Delusional Disorder

Outline

- Definition
- History
- Origins & Types
- Diagnostic Criteria
- Epidemiology
- Etiology
- Clinical Types
- Management
- Course & Prognosis

Definitions

- Derived from *delude* – playing/mocking/defrauding/cheating
- ***False, firm unshakable belief of personal significance which arises from internal morbid processes, that is out of keeping with person's education, social and cultural background, held with extraordinary conviction and subjective certainty***
- Subjectively/phenomenologically indistinguishable from true belief

History

- Recognized since the time of ancient Greeks, k/a paranoid disorders/ paranoia
- Early 19th century – Johann Heinroth & Jean Esquirol – irrational ideas & actions develop through plausible & logical reasoning
- 1863 – Karl Kahlbaum – “diastrephia” - preserved personality
- Late 19th century - Valentin Magnan – well circumscribed & highly structured delusional ideas

History

- Kraepelin – paranoia – 3rd form of psychosis (chronic, nonbizarre, well systematized delusions without deterioration of dementia precox)
- ***"One invariably observes the insidious development of a permanent unshakable delusional system from inner causes in which clarity and order of thinking, willing and action are completely preserved."***
- Kraeplin – paranoia in elderly – paraphrenia

History

- Eugen Bleuler – distinction b/w paranoid disorder and paranoid schizophrenia
- Kurt Kolle – reassessed Kraepelin's pts – deterioration similar to dementia precox

Types of Delusions

Primary

- Not understandable
- Not in response to psychopathological forms (mood disorder)
- Schizophrenia (include delusional perception and intuition)

Secondary

- Understandable
- In response to pervasive mood state or cultural content
- Other than schizophrenia

Types of Primary Delusions

1. Autochthonous delusion
2. Delusional percept
3. Delusional atmosphere
4. Delusional memory

Autochthonous Delusion

- Aka delusional intuition (German: *wahneinfall*)
- Phenomenologically similar to sudden arrival of a normal idea ('out of the blue')
- Pt. seeks explanation for the occurrence of the delusion
- Subjective difference b/w delusional idea and normal idea; requires empathy and understanding

Autochthonous Delusion

- Schneider - delusional idea based on outmoded psychology; abandonment
- Delusional intuition: single stage (delusional perception: 2 stages – perception and false interpretation)
- Self-referent & momentarily significant

Delusional Percept

- Normal perception interpreted with delusional meaning without any rational/ emotional (Schneider, 1949)
- Attribution of new meaning in the sense of self reference to a normally perceived object/persons
- Difficult to decide whether a delusion is truly delusional percept or being used to explain significance of certain objects of perception within a delusional system
- Different from delusional misinterpretation

Delusional Percept

- Two memberedness –
  - 1st link from the perceived object to the pts.' perception of this object
  - 2nd link to the new significance of this perception

Delusional Atmosphere

- Subtle alterations in pts.' world – anticipation/excitement
- Part of underlying process – delusional percept/intuition arises (1st rank symptom of SCZ)
- Delusional mood – uncomfortable/perplexed/apprehensive
- Accepts when delusion is fully formed – relief
- Berner (1991): atmosphere > mood – differentiate b/w perceptual and mood disturbances; not restricted to SCZ

Delusional Memory

- Delusional interpretation of a normal memory (Retrospective delusions)
- Schneider divided delusional memory into:
  - delusional perception
  - sudden delusional ideas
- 2 senses:
  - Normal memory misinterpreted in the present
  - Actual memory – false memory imbued with delusional interpretation

Origins of a Delusion

Trema

- Delusional mood

Apophany

- Search for new meanings for psychological events

Anastrophy

- Heightening of psychosis

Consolidation

- Forming new world/psychological set based on new meanings

Residuum

- Eventual autistic state

Dimensions of Delusional Severity

Conviction	Convinced of the reality of delusion
Extension	Areas of the pt.’s life involved
Bizarreness	Departure from reality
Disorganization	Internally consistent, logical & systematized
Pressure	Preoccupation & concern
Affective Response	Pt.’s emotions involved
Deviant Behaviour	Acting out

Delusion v/s Overvalued Ideas

Delusions

- False judgements
- Held with extraordinary conviction
- Incomparable subjective certainty
- Impervious to other experiences and to compelling counterargument

Overvalued Ideas

- Comprehensible beliefs
- Arising from history & experiences of an individual
- Held with conviction
- Motivate behaviour that may cause the patient harm & suffering

DSM

- DSM-I:
  - ‘paranoid reactions’ – persistent delusions (persecutory/grandiose) with emotional responses & behaviour – 2 types:
    - Paranoia: chronic, systematized delusions, rare
    - Paranoid state: acute, less systematized
- DSM-II & III:
  - paranoid state regarded as possible variants of SCZ

DSM

- DSM-III-R:
  - Kraepelinian concept – paranoid replaced by delusional disorder
  - Duration ≥ 1 month
- DSM-IV:
  - Paranoid disorders removed
  - Mixed category added

DSM

- DSM-5:
  - Delusion can be bizarre*/non-bizarre
  - Rule out body dysmorphic disorder & psychotic variants of OCD
  - Shared delusional disorder* included (else “Other specified SCZ spectrum & other psychotic disorder”)
  - Exclude other mental disorders (OCD/Body dysmorphic disorder)

* - Use specifier

DSM - 5

A. ≥ 1 delusions; duration ≥ 1 month
B. Criterion A for SCZ not met (± hallucinations – not prominent, related to delusion)
C. Functioning not markedly impaired, behaviour – not bizarre/odd
D. ± manic/depressive episodes – brief w.r.t. delusional period
E. Exclude substance use/medical conditions/mental disorders

DSM - 5

Specify:

- Type: Erotomanic, grandiose, jealous, persecutory, somatic, mixed, unspecified
- With bizarre content
- Episode: (1 year duration)
  - 1st - acute, partial or full remission
  - Multiple - acute, partial or full remission
  - Continuous

ICD - 10

A. ≥ 1 delusion (other than SCZ): persecutory, grandiose, hypochondriacal, jealous, erotic
B. Duration: ≥ 3 months
C. General criteria for SCZ not fulfilled
D. No persistent hallucination (± occ. auditory)
E. ± intermittent depressive Sx; delusions persist without mood disturbance
F. Rule out organic mental disorders (1°/2°) & substance use

Differences between DSM - 5 & ICD - 10

	DSM-5	ICD-10
Classified under	SCZ spectrum & other psy. disorders	Persistent delusional disorder
Duration	≥ 1 month	≥ 3 months
Functional impairment	Not markedly impaired	Not mentioned
Hallucinations	Related to delusion	No/only occ. auditory hallucinations
Subtypes	Specified	Not specified

Epidemiology

- General population study: lifetime prevalence: 0.18% (Finland)
- Prevalence (US): 0.025 - 0.03% (SCZ – 1%, Mood disorders – 5%)
- Annual incidence: 1 -3/100,000 persons
- Clinical studies: 1 - 4% of psychiatric admissions
- Mean age: ≈ 40 years (18 – 90s)
- MC type: Persecutory delusions
- Equal prevalence in both men & women (except jealous type – more common in women)

Etiology

- Unknown
- No genetic links b/w delusional disorder & schizophrenia
- Family studies: No increased incidence of schizophrenia/mood disorders in families of delusional disorders probands or vice-versa
- Stable diagnosis
- Some pts. reclassified as having:
  - SCZ: < 25%
  - Mood disorder: < 10%

Etiology

Freud's contributions:

- Delusions part of healing process
- Projection - main defence mechanism in paranoia
- Unconscious homosexual tendencies defended against by denial and projection → transformed into suspiciousness and rejection
- Classic psychodynamic theory: dynamics behind delusion formation is same for males & females
- Studies unable to corroborate Freud's theories

Etiology

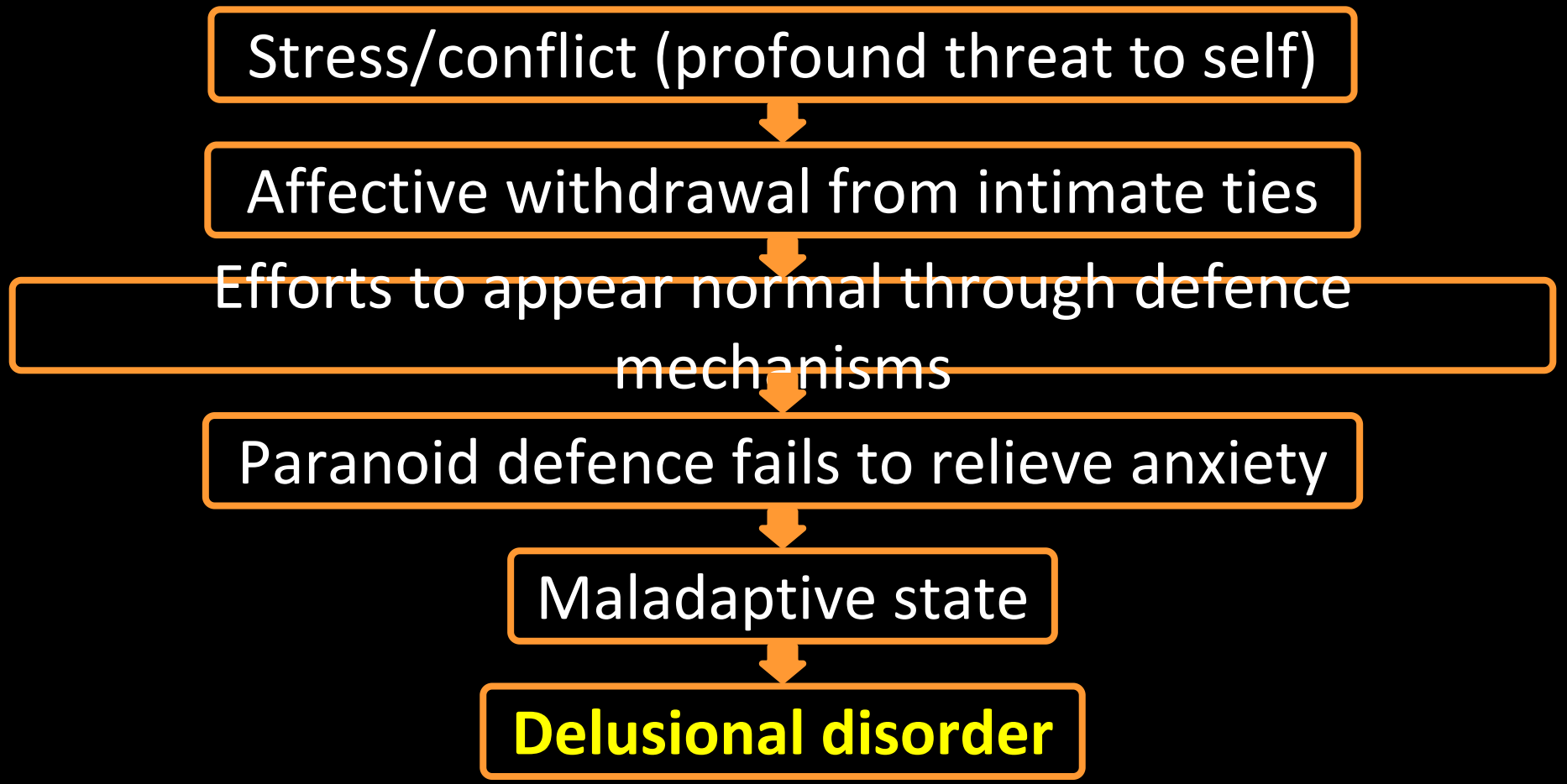
Norman Cameron

1. Increased expectation of receiving sadistic treatment
2. Situations that increase distrust and suspicion
3. Social isolation
4. Situations that increase envy and jealousy
5. Situations that lower self-esteem
6. Situations that cause persons to see their own defects in others
7. Situations that increase the potential for rumination over probable meanings and motivations

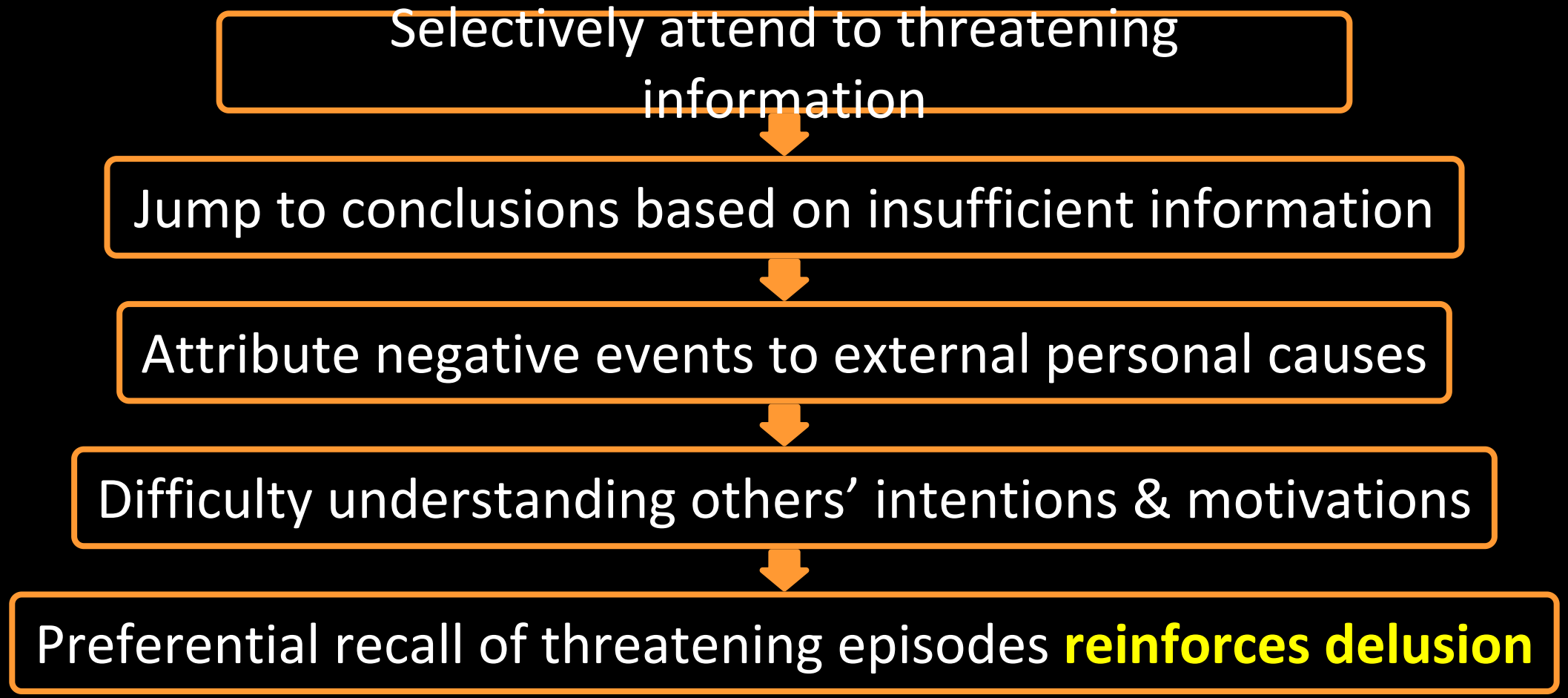
Etiology

- Frustration exceeds tolerance → withdrawn/anxious
- Seek explanation for their problem
- Make delusion system as solution
- Delusion elaborated to include imagined persons
- Attribution of malevolent motivations to real/imagined persons – pseudo-community – binds projected fears & wishes – justify pt's aggression and hostility

Etiology


Stress/conflict (profound threat to self)
Affective withdrawal from intimate ties
Efforts to appear normal through defence mechanisms
Paranoid defence fails to relieve anxiety
Maladaptive state
Delusional disorder

Etiology


Selectively attend to threatening information
Jump to conclusions based on insufficient information
Attribute negative events to external personal causes
Difficulty understanding others' intentions & motivations
Preferential recall of threatening episodes reinforces delusion

Etiology

Biological factors:

- Neurological conditions affecting limbic system & basal ganglia with intact cerebral cortical function; intellectual impairment:
  - Absent - complex delusions
  - Present - simple delusions

Etiology

Organic brain factors:

- Head injury - paranoid Sx
- Chronic alcoholism - pathological jealousy
- Old age - senile ‘paranoid' illness
- Drugs: Amphetamine, cocaine, L-dopa & methyldopa
- AIDS infection

Etiology

Other factors:

- Social & sensory isolation
- Socioeconomic deprivation
- Personality disturbance
- Recent immigration
- Family History

Diagnostic and Clinical Features

Types:

1. Persecutory
2. Jealous
3. Erotomanic
4. Somatic
5. Grandiose
6. Mixed
7. Unspecified

Persecutory Type

- Pt. convinced that (s)he/someone close is being malevolently treated or harmed in some way
- Complaining, irritability, anger, aggressive, homicidal behaviour
- Delusional disorder v/s Paranoid SCZ:
  - Delusions systematized & coherent
  - Social functioning uncompromised
- Difference b/w normal, pathological behaviour, overvalued ideas and delusions may not be very clear

Jealous Type

- Aka Othello syndrome/conjugal paranoia
- Normal jealousy → Pathological jealousy → Delusional
- Unfaithful spouse
- Maybe true, but magnitude of response & evidence may be of delusional quality
- Dangerous → evokes anger, arms the pt. with sense of righteous indignation, pts. justify their actions (physical harm/murder)

Erotomanic Type

- Aka De Clerambault syndrome or Psychose passionelle
- Pt. believes another person, usu. of higher status, is in love with him/her.
- Rationalize when love object ignores/rejects their advances
- Solitary, withdrawn, dependent & sexually inhibited
- Poor levels of social/occupational functioning
- Acute onset then become chronic.

Erotomanic Type

- Stalking
- Unwanted communications
- Implicit/explicit threat to the target
- Violence → murders target
- Also occur in other psychiatric disorders

Somatic Type

- Hypochondriacal/somatic nature
- Older literature: Monosymptomatic hypochondriasis
- Clear sensorium
- Symptoms not d/t underlying general medical condition/psychiatric disorder
- Onset – gradual/sudden
- Unremitting, severity may fluctuate
- Anxiety & hyperalertness

Somatic Type

Common themes:

- Delusional parasitosis (Ekbom's syndrome): Infestation, tactile sensory phenomena causes delusion
- Dysmorphic delusion: Body features
- Bromosis/halitosis: Body odour
- Others: Dental, delusions of STD & other communicable diseases
- Generally present to a specific medical specialists for evaluation, rarely present for psychiatric evaluation

Grandiose & Mixed Types

Grandiose

- Rare (grandiose delusions without manic/psychotic symptoms)
- Some grandiosity may be present, but rarely elaborated into a full blown delusion

Mixed

- Individuals exhibit more than one of the preceding types simultaneously

Unspecified Type

Misidentification syndromes:

- Cotard's Syndrome: loss of all possessions/status/entire being
- Fregoli's Syndrome: different people are a single person who changes appearance/is in disguise
- Capgras Syndrome: known persons replaced by identical impostor
- Syndrome of Intermetamorphosis: familiar persons change themselves into other persons at will
- Syndrome of Subjective Doubles: pt. has a double with same appearance, usu. with different character traits

Shared Psychotic Disorder

- Transfer of delusions between closely associated individuals, living together in social isolation for a long time (*folie à deux*)
  - 1° case – chronically ill, influential
  - 2° case – less intelligent, gullible, passive, low self-esteem
- 2°person may abandon delusion if pair separates; not consistent
- Associated factors: Old age, low intelligence, sensory impairment, CVD & alcohol abuse
- *Folie simultanée*: 2 persons simultaneously become psychotic
- *Folie à trois, quatre, cinq, famille*: > 2 individuals involved

Assessment

- Affective & psychotic disorders
- Threatened & perpetrated violence
- Quality of the relationship
- Family constitution
- Substance misuse
- Collateral and separate history from spouse
- Behavior s/o acting out of delusion
- Any primary or secondary gains

Assessment

MSE:

- Form of morbid jealousy
- Associated psychopathology
- Consideration of organic disorder

Assessment

Risk assessment for both partners:

- Suicide
- History of domestic violence
- History of interpersonal violence
- Risk to children

Assessment

General physical & systemic examination:

- General medical illness
  - Neurodegenerative disorders: Alzheimer's, Pick's, Huntington's, basal ganglia calcification, MS
  - Other CNS disorders: Brain tumors, epilepsy, head trauma, anoxic brain injury
  - Vascular disease: Atherosclerosis, HTN encephalopathy, SAH, subdural hematoma, temporal arteritis, fat embolism

Assessment

- Infectious disease: HIV/AIDS, syphilis, malaria, acute viral encephalitis, Creutzfeldt-Jacob disease
- Metabolic disorder: Hypercalcemia, hyponatremia, hypoglycemia, uremia, hepatic encephalopathy, porphyria
- Endocrinopathies: Addison's disease, Cushing's disease, hyper- or hypothyroidism, panhypopituitarism
- Vitamin deficiencies: Vitamin B12, folate, thiamine, niacin deficiency

Assessment

- Any form of physical or signs of drug abuse:
  - Medications: ACTH, steroids, cimetidine, antibiotics (cephalosporins, penicillin), disulfiram, anticholinergics
  - Cocaine, alcohol, cannabis, hallucinogens
- Signs of poisoning with toxins: Mercury, arsenic, manganese, thallium

Differential Diagnosis

- Dementia
- Delirium
- Schizophrenia
- Mood disorder with psychotic Sx
- Hypochondriasis
- Body Dysmorphic Disorder
- OCD
- Paranoid Personality Disorder

Investigations

- Routine: CBC, RBS, LFT, KFT, electrolytes, urine R/M/E CXR, ECG
- Specific: Drug screen, blood alcohol, blood cultures, cardiac enzymes, ABG, serum folate/vitamin B12, TFT, PT, urinary porphyrinogens, heavy metal & insecticides
- CSF examination
- VDRL/ HIV
- Imaging: CT/ MRI, EEG
- Hormonal assays

Treatment

Principles of management:

- Treat the mental disorder
- Manage the risk

Pharmacological treatment:

- Atypical antipsychotics (Manschrek et al)
- SSRI’s: somatic type
- ECT: efficacy not proved

Treatment

Psychotherapy:

- Individual therapy
- Insight oriented
- Supportive
- CBT
- Family interventions
- Treatment of substance misuse
- Couple therapy
- Dynamic psychotherapy

Course & Prognosis

- Course:
  - 66% - Acute onset
  - 50% - Complete remission
  - 10% - Improves
  - 31% - Unchanged
- Less deterioration in functioning over time
- Specific delusions – may persist, remain fixed & stabilize
- Functioning preserved
- -ve outcomes when pts unable to control acting out on delusion

Course & Prognosis

- Good prognostic factors:
  - (?) Early age of onset
  - Precipitating factor
  - Female sex
  - Married
- Poor prognostic factors:
  - Co-occurring diagnosis (esp. depression)

Conclusion

- Unique - virtually a newly discovered illness, yet much of the fundamental descriptive work was done a century or more ago
- Most practitioners have scant knowledge or experience of the disorder, and the few who are aware of it usually only see a small part of it
- Kendler – *'The paranoid disorders may be the third great group of functional psychoses along with affective disorders and schizophrenia.'*
- Though we know a great deal about delusional content little is understood about their origin or the reasons for their unique features.

References

- Kaplan HI. Kaplan & Sadock's Comprehensive Textbook of Psychiatry, (2 Volume Set, 2005).
- Kaplan HI. Kaplan & Sadock's Comprehensive Textbook of Psychiatry, (2 Volume Set, 2017).
- Oyebode F. Sims' symptoms in the mind: an introduction to descriptive psychopathology. Elsevier Health Sciences; 2008 Apr 25.
- Kay J, Tasman A. Essentials of psychiatry. West Sussex, UK: Wiley; 2006.

References

- World Health Organization. The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. World Health Organization; 1992.
- American Psychiatric Association. Diagnostic and statistical manual of mental disorders (DSM-5®). American Psychiatric Pub; 2013 May 22.
- Strub RL, Black FW. The mental status examination in neurology. FA Davis Company; 1993.

Thank You