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.