Schizophrenia Bulletin vol. 40 no. 2 pp. 244–247, 2014
doi:10.1093/schbul/sbt203
Advance Access publication January 13, 2014

Delusional Disorder as a Partial Psychosis

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In his textbook from 1838, Esquirol made the first comprehensive psychopathological description of paranoia, which he labeled partial psychosis. This was a condition with encapsulated, well organized, and persistent delusions. These are defended with a great deal of emotions and sharp argument. The individual appears quite convincing, especially because he or she otherwise behaves rationally. The intellectual capacity is used to achieve defined goals according to the delusional content. This condition is difficult to uncover because of dissimulation and adaptation. The frequency in the population is unknown, but the condition is rare in psychiatric treatment facilities, and usually only when the persons become litigious or criminal. In Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, the condition is covered by the concept of delusional disorder, but that concept also comprises benign acute/subacute conditions as well as cases that turn out to have the diagnosis changed to schizophrenia.

Key words: delusions/delusional disorder/partial psychosis/paranoia

Introduction

The concept of delusions has a long history. Current definitions are often dated back to Karl Jaspers,[1] who claimed that delusions were abnormal beliefs held with extraordinary conviction, were impervious to experiential evidence or counter-arguments, and were often bizarre. The last statement has been somewhat modified, using bizarre content as a distinction between schizophrenia and delusional disorder. According to Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV),[2] a diagnosis of delusional disorder implies that delusions are nonbizarre and involve situations that can occur in real life such as being followed, deceived by spouse, or having a disease. However, there is no strong agreement between experts on the distinction between bizarre and nonbizarre delusions.[3,4] Moreover, the distinction between delusions and ordinary beliefs or strongly held (overvalued) ideas is sometimes difficult to make.

Much of the confusion about the categorization of delusions has been approached by locating them along a continuum. Empirical evidence suggests that delusions are best conceptualized in multidimensional terms, with characteristics deviating more or less from normal beliefs and behavior on a number of dimensions. In line with this view, several rating scales have been created.[5] Factor analyses of these have revealed the following factors: conviction, delusional construct (organization and bizarreness), preoccupation, subjective distress, and behavior.[5,6]

One viewpoint for the clinician suggested by the continuum model is that delusions should be treatable. Improvement indeed occurs following pharmacological and cognitive-behavioral therapy, but nonresponsive patients still exist. It could be that they are qualitatively different persons, with a personality dominated by a passionate commitment to beliefs. For such a patient, a conviction is not only a belief but also a way of living or assessing life. Counterarguments are useless, no matter the relevance of the information. Such delusional tenacity has been attributed to the defensive or dynamic function of the delusion, ie, as attempts to escape from tension and anxiety through the processes of denial and projection.[4,7,8] Along with psychoanalytic explanations, other hypotheses posit organic brain disorders with perceptual difficulties, theory of mind alterations, emotional disturbances, probabilistic reasoning biases (jumping to conclusions), or attributional bias.[4,9]

Delusional Disorder in DSM-5

According to DSM-5,[10] schizophrenia spectrum and other psychotic disorders are defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking, grossly disorganized or abnormal motor behavior, and negative symptoms. The disorders are organized along a gradient of

psychopathology with delusional disorder in the "benign" end as a condition limited to one domain of psychosis only, namely delusions. Hence, delusional disorder is characterized by at least 1 month of delusions without other psychotic symptoms. However, hallucinations might be present, but are not prominent and in any case are related to the delusional theme only. DSM-5 does not require that delusions must be nonbizarre.

Section III of the manual[10] describes clinician-rated dimensions of psychosis symptom severity in the past 7 days. For delusions, the range is from not present (0), through equivocal (1), mild (2), moderate (3) to severe (4). The latter being described as "severe pressure to act upon beliefs, or is very bothered by beliefs." In addition to the five abovementioned domains, similar scores from 0 to 4 are given for impaired cognition, depression, and mania.

In patients with delusional disorder, ongoing behavior can be influenced by delusional content, but impairments in psychosocial functioning "may be more circumscribed than those seen in other psychotic disorders such as schizophrenia, and behavior is not obviously bizarre or odd."[10] According to DSM-5, the diagnosis of delusional disorder is generally stable, but a proportion of patients go on to develop schizophrenia.

Outcome of Delusional Disorder

Kraepelin[11] separated paranoia (the precursor of delusional disorder) as an independent group distinct from his category of dementia praecox. However, the nosologic and etiologic distinction between these two diagnostic entities continues to be debated. For example, Kolle[12] recognized paranoia as a mild form of schizophrenia and not as a separate category.

The diagnostic stability of schizophrenia is high (75%–99%), whereas the stability of the delusional disorder diagnosis is moderate, around 60% in long-term follow-up studies.[13,14] The most frequent change of diagnosis from delusional disorder is to schizophrenia. In long-term studies, this change has been found in about 20% of cases. On the other hand, remission has been found in about one-third of the patients. Remission does occur most often when duration of psychosis has been short before admission to treatment facilities and when precipitating factors have been clearly present during the development of psychosis.[13] In most patients with stable delusional disorder, the delusions tend to weaken in the long run, but for a small core group, they have the same intensity for years.

The Concept of Partial Psychosis

The Danish psychiatrist and psychoanalyst Erik Bjerg Hansen made a valuable contribution to this field by carefully describing a number of cases with hypochondriacal delusional symptoms.[15] He found these patients very hard if not impossible to treat. In his thesis, he reviewed the classic literature on paranoia, and described the perceived humiliation and the aggression by which the paranoia patients refuse psychiatric help. Such patients refuse to recognize that their belief is a symptom and might have something to do with psychological factors, emotions or relations. Such suggestions from the doctor are regarded by those patients as humiliating accusations and attacks.

According to Bjerg Hansen,[15] the first comprehensive psychopathological description of paranoid psychoses and paranoia was made by the French psychiatrist Esquirol (1772–1840). Esquirol was Pinel's most talented pupil. In his famous textbook from 1838, Esquirol reviewed his smaller contributions from the beginning of the century and ended up proposing delineations of different syndromes. Monomania was by Esquirol named a "partial delirium," and the delusions, which were the most prominent symptoms in this condition, could be hypochondriacal, religious, erotomanic, or mixed. The patient had beliefs that were not real, but idiosyncratic, primary, and unchangeable. These beliefs were defended and extended by the patient often with intelligence and sharp argument. For some onlookers, this argumentation could be quite convincing, especially because the patient otherwise behaved rationally and reasoned quite understandably the way other people did. The individual had strange beliefs, but in other respects presented clear thoughts and used his or her initiative to achieve defined goals according to the delusional content. Esquirol named such goal-directed planning and action as "la monomania raisonnante." The full intellectual capacity of the individual was used in the service of this limited madness.

The final outcome of this development of a system of fixed delusions was labeled "partial psychosis," where the psychopathological part, the delusions, was encapsulated, and the rest of the personality was as normal as it used to be. The condition was difficult to uncover, especially because of the patient's tendency to dissimulate. He or she was able to adapt to the surroundings and to hide the private inner beliefs in order to avoid being looked upon as odd or mad by other people. For those who were not professionals, it was easy to think that the delusions had vanished or were no longer important any more. Inside, however, the patient was as convinced and driven as before. Because of this context, it was often difficult for a professional to demonstrate a psychotic origin for the patient's beliefs and behavior.

From the very beginning, Esquirol's writings on this subject were debated from a medicolegal point of view. He and his pupils were challenged for seeing madness everywhere and for letting criminals be labeled insane, and thereby avoid punishment.

According to Esquirol, the partial psychosis is a condition with encapsulated and well-organized delusions that

are fixed, continuous, and defended in an intelligent way. The person with this disorder is often characterized by

1. an egocentric, autophilic, self-overrated arrogance.
2. a negative, suspicious attitude to the outside world, which is perceived as hostile, and from which the patient isolates him/herself.
3. a tendency to misinterpretations and misjudgments.
4. a diminished capacity for social adjustment and flexibility because of the above-mentioned points.

The frequency of a full-blown syndrome like this in the general population is unknown, and they are rare in psychiatric treatment facilities.

The Breivik Case

Ingrid Melle[16] has recently described the story about the Norwegian Breivik, who on July 22, 2011 killed 77 persons and later on by the court was sentenced to 21 years in prison. Before being sentenced after a lawsuit, he underwent two forensic evaluations. The first evaluation concluded that he had paranoid schizophrenia and therefore was legally unaccountable according to Norwegian law. In this law, different from many other countries, people are not criminally accountable if they are found to be psychotic, unconscious, or severely mentally retarded at the time of the crime, as it is defined in current diagnostic systems. This conclusion by the evaluating psychiatrists was followed by intense public discussions in media along with protests from Breivik himself. He claimed not to be insane, but had a mission for which he was responsible. Professionals were in doubt of the diagnosis because of lack of hallucinations, disorganization, and the fact that Breivik had been able to systematically plan the actions for many years. The requests for a new forensic evaluation by media, professionals, and politicians resulted in a second evaluation. The new pair of psychiatrists concluded that Breivik had a severe narcissistic personality disorder combined with pseudologia fantastica (pathological lying), and thereby he was legally accountable.

In the first evaluation, the psychiatrists reported that Breivik was psychotic while planning and carrying out his terror acts as well as during the subsequent interviews and assessments. He told them that he was the leader of the Knights Templars organization and thought he was a pioneer in a European civil war. He could be the new regent in Norway and said he was able to decide who should live and who should die in Norway. Moreover, he thought he would be given the responsibility for deporting several hundred thousands of Muslims to Africa, and he believed there was an ongoing ethnic cleansing in Norway. He also worked on plans for improving the Norwegian ethnic genetic pool.

The psychiatrists found his beliefs to be far beyond conspiracy notions of an Islamist take-over in Europe and diagnosed grandiose delusions with bizarre qualities because of his thoughts about his own role and mission in this extremist universe, where he turned out to be alone. The psychiatrists also reported his use of common words in new contexts mixed with unusual words, which they perceived as neologisms. They also observed affective flattening with episodes of incongruent affect.

From September 2011, Breivik underwent weekly consultations with a psychiatric treatment team in the prison, and later, he underwent inpatient observation in a psychiatric security department. The new pair of forensic psychiatrists conducted their consultations and assessments during February and March 2012. At that time, Breivik had toned down the importance of the Knights Templars, admitted to have exaggerated his own role, and described himself as a "foot-soldier" doing his duty. The evaluating psychiatrists noted the presence of pathological self-aggrandizement, which they felt had never reached a psychotic degree of severity, and they interpreted his social withdrawal and suspiciousness before the terror attack as a natural consequence of the planning phase.

It is no surprise that these two evaluations and their quite different conclusions have puzzled professionals as well as the general public. Nevertheless, the reaction is very similar to what was the case when the term partial psychosis was used to describe people with unusual thoughts that made them act criminally in the 19th century. It might be that the concept of partial psychosis, a concept in between the two different conclusions drawn by the forensic evaluations in this case, should have been more seriously considered from a diagnostic standpoint. However, according to current Norwegian law, Breivik then would have been found not criminally accountable. Such a conclusion would have challenged common sense of justice. The case has sparked a debate of the law, and a revision is now under consideration.

Final Remarks

Delusional disorder, as described in DSM-5, is a heterogeneous concept. Some cases with this diagnosis are acute or subacute and with favorable outcome. They remit or even recover. Others will turn out to have the diagnosis changed to schizophrenia. Between these two extremes are persons with persistent delusions, which earlier have been labeled partial psychosis or paranoia. They are relatively rare, and many of them do no harm to self or others. However, some of them come to the attention of psychiatrists or psychologists, most often without their own intention, when they become litigious or criminal. At that time, they represent a huge challenge for diagnosticians and therapists.

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