

DEFINITION

Delusional disorder is the current classification for a group of disorders of unknown cause, the chief feature of which is the delusion (Table 13.2–1). Although the specific content of the delusion may vary from one case to the next, it is the occurrence of the delusion, its persistence, its impact on behavior, and its prognosis that unifies these seemingly different disorders. In considerable agreement with Emil Kraepelin's concept of paranoia, the revised third edition of DSM-III-R provides reliable criteria for identifying cases and collecting systematic information about these conditions. This development in classification helped to reestablish the clinical importance of this group of disorders and may have reversed a trend of infrequent diagnosis. The criteria use the term delusional to avoid the ambiguity of the term paranoid used earlier in the third edition of DSM (DSM-III) classification, paranoid disorders, as well as to emphasize that the category includes disorders in which delusions other than those of the persecutory or jealous type are present. Although these changes were initially confusing, especially in terms of comparisons to diagnostic approaches elsewhere, they have gained acceptance and have created a more level playing field for further empirical contributions.

Definition of Delusion and Certain Common Types Associated With Delusional Disorders

Delusion A false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof of evidence to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture (e.g., it is not an article of religious faith). When a false belief involves a value judgment, it is regarded as a delusion only when the judgment is so extreme as to defy credibility. Delusional conviction occurs on a continuum and can sometimes be inferred from an individual's behavior. It is often difficult to distinguish between a delusion and an overvalued idea (in which case the individual has an unreasonable belief or idea but does not hold it as firmly as is the case with a delusion).

Delusions are subdivided according to their content. Some of the more common types are listed below:

Bizarre—A delusion that involves a phenomenon that the person's culture would regard as totally implausible.

Delusional jealousy—The delusion that one's sexual partner is unfaithful.

Erotomaniac—A delusion that another person, usually of higher status, is in love with the individual.

Grandiose—A delusion of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person.

Mood-congruent—See mood-congruent psychotic features.

Mood-incongruent—See mood-incongruent psychotic features.

Of being controlled—A delusion in which feelings, impulses, thoughts, or actions are experienced as being under the control of some external force rather than being under one's own control.

Of reference—A delusion whose theme is that events, objects, or other persons in one's immediate environment have a particular and unusual significance. These delusions are usually of a negative or pejorative nature, but also may be grandiose in content. This differs from an idea of reference, in which the false belief is not as firmly held nor as fully organized into a true belief.

Persecutory—A delusion in which the central theme is that one (or someone to whom one is close) is being attacked, harassed, cheated, persecuted, or conspired against.

Somatic—A delusion whose main content pertains to the appearance or functioning of one's body.

Thought broadcasting—The delusion that one's thoughts are being broadcast out loud so that they can be perceived by others.

Thought insertion—The delusion that certain of one's thoughts are not one's own, but rather are inserted into one's mind.

Mood-congruent psychotic features—Delusions or hallucinations whose content is entirely consistent with the typical themes of a depressed or manic mood. If the mood is depressed, the content of the delusions or hallucinations would involve themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment. The content of the delusion may include themes of persecution if these are based on self-derogatory concepts such as deserved punishment. If the mood is manic, the content of the delusions or hallucinations would involve themes of inflated worth, power, knowledge, or identity, or a special relationship to a deity or a famous person. The content of the delusion may include themes of persecution if these are based on concepts such as inflated worth or deserved punishment.

Mood-incongruent psychotic features—Delusions or hallucinations whose content is not consistent with the typical themes of a depressed or manic mood. In the case of depression, the delusions or hallucinations would not involve themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment. In the case of mania, the delusions or hallucinations would not involve themes of inflated worth, power, knowledge, or identity, or a special relationship to a deity or a famous person. Examples of mood-incongruent psychotic features include persecutory delusions (without self-derogatory or grandiose content), thought insertion, thought broadcasting, and delusions of being controlled whose content has no apparent relationship to any of the themes listed above.

Reprinted with permission from American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, ed 4. © American Psychiatric Association, Washington, DC, 1994.

In 1994 DSM-IV refined the definition and the boundaries with other disorders, including substance-induced disorders, mental disorders due to general medical conditions, mood disorders, and schizophrenia. No laboratory test exists to assist in diagnosis. The DSM-IV definition, like its predecessors, hinges on the presence of a nonbizarre delusion. DSM-IV acknowledges the difficulty of judging whether a delusion is bizarre, meaning clearly implausible, not understandable, and not derived from ordinary life experiences. In contrast, the nonbizarre delusion involves situations or circumstances that can occur in real life (e.g., being followed, infected, or deceived by a lover). DSM-IV also emphasizes the differential diagnoses of schizophrenia, mood disorders, substance-induced disorders, and mental disorders due to a general medical condition before the diagnosis of delusional disorders can be made. These conceptual refinements and demarcations from other conditions have increased the usefulness of the criteria for delusional disorder.

Delusional Disorder

According to DSM-IV, the diagnosis of delusional disorder can be made when a person exhibits nonbizarre delusions of at least 1 month's duration that cannot be attributed to other psychiatric disorders. Nonbizarre means that the delusions must be about situations that can occur in real life, such as being followed, infected, loved at a distance, and so on; that is, they usually have to do with phenomena that, although not

real, are nonetheless possible. There are several types of delusions, and the predominant type is specified when the diagnosis is made.

In general, the patient's delusions are well systematized and have been logically developed. The person may experience auditory or visual hallucinations, but these are not prominent features. Tactile or olfactory hallucinations may be present and prominent if they are related to the delusional content or theme, examples are the sensation of being infested by bugs or parasites, associated with delusions of infestation, and the belief that one's body odor is foul, associated with somatic delusions. The person's behavioral and emotional responses to the delusion appear to be appropriate. Impairment of functioning is not marked and personality deterioration is minimal, if it occurs at all. General behavior is neither obviously odd nor bizarre.

Shared Psychotic Disorder

This unusual condition has also been called *folie à deux* and induced or shared psychotic disorder. It develops in an individual in the context of a close relationship with another person who has an established delusion that he or she also believes, and requires an absence of psychotic disorder prior to the onset of the induced delusion; it is usually classified with paranoid disorders.

HISTORY

Nineteenth-century psychiatry devoted much attention to the description of paranoid disorders, in which delusions are a cardinal feature. Karl Ludwig Kahlbaum's description of paranoia in 1863 was the first in a series of contributions that culminated in the classification of paranoia, and inspired that of *folie à deux*, morbid jealousy, the better-known schizophrenias, and mania. His work also led to a recognition that paranoid features are nonspecific characteristics of many medical diseases. Subsequent work has led to refined criteria for paranoid and related disorders and has reestablished awareness of less common paranoid presentations such as delusional disorder.

Many clinicians remember being taught that paranoia is so rare that most would not see a single such patient during an entire career. This widespread belief has compromised interest in paranoid disorders. The fact that most persons with delusional disorder live in the community and do not generally seek psychiatric care has made it difficult to carry out systematic case studies. Indeed, knowledge of these conditions has grown slowly. However, case series such as those of Alistair Munro (for delusional disorder, somatic type) or those of Nils Retterstol have been influential in shaping understanding and awareness. What they reveal is that there are persons with these disorders, that the disorders are complex forms of psychiatric illness, and that much remains to be learned.

A major change in the classification of delusional disorders in DSM-III-R and DSM-IV has been to emphasize the central role of delusions in those disorders and to steer away from the vague label of paranoid, which has become synonymous with suspicious and has come to apply largely to a personality disorder. Indeed, suspiciousness occurs in only some of these disorders. The history of the concept of paranoia indicates that lack of clarity in its use is not new. The word paranoia was coined by the ancient Greeks from roots meaning beside and self. Hippocrates applied this term to delirium associated with high fever, but other writers used it to describe demented conditions and madness. It sometimes meant thinking amiss, folly, and the like; hence, its meaning was unclear. For centuries the term fell into disuse until a revival of interest in the nineteenth century.

In 1863 Karl Kahlbaum classified paranoia as a separate mental illness: "a form of partial insanity, which throughout the course of the disease, principally affected the

sphere of the intellect." Influenced by the new scientific methods of empirical medicine, Kahlbaum emphasized the importance of natural history in mental illness and restricted the use of the term paranoia to a persistent delusional illness that remained largely unchanged throughout its course. He noted that delusions could occur in other medical and psychiatric conditions.

Emil Kraepelin found the paranoid concept troublesome and altered his thinking on it with each edition of his influential textbook. His final view advocated three types of paranoid disorder. Like Kahlbaum, Kraepelin based his conclusions on an analysis of the natural history of mental disorders, particularly on outcome, because etiology was obscure. He restricted the definition of paranoia to an uncommon, insidious, chronic illness (he saw 19 cases) characterized by a fixed delusional system, an absence of hallucinations, and a lack of deterioration of the personality. The types of delusions included persecutory, grandiose, jealous, and possibly hypochondriacal. He considered this illness to derive from defects in judgment, a disorder of personality caused by constitutional factors and environmental stress. Paraphrenia was a second paranoid disorder that developed later than dementia precox and was milder.

Hallucinations (auditory in particular) occurred, but there was no mental deterioration (dementia). Finally, there was dementia paranoides, an illness that initially resembled paranoia but had an earlier onset and showed a deteriorating course. Because of this latter feature, Kraepelin considered dementia paranoides a form of dementia precox that arose from disorders of thought, cognition, and emotion. Kurt Mayer's follow-up of Kraepelin's 78 paraphrenia cases challenged the validity of this category because the vast majority of patients showed an outcome indistinguishable from that of dementia precox, casting doubt on the separability of this group. Karl Kolle's follow-up of Kraepelin's paranoia cases indicated some overlap with dementia precox. Kraepelin also emphasized that isolated paranoid symptoms occurred in a variety of psychiatric and medical illnesses.

Eugen Bleuler also recognized paranoia; he broadened its definition to include cases with hallucinations—a paranoid form of dementia precox for which he coined the term schizophrenia—and an intermediate group. However, he thought that the paranoia described by Kraepelin was so rare that it did not warrant a separate classification. Further, he argued that schizophrenic symptoms must be suspected and carefully sought even in those cases. He believed that paraphrenia and intermediate conditions were forms of schizophrenia linked by "much that was identical," and particularly by a common disturbance in associative processes. He also emphasized that paranoid symptoms occurred in other conditions and that to label the symptoms schizophrenic required at least one of the fundamental symptoms: loosened associations, ambivalence, inappropriate affect, and autism. Bleuler's contributions reinforced a trend toward the diagnosis of paranoid illness as a form of schizophrenia. Sigmund Freud used the autobiographical writings of Judge Daniel Schreber to illustrate the role of psychological defense mechanisms in the development of paranoid symptoms. He proposed that Schreber's illness involved a process of denial or contradiction of repressed homosexual impulses toward his father. Persecutory and other delusions result from projecting these denied yearnings onto the environment. Freud did not differentiate subtypes of paranoid disorder, and confused the issue somewhat by proposing that the term paraphrenia be substituted for the term dementia precox or schizophrenia. The major impact of Freud's work was to suggest hypotheses that indicated the relationship between certain delusions and personality.

Ernst Kretschmer's work on the theory of paranoia emphasized that certain sensitive personalities, characterized by depressive, pessimistic, and narcissistic traits,

developed paranoid features acutely when key or precipitating experiences occurred at critical moments in their lives. He observed that these individuals did not develop schizophrenia and had a favorable prognosis. A number of other observations, predominantly but not exclusively emanating from European clinicians (e.g., the American concept of hysterical psychosis), proposed connections between personality and delusion development. Those efforts, based on various theories of the cause of paranoid disturbance, have persisted despite modest empirical support. Out of such work have come terms, such as reactive and psychogenic psychosis, which have figured in various classification schemes, undermining the effort to bring international consistency in definition.

Many barriers remain to international agreement on definition. For example, the term paraphrenia, unlike paranoia, has slipped into near obscurity in North America. In the United Kingdom, however, the diagnosis of late paraphrenia is often used and it is occasionally used in the United States. This term refers to cases of late-onset paranoid symptomatology not characterized by the presence of dementia, confusion, or mood disorder. Interestingly, Kraepelin did not identify a late age of onset in his cases. The potential overlap with late-onset cases of schizophrenia has been a focus of investigation and controversy. With the removal of the DSM-III age criterion for schizophrenia (upper limit of age of onset at 45) in DSM-III-R, cases of late-onset symptoms have tended to be diagnosed as schizophrenia in the United States. Nevertheless, clinical research continues to address the puzzle of whether late-onset cases, despite considerable overlap in clinical features, arise from a variety of causes. Current controversy is based on these historical antecedents and contemporary practices. DSM-III introduced greater rigor in the assessment by requiring clearer criteria boundaries among the varied disorders with delusions. Increased awareness that delusions result from numerous conditions has had a positive influence on the diagnostic process. Yet much of current clinical and research writing on paranoid conditions has characteristically avoided defining the terms paranoid and delusion, apparently because everyone was assumed to know what these terms mean. In popular and literary usage the term paranoid has come to mean insane, angrily suspicious, distrustful, or irrationally irritable. However vague the concept may be, it continues to be used in clinical work. Because it is necessary to differentiate conditions with paranoid features, a useful concept of the term is fundamental. However, the nature and definition of delusions upon which modern psychopathology and psychiatry are built remain unclear.

Shared Psychotic Disorder

Jules Baillarger first described the syndrome in 1860, calling it *folie à communiquer* *communiquée*, although the first description is commonly attributed to Ernest Charles Lasègue and Jules Falret, who described the condition in 1877 and gave it the name of *folie à deux*. The syndrome has also been called communicated insanity, contagious insanity, infectious insanity, psychosis of association, and double insanity. Marandon de Montyel divided *folie à deux* into three groups (*folie imposée imposée*, *folie simultanée simultanée*, and *folie communiquée communiquée*), and Heinz Lehmann added a fourth group, *folie induite*.

PARANOID CONCEPT

Paranoid signs and symptoms are among the most dramatic and serious disturbances in psychiatry and medicine but the term paranoid refers to a variety of behaviors that may not be psychopathological nor indicative of schizophrenia; hence, the meaning of the term has become obscure. Some clinicians label ordinary suspiciousness paranoid; others restrict use of the term to persecutory delusions; still others apply the term only

to grandiose, litigious, hostile, and jealous behavior, despite the fact that those behaviors may be within the normal spectrum. To make the paranoid concept useful and less vague requires consideration of several points:

1. The term paranoid is a clinical construct used to interpret observations, and in order to apply this construct effectively, the clinician must know its meaning and be able to make accurate observations of potentially paranoid behavior.
2. Use of the term paranoid means the clinician has judged that the person's behavior is psychopathological. This judgment is usually based on the discovery that the person who displays such features is either disturbed or disturbing to others.
3. Although many contributions to understanding paranoid phenomena have focused on conditions in which paranoid features are central (e.g., schizophrenia for Bleuler, paranoia and dementia paranoides for Kraepelin), those features are not necessarily associated with schizophrenia and can appear in other psychiatric and medical disorders. Hence, paranoid features indicate psychopathology, but no specific cause or outcome (Table 13.2–2).