DELUSIONAL PSYCHOSES AND SCHIZOPHRENIA AS DISTINCT PATHOLOGY – PILOT STUDY

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ABSTRACT

Background: Nowadays psychiatric nosology, besides systematized delusional psychoses such as paranoia, also accepts the existence of another type of persistent delusional psychoses, which is different from schizophrenia and lasts for over 3 months. The clinical status of these psychoses was not clearly established, but they were differentiated from the short-term, transient psychoses and also from affective psychoses with mood incongruent delusions. This paper investigates the socio-demographic and clinical parameters, as well as those for global and social functioning within a group of persistent delusional psychoses compared to a group of schizophrenics, with a view to delimiting more clearly the two psychopathological entities from a clinical and nosological point of view. It is important to also mention the limited number of international studies of persistent delusional psychoses.

Material and methods: The two groups under investigation are part of the Case Registry of Timisoara Psychiatric Clinic (CRTPC), which monitors the functional psychoses that began in Timisoara in 1985. In the past, the groups were assessed from a socio-demographic/evolutive perspective. In the present, they are assessed from a clinical and global functioning perspective through Clinical Global Impression (CGI) and Global Assessment of Functioning (GAF).

Results: The average age for the onset of the disease is lower in the schizophrenic group than in the group diagnosed with persistent delusional psychoses. Similarly, the social and professional functioning is superior in the latter group, as a result of a better clinical evolution of the subjects in this group.

Conclusions: Case-book records argue for a continuum between paranoid schizophrenia and some persistent delusional psychoses. This raises the question of the extent to which the same etiopathogenic mechanism lies at the basis of the two forms of pathogenesis, with different manifestations depending on the age of the subject.

Key Words: schizophrenia, persistent delusional psychoses, continuum

INTRODUCTION

Over the years, the conceptualization of psychoses was influenced by a number of hypotheses, thus giving birth to a series of these theoretical concepts (Berner 1992): the endogen hypothesis; the nosological hypothesis (Kraepelin) – which deals with the evolutive approach; the pathogenic hypothesis (Bleuler); the hierarchy principle hypothesis (Jaspers); the structural-dynamical cohesion model (Janzarik); the hypothesis of the biorhythmic perturbation accompanying...
emotional disorders, and the hypothesis of bipolar-unipolar dichotomy.

The fundamental criterion for psychosis, according to the psychoanalysts, is the profound disturbance in the psychotic’s relation with reality.

ICD 10 (The International Classification of Diseases) currently defines psychosis in terms of the presence of hallucinations and delusions or a limited number of serious behavioral abnormalities, such as excessive excitation and hyperactivity, evident motor retardation and catatonic behaviour.1

According to DSM IV (The Diagnostic and Statistical Manual of Mental Disorders) the term “psychotic” refers to delusional thoughts, any kind of noticeable hallucinations, incoherence and disorganized or catatonic behaviour.2

Currently, we can polarize endogenous psychoses into three directions (M. Lazarescu): 1) Delusional psychosis, deriving from paranoia but extending towards classical delusional-hallucinatory psychosis (paranoid); 2) Schizophrenic psychosis centered on the symptoms described by Bleuler (the speech and behavioral disorganization syndrome, the apatho-abulic-amotivational syndrome, the depersonalization syndrome and the autistic syndrome); 3) Periodic affective psychosis.

Between these poles we can find atypical and intermediary cases both in terms of evolution and episode symptomatology as well. According to M. Lazarescu these three poles encompass: 1) Delusional psychoses closely resemble schizophrenia or periodic affective disorder; 2) Schizophrenic psychoses comparable to delirious psychoses and periodic affective disorder; 3) Periodic affective disorder verging on elements of schizophrenic psychoses or delusional psychoses.3

From a nosological point of view, schizophrenia is a very wide classification (DSM IV and ICD 10).

Thus, in the diagnostic criteria there is no reference regarding the optimum manifestation age, in certain cases a person can be diagnosed with schizophrenia based only on the presence of delusional-hallucinatory episodes or delusional episodes alone, if these delusions are bizarre. These aspects along with the fact that 90% of schizophrenics suffer from a paranoid form of the disease, lead to the conclusion that no clear boundary line can be drawn between schizophrenia and delusional psychoses, the latter representing a valid diagnosis in itself according to ICD 10 and DSM IV, a diagnosis that does not overlap over schizophrenia.

The ICD 10 international classification system includes these psychoses in the nosological category of ‘Persistent Delusional Disorders’, that have long-term delusions as the most important clinical features. Under the title of “Other Persistent Delusional Disorders” are included disorders that have schizophrenia-like symptoms such as persistent auditory hallucinations, but insufficient to be classified as schizophrenia.4,5

Paranoid productive schizophrenia is characterized by Schneiderian First-Rank Symptoms, among which the most important are symptoms related to transparency-influence syndrome, delusional interpretations, auditory hallucinations and primary delusions.6 Continuous intimacy surveillance brings paranoid delirium nearer to these symptoms.

Between paranoid schizophrenia and non-schizophrenic delusional disorder, there are certain areas of transition and interference, which are expected to appear on the level of the episode and the disorder as well.7 In long-term observation of mental disorders, these aspects can be approached more thoroughly, allowing a clearer identification of clinical characteristics of successive episodes.

**METHODOLOGY**

A good example in this respect is CRTPC, which has prospectively analyzed cases of functional psychoses occurring in Timisoara from 1985 up until present day. In the 2007 CRTPC report, two groups of patients, with an evolution of 10 to 20 years, have been studied comparatively in order to investigate deeper into the aspects mentioned above.

One of the groups was made of 20 patients categorically diagnosed with paranoid schizophrenia. The cases in this group had only episodes of this diagnosis throughout their evolution, without any other psychiatric diagnosis.

The second group, comprising an equal number
of patients, manifested throughout their evolution delusional or hallucinatory-delusional episodes but these symptoms were not enough for them to be diagnosed with schizophrenia. The study also included other cases which manifested some episodes of first-rank symptoms but too few to dominate the clinical picture. The presence of depressive symptoms was accepted, but did not lead to a diagnosis of depressive episode (8 out of 20 cases).

Patients from the second group were diagnosed with Persistent delusional disorder according to ICD 10. Cases which manifested schizoaffective and affective episodes were excluded from the second group.

The second group was divided into two subgroups:
- A subgroup diagnosed with “simple” persistent delusions (SD), comprising 8 cases who manifested exclusively delusional episodes throughout their evolution;
- A subgroup diagnosed with marginal schizophrenia (SxM), comprising 12 cases whose clinical picture has manifested first rank symptoms as well, throughout their evolution.

These groups have been analyzed from a demographic-evolutive point of view and subjected to an up-to-date evaluation from the perspective of their social functioning and from a clinical perspective as well, via CGI and GAF.

All cases comprised in the two groups had been admitted to The Psychiatry Hospital from Timisoara at some time or another, throughout 2006.

RESULTS

Patients in the two groups were distributed in terms of gender as follows: 7 men / 13 women in the first group and 9 men / 11 women in the second group.

In the group diagnosed with schizophrenia the average age for the onset of the illness was 26 years (range 17-36 years). The average age of onset for the group diagnosed with persistent delusional disorder was 33 years (range: 24-52 years).

In terms of marital status in the first group there were initially 8 married patients, of which only 6 are still currently married, while one unmarried patient got married after the debut of the illness but divorced eventually.

In the second group there were initially 12 married patients, of which 3 have divorced by the present date. The 5 unmarried patients are still unmarried at present date. Two of those who divorced were from the second subgroup and one from the first subgroup.

In terms of professional activity, all patients from both groups were working at the debut of the illness, while only 3 from the first group and 7 from the second group are still working now. Regarding the distribution in two subgroups, 4 of the 12 patients diagnosed with marginal schizophrenia and 3 of the 8 patients diagnosed with pure persistent delusional disorder are still involved in a professional activity.

The average GAF score was around 62.5 for the first group and approximately 72 for the second group, with a higher average score of 73.2, for the patients from the first subgroup, as opposed to 71.25 for those in the second subgroup.

As for the CGI scale indicating the severity of the illness, the first group had an average of 3.9 while the second group had an average of 3.25, where number 2 stands for marginal mental illness, 3 for mildly ill and 4 for moderate mental illness. The average score for patients in the two subgroups, of group two was 2.75 for those diagnosed as pure delusional and 3.33 for those labeled as marginal schizophrenic.

DISCUSSIONS

Delusional disorder is now a valid diagnostic entity, but it is still neglected in terms of importance for many specialists in the field. That it still remains in a shadow cone can be explained by the fact that this concept has undergone many changes in time and, moreover, currently no diagnostic criteria are fully crystallized.

In time, this nosological entity translated by paranoia in particular, has been strongly contested in the mid-twentieth century (1921 Mayer, Karl Kolla 1931, Slater and Roth 1960). Most cases used to be called schizophrenia, which was seen as having multiple forms of aberrant behavior. The revitalization of the concept has began in 1987, when the DSM-III appeared and paranoia was recognized as a distinct entity.

Although the interest on this delusional disorder has increased lately, yet there are only few studies on this nosological entity and in terms of therapeutical recommendations regarding the anti-psychotic medication, this nosological category it is not mentioned in any prospectus (only two other main endogenous psychosis poles are specified – the endogenous psychosis triangle).

Even in specialized books presenting psychosis in general, the predominantly delusional disorder are given a marginal role, this one too reserved mainly to paranoia, a form of persisting delusional disorder. Thus, in the book ‘Psychotic continuum of Marneros’, written by Andreasen and Tsuang in 1995, the authors
approach only the pole of Schizophrenia and bipolar affective disorder and their continuum, the pole of delusional psychosis being almost entirely neglected, i.e. becoming subsumed into schizophrenia.\(^{12}\) This subsuming process of predominantly delusional psychosis, schizophrenia, is made as a result of the fact that Schizophrenia represents a nosological environment rather wide where diagnoses can be quite easy to define, and as a result of that first-rank Kurt Schneider symptoms are seen as specific symptoms of schizophrenia, although nowadays there are approaches where these symptoms are presented as a syndrome that exceeds by far the boundaries of schizophrenia.\(^{13}\)

Unlike certain trends which subsume delusional psychosis into schizophrenia, in the present paperwork they are being seen as separate nosological entities, with their own characteristics, differencing from those of schizophrenia. Also, parts of the cases (SxM) are ranked between the two entities mentioned above, and their characteristics are placed, in terms of value, in between the values of the two distinct entities.

Regarding the age of onset of the disorder of the two groups, the results correspond to previous studies, which have shown that the age of onset of delusional disorders is more than the late case of schizophrenia.\(^{14-18}\)

The professional background history is also higher in the group with delusional people compared with the ones with schizophrenia.\(^{16,18}\)

In terms of marital status, unlike previous studies, where this has higher positive values in case of persisting delusional disorders,\(^{10}\) in the present case, we cannot find significant differences.

Moreover, the global and social functioning is more favorable in case of delusional disorders, which is one of the remarks that have determined Kraepelin to delimit paranoia from dementia praecox (current schizophrenia).\(^{5}\) Most studies support the idea that the global functioning is better to people with delusional disorders compared with those suffering from schizophrenia.

Regarding the presence of the depressive symptoms, previous studies have demonstrated an increasing comorbidity of the delusional disorders with depressive disorders that could reach approximately 55%,\(^{10}\) Another approach in order to understand the high rate of the depression comorbidity is its acceptance as part of the usual symptoms of delusional disorders (Serreti). In this case, the depressive shades are seen as part of the symptoms. Previous studies among groups of persistent delusional disordered people with/without depression failed to demonstrate significant differences on the social and demographical clinic and prognosis factors.\(^{9,10}\)

We would suggest the existence of a distinct psychosis pole, the one focused on delirium, which needs further study.

**CONCLUSIONS**

Average age for the onset of the disease is lower in patients diagnosed with schizophrenia than in those diagnosed with persistent delusions.\(^{5,10}\) Patients from the “marginal schizophrenia” subgroup have a higher mean age at onset than patients from the “simple” persistent delusions (SD) subgroup.

The number of married patients decreased in both groups, to almost the same extent.

A significantly greater number of patients from the “persistent delusional” group remained professionally active, in contrary to the patients diagnosed with schizophrenia.

Global and social functioning is far better in the patients diagnosed with persistent delusional disorder than in the case of those diagnosed with schizophrenia, and also the severity of the disease is greater in schizophrenics. Furthermore, patients from the “simple” persistent delusions (SD) subgroup enjoy better global and social functioning than patients from the “marginal schizophrenia” subgroup (SxM), but the latter manifest a more severe form of the illness. This leads to the conclusion that the illness will develop in a more unresponsive manner in the case of patients who, apart from delusions, manifest other first rank symptoms as well, and also their global and social functioning is more deficient.

This evaluation was limited by the small size of the two groups and by the differences between the catamnesis periods of the selected cases.

**REFERENCES**