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Review Article

Disorders with Overvalued Ideas

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Summary: The overvalued idea, first described by Wernicke, refers to a solitary, abnormal belief that is neither delusional nor obsessional in nature, but which is preoccupying to the extent of dominating the sufferer's life. Disorders conforming to his definition are well documented, though their recognition as such has been variable, and they may not be as rare as is often thought. As well as sharing a distinctive phenomenology, the conditions develop in similar settings and carry a uniformly poor prognosis. Their pathogenesis is obscure and difficult to account for in conventional terms.

Though there had been earlier traditions of the "*idée fixe*" and "*überwertige Idee*", Wernicke (1900) established the concept of the overvalued idea, defining it as a solitary belief that came to determine an individual's actions to a morbid degree, while at the same time being considered justified and a normal expression of his nature. Wernicke was the first to distinguish overvalued ideas from obsessions, pointing out that they were never felt to be senseless by the sufferer, and he also differentiated them from delusions. He noted that overvalued ideas appeared in a variety of clinical settings, tended to develop in predisposed personalities, and often dated from experiences that at the time aroused strong feelings. An overvalued idea could sometimes progress to full psychosis or was occasionally a manifestation of melancholia or general paralysis.

Following Wernicke's description, though the term remains in routine psychiatric usage, there has been an almost complete disregard of the overvalued idea. The literature contains no specific articles on the subject, the topic is referred to only in passing in British textbooks, and is ignored altogether in American psychiatry. The only exceptions have been in the work of Jaspers (1959) and Fish (Hamilton, 1974; 1976; 1978): these writers commented extensively on overvalued ideas, describing them as isolated beliefs accompanied by a strong affective response, that took precedence over all other mental activity and maintained this indefinitely. The belief was generally associated with an abnormal personality, and grew out of adverse experience in a way that made it comprehensible.

Jaspers also provided a formal distinction of overvalued ideas from delusions. Delusions, he argued, were the result of a specific abnormal process whose basis was unknown but which seemed to involve a radical transformation in the way meaning became attached to events. Their quality was thus essentially distinctive, the conviction being alien, far beyond normal and incorrigible in a way quite unlike that of regular beliefs. In short, delusions were qualitatively different from normal beliefs. In contrast, an overvalued idea was an isolated notion strongly toned by an affect, leading the personality to identify itself with it. Its quality was thus similar to passionate political, religious or ethical conviction, and differed from this only in degree. Fish added that in delusions there was frequently a discrepancy between the degree of conviction and the extent to which the belief directed action, but the patient with an overvalued idea invariably acted on it, determinedly and repeatedly.

The overvalued idea thus describes an isolated, preoccupying belief, neither delusional nor obsessional in nature, which comes to dominate the sufferer's life, often indefinitely. In many cases it seems to develop, to some extent comprehensibly, out of a previously abnormal personality, but it can equally be a sign of emerging psychosis or organic disorder. The concept has a reputable, but neglected tradition and carries an air of being of limited clinical relevance.

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In this review it is argued that disorders continue to be seen whose distinguishing feature is the development of an overvalued idea, that these cannot be accounted for in any other way, and that they are not as rare or exotic a phenomenon as is commonly supposed.

The querulous paranoid state

Despite its rarity and the lack of any detailed description since Kraepelin's (1905), this syndrome remains the standard clinical example of an overvalued idea. Following an occurrence that is often trivial, but which is viewed as a slight or injustice, the patient becomes convinced that he has been treated unfairly and begins making complaints. Any settlement, no matter how generous, is felt to be unsatisfactory and he takes his complaint to increasingly higher authorities until eventually the law is usually involved. The patient then proceeds to drag his case from court to court, supporting it with a growing body of one-sided interpretations of events, and denouncing judge, jury and his own legal advisors when the verdict goes against him, as by this stage it invariably does. He neglects all other business and spends money regardlessly, determined to fight to the end; when all legal means have been exhausted he resorts to other measures such as writing to legislators and heads of state, their rejections only creating more bitterness.

The unusual character of the preoccupation was vividly conveyed in Kraepelin's (1905) description:

> The innumerable petitions which the patient has drawn up in the course of the last few years, chiefly at night, are exceedingly long-winded, and always allege the same thing in a rather disconnected manner. In their form and mode of expression they incline to the legal document, beginning with "Concerning", going on throughout with "evidence" and concluding with "grounds". They abound in half or wholly misunderstood professional expressions and paragraphs of totally different laws. Often they are careless and appear to have been written under excitement, contain numerous notes of exclamation and interrogation, even in the middle of a sentence; one or more underlinings, some in red or blue pencil; marginal notes and addenda, so that every available space is made use of. Many of the petitions are written on the backs of judgements and refusals of other courts.

The condition is agreed on as generally arising in individuals with previously well marked abnormalities of personality, typically paranoid or hyperthymic (Jaspers, 1959; Mayer Gross *et al*, 1969; Hamilton, 1976), and though it may get progressively worse, tends to remain a stable, isolated abnormality with no evidence of spread of the ideas or deterioration in personality. The ultimate outcome is poor if not tragic: Kraepelin's patient brought his family to ruin, and the case quoted by Jaspers, after a ten year struggle for justice, committed suicide, first sending notice of the event to newspapers. In a minority of cases the illness evolves into a psychosis (Hamilton, 1976) or possibly an organically impaired state (Kraepelin, 1907), and a few give the impression of having been psychotic, with definite delusions of reference, from an early stage (Winokur, 1977).

The querulous paranoid patient's central belief lacks a specifically delusional quality, and the accompanying misinterpretations also seem uncritical more than delusional. This represents the view of almost every author: Kraepelin (1905) initially considered the state "a secondary form of paranoia", but later (Kraepelin, 1913) he excluded it from this delusional category. Subsequently, the belief has been referred to as an overvalued (Jaspers, 1959; Mayer Gross *et al*, 1969), delusion-like (Hamilton, 1978), or dominant (Lewis, 1970) idea. The querulous paranoid state thus illustrates many of the features of a disorder with an overvalued idea. The patient develops an isolated, preoccupying belief showing the passionate quality alluded to by Jaspers; in most cases this develops more or less comprehensibly out of a previously abnormal personality; occasionally it is the expression of an underlying psychotic or organic process.

Morbid jealousy

States of abnormal sexual jealousy, following Mairet's comprehensive description in 1908, have invariably been separated into three distinct clinical entities. One presentation takes the form of an excessive possessiveness which appears in otherwise undisturbed personalities, is similar in quality to normal jealousy, and seems to represent an exaggeration of this by neurotic mechanisms. At the other extreme is delusional or psychotic jealousy, describing a recognizably delusional belief in a partner's infidelity that may complicate a schizophrenic, affective or organic psychosis, occasionally to the point of dominating the clinical picture (Shepherd, 1961).

The existence of a third form of morbid jealousy has been documented by virtually every author (Cobb, 1979), and designates an uncommon, but by no means rare syndrome that is probably familiar to most psychiatrists. It has been referred to in terms such as "jealous monomania" (Mairet, 1908), "jealousy reaction of abnormal persons" (Ey, 1954), and "obsessive jealousy" (Mooney, 1965), and has a striking presentation that can be outlined as follows (Shepherd, 1961; Mooney, 1965).

Often following a trivial event that is misinterpreted, or other precipitants such as a decline in potency (Todd & Dewhurst, 1955), the patient becomes convinced that his partner is being unfaithful, typically indiscriminately. This belief is completely groundless or at least very disproportionate to any available evidence, but

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becomes intense, preoccupying and leads the patient to engage in a great deal of inappropriate activity. He makes continual accusations based on bits of flimsy, trivial and contradictory evidence, and interrogates his wife endlessly, sometimes with the assistance of torture (Hamilton, 1974). He makes constant attempts to verify his accusations, following her when she goes out, examining the state of her underwear and genitals, and setting ingenious traps; any equivocal findings are then interpreted as positive prood of unfaithfulness. Sometimes excessive sexual demands are made to exhaust her for the alleged other partners, or she may be prevented from wearing fashionable clothes and cosmetics. Violent assaults are characteristic of the condition and, perhaps more than in any other psychiatric disorder, may culminate in murder (Mowat, 1966).

In the majority of cases, this type of morbid jealousy runs a chronic course, persisting for years with exacerbations and improvements but without development of psychosis or personality deterioration (Shepherd, 1961). It is generally resistant to all forms of treatment, neuroleptics in particular being of little value (Mooney, 1965). Occasionally it may remit after psychiatric intervention (or imprisonment), only to recur years later with another partner (Langfeldt, 1961). A few cases ultimately give way to psychosis or an organic state (Shepherd, 1961; Cobb, 1979).

A number of aetiological factors have been identified in the development of morbid jealousy. Its association with a variety of personality disorders has been repeatedly stressed (Shepherd, 1961; Mooney, 1965; Hamilton, 1978; Cobb, 1979), the types implicated being paranoid, asthenic and sociopathic. Somewhat less commonly, morbid jealousy is the manifestation of a primarily psychotic or organic disturbance. The best known association is with alcoholism: Kolle (1932) described non-delusional jealous syndromes in alcoholics, some of whom showed independent evidence of cerebral damage and in some of whom there was none. Morbid jealousy that lacks delusional features can also complicate other drug intoxications, Parkinson's disease, dementias, both phases of manic-depressive psychosis and form the prodrome to schizophrenia (Shepherd, 1961; Cobb, 1979).

This presentation of morbid jealousy, as noted by Jaspers (1959) and Fish (Hamilton, 1974), is thus a classic example of a disorder with an overvalued idea. It is not a psychosis in the regular sense of the term, it does not conform to definitions of paranoia, particularly Kraepelin's (1913), and it would be difficult to maintain that it was an obsessional disorder. Phenomenologically, it takes the form of a solitary abnormal belief that is not considered to be delusional and which is passionate in its ability to evoke violence and murder. Aetiologically, it arises in the dual settings of the overvalued idea, either as an outgrowth of an abnormal personality or as the expression of a variety of psychotic and organic disorders.

Hypochondriasis

In much the same was as morbid jealousy, hypochondriasis is a term that has come to be applied in different contexts. Minor degrees of health concern are a common phenomenon which can become exaggerated in some individuals or even whole cultures (Mayou, 1976). Somewhat analogously, hypochondriacal themes frequently figure in obsessional states without being in any way specific to this type of disorder (Henne, 1955; Merskey, 1979). Hypochondriasis has also acquired a usage in the delusional sense, describing the bizarre ideas of bodily change and malfunction found in psychoses of all types. Hypochondriacal delusions occur in up to a fifth of cases of schizophrenia (Lucas *et al*, 1962), and are well known in affective psychoses, manic as well as depressive. In their most severe expression, they make up part of the Cotard syndrome of nihilistic delusions (Enoch & Trethowan, 1979).

In what may be its oldest usage, hypochondriasis designates another condition. This has resisted nosological classification, and its existence has been regarded as doubtful (Kenyon, 1964); nevertheless it manages to retain places in both ICD 9 and DSM III. The disorder has a distinctive presentation, usually showing many or all of the following features (Henne, 1955; Merskey, 1979).

Sometimes spontaneously, or sometimes in the presence of real disease or disability, the patient becomes over-concerned with his health and convinced that he is seriously ill. He notices various abnormal sensations, or even pains, and links these together in elaborate schemes that are incomprehensible to anyone else. He begins going from doctor to doctor presenting them with meticulously detailed descriptions of his symptoms, often accompanied by notes and diagrams. Every aspect of his treatment is followed to a ridiculous extent and he criticizes, distorts and attempts to influence doctors' opinions, becoming angry and emotional if this is resisted. Work is impossible, the patient's daily routine becomes minutely regulated, and he follows complex, self-devised regimes of medication. There is often a characteristic sombre, taciturn, introspective and self-centred affect, which however conceals genuine distress—and there may be considerable secondary depression.

The disorder is perhaps best illustrated by the case of Marcel Proust, who, though he probably genuinely

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suffered from asthma, bacame outlandishly preoccupied with this for most of has adult life (Fabricant, 1960; Pickering, 1974). He isolated himself from the outside world in a cork lined room, spending six and a half days out of seven in bed, and communicating detailed accounts of his health in his letters. He used and abused a variety of drugs in a complex routine and followed a self-invented procedure of 'fumigations'. On the few occasions he ventured out he wore many layers of clothing, several overcoats and cotton-wool padding round his neck, all of which he would unpredictably remove when he felt the need to acclimatise himself to a change in temperature. Once when he attended a wedding, he was so bulky that he could not fit in the pews and was forced to stand in the aisle.

Hypochondriasis as a primary condition unassociated with any other signs of mental illness is a well recognized presentation (Henne, 1955; Mayer Gross *et al*, 1969; Hamilton, 1978; Merskey, 1979), whose existence is documented in at least one formal study (Pilowsky, 1970). It carries a poor prognosis, the duration usually being measured in decades rather than years, and the response to treatments including neuroleptics, ECT and leucotomy is uniformly unsatisfactory. A significant number of patients ultimately commit suicide (Kenyon, 1964; Pilowsky, 1970; Bebbington, 1976).

A notable, and often the only discernable factor in the development of hypochondriasis, is pre-existent abnormal personality. There is agreement that the types particularly predisposed are obsessional and paranoid (Ladee, 1966; Pilowsky, 1970; Kenyon, 1976) and there may also be significant associations with sociopathic (Maddocks, 1970) and histrionic (Mayer Gross *et al*, 1969) personality disorders. At the same time, there is no doubt that the disorder sometimes has an origin in psychotic or organic disturbances. A non-delusional hypochondriacal preoccupation may form the prodrome to both schizophrenia (Kenyon, 1976; Merskey, 1979) and affective psychosis (Kreitman *et al*, 1965), and, in what is probably its best known association, hypochondriasis can complicate the whole course of an affective disorder. Endogenous depression was the primary diagnosis in over half of Pilowsky's (1970) cases of secondary hypochondriasis, and up to 80% of Kenyon's (1964) series were considered to have affective disorders. Hypochondriasis that lacks a delusional quality may also be the earliest feature of a dementia (Ladee, 1966; Merskey, 1979), occur in acute organic states (Kenyon, 1976) and follow head injury (Lishman, 1978).

The phenomenology of hypochondriasis is distinguished chiefly by a preoccupying conviction that disease is present, which though intense and impervious to reason, is invariably considered not to be delusional or obsessional in nature. Henne (1955) described the patient as being "not deluded but thoroughly convinced that he is ill", and subsequent authors (Kreitman *et al*, 1965; Ladee, 1966; Merskey, 1979) have regularly distinguished the disorder from both delusional and obsessional hypochondriacal states. Hypochondriasis has occasionally been referred to as a 'disease-phobia', but the element of fear that is often present seems to represent a state of continual, pervasive unease rather than the intermittent autonomic reaction of a phobia (Pilowsky, 1967).

This form of hypochondriasis is thus aligned phenomenologically and aetiologically to the overvalued idea and has been identified as such, but only apparently by Fish (Hamilton, 1974; 1978). It is a non-delusional, non-obsessional belief to which the sufferer's whole life becomes subordinated, and it develops in the by now familiar settings, on the one hand as an isolated syndrome in abnormal personalities, and on the other as a complication of various psychotic and organic disorders.

Dysmorphophobia and parasitophobia

These are disorders closely allied to hypochondriasis. Dysmorphophobia (Hay, 1970) describes the development of an excessive concern with unsightly appearance, usually referred to a single feature. The condition may take a delusional form, for instance appearing in the setting of a schizophrenic illness, but more often it arises as an isolated symptom that seems to lack a delusional quality (Hay, 1970; Andreasen & Bardach, 1977; British Medical Journal, 1978; Munro, 1980). In these cases the belief has characteristics resembling those of an overvalued idea, in which terms it is frequently described. As with other overvalued ideas dysmorphophobia is seen both as an enduring symptom in patients with personality disorders (Hay, 1970; Andreasen & Bardach, 1977) and as an early symptom of schizophrenia (Connolly & Gibson, 1978). It is also an occasional manifestation of endogenous depression (Hay, 1970).

Parasitophobia (Ekbom's syndrome) is a rare psychiatric disorder in which the patient becomes convinced that he is infested with insects. He describes the sensation of them crawling on him or burrowing under his skin, devotes all his energy to ridding himself of them, and presents doctors with evidence of the alleged infestation in the form of bits of fluff, dead skin, etc. The symptom is frequently isolated, when it develops in abnormal personality types and has been described as a delusion-like idea (Hopkinson, 1973); alternatively it may accompany depressive and schizo-

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phrenic illnesses, and notably a variety of organic states (Skott, 1978).

Anorexia nervosa

Considerable uncertainty surrounds anorexia nervosa. The psychopathology of the refusal to eat is unclear, whether its basis is biological or psychodynamic continues to be disputed, and a meaningful nosological classification has not been achieved. This kind of controversy is a recurrent theme in the conditions already described, and an argument can be made that anorexia nervosa is not a unique psychiatric entity, but in fact shows the specific aetiological and phenomenological features of a disorder with an overvalued idea.

A prominent aetiological factor in anorexia nervosa, and the only one that can be identified with certainty, is abnormal personality. This has been considered to virtually always antedate the disorder (Dally, 1969), and Kay & Leigh (1954) found a previously well adjusted personality in only 25% of cases. There is agreement that the types principally implicated are obsessional, histrionic and schizoid (Smart *et al,* 1976), with traits of immaturity, dependency and hypochondriasis also being commented on. These patients, as in the other conditions described here, tend to become chronically disabled and show a small but significant mortality (Hsu, 1983).

There is equally no doubt that in a minority of cases anorexia nervosa is intimately related to the evolution of a psychotic or organic state. In 3–10% of cases anorexia nervosa forms a prodromal phase to schizophrenia (Hsu *et al,* 1981; Hsu, 1983), and it may also precede, develop simultaneously with, or otherwise complicate manic-depressive psychosis (Dally, 1969) or endogenous depression (Cantwell *et al,* 1977). An association with organic disorders is recognized: apparently typical anorexia nervosa may be the initial feature of systemic lupus erythematosus, disseminated sclerosis and Addison's disease (Dally, 1969; Andersen, 1977), and there exist approximately 12 reports of hypothalamic and mid brain tumours presenting as an anorexic syndrome, the clinical picture sometimes being indistinguishable (e.g. Lewin *et al,* 1972; Heron & Johnston, 1976; White *et al,* 1977; Climo, 1982; Weller & Weller, 1982).

However, the most striking parallels with the overvalued idea are seen in the phenomenology of anorexia nervosa. A central theme of this (Bruch, 1962), and one that is not attributable to perceptual distortion (Crisp & Kalucy, 1974; Button *et al,* 1977) is the anorexic's conviction that she is overweight. This is held with extreme tenaciousness, and in the face of the plainest possible evidence to the contrary; it is never, however, considered delusional. The belief is preoccupying, acted on unquestioningly, and leads the patient to engage in sustained abnormal behaviour. It may also be accompanied by a fear of gaining weight (Kay & Schapira, 1972; Crisp, 1980), but this is not phobic in nature, anorexics showing no excessive arousal when presented with food (Salkind *et al,* 1980). The phenomenology of anorexia nervosa thus shows features that are characteristic of an overvalued idea, but typical of no other form of psychopathology.

Conclusion

A number of disorders, whose existence seems well documented, conform closely to Wernicke's definition of the overvalued idea, and contine to defy classification as anything else. They share a distinctive phenomenology, develop in the same aetiological settings and all show a tendency to run a chronic course unresponsive to any form of treatment. Such conditions include the querulous paranoid state, one form of morbid jealousy, hypochondriasis and related states, and arguably anorexia nervosa. In addition, it is not difficult to see the concept of the overvalued idea as having wider applications, in contexts ranging from a subtype of erotomania (Enoch & Trethowan, 1979), to cranky inventors (Jaspers, 1959) and transsexuals (Huxley *et al,* 1981).

The phenomenology of the overvalued idea seems to combine the unlikely elements of non-delusional conviction, non-obsessional preoccupation and non-phobic fear. At the heart of all the disorders is an abnormally intense conviction which has been repeatedly observed not to be delusional. This can only reflect — and provides a striking verification of — Jaspers contention that delusions are characterized, above all, by an indefinable, but easily recognizable alien quality. The preoccupation that inevitably accompanies the belief shows none of the features of obsessional preoccupation: the idea is seen as natural rather than intrusive, is acquiesced to without resistance, and is not regarded as senseless or even futile. The sense of fear that can be a conspicuous element of the states, and is frequently evident in their titles, is not however phobic in nature. Instead it represents a feeling of unease, apprehension and doubt that continually haunts the patient.

The occurrence of overvalued ideas is difficult to reconcile with the usual aetiological divisions in psychiatry. They develop in mutually incompatible settings, may appear sometimes psychogenically and sometimes biologically determined, and, even when isolated give an impression of being more than a reaction, yet less than a process. A reluctance to assign a cause to overvalued ideas is evident in the work of many authors, and even Jaspers was vague as to their status in process and reactive terms. Perhaps the only

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point which can be made with certainty is that overvalued ideas, in addition to showing phenomenological similarities to normal beliefs, also resemble these in the way they develop. Passionate political, religious and ethical convictions are as inextricably bound up with personality and experience, arise just as unpredictably, and have the same ability to alter an individual's whole way of life. The overvalued idea may thus be only the pathological expression of a pattern of behaviour of which we are all capable.

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