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Original article

A descriptive case-register study of delusional disorder

Enrique de Portugal [a], Nieves González [b], Josep M. Haro [b], Jaume Autonell [b], Jorge A. Cervilla [b,c,*]

[a] Department of Psychiatry, Hospital Gregorio Marañon, Madrid, Spain
[b] Research and Development Unit, Sant Joan de Déu-SSM, Barcelona, Spain
[c] Department of Psychiatry and Institute of Neurosciences, University of Granada, Spain

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Abstract

Objective. — A few empirically based studies' data on delusional disorder (DD) exist. We aim to describe sociodemographic and clinical correlates of DD and to identify clinical profiles associated to DD and its subtypes.

Methods. — This is a case-register study based on all those subjects attending community mental health services within a geographically well-defined area. Four hundred and sixty-seven patients had been diagnosed as DD cases at psychiatric services serving a catchment area of some 607,494 inhabitants living in South Barcelona (Spain) during a three-year period (2001–2003). A thorough systematic review of computerised medical records was used to establish DSM-IV diagnosis, rendering a valid sample of 370 patients who fulfilled DSM-IV criteria for DD. Independent variables gathered include sociodemographic data, family and personal psychiatric history, and comorbid diagnoses on all DSM-IV axes (including GAF). We used descriptive and univariate statistical methods to explore sample frequencies and correlates across DD types.

Results. — The mean age of the patients was 55 years and the sample had a mean GAF score of 51 suggesting a poor functionality; 56.5% of the patients were female. The most frequent DD types were persecutory (48%), jealous (11%), mixed (11%) and somatic (5%), whilst 23% qualified for the NOS type. Most frequent symptoms identified were self-reference (40%), irritability (30%), depressive mood (20%) and aggressiveness (15%). Hallucinations were present in 16% of the patients (6% tactile; 4% olfactory). Nearly 9% had a family history of schizophrenia (higher among those with the jealous subtype) and 42% had a comorbid axis II diagnosis (mostly paranoid personality disorder). Depression was significantly more frequent among the persecutory and jealous types. Finally, global functioning was significantly better among jealous and mixed types and worse amongst erotomanic and grandiose cases ($p = 0.008$).

Conclusions. — In the absence of other similar empirical data, this modest study provides unique empirical evidence of some clinical and risk correlates of DD and its subtypes.

Keywords: Delusional disorder; Delusions; Psychotic symptoms; Psychopathology; Psychosis; Paranoia

1. Introduction

The core psychopathology of delusional disorder (DD) is the presence of a persistent non-bizarre delusional system. DSM-IV describes seven different types of DD attending mainly to the content of the delusions (persecutory, jealous, somatic, grandiose, erotomanic, mixed and not otherwise specified (NOS)). [1] DD is a surprisingly poorly researched psychotic disorder on which both clinical and epidemiological studies are extremely rare. In addition, studies to date using current diagnostic criteria are even rarer, as the majority of such studies have not used DSM-IV criteria [20]. The lack of evidence about this disorder is partly due to an assumed low prevalence of DD and also to the fact that many DD patients do not seek psychiatric help unpromptedly [24].

* Corresponding author. Department of Psychiatry and Institute of Neurosciences, Faculty of Medicine, University of Granada, Avenida de Madrid 11, 18012 Granada, Andalucia, Spain. Tel./fax: +34958242017.
E-mail address: jacb@ugr.es (J.A. Cervilla).

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1.1. Sociodemographics of DD

Kendler's meta-analysis continues to be the seminal descriptive study on the epidemiology of DD [20]. It was based on 17 existing studies about the frequency of DD, mostly based on data from patients being admitted to hospital with a diagnosis of paranoia. Estimated prevalence for DD, inferred from admissions of patients with a diagnosis of paranoia, ranged between 24 and 30 cases in every 100,000 inhabitants. The mean age of onset ranged between 35 and 45 years and female patients slightly outnumbered male patients (female/male ratio is 1.2/1). Over the last decade, there have been four other smaller epidemiological studies on DD showing an even higher female/male ratio (female/male ratios ranging from 3/1.9) [21,22,25,31]. Conversely, another study showed minimal excess numbers of male patients (female/male ratio of 0.86) [12]. Regarding marital status, 60–75% of the patients were married when they were first admitted into hospital, whilst between a quarter and a third of the remaining sample were widowers, separated or divorced [20]. However, Maina et al., studying an out-patient sample, found a lower percentage of married patients (47.8%), a higher percentage of single individuals (43.5%) and a lower percentage of divorced or separated individuals (6.5%) and widowers (2.2%) [21].

1.2. Risk factors for DD

Social risk factors of DD include low socioeconomic status, older age, family history of psychiatric disorders, immigration, sensory deficit and exposure to stressful events. Kendler found that two-thirds of DD patients belong to low socioeconomic status and estimated that 20–25% of the new cases of DD take place in old age [20]. Relatives of DD patients do not seem to be at higher risk of either schizophrenia or mood disorders but appear to show an increased rate of paranoid personality disorder and/or a premorbid tendency to jealousy, suspiciousness, and secretiveness [14–17,19,28–30]. An English study by Hitch and Rack suggested a prevalence of 16% of paranoid ideas among immigrants compared to a significantly smaller rate of 4% among English natives [11]. As mentioned earlier, sensory deficits have also been reported as a risk factor for paranoia. Cooper et al. found that 21% of deaf people tend to develop delusions and other psychotic symptoms, whilst other studies have related deafness to late paraphrenia or schizophrenia [5,6,8,26]. Deafness can more likely be seen as a correlate of psychosis rather than a specific risk factor for DD.

1.3. Comorbid psychopathology

Maina et al. studied a series of 64 cases of DSM-IV DD out-patients establishing that 31.3% had at least one comorbid axis I disorder (21.9% had a mood disorder and 3.1% had at least one comorbid anxiety disorder [21]. In another study, Hsiao et al. found that hallucinations were also common among DD patients with non-prominent auditory hallucinations being the most frequent type (11.6%), followed by the tactile hallucinations (5.8%), non-prominent visual hallucinations (2.3%) and olfactory hallucinations (2.3%) [12]. Finally, reported comorbid personality disorders include paranoid, schizotypal and schizoid personality disorders [13,18,23].

1.4. DD types

Most studies report that by and large the most prevalent DD presentation is the so-called persecutory type [21,25,31]. Excluding the mixed type, Yamada found that, among their 54 DSM-III-R DD cases, the persecutory type was the most frequent (51%), followed by the somatic type (27.5%) and the jealous type (13.7%) [31]. Similarly, Hsiao et al., in a retrospective study with 86 cases of DD according to DSM-IV criteria, also found that the persecutory type was the most frequent (70%), followed by the mixed cases (14%) and those with jealous type (8%) [12]. The latter study also found no significant differences between these four most frequent types in terms of sex, age of onset, frequency of hallucinations and the presence of depression. Maina, with patients diagnosed using DSM-IV criteria, also found a higher prevalence of the persecutory type (54.4%), followed by somatic (17.4%), mixed (15.2%) and jealous types (6.5%) [21]. This study also reported a higher frequency of comorbid mental disorder (mainly mood disorders) among persecutory cases (54.4%) and a lower rate of psychiatric comorbid conditions among the mixed cases (66.7%) [21].

1.5. Aims of the study

Provided the conspicuous shortage of empirical descriptive studies on DD, this study provides a unique opportunity to explore and describe clinical correlates of DD based on a relatively large case register of DD patients. We aim to describe and quantify frequencies of DD types, empirically describe sociodemographic and psychopathological features of DD, explore the comorbidity and global functioning of DD patients and identify clinical and risk correlates of specific DD types.

2. Methods

2.1. Setting and design

Sant Joan de Déu – Serveis de Salut Mental (SJD – SSM) is a public mental health services provider covering both community and in-patient psychiatric care for a well-defined catchment area in the South of the province of Barcelona (Spain). Psychiatric care provision within this geographic area during the study period (2001–2004) was implemented via six community mental health out-patient teams, three day-hospitals, three acute in-patient care sub-units and a rehabilitation unit. Such groups of resources served some 607,494 inhabitants. In Spain, referral to psychiatric care is generally issued by general practitioners (GP); access to these referrals is free and universal. Therefore, most cases detected by GP