



Delusional Disorder and Risk of Suicide

John Snowdon*

Concord Clinical School, The University of Sydney, Australia

Introduction

Delusional Disorder (DD) is uncommon but can be dramatic in its presentation. The condition is characterised by delusions to which patients cling tenaciously, and which are superficially logical [1]. The delusional system is encapsulated, with preservation of personality attributes. The delusions do not interfere much with general logical reasoning, but the patient's way of life is driven by the dominating influence of their beliefs, which they constantly rehearse. Premorbid personality disorder is reported as common in cases of DD [2].

Relatively little has been written about the effectiveness of interventions in cases of DD, partly because of confusion about how it should be defined. To date there have been no randomised clinical trials of pharmacotherapy in cases of DD [3]. Successive DSM classifications of DD, since introduction of the term in 1987, have stated that hallucinations, if present, are not prominent and are related to the delusional theme. However, the ICD-10 manual declared that DD (as defined by ICD-10) encompassed cases of paranoia and paraphrenia. Roth et al. [4] had proposed that the label 'late paraphrenia' be used when referring to late onset paranoid psychosis with "well-preserved" personality, many cases being characterised by prominent hallucinations. DSM-III-R indicated that DD delusions were non-bizarre; DSM-5 allows them to be bizarre, meaning they are "clearly implausible, not understandable, and not derived from ordinary life-experiences".

Data from nine series of DD cases (n = 1413) reported in the world literature (references available from the author) show that co-morbid depression was present in about 40%. Mean age of onset was about 40 years. A majority of participants were female (1.3:1). Nearly half (45.7%) were of the paranoid type, 23.4% jealousy, 10.3 % somatic, 2.3% erotomanic, 1.4% grandiose and 16.9% unspecified or mixed type. Little attention has been given specifically to DD cases of late onset. Harris et al. [5] provided details about 19 psychiatric patients who fulfilled DSM-IV-TR criteria for delusional disorder, all being of late onset. Their mean age was 83.5 years and mean MMSE score 25.6; six scored between 21 and 24. Neuropsychological testing revealed "a significant and specific pattern of cognitive impairment". In a study of over 50 cases with mean onset age 69.6 years, J.Nagendra and J.Snowdon (unpublished findings) found a female preponderance (3:1). They were careful to exclude cases where there was evidence of a developing dementia, including any where the MMSE score was less than 25.

Few studies have investigated suicidal behaviour in patients with DD: González-Rodríguez et al. [6] reviewed the literature mentioned in this paragraph but did not look for or report cases of completed suicide. In a cross-sectional study of 86 cases (mean age 54 years), attempted suicide was recorded in 21%, with the persecutory type being more likely than others to present with suicide risk [7]. The same percentage (21%) was reported by Wustmann et al. [8] in a cross-sectional plus longitudinal study (mean age 47 years). Two studies of medical record reviews reported suicide attempts in about 11%, and one of these reported that physical illness was a precipitant of attempted suicide in nearly half the cases. Two single case reports (males aged 25 and 39) were of suicide attempts in cases of somatic type DD without co-morbid depression; another male aged 73 years with somatic (infestation) delusions was reported to be depressed and suicidal but made no suicide attempt.

Although little research has focussed on late life DD, epidemiological studies of late paraphrenia have included substantial proportions of DD cases. In a study of 7 older in patients with paraphrenia and 13 with DD (cases without hallucinations), some were depressed but none had "suicidal tendencies" [9].

In an ongoing longitudinal study of DD cases in Sydney, 3 (6%) of the 51 assessed so far (Nagendra and Snowdon, November 2017), being two of the 44 with persecutory type DD and one of the 6 with jealousy type DD, made suicide attempts. Three non-attempters were reported

OPEN ACCESS

*Correspondence:

John Snowdon, Clinical Professor,
Psychiatry, Concord Clinical School,
The University of Sydney, Australia, Tel:
0297675000; Fax: 0297678951;
E-mail: jsnowdon@mail.usyd.edu.au

Received Date: 01 Oct 2017

Accepted Date: 27 Nov 2017

Published Date: 04 Dec 2017

Citation:

Snowdon J. Delusional Disorder and
Risk of Suicide. *Ann Clin Case Rep.*
2017; 2: 1479.

ISSN: 2474-1655

Copyright © 2017 John Snowdon. This
is an open access article distributed
under the Creative Commons Attribution
License, which permits unrestricted
use, distribution, and reproduction in
any medium, provided the original work
is properly cited.

as showing suicidal ideation. Three others made threats they would kill themselves “if nothing was done”, “because no one believes me”, or because angry at his wife’s perceived unfaithfulness; all three appeared angry and distressed rather than depressed. Including the three who attempted suicide, eleven (22%) presented with one or more depressive symptoms but not with clear depressive disorders. Only three of the 11 were prescribed antidepressants.

Case Report

In order to de-identify the following case (one of the 51 mentioned above), certain details have been disguised.

Mrs A first presented to a mental health service when aged 65 years. She is intelligent, migrated to Australia, and is no longer married. She self-presented, saying she felt unsafe in her dwelling. She believed her ex-husband was trying to poison her, and she expressed various paranoid ideas. She was anxious but not depressed. She had a history of hyperthyroidism which had been treated with radioactive iodine. She was now hypothyroid and therefore was taking thyroxine. When treated with quetiapine the delusions ceased and she was discharged home after a fortnight. She was followed up by a private psychiatrist for several months and remained well. A CT scan of her brain showed no abnormalities.

Four years later she self-presented to a hospital with stab-wounds to three areas of her body, one wound being dangerously close to a major artery. She described having swallowed a previously unreported overdose a year after her first admission because of “harassment” by a group that included her ex-husband. She said the harassment had continued and her dwelling had been “poisoned”. She said “the group” could get to her wherever she went, and she felt hopeless. At no time did she hear her persecutors talking to her or about her. She denied being depressed but was clearly worried and distressed, and said that “if they keep harassing me I can’t live”. She expressed a fear that her persecutors “might have control over the doctors so I can’t say anything”. The next day she stated that “there’s nothing left for me to do but die”. There was no evidence of cognitive impairment.

Mrs A resumed taking thyroxine and was prescribed antipsychotic medication which was later given her in depot form once a month. Her distress progressively abated and she engaged well with other inpatients and with staff. She became remorseful about her actions, saying “I was scared and alone”. She denied ongoing feelings of persecution, but remained guarded; her family worried that she still might be harbouring false beliefs about harassment. To ensure that antipsychotic treatment would be maintained, and that she would continue thyroxine prescriptions from her primary care doctor, a 6-months Community Treatment Order was sought and granted. After 6 weeks in hospital she was discharged, assuring staff that she now felt safe and was keen to get back to activities in the community. Since then she has been seen at home by a community health worker on a number of occasions, and contact has been maintained with her family. She has engaged in various activities away from home. On review by her psychiatrist during the first few weeks after discharge she appeared cheerful and relaxed, and showed no evidence of any psychotic symptoms.

Discussion

Suicide is clearly a very real risk in cases of DD. Depression is common, but anger and distress may also contribute to suicidal feelings. Current standard treatments for DD appear only moderately effective. Not enough research has been done to show what works best. Convincing reasons for examining factors such as worry, negative self-beliefs, interpersonal sensitivity, reasoning bias and use of defence strategies when considering non-pharmacological interventions to treat DD (with or without medication), have been provided by Freeman et al. [10], whose ‘Feeling Safe Programme’ aims to reduce threat beliefs. Antidepressants may also have a place, particularly in somatic type DD cases, for which their prescription can lead to resolution of delusional symptoms [6]. Use of antidepressants in the treatment of DD patients when there is a risk of suicide should be further investigated and considered in particular cases.

References

1. Munro A. Aspects of persecutory delusions in the setting of delusional disorder: In: Freeman D, Bentall R, Garety P, editors. *Persecutory Delusions: Assessment, Theory and Treatment*. New York: Oxford University Press; 2008.
2. de Portugal E, Díaz-Caneja CM, González-Molinier M, de Castro MJ, del Amo V, Arango C, et al. Prevalence of premorbid personality disorder and its clinical correlates in patients with delusional disorder. *Psychiatry Res*. 2013;210(3):986-93.
3. Muñoz-Negro JE, Cervilla JA. A systematic review on the pharmacological treatment of delusional disorder. *J Clin Psychopharmacol*. 2016;36(6):684-90.
4. Roth M. The natural history of mental disorder in old age. *J Ment Sci*. 1955;101(423):281-301.
5. Harris BS, Kotsopoulos EJ, Yamin S. Phenotypic cognitive impairment in late-onset delusional disorder. *Int Psychogeriatr*. 2014;26(6):965-75.
6. González-Rodríguez A, Molina-Andreu O, Odriozola VN, Ferrer CG, Penadés R, Catalán R. Suicidal ideation and suicidal behaviour in delusional disorder: a clinical overview. *Psychiatry Journal*. 2014;2014:1-8.
7. De Portugal E, Martinez C, González N, delAmo V, Haro JM, Cervilla JA. Clinical and cognitive correlates of psychiatric comorbidity in delusional disorder outpatients. *Aust N Z J Psychiatry*. 2011;45(5):416-25.
8. Wustmann T, Pillmann F, Friedemann J, Piro J, Schmeil A, Marneros A. The clinical and sociodemographic profile of persistent delusional disorder. *Psychopathology*. 2012;45(3):200-2.
9. Yassa R, Suranyi-Cadotte B. Clinical characteristics of late-onset schizophrenia and delusional disorder. *Schizophr Bull*. 1993;19(4):701-7.
10. Freeman D, Waite F. Persistent persecutory delusions: the spirit, style and content of targeted treatment. *World Psychiatry*. 2017;16(2):208-9.