SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS

Delusional Disorder

DelD

DSM-5-TR 297.1 | ICD-10-CM F22

One or more fixed delusions lasting 1 month or longer, with functioning outside the delusion largely preserved and no other prominent psychosis.

LIFETIME PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~0.02-0.2%	Middle to late adulthood	Near equal; jealous type male	Chronic; often lifelong

CLINICAL PICTURE

- A single encapsulated delusional system dominates, whether persecutory, jealous, erotomanic, somatic, or grandiose, while the rest of the personality stays intact.
- Behavior outside the delusion appears unremarkable, so patients hold jobs and relationships and almost never present voluntarily to mental health services.
- First presentation is usually through dermatology, infectious disease, plastic surgery, law enforcement, or the courts rather than through psychiatry.
- Hallucinations, when present, are limited and thematically tied to the delusion, such as tactile formication in delusional infestation cases.
- Affect is congruent with the delusional content, producing irritability, litigiousness, or stalking behavior rather than global disorganization.
- Insight is absent by definition, and challenging the belief directly ruptures the alliance and predicts immediate dropout from treatment.

DIAGNOSTIC CRITERIA AT A GLANCE

- One or more delusions persist for at least 1 month, which is the minimum duration threshold and the defining requirement of the diagnosis.
- The full symptom picture for schizophrenia has never been met; hallucinations are absent or minor and are related to the delusional theme.
- Apart from the delusion and its direct consequences, functioning is not markedly impaired and behavior is not obviously bizarre or odd to others.
- Any concurrent mood episodes are brief relative to the duration of the delusional periods, separating this from psychotic mood disorders.
- Specify subtype as erotomanic, grandiose, jealous, persecutory, somatic, or mixed, note bizarre content, and exclude substances and medical causes.

NEUROBIOLOGY & PHYSIOLOGY

- Striatal dopamine dysregulation is implicated but appears milder and more focal than in schizophrenia, consistent with the partial antipsychotic response seen.
- Right hemisphere and frontotemporal dysfunction is reported, particularly in delusional misidentification syndromes and in late-onset presentations.
- Sensory impairment, especially untreated hearing and vision loss, together with social isolation, is an established risk factor in older adults.
- Family studies show elevated rates of delusional disorder and of paranoid and avoidant personality traits, with weaker schizophrenia loading than expected.
- Structural imaging is usually unremarkable, so new-onset delusions after age 50 warrant neuroimaging for tumor, stroke, or neurodegenerative disease.
- Dopaminergic agents, stimulants, corticosteroids, and levodopa can precipitate an identical presentation and must be reviewed in every single case.

PSYCHOLOGICAL MECHANISMS

- Jumping-to-conclusions bias, meaning decisions made on minimal evidence, is more pronounced than in schizophrenia and sustains conviction against disconfirmation.
- An externalizing and personalizing attributional style assigns negative events to the hostile intentions of others, protecting fragile self-esteem.
- Theory-of-mind errors combined with hypervigilance to threat cues generate paranoid interpretations of ordinary and ambiguous social behavior.
- Confirmation bias and selective attention convert coincidences into corroborating evidence, so the belief system grows more elaborate over time.
- Premorbid paranoid, schizoid, or narcissistic traits, plus immigration, deafness, and social marginalization, all increase vulnerability to onset.

DIFFERENTIAL & COMORBIDITY

- Schizophrenia is excluded by the absence of prominent hallucinations, disorganization, and negative symptoms and by the preservation of daily functioning.
- Body dysmorphic disorder and obsessive-compulsive disorder with absent insight are separated by phenomenology and insight specifiers, not by conviction alone.
- Rule out substance-induced psychosis, dementia, delirium, temporal lobe epilepsy, and paraneoplastic or autoimmune syndromes in any late-onset case.
- Depression is the most common comorbidity, often secondary to the social consequences of the delusion, followed by anxiety and profound isolation.
- Assess risk explicitly: jealous and persecutory subtypes carry elevated risk of stalking, assault, and homicide directed at specific named individuals.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- Antipsychotic response is partial and slower than in schizophrenia; **risperidone 2-6 mg/day** or olanzapine 5-15 mg/day are reasonable first choices.
- **Pimozide 2-8 mg/day** carries the strongest tradition in delusional infestation but requires baseline and follow-up ECG for QTc prolongation.
- Allow 8-12 weeks at an adequate dose before declaring failure, and expect reduced preoccupation and distress rather than outright retraction of the belief.
- Treat comorbid depression with an **SSRI**; SSRIs or clomipramine may help somatic-type presentations that overlap with the obsessive-compulsive spectrum.
- Adherence is the central obstacle, so frame medication as targeting stress, sleep, and preoccupation rather than as treatment for a psychotic illness.

PSYCHOTHERAPY

- **CBT for psychosis** works through collaborative empiricism, testing the predictions the belief generates rather than disputing it, across 16-24 sessions.
- Prioritize engagement and alliance for several sessions before any belief-focused work, because premature challenge strongly predicts dropout.
- **Motivational interviewing** techniques address ambivalence about medication and avoid the confrontation over insight that derails treatment.
- Behavioral experiments and reality-testing homework yield modest reductions in conviction and considerably larger reductions in associated distress.
- Family involvement supplies collateral history, monitors risk to third parties, and prevents accommodation of delusion-driven behavior at home.

ADJUNCT & SUPPORTIVE

- Correct sensory deficits directly, since hearing aids and cataract surgery measurably reduce paranoid ideation in late-onset presentations.
- Coordinate with dermatology or the referring specialist in delusional infestation, because joint or shared visits substantially improve retention.
- Document and manage risk toward named targets, including duty-to-warn analysis, protective orders, and an explicit written safety plan.
- Track conviction over time with the **PANSS** delusion items or the **Brown Assessment of Beliefs Scale** rather than relying on impression.
- Long-acting injectable antipsychotics are an option when repeated nonadherence drives relapse, escalating behavior, and risk to others.

CLINICAL PEARLS

- Never argue the delusion; treat the distress and preoccupation it generates.
- New delusions after age 50 mean imaging and a medication review before a psychiatric label.
- Jealous and persecutory subtypes require an explicit violence risk assessment.

References

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Boland, R., Verduin, M. L., & Ruiz, P. (2021). *Kaplan & Sadock's synopsis of psychiatry* (12th ed.). Wolters Kluwer.

Freeman, D., & Garety, P. (2014). Advances in understanding and treating persecutory delusions: A review. *Social Psychiatry and Psychiatric Epidemiology*, 49(8), 1179-1189. https://doi.org/10.1007/s00127-014-0928-7

National Institute for Health and Care Excellence. (2014). *Psychosis and schizophrenia in adults: Prevention and management* (NICE Guideline No. CG178). https://www.nice.org.uk/guidance/cg178

National Institute of Mental Health. (n.d.). *Schizophrenia*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/schizophrenia

Stahl, S. M. (2021). *Stahl's essential psychopharmacology: Neuroscientific basis and practical applications* (5th ed.). Cambridge University Press.

NOTE

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