

Gender Differences in Persistent Delusional Disorder

Sir,

Few studies have examined gender differences in persistent delusional disorder (PDD), which itself are under researched. Available literature suggests that PDD is slightly more predominant in females, who tend to have a later age at the onset of illness. Females have also been found to have better treatment response as compared to males, perhaps due to better adherence and treatment-seeking behavior.^[1-3] Some studies have reported erotomanic delusions as being more common in females. Others have reported that persecution is the most common theme of delusions among both males and females, with no gender differences in the content of delusions or comorbid

depression.^[4] Substance dependence is reportedly more common among males with PDD.^[2]

We examined gender differences in PDD at a tertiary care center in India. Ethical clearance for the study was obtained from the Institute Ethics Committee. We reviewed the case records of 455 patients with PDD (males: $n = 236$ [51.9%]; females: $n = 219$ [48.1%]) as part of a retrospective review published earlier.^[5] We examined gender differences on age, sociodemographics, illness variables including age at the onset of illness, duration of illness, family history, clinical and treatment details, occupational functioning, number of follow-ups,

and hospitalizations. For between-group comparisons, independent samples *t*-test was used for continuous variables and Chi-square test for categorical variables.

The two groups were comparable on age (females: 40.2 ± 11.2 years vs. males: 38.7 ± 11.3 years; $t = 1.3, P = 0.7$). There were no gender differences on sociodemographic variables, including marital status, the mean age at onset, and the mean duration of illness (all $P > 0.2$). We did not find gender differences in the phenomenology of the primary delusions; the delusion of infidelity ($\chi^2 = 0.03; P = 0.8$) was the most common in both groups followed by persecution ($\chi^2 = 0.5; P = 0.5$). Body dysmorphic delusions (females: 4 [1.8%] vs. males: 20 [8.5%]; $\chi^2 = 9.6, P < 0.005$) and comorbid substance dependence were significantly more in males (males: 57 [24.1%] vs. females: 4 [1.8%]; $\chi^2 = 18.1, P < 0.005$). There were no gender differences in the presence of auditory hallucinations, depressive symptoms, the mean chlorpromazine equivalents of antipsychotics prescribed, the observed adherence, and response to treatment (all $P > 0.5$).

Family history of schizophrenia was significantly more in females (females: 11.4% vs. males: 5.9%; $\chi^2 = 3.9, P < 0.05$). Family history of substance use disorders was significantly more in males (males: 12.3% vs. females: 3.7%; $\chi^2 = 10.3, P < 0.005$). A significantly greater number of males had occupational dysfunction during follow-up (males: 66.5% vs. females: 57.5%; $\chi^2 = 3.9, P = 0.04$). More females than males retained the diagnosis of PDD during subsequent follow-up visits (mean follow-up period: 16.6 months; 92.4% vs. 85.3%; $\chi^2 = 7.1, P < 0.05$).

Our study replicates the findings of earlier studies, in that there were no gender differences in the content of delusions. Unlike previous reports, our patients reported more delusion of infidelity than persecution/erotomania. Previous reports of erotomania and depression being higher in females were not reflected in our results, and it is unclear why more males in our sample reported body dysmorphic delusions.^[3]

The findings of our study are in consonance with the previous reports of higher substance dependence in males with PDD.^[2] The mean age of our sample was lower compared to the previous reports, most of the individuals in both groups were currently married, and the cultural significance associated with marriage in India could account for the delusion of infidelity being most common, although this is speculative. Diagnostic stability of PDD was observed more among females than males in our sample. Despite similarities in clinical presentation, the males in our sample tended to have poorer occupational functioning when compared with females. It is likely that gender differences were not apparent in our sample as it was hospital-based, where more severely ill patients seek treatment. Some of the gender differences in PDD reported in world literature

may have been more apparent in general hospitals or community samples. This is a limitation of our findings.

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Conflicts of interest

There are no conflicts of interest.

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