Editor:

In my reading of the otherwise well-written commentary about the article on a case of psychotic denial of pregnancy in *The Journal* in 2011, I took exception to Dr. Powsner's discussion of delusional disorder.[1] Setting aside that delusional disorder is easily ruled out in this case, given the bizarre nature of the symptoms presented, I was more concerned by the suggestion that delusional disorder was "much less responsive to pharmacologic management [than schizophrenia] and casts doubt on a recommendation for inpatient psychiatric stabilization" (Ref. 1, p 42). Dr. Powsner provided no reference to support either claim.

Delusional disorder is difficult to study, because affected persons often do not experience distress related to their fixed, false beliefs; they may not experience impairment if their beliefs are not acted on in a way that draws attention; and they usually lack the insight to seek treatment.[2] Munro[3] suggested that an 80 percent success rate from pimozide can be estimated when the existing case reports are considered in aggregate. Of great interest to this subject was the review by Herbel and Stelmach[4] of 22 forensically hospitalized defendants with a diagnosis of delusional disorder, who were adjudicated incompetent to stand trial, of which 17 (77%) were restored to competency with forced medication. These results, while certainly requiring further validation, hardly contrast with the findings of the PORT study of over 100 trials of antipsychotic medications other than clozapine which cited a 50 to 80 percent improvement of patients with schizophrenia.[5]

Persons with delusional disorder, especially erotomanic, persecutory, jealous, and grandiose types, may engage in criminal behavior (e.g., stalking, assault, or murder) in response to their beliefs. Based on clinical experience (mine and that of colleagues) in correctional facilities and a maximum-security forensic hospital, I think that delusional disorder does concentrate in these settings. I encourage further investigation of this disorder, which should be of special interest to forensic psychiatrists.

References

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Reply

Editor:

I thank Dr. Tamburello for highlighting the question of delusional disorder in this case. He calls attention to the findings of Herbel and Stelmach,[1] and I firmly agree that their article is worth a careful read.

As Tamburello notes, a formal diagnosis of delusional disorder is unlikely to be correct. I raised this possibility to combat a common assumption that any poor, odd person labeled schizophrenic is properly diagnosed with schizophrenia. Yes, this patient probably does have schizophrenia. But remember, formal diagnosis according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) hinges on whether a patient's beliefs are bizarre, and DSM-IV-TR cautions that "*bizarreness* may be difficult to judge, especially across different cultures" (Ref. 2, p 324). We are at a disadvantage when attempting to discern the limits of local belief systems from across the country.

I also raised the possibility of delusional disorder to combat a common assumption that psychotic symptoms imply the efficacy of antipsychotic treatment. On this point, Herbel and Stelmach[1] make for very interesting reading. Their literature review notes the absence of empirical support for (my) opinion that delusional disorder responds poorly to treatment, but it also notes no clinically significant improvement from medication during the only double-blind medication trial described. They offer much to contemplate.

From a purely clinical perspective, the findings of Herbel and Stelmach are hard to apply to a pregnant woman. Their cases involved 22 incarcerated men, no women, and, in over a third, weapons. It is a retrospective review, implicitly open-labeled and unblinded. Perhaps pertinent to a woman who is expecting in less than two months, 10 of their 17 responders "did not show significant improvement until. . .at least three months of continuous treatment" (Ref. 1, p 55).

I support Tamburello's assertion that further investigation into delusional disorder is of interest to forensic psychiatry. Readers will have to decide for themselves how effectively and how quickly to expect medication to subdue circumscribed delusions in the absence of hallucinations and disorganization.

References

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Editor:

In an article published in the December 2011 issue,[1] John M. Fabian, PsyD, JD, reviewed scholarly, clinical, and legal questions concerning hebephilia, with particular reference to sexually violent predator civil commitment proceedings. The term hebephile refers to individuals (usually men) who are most sexually attracted to pubescent children rather than to persons older or younger. This label stands in contrast to the term pedophile, which refers to men who are most sexually attracted to prepubescent children, and to the term teleiophile, which refers to men most attracted to persons between the ages of physical maturity and physical decline. I use hebephile to refer to men with an erotic preference for children who are generally 11 through 14 years of age.

Among the many and varied questions considered by Fabian is "whether attraction to postpubescent adolescents is, in actuality, a sexual deviation at all, especially given that from biological and evolutionary perspectives, such attraction patterns may be considered adaptive and normal" (Ref. 1, p 500). This question, as stated, contains several elements. I need to unpack them before I can explain a specific point on which Fabian misrepresented my views, thus necessitating this letter of correction.

It is true that normal men (i.e., teleiophiles) respond with some degree of penile tumescence, at least in the laboratory, to depictions of nude pubescent and even prepubescent children of their preferred sex. This finding was made in the Kurt Freund Laboratory,[2] and it has been confirmed in the same laboratory.[3] There is a difference, however, between the finding that teleiophiles respond at some detectable level to depictions of pubescents and the finding that other men (hebephiles) respond more strongly to depictions of pubescents than to those of prepubescents or adults. The former observation does not make the latter normal.

It certainly does not make the latter finding adaptive. That was the whole point of the study that I published on this topic a few years ago.[4] Unfortunately, Fabian accidentally reversed my conclusions from that study, thus seeming to place me in the camp of those who object to the classification of hebephilia as paraphilic on Darwinian grounds. The foregoing quote from Fabian's article is followed by this sentence:

> Along these lines, Blanchard suggests that when considering evolutionary adaptedness, men with erotic preference for pubescent females have greater reproductive success, either because they acquire female mating partners who are near their onset of fertility which prevents them from being impregnated by other men, or because they have more years in which to impregnate their female mates [Ref. 1, p 500].

That is the precise opposite of what I concluded from that study, in which I compared the mean number of biological children reported by 818 heterosexual teleiophiles, 622 heterosexual hebephiles, and 129 heterosexual pedophiles. The results showed that the teleiophiles had significantly more children than did the hebephiles, and the hebephiles had significantly more children than did the pedophiles. Here is my actual conclusion, which is the last paragraph of my two-page article:

> I am not concluding from these results that hebephilia should be included in the DSM on the grounds of reduced reproductive fitness. That reasoning would imply that homosexual teleiophilia should be reinstated in the DSM, which is not my view at all. My conclusion, rather, is that contemporary heterosexual hebephiles are significantly less