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delusions may be present and the predominant type is specified when the diagnosis is made. EPIDEMIOLOGY An accurate assessment of the epidemiology of delusional disorder is hampered by the relative rareness of the disorder, as well as by its changing definitions in recent history. Moreover, delusional disorder may be underreported because delusional patients rarely seek psychiatric help unless forced to do so by their families or by the courts. Even with these limitations, however, the literature does support the contention that delusional disorder, although uncommon, has a relatively steady rate. The prevalence of delusional disorder in the United States is currently estimated to be

0.2 to 0.3 percent. Thus, delusional disorder is much rarer than schizophrenia, which has a prevalence of about 1 percent, and the mood disorders, which have a prevalence of about 5 percent. The annual incidence of delusional disorder is one to three new cases per 100,000 persons. The mean age of onset is about 40 years, but the range for age of onset runs from 18 years of age to the 90s. A slight preponderance of female patients exists. Men are more likely to develop paranoid delusions than women, who are more likely to develop delusions of erotomania. Many patients are married and employed, but some association is seen with recent immigration and low socioeconomic status. ETIOLOGY As with all major psychiatric disorders, the cause of delusional disorder is unknown. Moreover, patients currently classified as having delusional disorder probably have a heterogeneous group of conditions with delusions as the predominant symptom. The central concept about the cause of delusional disorder is its distinctness from schizophrenia and the mood disorders. Delusional disorder is much rarer than either schizophrenia or mood disorders, with a later onset than schizophrenia and a much less pronounced female predominance than the mood disorders. The most convincing data come from family studies that report an increased prevalence of delusional disorder and related personality traits (e.g., suspiciousness, jealousy, and secretiveness) in the relatives of delusional disorder probands. Family studies have reported neither an increased incidence of schizophrenia and mood disorders in the families of delusional disorder probands nor an increased incidence of delusional disorder in the families of probands with schizophrenia. Long-term follow-up of patients with delusional disorder indicates that the diagnosis of delusional disorder is relatively stable, with fewer than one-fourth of the patients eventually being reclassified as having schizophrenia and fewer than 10 percent of patients eventually being reclassified as having a mood disorder. These data indicate that delusional disorder is not simply an early stage in the development of one or both of these two more common disorders. Biological Factors A wide range of nonpsychiatric medical conditions and substances, including clear-cut biological factors, can cause delusions, but not everyone with a brain tumor, for example, has delusions. Unique, and not yet understood, factors in a patient’s brain and personality are likely to be relevant to the specific pathophysiology of delusional disorder. The neurological conditions most commonly associated with delusions affect the limbic system and the basal ganglia. Patients whose delusions are caused by neurological diseases and who show no intellectual impairment tend to have complex delusions similar to those in patients with delusional disorder. Conversely, patients with neurological disorder with intellectual impairments often have simple delusions unlike those in patients with delusional disorder. Thus, delusional disorder may involve the limbic system or basal ganglia in patients who have intact cerebral cortical functioning.

Delusional disorder can arise as a normal response to abnormal experiences in the environment, the peripheral nervous system, or the central nervous system (CNS). Thus, if patients have

erroneous sensory experiences of being followed (e.g., hearing footsteps), they may come to believe that they are actually being followed. This hypothesis hinges on the presence of hallucinatory-like experiences that need to be explained. The presence of such hallucinatory experiences in delusional disorder has not been proved. Psychodynamic Factors Practitioners have a strong clinical impression that many patients with delusional disorder are socially isolated and have attained less than expected levels of achievement. Specific psychodynamic theories about the cause and the evolution of delusional symptoms involve suppositions regarding hypersensitive persons and specific ego mechanisms, which are reaction formation, projection, and denial. Freud's Contributions. Sigmund Freud believed that delusions, rather than being symptoms of the disorder, are part of a healing process. In 1896, he described projection as the main defense mechanism in paranoia. Later, Freud read Memories of My Nervous Illness, an autobiographical account by Daniel Paul Schreber. Although he never met Schreber, Freud theorized from his review of the autobiography that unconscious homosexual tendencies are defended against by denial and projection. According to classic psychodynamic theory, the dynamics underlying the formation of delusions for a female patient are the same as for a male patient. Careful studies of patients with delusions have been unable to corroborate Freud's theories, although they may be relevant in individual cases. Overall, no higher incidence of homosexual ideation or activity is found in patients with delusions than in other groups. Freud's major contribution, however, was to demonstrate the role of projection in the formation of delusional thought. Paranoid Pseudocommunity. Norman Cameron described seven situations that favor the development of delusional disorders: an increased expectation of receiving sadistic treatment, situations that increase distrust and suspicion, social isolation, situations that increase envy and jealousy, situations that lower self-esteem, situations that cause persons to see their own defects in others, and situations that increase the potential for rumination over probable meanings and motivations. When frustration from any combination of these conditions exceeds the tolerable limit, persons become withdrawn and anxious; they realize that something is wrong, seek an explanation for the problem, and crystallize a delusional system as a solution. Elaboration of the delusion to include imagined persons and attribution of malevolent motivations to both real and imagined persons results in the organization of the pseudocommunity—a perceived community of plotters. This delusional entity hypothetically binds together projected fears and wishes to justify the patient's aggression and to provide a tangible

target for the patient's hostilities. Other Psychodynamic Factors. Clinical observations indicate that many, if not all, paranoid patients experience a lack of trust in relationships. A hypothesis relates this distrust to a consistently hostile family environment, often with an overcontrolling mother and a distant or sadistic father. Erik Erikson's concept of trust versus mistrust in early development is a useful model to explain the suspiciousness of a paranoid individual who never went through the healthy experience of having his or her needs satisfied by what Erikson termed the "outer-providers." Thus, they have a general distrust of their environment. Defense Mechanisms. Patients with delusional disorder use primarily the defense mechanisms of reaction formation, denial, and projection. They use reaction formation as a defense against aggression, dependence needs, and feelings of affection and transform the need for dependence into staunch independence. Patients use denial to avoid awareness of painful reality. Consumed with anger and hostility and unable to face responsibility for the rage, they project their resentment and anger onto others and use projection to protect themselves from recognizing unacceptable impulses in themselves. Other Relevant Factors. Delusions have been linked to a variety of additional factors such as social and

sensory isolation, socioeconomic deprivation, and personality disturbance. Deaf and visually impaired individuals and possibly immigrants with limited ability in a new language may be more vulnerable to delusion formation than the normal population. Vulnerability is heightened with advanced age. Delusional disturbance and other paranoid features are common in elderly adults. In short, multiple risk factors are associated with the formation of delusions, and the source and pathogenesis of delusional disorders per se have yet to be specified (Table 7.4-1). Table 7.4-1 Risk Factors Associated with Delusional Disorder DIAGNOSIS AND CLINICAL FEATURES The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria for delusional disorder are listed in Table 7.4-2.

Table 7.4-2 DSM-5 Diagnostic Criteria for Delusional Disorder Mental Status General Description. Patients are usually well groomed and well dressed, without evidence of gross disintegration of personality or of daily activities, yet they may seem eccentric, odd, suspicious, or hostile. They are sometimes litigious and may make this inclination clear to the examiner. The most remarkable feature of patients with delusional disorder is that the mental status examination shows them to be quite normal except for a markedly abnormal delusional system. Patients may attempt to engage

clinicians as allies in their delusions, but a clinician should not pretend to accept the delusion; this collusion further confounds reality and sets the stage for eventual distrust between the patient and the therapist. Mood, Feelings, and Affect. Patients' moods are consistent with the content of their delusions. A patient with grandiose delusions is euphoric; one with persecutory delusions is suspicious. Whatever the nature of the delusional system, the examiner may sense some mild depressive qualities. Perceptual Disturbances. By definition, patients with delusional disorder do not have prominent or sustained hallucinations. A few delusional patients have other hallucinatory experiences—virtually always auditory rather than visual. Thought. Disorder of thought content, in the form of delusions, is the key symptom of the disorder. The delusions are usually systematized and are characterized as being possible (e.g., delusions of being persecuted, having an unfaithful spouse, being infected with a virus, or being loved by a famous person). These examples of delusional content contrast with the bizarre and impossible delusional content in some patients with schizophrenia. The delusional system itself can be complex or simple. Patients lack other signs of thought disorder, although some may be verbose, circumstantial, or idiosyncratic in their speech when they talk about their delusions. Clinicians should not assume that all unlikely scenarios are delusional; the veracity of a patient's beliefs should be checked before deeming their content to be delusional. Sensorium and Cognition. ORIENTATION. Patients with delusional disorder usually have no abnormality in orientation unless they have a specific delusion about a person, place, or time. MEMORY. Memory and other cognitive processes are intact in patients with delusional disorder. Impulse Control. Clinicians must evaluate patients with delusional disorder for ideation or plans to act on their delusional material by suicide, homicide, or other violence. Although the incidence of these behaviors is not known, therapists should not hesitate to ask patients about their suicidal, homicidal, or other violent plans. Destructive aggression is most common in patients with a history of violence; if aggressive feelings existed in the past, therapists should ask patients how they managed those feelings. If patients cannot control their impulses, hospitalization is probably necessary. Therapists can sometimes help foster a therapeutic alliance by openly discussing how hospitalization can help patients gain additional control of their impulses. Judgment and Insight. Patients with delusional disorder have virtually no insight

into their condition and are almost always brought to the hospital by the police, family members, or employers. Judgment can best be assessed by evaluating the patient's past, present, and planned behavior. Reliability. Patients with delusional disorder are usually reliable in their information, except when it impinges on their delusional system. TYPES Persecutory Type The delusion of persecution is a classic symptom of delusional disorder; persecutory-type and jealousy-type delusions are probably the forms seen most frequently by psychiatrists. Patients with this subtype are convinced that they are being persecuted or harmed. The persecutory beliefs are often associated with querulousness, irritability, and anger, and the individual who acts out his or her anger may at times be assaultive or even homicidal. At other times, such individuals may become preoccupied with formal litigation against their perceived persecutors. In contrast to persecutory delusions in schizophrenia, the clarity, logic, and systematic elaboration of the persecutory theme in delusional disorder leave a remarkable stamp on this condition. The absence of other psychopathology, of deterioration in personality, or of deterioration in most areas of functioning also contrasts with the typical manifestations of schizophrenia. Mrs. S, 62 years old, was referred to a psychiatrist because of reports of being unable to sleep. She had previously worked full time taking care of children, and she played tennis almost every day and managed her household chores. However, she had now become preoccupied with the idea that her downstairs neighbor was doing a variety of things to harass her and wanted to get her to move away. At first, Mrs. S based her belief on certain looks that he gave her and damage done to her mailbox, but later she felt he might be leaving empty bottles of cleaning solutions in the basement so she would be overcome by fumes. As a result, the patient was fearful of falling asleep, convinced that she might be asphyxiated and unable to awaken in time to get help. She felt somewhat depressed and thought her appetite might be decreased from the stress of being harassed. However, she had not lost weight and still enjoyed playing tennis and going out with friends. At one point she considered moving to another apartment but then decided to fight back. The episode had gone on for 8 months when her daughter persuaded her to have a psychiatric assessment. In the interview, Mrs. S was pleasant and cooperative. Except for mild depressive symptoms and the specific delusion about being harassed by her neighbor, her mental status was normal. Mrs. S had a past history of depression 30 years before, which followed the death of a close friend. She saw a counselor for several months and found this helpful, but she was not treated with medication. For the current episode, she agreed to take

medications, although she believed her neighbor was more in need of treatment than she was. Her symptoms improved somewhat with risperidone (Risperdal) 2 mg at bedtime and clonazepam (Klonopin) 0.5 mg every morning and at bedtime. This patient presented with a single delusion regarding her neighbor that was within the realm of possibility (i.e., not bizarre). Other areas of her functioning were normal. Although mild depressive symptoms were present, she did not meet criteria for major depressive disorder. Her prior symptoms of depression appeared to be related to a normal bereavement reaction and had not required pharmacotherapy or hospitalization. Thus, her current presentation is one of delusional disorder, persecutory type and not major depressive disorder with psychotic features. In terms of treatment, the ability to create a working alliance with the patient; avoiding the discussion of the veracity of her delusion; and focusing on her anxiety, depression, and difficulty falling asleep enabled her psychiatrist to introduce the medications with beneficial results. (Courtesy of Laura J. Fochtmann, M.D., Ramin Mojtabai, M.D., Ph.D., M.P.H., and Evelyn J. Bromet, Ph.D.) Jealous Type Delusional disorder with delusions of infidelity has been called conjugal paranoia when it is limited to the delusion that a spouse has been unfaithful. The eponym

Othello syndrome has been used to describe morbid jealousy that can arise from multiple concerns. The delusion usually affects men, often those with no prior psychiatric illness. It may appear suddenly and serve to explain a host of present and past events involving the spouse's behavior. The condition is difficult to treat and may diminish only on separation, divorce, or death of the spouse. Marked jealousy (usually termed pathological or morbid jealousy) is thus a symptom of many disorders—including schizophrenia (in which female patients more commonly display this feature), epilepsy, mood disorders, drug abuse, and alcoholism—for which treatment is directed at the primary disorder. Jealousy is a powerful emotion; when it occurs in delusional disorder or as part of another condition, it can be potentially dangerous and has been associated with violence, notably both suicide and homicide (Fig. 7.4-1). The forensic aspects of the symptom have been noted repeatedly, especially its role as a motive for murder. Physical and verbal abuse occur more frequently, however, than do extreme actions among individuals with this symptom. Caution and care in deciding how to deal with such presentations are essential not only for diagnosis but also from the point of view of safety.

FIGURE 7.4-1 A detail from the painting An Allegory with Venus and Cupid by Bronzino depicting a jealous lover. There is a high risk of homicide when morbid jealousy becomes the dominant theme in a relationship in which one partner is jealous of the other. That rage is well-depicted in Bronzino's painting. Mr. M was a 51-year-old married white man who lived with his wife in their own home and who worked full time driving a sanitation truck. Before his hospitalization, he became concerned that his wife was having an affair. He began to follow her, kept notes on his observations, and badgered her constantly about this, often waking her up in the middle of the night to make accusations. Shortly before admission, these arguments led to physical violence, and he was brought to the hospital by police. In addition to concerns about his wife's fidelity, Mr. M reported feelings of depression over his wife's "betrayal of [their] marriage vows," but he noted no changes in sleep, appetite, or work-related functioning. He was treated with a low dose of an antipsychotic medication and described being less concerned about his wife's behavior. After discharge, he remained on medications and was seen by a psychiatrist monthly, but 10 years later, he continued to believe that his wife was unfaithful. His wife noted that he sometimes became upset about the delusion but that he had not become aggressive or required readmission. This patient experienced a fixed, encapsulated delusion of jealousy that did not interfere with his other activities and that showed a partial response to antipsychotic medications. Although he initially reported feeling somewhat depressed over his wife's

perceived infidelity, he did not have other symptoms suggestive of a major depressive episode. (Courtesy of Laura J. Fochtmann, M.D., Ramin Mojtabai, M.D., Ph.D., M.P.H., and Evelyn J. Bromet, Ph.D.) Erotomanic Type In erotomania, which has also been referred to as de Clérambault syndrome or psychose passionelle, the patient has the delusional conviction that another person, usually of higher status, is in love with him or her. Such patients also tend to be solitary, withdrawn, dependent, and sexually inhibited as well as to have poor levels of social or occupational functioning. The following operational criteria for the diagnosis of erotomania have been suggested: (1) a delusional conviction of amorous communication, (2) object of much higher rank, (3) object being the first to fall in love, (4) object being the first to make advances, (5) sudden onset (within a 7-day period), (6) object remains unchanged, (7) patient rationalizes paradoxical behavior of the object, (8) chronic course, and (9) absence of hallucinations. Besides being the key symptom in some cases of delusional disorder, it is known to occur in schizophrenia, mood

disorder, and other organic disorders. Patients with erotomania frequently show certain characteristics: They are generally unattractive women in low-level jobs who lead withdrawn, lonely lives; they are single and have few sexual contacts. They select secret lovers who differ substantially from them. They exhibit what has been called paradoxical conduct, the delusional phenomenon of interpreting all denials of love, no matter how clear, as secret affirmations of love. The course may be chronic, recurrent, or brief. Separation from the love object may be the only satisfactory intervention. Although men are less commonly affected by this condition than women, they may be more aggressive and possibly violent in their pursuit of love. Hence, in forensic populations, men with this condition predominate. The object of aggression may not be the loved individual but companions or protectors of the love object who are viewed as trying to come between the lovers. The tendency toward violence among men with erotomania may lead initially to police, rather than psychiatric, contact. In certain cases, resentment and rage in response to an absence of reaction from all forms of love communication may sufficiently escalate to put the love object in danger. So-called stalkers, who continually follow their perceived lovers, frequently have delusions. Although most stalkers are men, women also stalk, and both groups have a high potential for violence. Mrs. D was a 32-year-old nurse who was married and had two children. She had worked in the hospital for 12 years and functioned well in her job. She had previously believed that one of the hospital's attending physicians was in love with her. Now she was referred by her supervisor for a psychiatric evaluation after she had assaulted one of the residents, claiming he was in love with her. Her current delusion began when the young physician entered a room where she was lying in bed after cosmetic surgery

and pointed at her. She had not known him before, but at that moment she became convinced that he was in love with her. She tried to approach him several times by letter and phone, and although he did not respond, she was convinced that he was trying to transmit his love through looks he gave her and through the tone of his voice. She did not report any associated hallucinatory experiences. The resident met her and denied being in love with her, but she began stalking him, culminating in the assault and the request for consultation. Mrs. D initially refused to take any medications. She was treated with psychotherapy for several months, during which she continued to work and was able to avoid contact with the resident. The therapist arranged a three-way meeting with himself, the patient, and the resident. After this meeting, there was a small reduction in the intensity of Mrs. D's belief, but she continued to maintain it nonetheless. She subsequently agreed to take antipsychotic medications and was given perphenazine 16 mg per day, but there was no improvement. The delusion subsided only after the resident moved to another hospital. This patient's presentation demonstrates a number of the features of the erotomanic type of delusional disorder. In particular, her delusion began abruptly with what she perceived to be a specific response to her by the resident. Her delusional conviction that he was in love with her persisted even after being confronted, and she rationalized his lack of apparent interest in her. The presence of a previous episode and the poor response to antipsychotic medications are consistent with the often chronic nature of the disorder, albeit with a different person being the object of her delusions. The absence of hallucinations and the preservation of her ability to function suggest a diagnosis of delusional disorder rather than schizophrenia. (Example provided by S. Fennig and originally published in Fennig S, Fochtmann LJ, Bromet EJ. Delusional disorder and shared psychotic disorder. In: Sadock BJ, Sadock VA, eds. Kaplan and Sadock's Comprehensive Textbook of Psychiatry. 8th edition. Philadelphia: Lippincott Williams & Wilkins; 2005:1525.) Somatic Type Delusional disorder with somatic delusions has been called monosymptomatic hypochondriacal psychosis. The

condition differs from other conditions with hypochondriacal symptoms in the degree of reality impairment. In delusional disorder, the delusion is fixed, unarguable, and presented intensely because the patient is totally convinced of the physical nature of the disorder. In contrast, persons with hypochondriasis often admit that their fear of illness is largely groundless. The content of the somatic delusion can vary widely from case to case. The three main types are (1) delusions of infestation (including parasitosis); (2) delusions of dysmorphophobia, such as of misshapenness, personal ugliness, or exaggerated size of body parts (this category seems closest to that of body dysmorphic disorder); and (3) delusions of foul body odors or halitosis. This third category, sometimes referred to as olfactory reference syndrome,

appears somewhat different from the category of delusions of infestation in that patients with the former have an earlier age of onset (mean, 25 years), male predominance, single status, and absence of past psychiatric treatment. Otherwise, the three groups, although individually low in prevalence, appear to overlap. The onset of symptoms with the somatic type of delusional disorder may be gradual or sudden. In most patients, the illness is unremitting, although the delusion severity may fluctuate. Hyperalertness and high anxiety also characterize patients with this subtype. Some themes recur, such as concerns about infestation in delusional parasitosis, preoccupation with body features with the dysmorphic delusions, and delusional concerns about body odor, which are sometimes referred to as bromosis. In delusional parasitosis, tactile sensory phenomena are often linked to the delusional beliefs. Patients with the somatic type of delusional disorder rarely present for psychiatric evaluation, and when they do, it is usually in the context of a psychiatric consultation or liaison service. Instead, patients generally present to a specific medical specialist for evaluation. Thus, these individuals are more often encountered by dermatologists, plastic surgeons, urologists, acquired immune deficiency syndrome (AIDS) specialists, and sometimes dentists or gastroenterologists. Ms G. was a 56-year-old homemaker and mother of two who was hospitalized in the burn unit for wound care and skin grafting after sustaining chemical burns to her trunk and extremities. Six months before admission, Ms. G had become increasingly convinced that tiny bugs had burrowed underneath her skin. She tried to rid herself of them by washing multiple times each day with medicated soap and lindane shampoo. She also visited several dermatologists and had provided samples of “dead bugs” for them to examine under the microscope. All told her there was nothing wrong with her and suggested that her problems were psychiatric in nature. She became increasingly distressed by the infestation and worried that the bugs might invade her other organs if not eradicated. Consequently, she decided to asphyxiate the bugs by covering her body with gasoline and holding it against her skin with plastic wrap. She noted that her skin became red and felt as though it were burning, but she viewed this as a positive sign that the bugs were being killed and writhing around as they died. Several hours after she had applied the gasoline, her daughter came to the house, saw Ms. G’s condition, and took her to the hospital. When evaluated in the burn unit, Ms. G spoke openly of her concerns about the bugs and was still unsure whether they were present or not. At the same time, she recognized that it had been a mistake to try to kill them with gasoline. She was oriented to person, place, and time and had no other delusional beliefs or auditory or visual hallucinations. She said her mood was “okay,” although she was realistically concerned about the extensive treatment that she would require and the difficult process of recovering from her injury. She reported no suicidal ideas or intent before admission and had no history of psychiatric treatment. She also did not report any use of substances except for drinking several beers socially about twice each month. During her stay in the hospital, she was treated with

haloperidol in doses of up to 5 mg per day with improvement in her delusions. This patient demonstrates a classic presentation of delusional parasitosis, including the repeated visits to other physicians, the absolute conviction that an infestation is present, and the collection of “evidence” to support this belief. The lack of a significant history of alcohol or substance use suggests that the sensation of bugs crawling on her skin was not associated with substance intoxication or withdrawal. She also did not have disorientation or fluctuations in her level of consciousness that would suggest delirium, other psychotic symptoms that would suggest schizophrenia, or depressive symptoms that would suggest major depressive disorder with psychotic features. (Courtesy of Laura J. Fochtmann, M.D., Ramin Mojtabai, M.D., Ph.D., M.P.H., and Evelyn J. Bromet, Ph.D.) Grandiose Type Delusions of grandeur (megalomania) have been noted for years. They were first described by Kraepelin. A 51-year-old man was arrested for disturbing the peace. Police had been called to a local park to stop him from carving his initials and those of a recently formed religious cult into various trees surrounding a pond in the park. When confronted, he had scornfully argued that having been chosen to begin a new town-wide religious revival, it was necessary for him to publicize his intent in a permanent fashion. The police were unsuccessful in preventing the man from cutting another tree and arrested him. Psychiatric examination was ordered at the state hospital, and the patient was observed there for several weeks. He denied any emotional difficulty and had never received psychiatric treatment. He had no history of euphoria or mood swings. The patient was angry about being hospitalized and only gradually permitted the doctor to interview him. In a few days, however, he was busy preaching to his fellow patients and letting them know that he had been given a special mandate from God to bring in new converts through his ability to heal. Eventually, his preoccupation with special powers diminished, and no other evidence of psychopathology was observed. The patient was discharged, having received no medication at all. Two months later he was arrested at a local theater, this time for disrupting the showing of a film that depicted subjects he believed to be satanic. Mixed Type The category mixed type applies to patients with two or more delusional themes. This diagnosis should be reserved for cases in which no single delusional type predominates. Unspecified Type

The category unspecified type is reserved for cases in which the predominant delusion cannot be subtyped within the previous categories. A possible example is certain delusions of misidentification, for example, Capgras syndrome, named for the French psychiatrist who described the illusion des sosies, or the illusion of doubles. The delusion in Capgras syndrome is the belief that a familiar person has been replaced by an impostor. Others have described variants of the Capgras syndrome, namely, the delusion that persecutors or familiar persons can assume the guise of strangers (Frégoli’s phenomenon) and the very rare delusion that familiar persons can change themselves into other persons at will (intermetamorphosis). Each disorder is not only rare but may also be associated with schizophrenia, dementia, epilepsy, and other organic disorders. Reported cases have been predominantly in women, have had associated paranoid features, and have included feelings of depersonalization or derealization. The delusion may be short lived, recurrent, or persistent. It is unclear whether delusional disorder can appear with such a delusion. Certainly, the Frégoli and intermetamorphosis delusions have bizarre content and are unlikely, but the delusion in Capgras syndrome is a possible candidate for delusional disorder. The role of hallucination or perceptual disturbance in this condition needs to be explicated. Cases have appeared after sudden brain damage. In the 19th century, the French psychiatrist Jules Cotard described several patients with a syndrome called délire de négation, sometimes referred to as nihilistic delusional disorder or Cotard syndrome. Patients with the syndrome complain of having

lost not only possessions, status, and strength but also their heart, blood, and intestines. The world beyond them is reduced to nothingness. This relatively rare syndrome is usually considered a precursor to a schizophrenic or depressive episode. With the common use today of antipsychotic drugs, the syndrome is seen even less frequently than in the past. SHARED PSYCHOTIC DISORDER Shared psychotic disorder (also referred to over the years as shared paranoid disorder, induced psychotic disorder, folie impose, and double insanity) was first described by two French psychiatrists, Lasegue and Falret, in 1877, who named it folie á deux. In DSM-5, this disorder is referred to as “Delusional Symptoms in Partner of Individual with Delusional Disorder,” an unnecessary nomenclature change in the view of most psychiatrists. It is probably rare, but incidence and prevalence figures are lacking, and the literature consists almost entirely of case reports. The disorder is characterized by the transfer of delusions from one person to another. Both persons are closely associated for a long time and typically live together in relative social isolation. In its most common form, the individual who first has the delusion (the primary case) is often chronically ill and typically is the influential member of a close relationship with a more suggestible person (the secondary case) who also develops the delusion. The person in the secondary case is frequently less intelligent, more gullible, more passive, or more lacking in self-esteem than the person in the primary case. If the pair separates, the secondary person may abandon the delusion, but this outcome is not

seen uniformly. The occurrence of the delusion is attributed to the strong influence of the more dominant member. Old age, low intelligence, sensory impairment, cerebrovascular disease, and alcohol abuse are among the factors associated with this peculiar form of psychotic disorder. A genetic predisposition to idiopathic psychoses has also been suggested as a possible risk factor. Other special forms have been reported, such as folie simultanée, in which two persons become psychotic simultaneously and share the same delusion. Occasionally, more than two individuals are involved (e.g., folie á trois, quatre, cinq; also folie á famille), but such cases are especially rare. The most common relationships in shared psychotic disorder are sister–sister, husband–wife, and mother–child, but other combinations have also been described. Almost all cases involve members of a single family. A 52-year-old man was referred by the court for inpatient psychiatric examination, charged with disturbing the peace. He had been arrested for disrupting a trial, complaining of harassment by various judges. He had walked into a courtroom, marched to the bench, and begun to berate the probate judge. While in the hospital, he related a detailed account of conspiratorial goings-on in the local judiciary. A target of certain judges, he claimed he had been singled out for a variety of reasons for many years: he knew what was going on; he had kept records of wrongdoings; and he understood the significance of the whole matter. He refused to elaborate on the specific nature of the conspiracy. He had responded to it with frequent letters to newspapers, the local bar association, and even to a Congressional subcommittee. His mental state, apart from his story and a mildly depressed mood, was entirely normal. A family interview revealed that his wife and several grown children shared the belief in a judicial conspiracy directed against the patient. There was no change in delusional thinking in the patient or the family after ten days of observation. The patient refused follow-up. In this case, protection is provided by others who share the delusion and believe in the reasonableness of the response; such cases are uncommon, if not rare. (Courtesy of TC Manschreck, M.D.) DIFFERENTIAL DIAGNOSIS Medical Conditions In making a diagnosis of delusional disorder, the first step is to eliminate medical disorders as a potential cause of delusions. Many medical conditions can be associated with the development of delusions (Table 7.4-3), at times accompanying a delirious state. Table 7.4-3

Potential Medical Etiologies of Delusional Syndromes

Toxic-metabolic conditions and disorders affecting the limbic system and basal ganglia are most often associated with the emergence of delusional beliefs. Complex delusions occur more frequently in patients with subcortical pathology. In Huntington's disease and in individuals with idiopathic basal ganglia calcifications, for example, more than 50 percent of patients demonstrated delusions at some point in their illness. After right cerebral infarction, types of delusions that are more prevalent include anosognosia and

reduplicative paramnesia (i.e., individuals believing they are in different places at the same time). Capgras syndrome has been observed in a number of medical disorders, including CNS lesions, vitamin B12 deficiency, hepatic encephalopathy, diabetes, and hypothyroidism. Focal syndromes have more often involved the right rather than the left hemisphere. Delusions of infestation, lycanthropy (i.e., the false belief that the patient is an animal, often a wolf or "werewolf"), heutoscopy (i.e., the false belief that one has a double), and erotomania have been reported in small numbers of patients with epilepsy, CNS lesions, or toxic-metabolic disorders. Delirium, Dementia, and Substance-Related Disorders Delirium and dementia should be considered in the differential diagnosis of a patient with delusions. Delirium can be differentiated by the presence of a fluctuating level of consciousness or impaired cognitive abilities. Delusions early in the course of a dementing illness, as in dementia of the Alzheimer's type, can give the appearance of a delusional disorder; however, neuropsychological testing usually detects cognitive impairment. Although alcohol abuse is an associated feature for patients with delusional disorder, delusional disorder should be distinguished from alcohol-induced psychotic disorder with hallucinations. Intoxication with sympathomimetics (including amphetamine), marijuana, or L-dopa is likely to result in delusional symptoms. Other Disorders The psychiatric differential diagnosis for delusional disorder includes malingering and factitious disorder with predominantly psychological signs and symptoms. The nonfactitious disorders in the differential diagnosis are schizophrenia, mood disorders, obsessive-compulsive disorder, somatoform disorders, and paranoid personality disorder. Delusional disorder is distinguished from schizophrenia by the absence of other schizophrenic symptoms and by the nonbizarre quality of the delusions; patients with delusional disorder also lack the impaired functioning seen in schizophrenia. The somatic type of delusional disorder may resemble a depressive disorder or a somatoform disorder. The somatic type of delusional disorder is differentiated from depressive disorders by the absence of other signs of depression and the lack of a pervasive quality to the depression. Delusional disorder can be differentiated from somatoform disorders by the degree to which the somatic belief is held by the patient. Patients with somatoform disorders allow for the possibility that their disorder does not exist, but patients with delusional disorder do not doubt its reality. Separating paranoid personality disorder from delusional disorder requires the sometimes difficult clinical distinction between extreme suspiciousness and frank delusion. In general, if clinicians doubt that a symptom is a delusion, the diagnosis of delusional disorder should not be made. COURSE AND PROGNOSIS

Some clinicians and some research data indicate that an identifiable psychosocial stressor often accompanies the onset of delusional disorder. The nature of the stressor, in fact, may warrant some suspicion or concern. Examples of such stressors are recent immigration, social conflict with family members or friends, and social isolation. A sudden onset is generally thought to be more common than an insidious onset. Some clinicians believe that a person with delusional disorder is

likely to have below-average intelligence and that the premorbid personality of such a person is likely to be extroverted, dominant, and hypersensitive. The person's initial suspicions or concerns gradually become elaborate, consume much of the person's attention, and finally become delusional. Persons may begin quarreling with coworkers; may seek protection from the Federal Bureau of Investigation (FBI) or the police; or may begin visiting many medical or surgical physicians to seek consultations, lawyers about suits, or police about delusional suspicions. As mentioned, delusional disorder is considered a fairly stable diagnosis. About 50 percent of patients have recovered at long-term follow-up, 20 percent show decreased symptoms, and 30 percent exhibit no change. The following factors correlate with a good prognosis: high levels of occupational, social, and functional adjustments; female sex; onset before age 30 years; sudden onset; short duration of illness; and the presence of precipitating factors. Although reliable data are limited, patients with persecutory, somatic, and erotic delusions are thought to have a better prognosis than patients with grandiose and jealous delusions. TREATMENT Delusional disorder was generally regarded as resistant to treatment, and interventions often focused on managing the morbidity of the disorder by reducing the impact of the delusion on the patient's (and family's) life. In recent years, however, the outlook has become less pessimistic or restricted in planning effective treatment. The goals of treatment are to establish the diagnosis, to decide on appropriate interventions, and to manage complications (Table 7.4-4). The success of these goals depends on an effective and therapeutic doctor–patient relationship, which is far from easy to establish. The patients do not complain about psychiatric symptoms and often enter treatment against their will; even psychiatrists may be drawn into their delusional nets. Table 7.4-4 Diagnosis and Management of Delusional Disorder

In shared psychiatric disorder, the patients must be separated. If hospitalization is indicated, they should be placed on different units and have no contact. In general, the healthier of the two will give up the delusional belief (sometimes without any other therapeutic intervention). The sicker of the two will maintain the false fixed belief. Psychotherapy The essential element in effective psychotherapy is to establish a relationship in which patients begin to trust a therapist. Individual therapy seems to be more effective than group therapy; insight-oriented, supportive, cognitive, and behavioral therapies are often effective. Initially, a therapist should neither agree with nor challenge a patient's delusions. Although therapists must ask about a delusion to establish its extent, persistent questioning about it should probably be avoided. Physicians may stimulate the motivation to receive help by emphasizing a willingness to help patients with their anxiety or irritability without suggesting that the delusions be treated, but therapists should not actively support the notion that the delusions are real. The unwavering reliability of therapists is essential in psychotherapy. Therapists should be on time and make appointments as regularly as possible, with the goal of developing a solid and trusting relationship with a patient. Overgratification may actually increase patients' hostility and suspiciousness because ultimately they must realize that not all demands can be met. Therapists can avoid overgratification by not extending the designated appointment period, by not giving extra appointments unless absolutely necessary, and by not being lenient about the fee. Therapists should avoid making disparaging remarks about a patient's delusions or ideas but can sympathetically indicate to patients that their preoccupation with their delusions is both distressing to themselves and interferes with a constructive life. When patients begin to waver in their delusional beliefs, therapists may increase reality testing by asking the patients to clarify their concerns. A useful approach in building a therapeutic alliance is to empathize with the patient's

internal experience of being overwhelmed by persecution. It may be helpful to make such comments as, “You must be exhausted, considering what you have been through.” Without agreeing with every delusional misperception, a therapist can acknowledge that from the patient’s perspective, such perceptions create much distress. The ultimate goal is to help patients entertain the possibility of doubt about their perceptions. As they become less rigid, feelings of weakness and inferiority, associated with some depression, may surface. When a patient allows feelings of vulnerability to enter into the therapy, a positive therapeutic alliance has been established, and constructive therapy becomes possible. When family members are available, clinicians may decide to involve them in the treatment plan. Without being delusionally seen as siding with the enemy, a clinician should attempt to enlist the family as allies in the treatment process. Consequently, both the patient and the family need to understand that the therapist maintains physician– patient confidentiality and that communications from relatives are discussed with the patient. The family may benefit from the therapist’s support and thus may support the patient. A good therapeutic outcome depends on a psychiatrist’s ability to respond to the patient’s mistrust of others and the resulting interpersonal conflicts, frustrations, and failures. The mark of successful treatment may be a satisfactory social adjustment rather than abatement of the patient’s delusions. Hospitalization Patients with delusional disorder can generally be treated as outpatients, but clinicians should consider hospitalization for several reasons. First, patients may need a complete medical and neurological evaluation to determine whether a nonpsychiatric medical condition is causing the delusional symptoms. Second, patients need an assessment of their ability to control violent impulses (e.g., to commit suicide or homicide) that may be related to the delusional material. Third, patients’ behavior about the delusions may have significantly affected their ability to function within their family or occupational settings; they may require professional intervention to stabilize social or occupational relationships. If a physician is convinced that a patient would receive the best treatment in a hospital, then the physician should attempt to persuade the patient to accept hospitalization; failing that, legal commitment may be indicated. If a physician convinces a patient that hospitalization is inevitable, the patient often voluntarily enters a hospital to avoid legal commitment. Pharmacotherapy In an emergency, severely agitated patients should be given an antipsychotic drug intramuscularly. Although no adequately conducted clinical trials with large numbers of patients have been conducted, most clinicians consider antipsychotic drugs the treatment of choice for delusional disorder. Patients are likely to refuse medication

because they can easily incorporate the administration of drugs into their delusional systems; physicians should not insist on medication immediately after hospitalization but, rather, should spend a few days establishing rapport with the patient. Physicians should explain potential adverse effects to patients, so that they do not later suspect that the physician lied. A patient’s history of medication response is the best guide to choosing a drug. A physician should often start with low doses (e.g., 2 mg of haloperidol [Haldol] or 2 mg of risperidone [Risperdal]) and increase the dose slowly. If a patient fails to respond to the drug at a reasonable dosage in a 6-week trial, antipsychotic drugs from other classes should be tried. Some investigators have indicated that pimozide may be particularly effective in delusional disorder, especially in patients with somatic delusions. A common cause of drug failure is noncompliance, which should also be evaluated. Concurrent psychotherapy facilitates compliance with drug treatment. If the patient receives no benefit from antipsychotic medication, discontinue use of the drug. In patients who do respond to antipsychotic drugs, some data indicate that maintenance doses can be low. Although essentially no studies evaluate the use of antidepressants, lithium (Eskalith), or anticonvulsants (e.g., carbamazepine [Tegretol] and valproate [Depakene]) in the treatment of delusional disorder, trials

with these drugs may be warranted in patients who do not respond to antipsychotic drugs. Trials of these drugs should also be considered when a patient has either the features of a mood disorder or a family history of mood disorders. REFERENCES Bury JE, Bostwick JM. Iatrogenic delusional parasitosis: A case of physician–patient folie a deux. Gen Hosp Psychiatry. 2010;32(2):210. Christensen RC, Ramos E. The social and treatment consequences of a shared delusional disorder in a homeless family. Innov Clin Neurosci. 2011;8(4):42. Edlich RF, Cross CL, Wack CA, Long WB III. Delusions of parasitosis. Am J Emerg Med. 2009;27(8):997. Fochtmann LJ, Mojtabai R, Bromet EJ. Other psychotic disorders. In: Sadock BJ, Sadock VA, Ruiz P, eds. Kaplan & Sadock’s Comprehensive Textbook of Psychiatry. 9th edition. Philadelphia: Lippincott Williams & Wilkins; 2009:1605. Freeman D, Pugh K, Vorontsova N, Antley A, Slater M. Testing the continuum of delusional beliefs: An experimental study using virtual reality. J Abnorm Psychiatry. 2010;119:83. Hayashi H, Akahane T, Suzuki H, Sasaki T, Kawakatsu S, Otani K. Successful treatment by paroxetine of delusional disorder, somatic type, accompanied by severe secondary depression. Clin Neuropharmacology. 2010;33:48. Mishara AL, Fusar-Poli P. The phenomenology and neurobiology of delusion formation during psychosis onset: Jaspers, Truman symptoms, and aberrant salience. Schizophrenia Bulletin. 2013;39(2):278–286. Smith T, Horwath E, Cournos F. Schizophrenia and other psychotic disorders. In: Cutler JS, Marcus ER, eds. Psychiatry. 2nd edition. New York: Oxford University Press; 2010:101. Szily E, Keri S. Delusion proneness and emotion appraisal in individuals with high psychosis vulnerability. Clin Psychol Psychother. 2013;20(2):166–170. 7.5 Brief Psychotic Disorder, Other Psychotic Disorders,

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