewed as a pragmatic resolution of the difficulties highlighted. It is hoped that the use of such criteria would not forestall either investigations of the relevance at the cognitive level of the phenomenological aspects discussed, or clear description of the phenomenon that a research study is targeting. In other words, the criteria may serve as a means to select a more homogeneous sample of persecutory delusions, and thereby increase the rigor of experimental work, whilst also serving as an encouragement to examine dimensional content aspects of persecutory beliefs (such as the severity of threat, the imminency of threat, the intentions of the persecutors etc.). As Spitzer (1992) notes, 'There is more to say about delusions than that they are present or absent'.

A lack of clarity in definitions is not, of course, the sole potential reason for different research studies to be investigating different clinical phenomena. There are related methodological issues, which also require more serious attention. It is of note that studies of persecutory delusions have rarely provided details of participant recruitment, important dimensional aspects of delusional beliefs (e.g. conviction, preoccupation, distress), and of possibly influential co-morbid symptoms (other symptoms of psychosis, emotional disorder). Studies have not reported the number

of individuals who have refused to participate in this difficult area of research. However, it is likely that refusals are not uncommon and are highest for individuals at the most severe stages of illness, when delusional processes are most active, and this may distort research findings. The individuals most likely to refuse may have the highest delusional conviction, preoccupation and distress. Such data are reported rarely even for study participants, so studies may have differed in terms of these important variables. The multi-dimensional nature of the form of delusional beliefs should not be neglected by researchers. Furthermore, individuals with high co-morbid emotional distress may be more likely to refuse to participate in research, resulting in the influence of emotional processes on delusional beliefs being overlooked (Freeman & Garety, 1999). In short, a question to be posed of research studies is: how representative are the individuals included? Finally, consideration needs to be given to the other symptoms of psychosis present, including other types of delusional belief, which have often been neglected by the single-symptom approach. Researchers will need to examine the inter-relationships between psychotic symptoms, for example between persecutory delusions and delusions of reference. Just like the inconsistencies in the definitions of persecutory delusions, these methodological factors may make it difficult to refine the understanding of psychological processes in the formation, maintenance, and appraisal of delusional beliefs.

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