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Assessment of Clinical Profile, Treatment Outcome of Individuals Treated for Delusional Disorder

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ABSTRACT
Due to the nature of delusions, many patients deny the disease and refuse treatment. A positive response to treatment is observed in a high proportion of patients,1 and many patients can maintain overtly normal activities. Given the long history of PDD as a psychiatric diagnosis, very few studies have specifically researched this condition, with most of the available information being retrospective. Duration of illness was defined as the time between the onset of illness and the age at first consultation in our OPD. The total duration of contact was the total duration for which the patient was followed up. Treatment response was assessed for patients who received anti-psychotics = 300mg chlorpromazine equivalents for at least 12 weeks. Initial assessment of the patient in the OPD was done by the postgraduate resident after conducting a formal mental status examination which was then verified by the consultant psychiatrist. On further follow up the patients were assessed by the consultant psychiatrist. 30 (29.4%) had positive family history while 38 (55.8%) had no family history of any related illness. Among patients the common delusions were infidelity and persecution with a frequency of 44 (64.7%) and 19 (27.9%) respectively. The delusional disorder has much co-morbidity. Non-compliance with the treatment must be addressed meticulously. But the level of functioning is found to be reasonably fair irrespective of the treatment status. Though the information gathering was through telephone call it was found to be working well.

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Key Words
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INTRODUCTION

It presents with a stable and well- defined delusional system, which is typically encapsulated within the personality, which retains many normal aspects unlike in schizophrenia where there is widespread personality disorganization.1 Due to the nature of delusions, many patients deny the disease and refuse treatment. A positive response to treatment is observed in a high proportion of patients[1] and many patients can maintain overtly normal activities. Onset can be anytime from late adolescence to extreme old age, but usually restricted to the middle aged and elderly. The disease is equally distributed among both sexes, though higher incidence in females was reported[2]. Persecutory delusions were the most commonly observed. Indian studies also made a similar observation[3] or reported delusions of infidelity as the most common[4]. A combination of organic brain disorders and alcohol abuse was observed in male subjects[5]. High lifetime co-morbidity with affective disorders is reported[6]. Ten or more per cent of delusional disorder patients experienced significant degrees of mood disorder during recovery. Most patients remain diagnostically stable in the long term while approximately 10 percent deteriorates into schizophrenia[1]. Some of those with an episodic course may prove to be bipolar illness later. Since 1980 pimozide was the drug of choice[3]. risperidone and clozapine[8-9] were reported to be beneficial. Indian authors have reported a good response to trifluoperazine, haloperidol, chlorpromazine, and electro convulsive therapy[3].

Being a chronic illness the distress to the relatives especially the spouses is high, physical and verbal abuse occurs more frequently. It can be potentially dangerous as well and has been associated with violence, notably both suicide and homicide[10]. In a study from India[11], the authors reported good response to both typical and atypical anti-psychotics, particularly risperidone. A more recent study[12] found no differences between long-acting risperidone, oral risperidone and other atypical anti-psychotics in treating PDD, however, compliance was understandably better in the long-acting risperidone group. Given the long history of PDD as a psychiatric diagnosis, very few studies have specifically researched this condition, with most of the available information being retrospective.

MATERIALS AND METHODS

All the case records of three years for the period between January 2011 and December 2012 were retrieved and relevant details were gathered. Duration of illness was defined as the time between the onset of illness and the age at first consultation in our OPD. The total duration of contact was the total duration for which the patient was followed up. Treatment response was assessed for patients who received anti-psychotics = 300mg chlorpromazine equivalents for at least 12 weeks. Initial assessment of the patient in the OPD was done by the postgraduate resident after conducting a formal mental status examination which was then verified by the consultant psychiatrist. On further follow up the patients were assessed by the consultant psychiatrist. Treatment response in follow up was taken as good based on the consultant psychiatrist's recording in the case sheet as having an improvement in the clinical status and 50% and more reduction of symptoms, after conducting a mental status examination and sustained dose reduction. Treatment response was taken as poor if the patient has <50% reduction of symptoms and has no sustained dose reduction. Those who did not meet the above criteria were put under not sure group. Follow-Up status was divided into regular, irregular and drop out. Those who kept >50% of their scheduled visits during their period of contact were considered to be regular. Those who kept <50% of such scheduled visits were classified as irregular. Those who did not report for follow-up even once or had less than two visits after initial consultation were categorised as dropouts. The current status of the patients was assessed by the primary investigator using telephone call mostly to the spouses of the patients after getting oral informed consent. The telephone number is stored as part of the required data at the time of OP/Casualty registration. The assessment parameters included whether the patient was working/doing household activities, whether there was improvement in his/her clinical condition/not as per the spouse's subjective assessment, was the patient expressing delusions, whether the patient was creating any sort of issues in the family and was he/she currently taking treatment or has quit taking it.

The data were analyzed using the Statistical Package for Social Sciences (SPSS, version 16.0). Descriptive statistics were used for the analysis of socio-demographic and clinical data. The study was approved by the institute ethics committee. No patients were contacted.

RESULTS

Tow thousand thiry hundred eighteen patients attended the OPD services of the Department of Psychiatry of our hospital during the disorder and out of them 60 case records were excluded from the study due to lack of all the information required for the study. Thus 48 case records were taken up for the study. Out of 68 patients, 36 (52.9%) were males and 32 (47.0%) were females, 64 (94.1%) were married and 5 (7.3%) were unmarried while 2 (2.9%) was a widow. Details of the age of onset, age at first consultation and the total duration of illness are given in Table 1. 30 (29.4%) had positive family history while 38 (55.8%)

Table 1. Age of onset and first consultation and the total duration of illness in patients with Delusional disorder

	No.	Minimum	Maximum	Mean ± SD	Median (IQR)
Age of onset	68	20.00	56.00	38.08±10.46	37.52 (32.00, 46.00)
Age at first consultation	50	26.00	65.00	43.41±10.51	45.00 (38.00, 50.27)
Total duration of illness (years)	68	0.52	34.00	8.65±8.11	6.00 (3.21, 12.00)

Table 2. Illness profile

Variables	Frequency (no.)	Percentage
Delusions of infidelity	44	64.7
Delusions of persecution	19	27.9
Delusions of grandeur	3	4.4
Delusions of reference	1	1.4
Delusions of hypochondriasis	1	1.4

Others- amisulpride, aripiprazole, quetiapine, olanzapine, blonaserin

Table 3. Response to antipsychotic treatment in patients presenting with Delusional disorder (n = 68)

			Response		
		Number	Good	Bad	Not sure
Atypical	Risperidone	19 (100%)	12 (63.1%)	0 (0%)	7 (36.8%)
	Clozapine	34 (100%)	12 (35.2%)	7 (20.5%)	15 (44.1%)
	Others	6 (100%)	4 (66.6%)	0 (0%)	2 (33.3%)
Typical	Trifluoperazine, chlorpromazine, haloperidol	9 (100%)	4 (44.4%)	3 (33.3%)	2 (22.2%)
Any		68 (100%)	32 (47.0%)	10 (14.7))	26 (38.2%)

Table 4. Treatment adherence (degree of contact with our hospital)

	Minimum	Maximum	Mean ± SD	Median (IQR)
Average number of visits	68 2.00	23.00	8.30±7.09	5.51 (3.21,13.00)
Total duration of contact in hospital (months)	68 0.52	55.00	10.65±11.91	4.23 (2.00,19.23)

Table 5: Number of patients according to follow up pattern and status of diagnosis at follow up

Variables		Frequency	Percentage
Follow up status	Regular	23	33.8
	Irregular	10	14.7
	Drop out	35	51.4
Change of diagnosis	Yes	9	13.2
	No	59	86.7

had no family history of any related illness. Among patients the common delusions were infidelity and persecution with a frequency of 44 (64.7%) and 19 (27.9%) respectively (Table 2). Details about the average number of visits and the total duration of contact in the hospital are given in Table 4. Of the total 68 patients, 23(33.8%) had regular follow up, 10 (14.7%) had irregular and 35 (51.4%) dropped out (Table 5).

DISCUSSIONS

This may be following the general pattern of more male patients getting the benefit of inpatient care because of socio-cultural factors favouring it like male dominance in the family, male being earning member and head of household, getting the privilege of treatment is more for males. All earlier Indian studies mention about varying sex ratio in hospital and community settings which may be another explanation. There were contrary observations in other studies[13,14]. There were reports that delusional disorder patients were married, self-supporting and working.3 Our observation was also the same. Mean age of onset and the first presentation for treatment were similar to other studies[15]. There was a time lag of 5.39 years before treatment was sought. Non-recognition of abnormal behavior as a symptom of illness may be a reason. Further studies are needed to explore this area to encourage early treatment. Marneros *et al.* reported 23.3 % had a positive family history of psychiatric disorder;16 whereas Sandeep et. al.'s study showed 35.2%.3 In our study it was 41.7%. The reason for the difference is not explainable and needs specific exploration. Sandeep *et al*[1] reported persecutory delusions as the most common delusion whereas Kulkarni *et al*.[4] reported delusion of infidelity. Our study goes in line with the latter. Grandiose, hypochondriac and referential delusions were rare. A few subjects had more than one delusion but within the same delusional system. In males an association of infidelity delusions and co- morbid alcohol dependence syndrome was observed. Evidence for the association with alcohol and substance use disorders was reported else where also[1,2] and in a meta-analysis by Munro *et al*.[5] Co-morbidity with other psychiatric conditions were high elsewhere[17] but was comparably less in our sample. Unlike other reports our sample had alcohol use disorder as the most frequent co-morbidity. This is explainable based on the male preponderance in the study sample.

Some limitations have to be mentioned. Since this was a chart review, we did not interview any of the included patients for the study, so we are unable to comment on their current clinical status or earlier diagnosis. We did not attempt to confirm a diagnosis of PDD for our study and accepted the diagnosis made by the treating clinicians. It is likely that some of the patients may have received a different diagnosis had we attempted to do so, given that 11% had a change in diagnosis during follow-up. We also did not analyze the data of patients who were lost to follow-up separately. Our data are from a tertiary care center that treats severe mental disorders and it is likely that our patients have more severe forms of PDD with more

comorbidity than what is encountered in community and general hospital-based samples. It can be surmised that if compliance to treatment with second-generation anti-psychotics, particularly risperidone, can be ensured, patients with PDD are likely to respond well to treatment. However, almost one-third of the patients were lost to follow-up, which again highlights the difficulty of retaining them in the treatment process. Compliance with treatment appears to be the most important determinant of outcome. Approximately half of the patients were not on any treatment at the time of the study. Their compliance to treatment was poor in the long run. However, relatives reported improvement in about 85% of cases. Recovery rate, surprisingly high and fast was reported earlier also[1]. About one-third had delusions but all were doing some job or household activities, and most were not creating issues in the family. The current investigation supports the fact that they can return to a considerable degree of adequate intra psychic, interpersonal and occupational functioning[1].

CONCLUSION

Our study showed male preponderance, the delusion of infidelity as the most common delusion and most of them were married. The delusional disorder has much co-morbidity. Non-compliance with the treatment must be addressed meticulously. But the level of functioning is found to be reasonably fair irrespective of the treatment status. Though the information gathering was through telephone call it was found to be working well.

REFERENCES

1. Munro, A., 2001. Persistent delusional symptoms and disorders.
2. Kendler, K.S., 1982. Demography of paranoid psychosis (delusional disorder). Arch. Gen. Psychiatry, 39: 890-902.
3. Grover, S., P. Biswas and A. Avasthi, 2007. Delusional disorder: Study from north India. Psych. Clin. Neurosci., 61: 462-470.
4. Kulkarni, K.R., R. Arasappa, K.M. Prasad, A. Zutshi, P.K. Chand, K. Muralidharan and P. Murthy, 2016. Clinical presentation and course of persistent delusional disorder. Prim. Care. Comp. CNS. Disord., Vol. 18 .10.4088/pcc.15m01883
5. Munro, A. and H. Mok, 1995. An overview of treatment in paranoia / delusional disorder. Can. J. Psychi., 40: 616-622.
6. Maina, G., U. Albert, A. Badà and F. Bogetto, 2001. Occurrence and clinical correlates of psychiatric co-morbidity in delusional disorder. Eur. Psychi., 16: 222-228.
7. Elmer, K.B., R.M. George and K. Peterson, 2000. Therapeutic update: Use of risperidone for the treatment of monosymptomatic hypochondriacal psychosis. J. Am. Acad. Dermatol., 43: 683-686.
8. Manschreck, T.C. and N.L. Khan, 2006. Recent advances in the treatment of delusional disorder. Can. J. Psychi., 51: 114-119.
9. Buckley, P.,F. M. and Sajatovic, 1994. Treatment of Delusional Disorders with Clozapine. Am. J. Psychi., 151: 1394-1395.
10. Sadock, B.,J.V.A. and Sadock, 2010. Schizophrenia spectrum and other psychotic disorders.
11. González-Rodríguez, A., O. Molina-Andreu, M.L.I. Gurrutxaga, R.C. Campos and M.B. Arroyo, 2014. Estudio retrospectivo del tratamiento y uso de consultas en un grupo clínico de pacientes con trastorno delirante. Rev. Psiquia. Salud. Mental., 7: 64-71.
12. Yamada, N., S. Nakajima and T. Noguchi, 1998. Age at onset of delusional disorder is dependent on the delusional theme. Acta. Psychiatr. Scand., 97: 122-124.
13. Celine, T. and J. Antony, 2010. A study on mental disorders: 5-year retrospective study. J. Fami. Med. Prima. Care., 3: 12-16.
14. Hsiao, M., C. Liu, Y. Yang and E. Yeh, 1999. Delusional disorder: Retrospective analysis of 86 Chinese outpatients. Psychiat. Clin. Neurosci., 53: 673-676.
15. Marneros, A., F. Pillmann and T. Wustmann, 2010. Delusional disorders-are they simply paranoid schizophrenia. Schizophre. Bull., 38: 561-568.
16. Marino, C., M. Nobile, L. Bellodi and E. Smeraldi, 1993. Delusional disorder and mood disorder: Can they coexist. Psychopathol., 26: 53-61.