group might have influenced outcome. With respect to character-
istics of the study group, participants in our study manifested
both self-poisoning (91%) and self-injury (9%) irrespective of
the apparent purpose of the act, and therefore can be considered a
representative sample of patients who self-harm. Of the contacted
participants, only 7.3% were excluded because of schizophrenia or
alcohol and drug misuse. Our final sample consisted of females
(94%) with a long history of self-harm (77% reported 10 or more
previous episodes of self-poisoning and/or self-injury) and severe
psychological and psychiatric problems (on average four psychiatric
diagnoses (mood and anxiety disorders in particular)). It is possible
that CBT as an add-on to TAU is more likely to be effective for
people with such chronic and severe self-harm. The fact that rate of
withdrawal from CBT amounted to 17% underscores the feasibility
of an intervention tailored to the needs of this particular group.

In conclusion, CBT appears to be an effective adjunct to TAU
in chronic self-harm and further research on moderators and
mediators of change seems warranted.

Virtual reality and paranoia

The use of virtual reality to create a ‘laboratory’ is promising. As
someone who has played computer games and has used the
London underground (‘tube’) trains almost daily for 4 years, I
was interested in the observations that those who used the tube
regularly were less likely to have persecutory thinking in virtual
reality, whereas an experience of playing computer games was a
strong predictor of paranoid thinking.1,2

I am not sure whether the observations can be justified by an
assumption that the game-playing individuals were reacting because
they automatically processed the environment as being
hostile thus making the findings ‘a strong predictor of paranoid
thinking’ only in a virtual world?

The data provided in the paper fail to show the nature of
gaming experience these people have had. Is it possible that a
person who plays non-violent strategy games, or gambles online,
will have a different experience of virtual reality compared with
someone who plays first-person shooters where one of the
primary objectives of the game would be to survive, keep safe
distance and, of course, to ‘kill’ other players when they are in
range? Also, would the findings be different if some of these
people who played computer games spent their time in virtual
reality social networking worlds such as ‘Second Life’?

If an experience of travelling on the tube regularly shows less
likelihood of feeling persecuted in a virtual train ride, can it be said
that a prior experience of a threatening virtual reality environment
make those who play games more likely to feel persecuted in the
chosen medium than they would otherwise be in the real life?

1 Freeman D, Pugh K, Antley A, Slater M, Bebbington P, Gittins M, Dunn G,
Kuipers E, Fowler D, Garety P. Virtual reality study of paranoid thinking in

Freeman et al have used an innovative technique in a non-clinical
population to confirm a high background prevalence of negative,
mistrustful and fearful thoughts about others.1 Their paper may
be helpful in encouraging healthcare professionals in their
attempts to normalise rather than medicalise such thoughts,
which are particularly common and pronounced in patients with
neurotic and personality disorders.2

I am concerned, however, by the authors’ use of the word
‘paranoia’ to describe these thoughts. Freeman et al define
paranoia as ‘the unfounded fear that others intend to cause you
harm’, with reference only to an earlier publication by the main
author; later in the paper the words ‘persecutory’ and ‘paranoid’
are used synonymously. This definition and usage are erroneous.

Varying definitions of paranoia exist in the literature but the
correct meaning of ‘paranoid’ is ‘delusional’.3 With a Greek
derivation and a literal meaning of ‘out of the mind’; German
psychiatrists revived the term in the mid-19th century to describe
disturbances characterised by delusions, not only of persecution
but also of grandeur.4 Later, Kraepelin, Bleuler and others variously
attempted to classify paranoia, but central to all concepts was that
it referred only to delusional rather than non-delusional ideation,
and could include grandiose, jealous or somatic, as well as
persecutory, delusions.4 Indeed, the ‘paranoid’ subtype of
schizophrenia, still in use, refers to an illness dominated by hallu-
cinations and delusions, and the latter need not be persecutory in
nature.5

Of course, over the 20th century, the word has taken on an
totally different meaning outside psychiatry. Anecdotally,
patients frequently report ‘paranoia’ as an unpleasant presenting
complaint, despite the fact that, by its very nature, a fixed false
belief cannot be viewed by its sufferer as a symptom. Similarly,
mental health professionals commonly use the term erroneously,
sometimes resulting in non-psychotic patients being inappropri-
ately referred to specialist services for those with psychosis. I fear
that Freeman et al’s rejection of the longstanding psychiatric
definition of paranoia, in favour of its lay meaning, will only
add to this unnecessary confusion.

1 Freeman D, Pugh K, Antley A, Slater M, Bebbington P, Gittins M, Dunn G,
Kuipers E, Fowler D, Garety P. Virtual reality study of paranoid thinking in
2 Reid Wei, Thorne SA. Personality disorders and violence potential. J Psychiatr
3 Hamilton M (ed). Fish’s Clinical Psychopathology (2nd edn). Butterworth-
Heinemann, 1985.
4 Gelder M, Gath D, Mayou R, Cowen P. Oxford Textbook of Psychiatry (2nd
5 World Health Organization. The ICD–10 Classification of Mental and
Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines. WHO,

Author’s reply: All too often the presence of paranoid thinking
has only been given significance in relation to diagnosing illness. It
has been viewed as a symptom that leads to a diagnosis and that,
more or less, is the end of it. An alternative view is that the
experience itself should take centre stage.1,2 Persecutory thinking is

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81