Delusional Disorder

Subjects: Psychiatry

Contributor: Mary Seeman

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) defines delusional disorder (DD) as the presence of one or more delusions, lasting for at least one month or longer, in the absence of affective symptoms, prominent hallucinations or other symptoms of schizophrenia. The prevalence of DD is estimated to be approximately 0.2%. Subtypes of DD have been categorized according to the content of the primary delusion: persecutory, jealous, erotomanic, somatic, grandiose, mixed and unspecified.

Keywords: Delusional Disorder

1. Introduction

Gender differences in DD have thus far been poorly studied, in marked contrast to illnesses such as schizophrenia, in schizophrenia, symptoms in women emerge later than they do in men, with a two peak of incidence, one in early adulthood and one toward the end of the reproductive years. In schizophrenia, it has also been shown that young women respond more completely to antipsychotic medication than do men, but that this wanes after menopause. DD, in which social and personal functioning is superior to that in schizophrenia, starts later in life, which may attenuate gender difference[1].

For many decades, DD has been considered a difficult condition to treat, in part because both male and female patients with this diagnosis adhere poorly to prescribed medication regimens[2]. It makes sense to think that more effective clinical approaches to patients and families would enhance patient recovery even though, despite notable efforts to disseminate results of DD research promptly[3], there is still little available evidence as to what the most therapeutic approaches to DD are. It is possible that the optimal management of the two sexes is not the same[4][5].

2. Therapeutic Conversations with Patients Suffering from Delusions

Zangrilli and co-workers[6] [30] qualitatively analyzed audio-recorded meetings between five psychiatrists and 14 of their patients in an acute care inpatient setting. Using content analysis, they identified six subthemes in the conversations, with three approaches achieving prominence. The most commonly occurring approach by psychiatrists was to elicit the content of the delusion and the evidence for it (subtheme 1—e.g., “What makes you believe this is so?”). The second most common approach (subthemes 2–4) was an attempt to go deeper by identifying associated emotions, exploring the connections between thought and behavior, and discussing reasons for hospital admission—e.g., “How does this makes you feel, what have you done about it, what led to your hospitalization?”. The third approach was challenging patients’ logic and suggesting alternatives to their explanations of events (subthemes 5 and 6—e.g., “Could it have been a coincidence? Could it have meant something else?”). In the study, this latter strategy often elicited defensiveness on the part of the patient. Potential alternative approaches, such as explaining physical symptoms as sequelae of a psychological disturbance—e.g., “The stress that you describe as a result of your divorce can sometimes cause breathing difficulties”—or linking symptoms to a previous history of adversity—e.g., “Your father’s betrayal must make it difficult to imagine that men can ever be trusted”—did not emerge as themes in the Zangrilli et al. study[6] (Table 1).

Table 1. Therapeutic approach to patients suffering from delusions.

Issues	Purpose	Recommendation
(1) Introductory remarks	To engage with patients	Summarize the steps the interview will take

(2) How to respond to a patient's delusions	To establish alliance and help with diagnosis and treatment	When possible, avoid commenting on the factual basis of a delusion
(3) Establishing trust	To build a foundation for working together	Show genuine interest in the patient's story
(4) Empathizing with feelings	To consolidate the therapeutic alliance	Show appreciation of the patient's distress
(5) Working together	To create a shared goal for therapy	Focus on distress tolerance and coping skills, not on the delusion itself
(6) Importance of form over content	To identify cognitive biases	Help the patient recognize and alter modes of thinking
(7) Psychological purposes served by delusion	To understand what is gained by a delusion	Help patient recognize the role played by the delusion
(8) Fixity of delusion	To establish possibilities for distraction	Use distraction techniques when needed and teach them to family members
	To monitor safety	Carefully assess potential for self-harm and aggression

2.1. Initial Introductions

How psychiatrists initially engage with patients is generally acknowledged as important to the quality of the therapeutic relationship that subsequently develops. Priebe and collaborators[7] carried out a study on patients' preferences for how psychiatrists introduce themselves during the first psychiatric consultation. They found that most patients preferred a lead-in that summarized what the interview would consist of, what would be asked, and what was expected of the patient. They preferred this over the psychiatrist talking about his/her own background, education, beliefs, or philosophy of treatment.

2.2. Responding to Delusions

How one addresses the issue of delusions in an initial consultation not only helps to establish an alliance between patient and doctor but also helps with diagnosis and may determine whether or not patients will adhere to recommended treatment[7][8]. It has been said that initial interviews, when properly conducted, can be therapeutic in themselves and can have long range effects on ultimate outcomes[8]. The nature and severity of symptoms do, of course, play a role in how an initial interview is best shaped. Federico et al. [9] conducted a study of 27 psychiatrists and 100 patients with schizophrenia investigating whether symptom levels influenced what was said during consultations. In the 27% of cases where patients brought up their delusions, 18% of psychiatrists deliberately avoided probing the issue, while 15% engaged with it. Psychiatrists were most likely to address negative and general symptoms of psychosis rather than the delusions themselves, and more likely to do so when the symptom level was relatively low. In other words, acute psychotic symptoms were not initially addressed, presumably to avoid confrontation.

2.3. Establishing Trust

Establishing trust before addressing delusions is important in order to set the stage for a firmer therapeutic alliance. People with DD tend to be suspicious, particularly if they have had prior negative experiences with physicians. Before unburdening themselves, they need to feel they will not be hurt or harmed. Active listening on the part of the psychiatrist is a good initial strategy. Patients obsessed with a delusion will talk about it once they feel safe. The first task, therefore, is to create a safe place where the patient can express fears and concerns without their conclusions being disparaged. An unhurried attitude and genuine interest in the patient's story convey a willingness to listen and to be of help[10].

2.4. Empathizing with Feeling

Frequently, what a DD patient wants most from a psychiatrist is to be cleared of the insanity label intimated by family or friends. The ability to frame the delusional belief in a normative way, as an idea not necessarily out of the ordinary[11][12] is conveyed via facial expression and gesture; this goes a long way toward consolidating a therapeutic alliance. Neutrality as to the accuracy of the belief needs to be maintained, but respect for patients and empathy toward their distress can be openly expressed. When, for example, a patient suffering from a delusion of theft accuses nursing staff of stealing, one can empathize with the patient about how terrible it is to not find something one wants without agreeing that the nurse is a thief[13]. Arguing about the truth of delusional experiences is always futile. That is not to say that psychiatrists should pretend to agree with the patient; the important thing is to always show respect towards the patient's perspective.

2.5. Working Together

Whatever the interviewer thinks of the logic behind the belief, it remains real to the patient. Its personal meaning is important to explore, as well outlined in a paper dealing with delusional infestation[14]. The authors recommend a shared understanding of the life factors that have contributed to the patient's intense concern about her skin. They recommend starting with a focus on the emotional and physiological sequelae of the belief, rather than on its content. The next step they suggest is teaching distress tolerance and coping skills, and self-soothing techniques as a way to decrease panic. A further recommendation is assisting the patient in coming out of self-imposed isolation, participating in enjoyable activities, and finding purpose and meaning in life despite ongoing skin symptoms. Such steps may not dissolve a delusion, but they will strengthen the therapeutic alliance and improve the patient's quality of life.

2.6. Importance of Form Over Content

Patients will ask awkward questions. "Do you believe me?" "Can you see what I see, the crawling creatures under my skin?" Whatever one thinks of the circuitous route by which patients reach their delusional explanation of events, one can always adamantly answer, "I can certainly see your distress." As in all psychotherapeutic exchange, it is important to identify the patient's feelings. Simultaneously, the interviewer gauges the intensity of the conviction, the frequency of events that trigger the delusion, the duration (when the delusion first started) and how it started. Periodicity, chronicity, and the association of delusional beliefs with specific people or circumstances all contribute to the psychological formulation around which a therapeutic plan can be organized. For instance, one of our patients, a college professor, whenever she saw the color red[15] was tormented by the idea that strangers were trying to lure her into sex. Kurt Schneider (of Schneiderian first-rank symptom fame) believed that it was the form, not the content, of a delusion that permits accurate diagnosis. He observed that psychotic delusions always tended towards self-reference and were experienced by the patient as "momentous, urgent, somehow filled with personal significance as if they were signs or messages from another world"[16] (p. 33). This was true for the patient just described; red had momentous meaning for her, even though what that meaning was remained unclear.

The shared formulation of the critical life story precedents that patient and physician work towards in DD need not be historically accurate[17] [41]. It is not the accuracy that matters but the fact of, together, being able to develop a trusting partnership. On that foundation, a successful treatment plan can gradually be co-constructed.

2.7. Delusions Serve Psychological Purposes

Treatment efficacy is assisted by the psychiatrist's appreciation of the purpose that a delusion serves in an individual's life. How does a particular delusion either interfere with or facilitate everyday function? Which relationships are affected? Does the patient act on the delusions and, if so, in what way? For instance, patients suffering from delusions of jealousy tend to minutely observe their partner and actively search for evidence of infidelity. It is intensely aggravating to the partner, but the patient's life is thereby infused with purpose[18]. Not only that but, according to reports of women wrongfully convinced of their husbands' infidelities, jealousy inflames sexual desire and the sexual aspect of the marital relationship improves[19].

Another example is delusional pregnancy. This false conviction can easily be understood as a wish fulfillment for infertile or postmenopausal women. In addition, physical abuse can often be prevented if the abuser thinks his wife is pregnant[20].

Yet another example is the secondary gain inherent in erotomania, the conviction by a lonely isolated person of being loved by someone of importance[21]. A therapist not recognizing the role the delusion serves can lead to tragic consequences. One of our patients, for instance, after treatment with antipsychotic medication, realized that her conviction of being loved was unreal and, as a consequence, attempted suicide[21].

The secondary gain of any particular delusion is usually culturally determined and serves very different purposes in different individuals.

2.8. How Fixed is the Delusion?

Important information that can be gleaned from an interview is the fixity of a delusion, whether patients are able to distract themselves from it for a period of time and what it is that distracts them. It is important therapeutically to know what intervention can act as a distraction, even if only temporarily. Shared humor often serves as a good distraction. As mentioned earlier, elderly people who are losing their memory not uncommonly develop the delusion that their caregivers are stealing from them[13]. Experienced nursing home staff are usually very adept at saying something gentle or humorous that distracts and dispels the tension that could otherwise develop.

2.9. Will a Delusion Translate into Action?

It is clinically important to elicit the ways patients cope with their delusions[22]. Some people cope by avoidance (in dysmorphophobia, for instance, avoiding situations where others might mock them for their supposed deformity). Some patients may cope by confrontation. A delusionally jealous woman, for instance, may deliberately harass the woman she imagines to be her husband's lover. Patients with somatic delusions go from doctor to doctor hoping for a cure; patients with erotomania may stalk the person they think is secretly in love with them. Patients with delusional skin infestations may scratch or cut their skin in an attempt to eliminate the supposed invaders[14][23] [38,46]. Angry patients can be potentially violent to themselves or others[24]. Even grandiose delusions can result in violence, usually against the self. Imagining themselves occupying exalted positions and feeling unworthy of the honor has been reported to lead sometimes to suicide[25]. Clinicians must always carefully evaluate the potential for violent behavior in DD and, if need be, hospitalize the patient involuntarily.

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