

Persistence and Stability of Delusions Over Time

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Traditional descriptions of delusions have emphasized the conviction with which they are held and their resistance to change. This study utilizes data from a large cohort of delusional subjects to assess the persistence and stability of delusional beliefs, and the predictors of change. Data were collected from 1,136 acutely hospitalized psychiatric patients, reinterviewed at 10-week intervals for 1 year. Persistence of delusional beliefs was determined for those delusional subjects with at least one follow-up visit ($n = 405$), and stability for the subset with delusions at two or more points in time ($n = 262$). Marked plasticity in

delusional beliefs was observed, with one third of delusional subjects at any interview no longer delusional 10 weeks later. Persistence of delusions was associated with schizophrenia, global psychopathology, and having acted on a delusion, among other variables. Most subjects showed variation in the content of their primary delusion over time. Delusions appear to be more fluid over relatively short periods of time than has been suggested by many classic descriptions and contemporary formulations.

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DELUSIONS, the paradigmatic symptoms of psychosis, remain curiously underexplored, even as regards their essential characteristics. To what extent, for example, are delusions transitory phenomena that mark a particular stage of psychotic illness, as opposed to permanent stigmata that once present will always endure? The psychiatric literature appears to be of two minds about this question.

Much theoretical writing sketches delusions as deeply held and resistant to change. Karl Jaspers' influential characterization, for example, emphasized that delusions "are held with an *extraordinary conviction*, with an incomparable, *subjective certainty*," and that "there is an *imperviousness* to other experiences and to compelling counter-argument" [emphasis in the original] (pp 95-96).¹ DSM-IV echoes that approach in defining a delusion as "A false belief . . . that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary" (p. 765).² Although depth of conviction at a given point does not preclude change over time, graphic accounts of the resistance of delusions to confrontation with reality³ have reinforced the view of delusions as stable phenomena, as have arguments regarding the self-reinforcing aspects of delusional ideation.⁴

On the other hand, considerable evidence exists of the plasticity of delusional beliefs. Delusions often fade or disappear with the resolution of an acute episode of psychosis, as most clinicians can testify from their own experience.⁵⁻⁷ Longitudinal studies suggest that the presence of delusions may vary over time, and that in certain cases they may disappear entirely.⁷⁻¹⁶ For example, Jorgensen's¹⁷ follow-up data on 75 patients with acute delusional psychoses, who were interviewed three times during the 8 years following discharge, showed that 43% were continuously delusional, 28% were intermittently delusional, and 29% had complete re-

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Supported by funding from the Research Network on Mental Health and the Law of the John D. and Catherine T. MacArthur Foundation, and by NIMH Grant No. RO1 49696. P.S.A. was supported in part by a fellowship from the Center for Advanced Studies in the Behavioral Sciences, funded by the Center's Foundations Fund for Research in Psychiatry and NSF Grant No. SBR-9022192.

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0010-440X/04/4505-0001\$30.00/0

doi:10.1016/j.comppsy.2004.06.001

missions. Recent data from Myin-Germeys et al.¹⁸ indicate that a group of schizophrenic subjects were delusional on average only 32% of the time. Even when delusions persist, some data indicate that the type of delusion that patients manifest and the delusional theme are susceptible to change.^{19,20}

Given the evolving consensus about the plasticity of delusions,²¹ it is surprising that few efforts have been made to explore the predictors of this heterogeneity in the persistence and stability of delusional beliefs. In the study by Jorgensen mentioned above, a diagnosis of schizophrenia had by far the strongest predictive value for the persistence of delusions, followed by a primary delusion other than a delusion of reference, absence of psychosocial stressors prior to the index episode, and living alone.¹³ Harrow et al.¹⁵ also reported that delusions were significantly more likely to persist in schizophrenia than in schizoaffective or affective disorders. Duration of illness and presence of premorbid stressors were identified as predictors by Schanda et al.¹²

The importance of identifying those variables that are associated with persistence or remission of delusions is several-fold. Clinicians will be better able to predict the likely course of patients' symptoms and perhaps better situated to intervene so as to mitigate their effects. Difficult diagnostic determinations may be aided by knowledge of patterns of delusional persistence characteristic of different disorders. In addition, the analyses may shed light on critical aspects of the psychopathological construct of delusions itself. If delusions are heterogeneous in their origins across differing diagnostic categories or delusional types (e.g., persecutory, grandiose, etc.), we may expect to see different patterns and predictors of remission in various diagnostic and typological groups. Alternatively, similar patterns of presentation over time despite diagnostic and other differences would be compatible with the view of delusions as unitary phenomena, as has previously been demonstrated for their non-content-related dimensional characteristics.²²

Here, we explore the persistence and stability of delusional beliefs in a large and diverse sample of acutely hospitalized psychiatric patients, followed intensively for 1 year after discharge. In addition to examining the effect of diagnostic categories, we focus on type of delusion and non-content-related descriptors to assess their impact on patterns of delusional presentation.

METHOD

The data presented are drawn from a prospective, multisite study of violence among persons with mental disorder, the MacArthur Violence Risk Assessment Study. The methods of the larger study are described in detail elsewhere.²³ In brief, soon after hospitalization on an acute psychiatric unit at one of the three study sites (Western Missouri Mental Health Center, Kansas City, MO; Western Psychiatric Institute and Clinic, Pittsburgh, PA; and Worcester State Hospital and the University of Massachusetts Medical Center, Worcester, MA) patients were approached and asked for written consent to participate in the study. Those approached were selected randomly from all admissions to these facilities, within the constraints of a stratified sampling scheme designed to equalize the proportion of subjects recruited at each site by age, race, and gender. Of 1,695 patients approached, 1,203 (71%) agreed to participate, and 1,136 completed the baseline interview, a mean of 7 days after admission. Eligibility was limited to patients 18 to 40 years of age who were white, African-American, or Hispanic. Eligible primary diagnoses were grouped into the following categories: schizophrenia (including schizophreniform and schizoaffective disorders), depression (including major depression and dysthymia), bipolar disorder (including cyclothymic disorder), other psychotic disorders (including delusional disorder and brief reactive psychosis), alcohol/drug abuse or dependence, or personality disorder.

During the hospital admission, study clinicians (one Ph.D. and two masters' level) used the DSM-III-R Checklist,^{24,25} a semistructured interview, to establish subjects' diagnoses and, following the criteria in that instrument, to determine the primary diagnosis, i.e., the diagnosis of greatest immediate clinical significance. When multiple diagnoses were present, that was almost always (84.5% of cases) the diagnosis judged most impairing. Interviewers underwent 3 days of intensive training in the use of study instruments, including mock interviews and patient interviews supervised by experienced psychiatrists. Inter-rater reliability for the primary diagnoses were calculated by examining the ratings of the three study clinicians on 22 videotaped diagnostic interviews; 12 of the interviews were rated by all three clinicians, and 10 were rated by two of the clinicians. The resulting 46 clinician pairs had an overall agreement rate of 83%, which corresponded to a Cohen kappa of .59.

To determine whether subjects had a delusion, clinicians asked a series of 17 questions drawn primarily from the Diagnostic Interview Schedule (questionnaire available from the authors).²⁶ Interviewers were trained to apply the DSM-III-R definition of a delusion and, by further structured questioning and review of subjects' medical records, to use their best judgment to determine whether subjects were definitely or possible delusional, or whether subjects' responses reflected reality (e.g., someone in their neighborhood really *was* trying to harm them) or some other nondelusional motivation (e.g., malingering). In case of doubt, interviewers were instructed to err on the side of inclusiveness, i.e., categorizing the belief as a delusion. At baseline, 83.8% of delusional subjects were rated definitely delusional; the percentage at each follow-up visit varied between 60% and 70%. To insure the consistency of these determinations, the first author reviewed all screening forms, which contained subjects' verbatim descriptions of their beliefs, and when necessary, listened to audiotapes of the interviews. In only

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