Defining Delusional Disorder

Our modern conception of delusional disorder is based on Kraepelin's original formulations. He noted that in contrast to patients with dementia praecox, there was a subset of patients who held delusional beliefs but did not manifest hallucinations. Furthermore, functional capacities were generally preserved and the downhill course he saw as central to the dementia praecox diagnosis was not shown. Nevertheless, Kraepelin often had difficulty definitively diagnosing these individuals. Delusional disorder remains to this day a controversial and complex disorder.

Modern Definition and Criteria

The DSM diagnostic criteria for delusional disorder emphasize the presence of nonbizarre delusions, the absence of schizophrenia, the absence of prominent mood symptoms, and preservation of functioning. There are several subtypes that have been identified, including erotomaniac, grandiose, jealous, persecutory, somatic, mixed, and unspecified. In addition to schizophrenia, there are several other disorders that may mimic delusional disorder. Some of these disorders include affective psychotic disorders including bipolar disorder and major depression with psychotic features, delirium, dementia, substance abuse psychotic disorders, psychosis not otherwise specified, hypochondriasis, body dysmorphic disorder, obsessive-compulsive disorder, and paranoid personality disorder.

Delusional disorder is difficult to treat and often resistant to medications and therapeutic interventions. Since the patient is frequently noncompliant with treatment, this compounds the treatment difficulties. Schizophrenics are subject to repeated hospitalizations when symptom exacerbations occur. In contrast, the individual suffering from delusional disorder is generally able to function effectively and thereby avoid hospitalization. Symptoms such as thought disorganization and multiple psychotic symptoms are common in schizophrenia but are by definition not present in delusional disorder. Therefore, patients are often able to escape clinical detection.

Historical Background

Kraepelinian Formulation

Allen Stone, MD (2003), of Harvard University Law School, Boston, Massachusetts, reviewed the historical aspects of the delusional disorder diagnosis. The progressive downhill course Kraepelin identified in dementia praecox (early dementia) was central to his definition of the disorder. The typical clinical characteristics that Kraepelin delineated for dementia praecox were early age of onset, marked deterioration, chronic course, diverse psychotic symptoms, and impairment in volition and affect. He recognized, however, that a subset of patients had a better outcome and some did not show the multiple symptoms and disabilities characteristic of the disorder.

He hypothesized that individuals presenting with a fixed delusional system in the absence of hallucinations and personality deterioration warrant a diagnosis of a paranoid disorder. This closely parallels modern descriptions of delusional disorder. Kraepelin also observed various
subtypes of paranoia, including persecutory, grandiose, erotomanic, and jealous. He did not include a somatic subtype that we include today. Kraepelin concluded that paranoia was primarily a disorder of personality and judgment, and he thought that the disorder was influenced by environmental factors.

**Freudian Interpretations**

While Kraepelin was committed to developing a nosological system, many of his contemporary psychiatrists developed theoretical systems where diagnostic distinctions were not considered central. Freud, for example, gave a psychodynamic causal explanation to delusions and paranoia. Freud's analysis of paranoia was best delineated in his interpretation of Paul Schreber (Schreber & Macalpine, 2004). Schreber was a Dresden judge who began to suffer from delusions in 1893. He was hospitalized for 9 years and documented his struggle in a book of memoirs entitled *Denkwürdigkeiten eines Nervenkranken*, translated as *Memoirs of My Nervous Illness*. Freud offered his interpretation of Schreber's illness and conflict in his essay *Psychoanalytic Notes on an Autobiographical Account of a Case of Paranoia (Dementia paranoides)*, published in 1911. Schreber believed that God was transforming him into a woman so that he could be impregnated to save the human race. Freud contended that Schreber suffered from an inverted Oedipus complex and was dealing with conflicts against homosexual strivings. This became a model for interpretation of paranoid symptoms.

**The Case of Ernst Wagner**

The case of Ernst Wagner was described by the German psychiatrist Robert Gaupp. Wagner, born at the end of the 19th century, kept a journal of his struggles beginning in adolescence. He reported that at age 18 years he began to be troubled by obsessions with masturbation. He began to experience ideas of reference and was sure that people were talking about his masturbatory behavior. His ideas of reference increased in intensity after a poorly described incident of sexual behavior with animals. After 4 years of contemplation, he slit the throat of his wife and 4 children in the middle of the night. He then rode to the nearby village and began to light fires. As people ran, he shot and killed 8 people and wounded 12. After he was hospitalized, he made a radical political shift from being leftist to being Nazi and justified his killing as a need for racial cleansing. He maintained his intellect despite the extent of his psychosis, and Wagner is often considered a classic case of paranoid disorder. However, a schizophrenic process or affective psychosis may also explain the disorder. This "paradigm" case therefore is diagnostically controversial and is an example of the controversial nature of the disorder and disagreement in the field.

**Diagnostic Validity of Delusional Disorder**

Theo C. Manschreck, MD (2004), of Harvard Medical School, Boston, Massachusetts, discussed the diagnostic validity of delusional disorder. He identified several factors that limit our ability to understand delusional disorder, including:

- Limited scientific data;
- Problems in the criteria and definition; and
- The fundamental puzzle of delusions.
**Limited Scientific Data**

Most of the studies concerning delusional disorder are of small sample size and uncontrolled. Many reports rely only on clinical descriptions rather than systematically collected data and are therefore difficult or impossible to replicate. In addition, the terminology utilized is often inconsistent, making comparisons between studies difficult. Delusional disorder is thought to be an uncommon disorder and, since patients often hide symptoms and resist treatment, they frequently escape clinical detection and systematic study. Patients may look for help for their difficulties in nonpsychiatric settings. Somatic delusions about skin may present to a dermatologist. Patients with the jealous or paranoid subtype may go to a private detective for help. Since the boundaries between delusional disorder and other disorders are often indistinct, diagnostic validity and reliability may be compromised. For example, somatic forms tend to occur significantly earlier than persecutory forms, and this might be indicative of a different clinical syndrome.

**Problems in Criteria and Definition**

In long-term follow-up studies, it is not uncommon for there to be a revision of the diagnosis as symptoms not present on initial analysis may surface later. For example, it is not uncommon to observe depressive symptoms. Although this may be a secondary phenomenon due to the chronic disturbing symptoms unshared by one's peers and family, it may also be a hallmark of an underlying affective psychosis. These affective symptoms may not present until later in the course, and the affective features may therefore be overlooked. Similarly, the delusional system may become more widespread and other psychotic symptoms indicative of schizophrenia may not be apparent early on. In addition, medical disorders may result in delusional thinking, and these medical issues may be difficult to detect.

**The Fundamental Puzzle of Delusions**

Since the delusions by DSM-IV definition must be of a somewhat plausible "nonbizarre" nature, they tend to blend with thinking that may be considered a variant of normal. In a study in a normal population, the rate of belief in paranormal phenomena such as contact with the dead, prophecy, telepathy, UFOs, and reincarnation was high and correlated negatively with the strength of religious conviction. In nominal and nonbelievers, the rate of at least moderate acceptance of paranormal phenomena was 30% to 50%.

**Development of DSM Criteria and Definitions**

The development of the DSM definitions of schizophrenia and delusional disorders was reviewed by Nancy C. Andreasen, MD (2004), of the University of Iowa, Iowa City, Iowa. The DSM III diagnostic system was developed in order to develop uniform criteria that were reliable and valid, similar to a model created by the Feighner criteria. A major goal was to establish a system that would enable clinicians and researchers to communicate effectively with each other. Ultimately, it was hoped that the uniformity and rigor of the DSM system would allow us to better determine psychopathological and pathophysiological processes underlying the disorder.
However, clear definition and delineation of the delusional disorders has proven difficult as the boundary with schizophrenia is blurred.

**Bleuler's Views**

There were several competing conceptual frameworks that were considered in the formulation of the DSM classification of psychoses in addition to the Kraepelinian system. Bleuler attempted to find unifying factors that linked seemingly diverse clinical presentations and viewed the loosening of associations as the key factor in schizophrenia. Since he saw loosening of the thought process as a splitting or fragmenting of the mind, he coined the name schizophrenia. Bleuler emphasized that there was more of a possibility for reconstitution in some patients than Kraepelin allowed. He utilized a broader definition and viewed the disorder as heterogeneous. He identified autism, ambivalence, association, and affect as defining features of schizophrenia. He used autism to refer to idiosyncratic thinking while ambivalence was used to refer to behaviors we now label as seen in obsessive-compulsive disorder. He also identified attention and avolition as core features, constructs that we now associate with negative symptoms of schizophrenia.

**Schneider's Influence**

Like Bleuler, Kurt Schneider was also interested in finding fundamental constructs and symptomatology underlying schizophrenia. Borrowing from Karl Jasper, he viewed the psychotic experience as a loss of ego boundaries and the sense of the self. The psychotic individual was therefore seen as having a core difficulty in distinguishing the internal self experience from the external world. He labeled the primary symptoms in schizophrenia as "first rank" symptoms. The first rank symptoms were thought to be manifestations of the loss of ego boundary. Schneiderian first rank symptoms were viewed as clearly outside the range of normal experience. Compared with the Bleulerian system, Schneider's criteria could be utilized to more effectively separate more serious psychotic disorders from less pernicious ones. It assumed more importance, therefore, in the development of the structured diagnostic system being developed in the DSM. First rank symptoms were also influential in ICD and other European classifications.

The symptoms included:

- Audible thoughts;
- Hearing voices commenting on one's actions;
- Hearing 2 voices arguing;
- Thought broadcasting;
- Thought insertion;
- Thought withdrawal;
- Somatic passivity; and
- Delusions of being controlled.

Although Schneider saw these symptoms as distinguishing features of the schizophrenic syndrome, it became clear that they also were present in other disorders such as the affective psychoses. This raised doubts about the specificity of the symptoms for schizophrenia. There were also wide differences in the frequency distribution of these symptoms between studies,
raising reliability and validity questions.

The Concept of "Bizarre"

The requirement of "nonbizarre" delusions in the DSM criteria for delusional disorder is at times problematic and open to interpretation. Cultural differences, for example, may have significant effects on the content of symptoms and standards for "bizarre." For examples, some Christian sects contend that the dead can influence the lives of the living, yet this might be considered bizarre by others. Since the interpretation of bizarre depends on clinician variables, cultural and educational factors among others, establishing a uniform definition is difficult. Dr. Andreasen contended that to use the bizarre criteria to differentiate schizophrenia from delusional disorder is problematic. She suggested that we utilize indicators such as the preservation of affect and function as primary distinguishing factors.

Personality Factors

C. Robert Cloninger, MD (2004), of Washington University Medical School, St. Louis, Missouri, suggested that we focus on the prepsychotic personality and the factors leading to the development of the delusional disorder. Some family studies indicate that there are little or no mood or schizophrenic disorders in relatives of patients with delusional disorder. However, a higher incidence of inferiority feelings in probands of patients with delusional disorder compared with probands of schizophrenic patients has been found.[13] Inferiority feelings include a negative self-image and feelings of inadequacy, and they are associated with hypersensitivity reactions. Dr. Cloninger has observed that a high percentage of patients with delusional disorder manifest narcissistic traits in contrast to the schizoid traits seen in many schizophrenics. These narcissistic feelings may be provoked by feelings of insecurity. There also tends to be a high level of novelty-seeking characteristics.

Dr. Cloninger suggested that there were different conflictual patterns observable in the different subtypes. The jealous type is characterized by conflicts between self-efficacy vs jealousy and envy. The persecutory type manifests conflicts between superiority and inferiority. The somatic type struggles with social attachment vs disloyalty. Conflicts in erotomania revolve around struggles with intimacy. If the conflict is activated, personality traits may progress to delusions. Dr. Cloninger argued that treatment with a strong psychotherapeutic alliance may help the individual to deal with the narcissistic injuries. Alternatively, punitive or involuntary treatments may exacerbate the conditions.

Legal Issues

Richard G. Taranto, JD (2004), of Farr and Taranto, Washington, DC, discussed complex legal issues related to delusional disorder. The law does not directly incorporate the DSM-IV categorical diagnostic system in a formal way. Instead, issues easily understood by the layperson are primary. Some of these legal questions applicable in the mentally impaired individual include judgment of the capacity to distinguish right from wrong, competence to stand trial as evidenced by the capacity to understand the nature of the proceedings and assist counsel, and the assessment of dangerousness for purposes of commitment or administration of medication over
objection. The lay public might have difficulty understanding the nuances of the DSM system, especially with regard to the complex diagnostic and treatment issues raised with delusional disorder. In *Kansas v Hendricks*, the first sexual predator case, the Supreme Court sidestepped issues concerning what constituted mental illness but used the criteria as the ability to control one's self.

The case of Dr. Charles T. Sell, a St. Louis dentist, was used as an example (2003). Dr. Sell was indicted in 1997 for mail fraud, Medicaid fraud, as well as money laundering. As the trial neared, he became increasingly paranoid and agitated. He was diagnosed as having a delusional disorder and it was thought that he was too delusional to be competent to stand trial. He refused to take psychotropic medications and the case was eventually heard by the Supreme Court. His defense lawyers argued that taking antipsychotic medications would induce "synthetic sanity," breach his liberty, and expose him to potentially permanent side effects. The court ruled that medications can be administered over objection if they are considered to be medically appropriate, there is a reasonable likelihood of restoring competence, there are no alternative treatments that might have the same effect, and there is no possibility that the medications would further impair competence (eg, excess sedation or cognitive impairments). The decision was supported by the American Psychiatric and Psychological Associations, and this may have helped to reinforce the court's standing on the issue.

Most cases of medication administration by injection involve schizophrenia or affective psychosis. However, the delusional disorder diagnosis of Dr. Sell meant that medication effectiveness was less apparent. The court, however, elected not to discuss the particular aspects of the medications, including effectiveness and side effects. It was decided that the issue of restoration to trial competence should not be reached unless the issue of dangerousness as a justification is decided first. This decision reflected the confidence of the court in the medical decision of dangerousness. Medication in the case of dangerousness to others indicates a willingness to limit personal freedom of the defendant if the freedom of another individual is enhanced by the potential decrease in external threat. In the case of dangerousness to self, the role of the court is more paternalistic and focuses on the perceived potential good to an individual with presumed impaired judgment. However, the intrusion to autonomy is considered to be a very serious one, and the court's decision to give preference to dangerousness was an attempt at avoiding raising competency issues in these cases if possible. However, there are now 50 to 60 cases of refusal to take medication in the federal prison system. Nineteen of these cases have gone to trial and medications have been ordered in 12. Despite the Supreme Court ruling, each has been argued in terms of competence to stand trial and not dangerousness.

**Summary and Conclusions**

Although delusional disorder is considered to be a relatively rare syndrome, it serves as an example of the complexities of the diagnostic system we utilize today. We are still struggling with issues that concerned Kraepelin in his original formulations, and we have not been able to adequately address the questions that he raised. Thus, the disorder still challenges the nosological system, our clinical skills, and our legal system.

**References**


