DELUSIONAL DISORDERS

DSM-5 uses the term delusional disorder to describe a disorder with one or more persistent delusions that is not due to any other disorder. It is synonymous with the widely used term paranoid psychosis, and includes the non-specific term paranoid states. ICD-10 has a similar category of persistent delusional disorders. The essence of the modern concept of delusional disorder is that of a stable delusional system that develops insidiously in a person in middle or late life. The delusional system is encapsulated, and there is no impairment of other mental functions. The patient can often continue working, and his .social life may be maintained fairly well

DSM-5 CRITERIA FOR DELUSIONAL DISORDER

.A. One or more delusions, of at least 1 month's duration

B. Criterion A for schizophrenia has never been met. Hallucinations, if present, are not .prominent, and are related to the delusional theme

C. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly .impaired and behaviour is not obviously odd or bizarre

D. The total duration of any mood episodes has been brief relative to the duration of the .delusional periods

E. The disturbance is not due to the direct physiological effects of a substance (e.g. a drug of .abuse, a medication) or a general medical condition

EPIDEMIOLOGY OF DELUSIONAL DISORDER

Delusional disorder is regarded as being an uncommon illness, although there are relatively few data. Kendler (1982) reviewed the literature and reported an incidence of 1–3 per 100,000 per year, with delusional disorder constituting 1–4% of all psychiatric admissions. In a large population survey, delusional disorder had a lifetime prevalence of 0.18%. In a large case series, the mean age of onset of delusional disorder was 46 years, and the diagnosis remained stable over a 10-year period, with only 21% being rediagnosed with .schizophrenia

AETIOLOGY OF DELUSIONAL DISORDER

What little is known about the aetiology of delusional disorder is based upon its relationship to, and comparison with, schizophrenia, paranoid personality disorder, and depressive disorder. This question has been addressed by family and neurobiological studies. However, the relatively small sample sizes and varying diagnostic definitions mean that few conclusions can be drawn. Psychological explanations for delusional disorder .centre upon the delusions themselves

Family studies of delusional disorder

First-degree relatives of patients with delusional disorder have an increased incidence of paranoid personality disorder. The familial relationship of delusional disorder to schizophrenia is less clear. Although the risk of delusional disorder is increased in first-degree relatives of patients with schizophrenia, relatives of patients with delusional disorder do not have an increased risk of .schizophrenia or schizotypal personality

Neurobiological studies

Very little is known regarding biological correlates of delusional disorder, nor the extent to which they overlap with or differ from schizophrenia. One MRI study reported that elderly patients with .delusional disorder have enlarged cerebral ventricles

Specific delusional disorders

Type	Synonymous with, or includes
Jealous	Morbid jealousy, pathological jealousy, erotic jealousy, sexual jealousy, Othello syndrome
Erotic	Erotomania, De Clèrambault's syndrome
Somatic	Monosymptomatic hypochondriacal psychosis, delusional body dysmorphic disorder
Querulous Persecutory	
Shared	Induced delusional disorder, folie à deux, communicated insanity
Other	Delusional misidentification syndrome, Capgras syndrome, Fregoli delusion, .intermetamorphosis, syndrome of subjective doubles

PATHOLOGICAL JEALOUSY

It is the archetypal delusional disorder; it is also the commonest (other than 'persecutory delusional disorder', not otherwise specified) and, importantly, appears to carry the greatest risk of dangerousness. The essential feature is an abnormal belief that the patient's partner is being unfaithful. The condition is termed pathological because the belief, which may be a delusion or an overvalued idea, is held on inadequate grounds and is unaffected by rational argument. The belief is often accompanied by strong emotions and characteristic behaviour, but these do not in themselves constitute pathological jealousy. A man who finds his wife in bed with a lover may experience extreme jealousy and may behave in an uncontrolled way, but this should not be called pathological jealousy. The term should be used only when the jealousy is based on unsound .evidence and reasoning

Pathological jealousy is more common in men, with surveys finding that about two men were affected for every woman. The frequency of the condition in the general population is unknown, but it is not uncommon in psychiatric practice. Each case merits careful attention, not only because of the great distress that the condition causes within .relationships, but also because these individuals may be highly dangerous

As indicated above, the main feature is an abnormal belief in the partner's infidelity. This may be accompanied by other abnormal beliefs—for example, that the partner is plotting against the patient, trying to poison him, taking away his sexual capacities, or infecting him .with venereal disease

The mood of the pathologically jealous patient may vary with the underlying disorder, but .often it is a mixture of misery, apprehension, irritability, and anger

Typically, the behaviour involves an intensive search for evidence of the partner's infidelity—for example, by looking through diaries and by examining bed linen and underwear. The patient may follow the partner about, or engage a private detective. The jealous person often cross-questions the partner incessantly. This may lead to violent quarrelling and paroxysms of rage in the patient. Sometimes the partner becomes exasperated and worn out, and is finally goaded into making a .false confession. If this happens, the jealousy is inflamed rather than assuaged

An interesting feature is that the jealous person often has no idea who the supposed lover may be, or what kind of person they may be. Moreover, he may avoid taking steps that could produce .unequivocal proof one way or the other

- Behaviour may be strikingly abnormal. A successful city businessman carried a briefcase that contained not only his financial documents but also a machete for use against any lover who might be detected. A carpenter installed an elaborate system of mirrors in his house so that he could watch his wife from another room. A third patient avoided waiting alongside another car at traffic lights, in case his wife, who was sitting in the .passenger seat, might surreptitiously make an assignation with the other driver

AETIOLOGY OF PATHOLOGICAL JEALOUSY

Pathological jealousy, like other paranoid symptoms and syndromes, can occur in a range of primary disorders, paranoid schizophrenia was reported in 17–44% of patients, depressive disorder in 3– 16%, neurosis and personality disorder in 38–57%, alcoholism in 5–7%, and organic .disorders in 6–20%

The role of personality in the genesis of pathological jealousy should be emphasized. It is often found that the patient has a pervasive sense of inadequacy, together with low self-esteem. There is a discrepancy between his ambitions and his attainments. Such a personality is particularly vulnerable to anything that may threaten this sense of inadequacy, such as loss of status or development of sexual dysfunction. In the face of such threats the person may project the blame .on to others, and this may take the form of jealous accusations of infidelity

Freud believed that unconscious homosexual urges played a part in all jealousy, but clinical studies do not support an association between homosexuality and pathological jealousy. Similarly, although pathological jealousy has sometimes been attributed to the onset of .sexual difficulties, there is no good evidence of such an association

PROGNOSIS OF PATHOLOGICAL JEALOUSY

Little is known about the prognosis of pathological jealousy. It probably depends on a number of factors, including the nature of any underlying psychiatric disorder and the patient's premorbid personality. When Langfeldt (1961) followed up 27 of his patients after 17 years, he found that over 50% of them still had persistent or recurrent jealousy. This confirms a general clinical impression that the prognosis is often .poor

Risk of violence

Although there are no reliable estimates of the risks of violence, there is no doubt that people with pathological jealousy can be dangerous. In addition to homicide, the risk of physical injury inflicted by jealous patients is considerable. In one series, around 25% had threatened to kill or injure their partner, .and 56% of men and 43% of women had been violent towards or threatened the supposed rival

ASSESSMENT OF PATHOLOGICAL JEALOUSY

The assessment of a patient with pathological jealousy should be particularly thorough, and should always include the partner, who should be interviewed separately whenever possible. The partner may give a much more detailed account of the patient's morbid beliefs and actions than can be elicited from the patient. The doctor should try to find out tactfully how firmly the patient believes in the partner's infidelity, how much resentment he .feels, and whether he has contemplated any vengeful action

TREATMENT OF PATHOLOGICAL JEALOUSY

The treatment of pathological jealousy, as with other delusional disorders, is in principle fairly straightforward, the mainstay being antipsychotic drugs, but in practice can be very difficult because of the patient's lack of insight and their reluctance to collaborate with the treatment plan. Furthermore, there is a lack of randomized evidence. Adequate treatment of any associated disorder, such as schizophrenia or a mood disorder, is a first requisite. If alcohol or other substance misuse is present, specific treatment will be needed. In other cases the pathological jealousy may be the symptom of a delusional disorder, or an .overvalued idea in a patient with low self-esteem and personality difficulties

If the jealousy appears to be delusional in nature, a careful trial of an antipsychotic drug is worthwhile, although the results are often disappointing. As noted above, even when depressive disorder is not the primary diagnosis, it frequently complicates pathological jealousy and may worsen it. Treatment with an antidepressant may help in these circumstances, and also when the .jealousy appears to be an overvalued idea rather than a delusion

If there appears to be a risk of violence, the doctor should warn the partner, even if this involves a breach of confidentiality. In some cases the safest procedure is to advise separation. It is not uncommon for feelings of pathological jealousy to wane once a relationship has ended. Sometimes, .however, the problem re-emerges if the patient enters a new relationship

OTHER DELUSIONAL DISORDERS

EROTOMANIA AND EROTIC DELUSIONS

Erotic delusions can occur in any psychotic disorder, especially paranoid schizophrenia, but they are the predominant and persistent symptom in a form of delusional disorder called erotomania. It was a French psychiatrist, De Clérambault, who in 1921 proposed that a distinction should be made between paranoid delusions and delusions of passion. The latter differed in their pathogenesis and in being accompanied by excitement. This distinction is of historical interest only, but the syndrome is still sometimes known as De Clérambault's .syndrome

Erotomania is rare and occurs almost entirely in women, although rarely cases in men .were identified

The woman, who is usually single, believes that an exalted person is in love with her. The .supposed lover is usually inaccessible, as he is already married, or is a famous person

According to De Clérambault, the infatuated woman believes that it is the supposed lover who first fell in love with her, and that he is more in love with her than she is with him. She derives satisfaction and pride from this belief. She is convinced that the supposed lover .cannot be a happy or complete person without her

The patient often believes that the supposed lover is unable to reveal his love for various unexplained reasons, and that he has difficulties in approaching her, has indirect .conversations with her, and has to behave in a paradoxical and contradictory way

The woman may cause considerable nuisance to the supposed lover. She may be extremely tenacious and impervious to reality. Other patients turn from a delusion of love to a delusion of persecution, become abusive, and make public complaints about the supposed lover. This was described by De Clérambault as two phases—hope followed by .resentment

STALKING

A proportion of ‘stalkers’ appear to suffer from delusional disorders, including erotomania, which is why the topic is mentioned here. There is no clear consensus about :the definition of stalking. Most formulations contain the following elements

- a pattern of intrusive behaviour
- the intrusive behaviour is associated with implicit or explicit threats
- .the person being stalked experiences fear and distress

Stalkers typically follow their victims around and loiter outside their house or place of work. Unwanted communications by telephone, letter, or graffiti, and, in more recent times, by email or social media, are very common. Behaviour can then become more threatening, with hoax advertisements or orders for services, scandalous rumour .mongering, damage to the victim's property, threats of violence, and actual assault

Stalkers are a heterogeneous group with differing underlying psychopathologies. Some, usually women, have erotomania or erotic delusions secondary to other psychotic disorders. More commonly, stalkers suffer from a personality disorder, predominantly with .borderline, narcissistic, and sociopathic traits

They have often had a relationship with their victim that may have been quite superficial; in other cases, however, a serious relationship has cooled. A previous history of domestic violence in the relationship puts the victim at particularly high risk of assault and injury. Whether or not the victim suffers actual assault, they invariably experience severe psychological stress, which can lead to anxiety and mood disorders and post-traumatic .stress disorder

SOMATIC DELUSIONAL DISORDER

People with somatic delusional disorder believe that they suffer from a physical illness, deformity, or infestation (e.g. delusional parasitosis, also called Morgellons disease). The term encompasses monosymptomatic hypochondriacal psychosis, as there is often a single, intense delusional belief of this kind. Somatic delusional disorder needs to be distinguished from the hypochondriacal delusions (and somatic hallucinations) that can occur in other disorders (e.g. schizophrenia, psychotic depression, cocaine abuse), and from genuine somatic symptoms that occur secondary to organic disorders (e.g. the pruritus of hepatic .failure)

- It must also be distinguished from the common occurrence of obsessional thoughts or overvalued ideas about similar bodily issues. A specific example of the latter is body dysmorphic disorder (also called dysmorphophobia). In fact there is much overlap clinically, and perhaps therapeutically, between delusional and non-delusional forms of .body dysmorphic disorder

Because of the content of the belief, somatic delusional disorders often present to the relevant medical specialism—for example, body dysmorphic disorder to plastic surgeons, or delusional parasitosis to dermatologists. To ensure correct identification and appropriate treatment, it is necessary that the physician recognizes the nature of the disorder, and is able either to treat it or to involve a psychiatrist in its management. However, this does not always occur, and in any event patients are often reluctant to .accept the diagnosis

QUERULANT DELUSIONS AND REFORMIST DELUSIONS

Querulant delusions were the subject of a special study by Krafft-Ebing in 1888. Patients with this kind of delusion indulge in a series of complaints and claims lodged against the authorities. Closely related to querulant patients are paranoid litigants, who undertake a succession of lawsuits, and become involved in numerous court hearings, in which they .may become passionately angry and may make threats against the magistrates

- Baruk (1959) described ‘reformist delusions’, which are based on religious, philosophical, or political themes. People with these delusions constantly criticize society and sometimes embark on elaborate courses of action. Their behaviour may be violent, particularly when the delusions are political. Some political assassins fall within this group. It is extremely important that this diagnosis is made on clear psychiatric grounds .rather than on political grounds, as occurred in the former Soviet Union

DELUSIONAL MISIDENTIFICATION SYNDROME

Another group of delusions involves different aspects of misidentification, either of the self or of others. Like all delusions, they often occur in other psychotic disorders, especially schizophrenia and organic disorders, but they can also occur in isolation, and have been .given the collective label of delusional misidentification syndrome

One argument for bringing them together is that they all appear to be 'face-processing disorders', and associated with abnormalities in the posterior part of the right hemisphere, .where the systems responsible for face recognition are located

Note also the seemingly close relationship of these disorders to the neurological category of prosopagnosia (the inability to recognize familiar faces). Interestingly, the delusions are specific to a few, usually familiar, people, and recognition of other faces (and objects) is not impaired. Although the beliefs are delusional, the patient is aware that something is wrong with the ‘replacement’ person. The patient may be extremely distressed, and may .occasionally act against individuals whom they believe to be impostors

SHARED (INDUCED) DELUSIONAL DISORDER

- Sometimes a person who is in a close relationship with someone who already has an .established delusional system develops similar ideas
- Over 90% of reported cases are members of the same family. Usually there is a dominant partner with fixed delusions who appears to induce similar beliefs in a dependent or suggestible partner, sometimes after initial resistance. The beliefs in the recipient may or may not be truly delusional. Generally the two people have lived together for a long time in close intimacy, often in isolation from the outside world. .Once established, the condition runs a chronic course

ASSESSMENT OF PARANOID SYMPTOMS

The assessment of paranoid symptoms involves two stages—first, the recognition of the symptoms themselves, and, secondly, the diagnosis of the underlying condition. Sometimes it is obvious that the patient has persecutory ideas or delusions. At other times recognition of paranoid symptoms may be exceedingly difficult, and considerable skill is required by the .interviewer

The patient may be suspicious or angry. They may be very defensive, say little, or speak fluently about other topics while steering away from persecutory beliefs or denying them completely. The psychiatrist should be tolerant and impartial, acting as a detached but .interested listener who wants to understand the patient's point of view

The interviewer should show compassion, but not collude in the delusions or give promises that cannot be fulfilled. When an apparently false belief is disclosed, considerable time and effort may then be needed to determine whether or not it meets the criteria for a delusion rather than an overvalued idea or other form of belief. This is of crucial diagnostic significance, as the presence of a delusion is likely to be the symptom upon which a diagnosis of psychotic disorder is based, whereas non-delusional thoughts which .may be similar in content are consistent with a range of other diagnostic categories

TREATMENT OF PARANOID SYMPTOMS AND DELUSIONAL DISORDER

General principles

Management of paranoid symptoms and delusional disorder is frequently difficult. Patients will typically regard their delusional beliefs as justified, and therefore see no need for treatment. Or, they may be .suspicious and distrustful, believing that psychiatric treatment is intended to harm them

Considerable tact and skill are needed when dealing with such patients, not only to encourage them to describe their symptoms fully, but also to persuade them to accept treatment and then to adhere to it. Sometimes treatment can be made acceptable by offering to help non-specific symptoms such as anxiety or insomnia, or by pointing out the harmful consequences of the beliefs. Thus a patient who believes that he is surrounded by persecutors may agree that his nerves are being strained as a result, and that this needs .treatment

Drug treatment

Paranoid symptoms in delusional disorder are treated with antipsychotic drugs just as in other psychoses, although there are few randomized trial data to guide decision-making. Pimozide was advocated as the antipsychotic of choice for monosymptomatic hypochondriacal psychosis (delusional disorder, somatic type) and pathological jealousy. However, the assertion is not supported by good evidence, and the cardiotoxicity of pimozide should also be taken into account. In general, any high-potency, non-sedating .antipsychotic is suitable (e.g. risperidone), always starting with a low dose

Signs of improvement, notably a decrease in preoccupation with the delusion(s) and a reduction in agitation, may be seen within a few days. The importance of establishing a good therapeutic relationship to improve collaboration with treatment has already been emphasized. With regard to the delusional form of body dysmorphic disorder, some data suggest that selective serotonin reuptake inhibitors (SSRIs) rather than antipsychotics should be used as first-line treatment, with antipsychotic augmentation for those patients .who do not respond

PROGNOSIS OF DELUSIONAL DISORDER

There are no reliable data on long-term outcomes. Clinical impression suggests that the prognosis in delusional disorder is poor, although some claim that in patients who are compliant with medication, recovery occurs in 50% of cases, with substantial improvement in a further 30%. Certainly, compared to schizophrenia, long-term outcome and overall .functioning are relatively good