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INDIVIDUAL & FAMILY PSYCHOPHARMACOLOGIC TREATMENT OF:
- MOOD AND ANXIETY DISORDERS • OBSESSIVE-COMPULSIVE DISORDER
- PERVASIVE DEVELOPMENTAL DISORDERS/AUTISM •MENTAL RETARDATION
- ATTENTION DEFICIT DISORDER • TOURETTE'S DISORDER • TRAUMATIC PSYCHIATRY
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DISCUSSION:

DIAGNOSIS OF DELUSIONAL DISORDER WITH FEATURES OF PARANOIA

The symptomatology of this disorder is complex. Thus, I have reviewed the chapter, *"Delusional Disorder and Shared Psychotic Disorder"* by Theo C. Manschreck, M.D., from the textbook, Comprehensive Textbook of Psychiatry/VI[1]. Dr. Manschreck states:

> *"Persons with [delusional disorder] do not regard themselves as mentally ill ... may behave in a remarkably normal way much of the time; they become strikingly different when the delusion is focused on, at which time thinking, attitude, and mood may change direction abruptly. Social and marital functioning are more likely to be compromised than intellectual and occupational functioning."*

REGARDING MENTAL STATUS, DR. MANSCHRECK STATES:

> *"The patient may have acted to draw attention by asking for protection."*

REGARDING THE MANNER IN WHICH A PATIENT MAY COMPLAIN OF SYMPTOMATOLOGY, DR. MANSCHRECK STATES:

> *"The complaint focuses on the distressing behavior. ... The patient will not complain of a psychiatric condition; in fact, he or she will deny the presence of any psychiatric symptoms."*

REGARDING PERCEPTION, DR. MANSCHRECK STATES:

> *"Examination of the patient leads to the discovery ... that thinking ... perception, and personality are intact. The patient's thinking is so clear and the delusional features are so central to his or her concerns that the clinician begins to anticipate precisely the responses of the patient ..."*

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[1] Comprehensive Textbook of Psychiatry/VI, Vol. I, 6th Edition, Edited by Harold I. Kaplan, M.D. and Benjamin J. Sadock, M.D., Chapter *"Delusional Disorder and Shared Psychotic Disorder"* by Theo C. Manschreck, M.D., Section 15.2, Williams & Wilkins, 1995.

REGARDING TREATMENT, DR. MANSCHRECK STATES:

"[These patients] show a lack of cooperation regarding treatment. ... Paranoid patients are frequently unwilling to reveal their subjective experience to examine or to cooperate in the clinical investigation. Careful interviewing of the patient and other informants may disclose further evidence that the behavior is clearly psychopathologic ..."

In the area of Workers' Compensation cases, this "lack of cooperation regarding treatment may result from the person's fears that their psychiatric problem(s) may be revealed to their employer or others. This is due to the fact that in a forensic setting there is no doctor-patient confidentiality as there is in a non-forensic setting. Thus, a patient in a forensic setting often fears seeking much-needed treatment for fear that their innermost thoughts, feelings, and problems will be exposed

REGARDING THE ASSESSMENT OF DELUSIONAL DISORDERS, DR. MANSCHRECK STATES:

"Attempts to dissuade the patient with counter-evidence and counter-arguments may be useful in determining whether the patient's beliefs can be influenced with evidence usually sufficient to alter the belief of a non-delusional person."

In the assessment of delusion disorder, there is a concept call "conviction" which is important because it determines how convinced a person is of their beliefs. Therefore, a patient's conviction that they are at risk from potential harm by someone is a significant core belief upon which an Examiner would base a diagnosis of Paranoid Delusional Disorder (with Features of Paranoia).

REGARDING SYSTEMATIZATION OF THE DELUSION, DR. MANSCHRECK STATES:

"Spending time in discussion with the patient to grasp the nature of delusional thinking in terms of its themes, impact on the patient's life, complexity, systematization ... may be crucial in making the judgment."

It should be noted that in patients with delusional disorder, there is always a concern about the possibility of violent behavior.

REGARDING THE DIFFERENTIAL DIAGNOSIS OF DELUSIONAL DISORDER, DR. MANSCHRECK STATES:

"The clinician must recognize ... and judge as pathologic the presence of paranoid features ... should determine whether they form a part of syndrome or are isolated. ... Sometimes the plausibility of the delusion requires investigating to determine whether the belief is indeed delusional or not ... Delusional thinking should be examined for its fixity, logic ... and its effect on action and planning."

Sometimes patients may make statements such as: "Seemingly normal people have done bizarre things, like Jeffrey Daumer." Although the core statement is true and anything is possible, if the patient's example is far-removed from the realities of their current situation, paranoid delusion may be present.

In addition, there are a number of other disorders which must be excluded in these cases, including: Psychotic Disorder due to a Medical Problem; Substance Abuse; Psychotic Disorder with Delusion; Cognitive Disorder (e.g., Dementia); Schizophrenia; Shared Psychotic Disorder; Mood Disorder with Psychotic Features; Manic Episode; Obsessive-Compulsive Disorder with Preoccupations with unusual rituals, obsessional beliefs; Somatoform Disorders; Paranoid Personality Disorder; Schizoid Personality Disorder; and Schitzotypal Personality Disorder.

1. **Determination of Presence/Absence of Paranoid Personality Disorder:**

   It must be determined whether or not the individual has any previous history of paranoid ideation -- or any history of traits of paranoid personality -- prior to the time of onset of the problems at work. These traits would include: Persistently overtly sensitive; ready to take offense; suspicious; resentful; rigid; self-centered. Also determine whether the person's fears are isolated to those involved with the work-problems, or is generalized to others around them. Substantiation of these issues can be obtained by interviewing family members.

2. **Determination of Presence/Absence of Paranoid Delusional Personality Disorder:**

   In cases where Paranoid-Delusional Disorder may be present, the results of psychological testing is significant, especially the results of the Minnesota Multiphasic Personality Inventory-2 (MMPI-2). For instance, in this test, a significant indicator is the person's score on *"Persecutory Ideas."* It will be for the Trier-of-Fact to determine whether or not the facts of the person's case justify their fears.

3. **Determination of Presence/Absence of Schizoid/Schitzotypal Personality Disorders:**

   The quality of the individual's interpersonal relationships must be evaluated, such as whether they are a "loner" and socially isolated, or whether they have warm and loving relationships with friends/family in their life outside of the problematic work situation.

4. **Determination of Presence/Absence of Schizophrenia:**

   In determining whether schizophrenia or other severe psychotic disorder is present in cases of delusional disorder, there must be deterioration of personality or deterioration in most areas of functioning. Is there general deterioration in functioning? Is there a decrease in cognitive efficiency? Is there manifestation of general premorbid functioning? The patient may exhibit personality changes, such as remaining more to themselves with less interest in others, however if there is no evidence of abrupt changes of personality or mood lability functioning, this symptomatology may not warrant a diagnosis of Schizophrenia.