12 - 3. Delusions

3. Delusions

DSM-IV defines a delusion as “A false belief … that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary”. This definition, though very useful, conceals the multidimensionality of delusional experience, which is now well endorsed by cognitive psychologists, phenomenologists, philosophers as well as clinicians. Do delusions exist in a continuum? Some authors suggest that ‘delusions and hallucinations are commonplace in healthy populations, with prevalence up to approximately 25% depending on the definitional criteria, and so psychosis exists in a continuum model’. This claim is yet to be validated and established. (Lincoln, 2007). Using data based solely on self-report measures, Lincoln (2007) found that high distress associated with beliefs seems to be a relevant characteristic of delusions in persons with schizophrenia, compared to ‘delusion-like beliefs in common population’. The presence of hallucinatory experiences accompanying delusions did not differ between schizophrenia and ‘common’ population. Are delusions really persistent? Though classically defined as persistent belief, doubts have been cast on this of late. In a follow-up of nearly 1100 acutely hospitalized psychiatric patients who were re-interviewed at 10-week intervals for 1 year, it was demonstrated that most delusions exhibited a high degree of plasticity; in nearly one-third delusions completely subsided on follow-up (Applebaum et al. 2004). Delusional ideation is more likely to persist in never married, older patients, those with schizophrenia, and with delusions of thought broadcasting, those with higher degree of preoccupation and higher behavioural relevance, and those with more than one primary delusion. Even when delusional experience persists in certain patients, this does not mean that the same delusion will be maintained; considerable change in content was noted during the follow-up. What are the dimensions of delusions? Kendler (AJP, 1983) has listed the dimensions of delusional experiences. The dimensions of delusions include

1. Conviction: The extent to which the patient believes.
2. Extension: The extent to which the belief extends to various spheres of life.
3. Disorganisation (or organisation): the degree of internal consistency and systematisation of the belief.
4. Bizarreness: The implausible quality of the belief (especially in schizophrenia). 4%–8% of patients receive a diagnosis of schizophrenia because of the presence of Bizarre Delusions. Bizarreness is defined using the following notions: physical (or logical) impossibility and overall implausibility or

© SPMM Course incomprehensibility with the lack of grounding in ordinary experience. Most bizarre delusions are Schneiderian (i.e. of FRS type). 5. Pressure: The extent to which the patient is preoccupied and distressed. 6. Acting on delusion: The extent to which the belief drives behaviour 7. Seeking evidence: The extent to which the patient questions the veracity of belief or seeks to strengthen the belief. Often patients with delusions, do not need any external proof or evidence, and despite showing evidence to contrary, will continue to hold their delusional beliefs. 8. Lack of insight.

Primary delusions: These are defined in two different ways

1. Jaspers' concept: primary delusions are the true, un-understandable beliefs that arrive fully formed and cannot be reduced further to any other mental experiences. This has been challenged recently.
2. Primary delusions are the first psychopathology to occur in the course of symptoms (temporal sequence). Often both are true i.e. they are irreducible and precede other mental phenomena. There are 4 types:
3. Autochthonous delusions or delusional intuitions or simply, primary/true delusions: These are ideas that occur de novo, or 'out of the blue' - takes form in an instant, without identifiable DELUSION Conviction Extension Disorganis ation Bizareness Distress Action Evidence Insight

© SPMM Course preceding events, as if full awareness suddenly burst forth in an unexpected flash of insight, like a bolt from the blue. This can be a quite elaborate delusional system on arrival itself. Wernicke formulated the concept of autochthonous delusions. Autochthonous stands for 'out of soil', 'aboriginal'. 2. In delusional perception, a normally perceived object is given a new meaning, usually in the sense of self-reference - the conclusion being entirely unwarranted, the perception is normal. Hence, it is a two-staged process – normal perception preceding the attachment of delusional significance; these two steps need not be simultaneous - might even be separated for years! The only type of delusion included in Schneider's first-rank symptoms is delusional perception. 3. Delusional mood or atmosphere refers to the sense of perplexity and uncertainty that exists during a prodrome of psychosis, usually ending in an autochthonous delusion which will make sense of the perplexity on arrival. Delusional mood/atmosphere can precede other primary delusions. It is the only psychiatric phenomenon that can directly precede and causally related to primary autochthonous delusion. Note that delusional mood is a specific affective experience – not thought content. 4. Delusional memory can be of two types. It can be a retrospective delusion where something that never happened and so false, irrational or bizarre is reported as if occurred in the past and recollected now. E.g.,. A male schizophrenia patient said I had a hysterectomy at age 3 and since then I became a man. Sometimes a normal memory might be delusionally elaborated – "My dad bought me a camera when I was seven, now I understand it is because he was homosexual". It is difficult sometimes to say what is fact and what is not though the distinction between above two variants is more an academic exercise. More importantly delusional perception can mimic delusional memory when the first stage of normal perception is actually a 'recollected' normal perception from memory. But in spite of this delusional perception is a two stage process – e.g. "I saw an envelope yesterday (normal perception but recollected from memory), I realised my stomach is upturned". Primary delusions do not carry any prognostic significance in schizophrenia though they have diagnostic relevance. While primary delusions can occur in epileptic psychoses,

they are not generally associated with epilepsy when they occur in psychotic disorders. Primary delusional experiences occur more in acute stages of schizophrenia and are not seen in chronic schizophrenia, due to being mixed with secondary delusions, hallucinations, FTD, etc. Other delusions that follow a primary delusion or other mental phenomena like hallucinations, affective disturbances, etc. are termed as secondary delusions.

© SPMM Course In delusional perception, the delusional judgment or belief that follows a perception will be unrelated to the prior perception

Persecutory delusions: Primary delusions vary considerably in content and are not characteristically persecutory in nature. In contrast, most secondary delusions are often persecutory, making persecutory themes the commonest contents of delusions as a whole. Paranoid delusions: The term paranoid is very much misused in psychiatric practice. Paranoia stands for ‘besides mind’. In the strict sense, the term paranoid can be used only for self-referential delusions, irrespective of their content. For example, grandiose delusion ‘God is sending a messiah to help me’, persecutory delusion ‘mafia is after me’, referential delusion ‘those kids are talking about me, cameras are fixed to watch me’, hypochondriacal delusion or nihilistic delusion ‘my body is rotting away’ etc are all paranoid delusions. Monothematic delusions: These can occur as single delusions in various disorders though in their commonest form they occur in major psychotic illnesses like schizophrenia or affective psychosis. Delusion Example Content of monothematic delusions Capgras delusion "That's not my wife; it is an impostor who looks just like her." Cotard delusion "I am dead." Fregoli delusion "I am constantly being followed by people I know, but I can't recognize them because they are always in disguise." Mirrored-self misidentification "The person I see when I look in the mirror isn't me; it is some stranger who looks like me." Perception (factual) Judgement Delusional perception Perception (factual) Perception (factual) Judgement Judgement Delusional Misinterpretati on Delusional Misinterpretati on

© SPMM Course De Clerambault's delusion (erotomania) "Person X is secretly in love with me" (Person X being some important or famous person who has never encouraged this idea) Othello syndrome (pathological jealousy) "My wife is having an affair." From Coltheart, M, et al. Schizophrenia and Monothematic Delusions. Schizophrenia Bulletin 2007 33(3):642-647 Morbid jealousy can occur in various forms – delusion, overvalued idea, in depression and in anxiety states; it is not a misidentification syndrome. It was first described by Ey. It is common in alcoholics. It has a potential of violence, especially against rival than a partner and can occur among cohabiters and homosexual couples too. De Clerambault’s syndrome is a type of delusion of love, in which a woman believes that an older man who is of higher social status is in love with her. It is not related to delusional misidentification. It is also called Old Maid's insanity where persecutory beliefs coexist. Cotard’s syndrome is severe depression with nihilistic and hypochondriacal delusions tinged with grandiosity and a negative attitude. It is not related to delusional misidentification. Cotards syndrome is seen in schizophrenia though more commonly in depressive psychosis. It is generally seen in the elderly, with hypochondriacal and nihilistic delusions with a tinge of grandiosity amidst nihilism (not grandiose delusions!).It is also reported in organic lesions and migraine. Hypochondriacal delusions: These are seen typically in psychotic depression especially in elderly, as a part of Cotard’s syndrome. A specific type described by Munro called monosymptomatic hypochondriacal psychosis consists of

1. Delusions of body odour and halitosis (olfactory delusions). Some of these may have olfactory reference syndrome – no olfactory experiences but only fixed belief about body order with anxiety reaction. Paranoid personality disorder is often associated with this syndrome.
2. Delusional infestation (Ekbom's syndrome) It is a delusion of parasitic – macroscopic - infestation with classical matchbox sign: An old lady comes to clinic with a match box, of skin scrapings usually, as evidence for the parasite that infests her causing itching. This can predate the onset of dementia. It may or may not be associated with a somatic hallucination.
3. Dysmorphic delusions (misshaped nose, etc.). The various misidentification syndromes (Ellis, 2005) are
4. In Capgras syndrome, a person believes that a person usually close to him has been replaced by an exact double. Capgras syndrome is sometimes referred to as the illusion of doubles though it is a delusion. First reported by Kahlbaum (1866) but more extensively described by Capgras and colleagues (1923, 1924). The Capgras delusion is classified as a dangerous delusion and may be associated with violence. Capgras delusion is etiologically heterogeneous – at least 15 different causes are recorded. It is now thought to be mostly due to organic brain damage (>50%, Lishman) apart from being seen as a part of schizophrenia or isolated delusional disorder including brain

© SPMM Course injury and schizophrenia. It is thought to be cognitively mediated by the combination of reduced affective responsivity to familiar faces plus impaired belief evaluation, and neuropsychologically it is believed to be due to the combination of the disconnection of the face recognition system of the brain from the autonomic nervous system plus damage to a specific region of right frontal lobe. 2. In Fregoli syndrome, there is the false identification of familiar persons in strangers. A familiar person is thought to be taking various disguises. First reported by Courbon and Fail (1927). They described a 27-year-old woman, a domestic servant with a passion for the theatre, who developed the delusion that the actresses Robin and Sarah Bernhardt were persecuting her in the guise of others. They suggested the term Frégoli delusion with reference to the celebrated Italian mimic Léopoldo Frégoli. The essential feature of this delusion is that there is no belief in actual physical change: instead the patient believes that his/her persecutors can invade the body of others. It is rare compared to Capgras. 3. In the syndrome of subjective doubles, the patient believes that another person has been physically transformed into his own self and the patient is convinced that exact doubles of him- or herself exist. 4. Intermetamorphosis - A becomes C, C becomes B etc. People keep transforming their physical and psychological identities. Courbon and Tusques (1932) described Sylvie G, a 49-year-old woman who claimed that objects and animals seemed altered. People could change gender as she looked at them. Many people looked like her son or her aunt. She could distinguish them from her true son only by examining their feet (his were large and were invariably shod in dirty shoes). Her husband might change appearance into that of a neighbour (all except his eye colour and missing finger). There were no further reports of intermetamorphosis for 46 years since when five cases have been described, including three by Young et al. (1990). Feature recognition (appearance) Affect recognition (warmth) RESPONSE SYNDROME

Looks like my dad, but he is not my dad, probably an impostor Capgras syndrome

My dad, but does not look like him… is he disguising himself? Fregoli syndrome

Who is he? Prosopagnosia (Seen in neurological disorders)

© SPMM Course 5. Paraprosopia: This is very rare, re-described by Ellis. Here, a face appears to transform within seconds into a grotesque mask, often described by patients as a "monster", "vampire" or "werewolf" [Krauss, 1852]. Most likely to be reported by schizophrenic children but also observed in adults (e.g. Daniel Paul Schreber, 1842-1911, President of the Court of Appeal in Dresden, saw two men "as devils with particularly red faces…"). The concept of misidentification is now being extended to misidentification of time, a place apart from the person (reduplication phenomenon). Other disturbances in thought content: Ideas of reference are seen in paranoid PD where the individual is unduly self-conscious and feels that people take notice of him or observe things about him that he would rather not be seen. It can also precede the development of full-blown schizophrenia where it is called sensitive ideas of reference or "sensitiver Beziehungswahn"! It is not characteristic of mania. Overvalued ideas: Overvalued ideas (Wernicke) are solitary abnormal beliefs that are neither delusional nor obsessional in nature, but which dominates a person's life and his actions. They have a poor prognosis and tend to dominate the sufferer's life. Common conditions presenting with overvalued ideas are paranoid or anankastic personality disorder, Body Dysmorphophobia, anorexia nervosa, morbid jealousy & transsexualism. Folie a deux is a shared delusion, in which a psychotic person transfers his delusions to one or more people close to him. The non-psychotic victim usually exhibits dependent traits on the primary patient. Separation of the pair can result in remission. Doppelganger: This is also known as double phenomenon – it is the awareness of oneself as being both outside and inside oneself. It is a cognitive and ideational disturbance as opposed to autoscopy, which is a perceptual disturbance. It can occur in the absence of mental illness too. It is not a delusional misidentification syndrome; unlike doppelganger, the latter is the pathology of familiarity. How are delusions formed?

1. Attentional biases: People with persecutory delusions preferentially attend to threat-related stimuli and preferentially recall threatening episodes. (Blackwood, AJP 2001)
2. Attributional biases: An exaggeration of self-serving attribution bias is seen in psychosis. Patients excessively attribute hypothetical positive events to internal causes (stable and global – grandiose) and hypothetical negative events to external causes (stable and global- persecutory). The attribution bias in paranoid subjects shapes delusional content rather than form, as patients with non-persecutory delusions do not show this bias significantly. Paranoid patients specifically attribute negative self-referent events active malevolence on the part of the other person (external personal attribution) rather than circumstances or chance (external situational attribution). (Blackwood, AJP 2001). This might serve to preserve the self-esteem of paranoid patients, acting as a self-defence.

© SPMM Course 3. Probabilistic reasoning bias: When deluded patients were shown sequences of black and white beads and were asked to decide which jar [jar A had majority black beads and B had majority white] the sequence was probably drawn from, they came to a conclusion with far lesser beads in a sequence than controls. They were also relatively overconfident about the accuracy of their judgement. This was hypothesized to be due to impaired probabilistic reasoning (generating hypothesis and testing statistical probability). But later studies showed that when allowed to see as many numbers of beads as controls generally do, patients reached similar correct conclusions – they were able to generate hypothesis and test the probability; the defect being

deficient datagathering (less information before decision). This is called Jumping-to-conclusion style of reasoning. (JTC). 4. Mentalising deficits/bias: Persecutory delusions reflect false beliefs about the intentions and behavior of others that could arise from the theory of mind deficits.

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