Delusional Disorder because the period of delusions and hallucinations was not continuous with
the initial period of disturbance. Instead, the appropriate diagnoses for the first epi-
sode would be Mood Disorder With Psychotic Features, In Full Remission, and
Schizophreniform Disorder (Provisional) for the current episode.

Mood disturbances, especially depression, commonly develop during the course
of Delusional Disorder. However, such presentations do not meet criteria for
Schizoaffective Disorder because the psychotic symptoms in Delusional Disorder are
restricted to nonbizarre delusions and therefore do not meet Criterion A for Schizo-
affective Disorder.

If there is insufficient information concerning the relationship between psychotic
and mood symptoms, Psychotic Disorder Not Otherwise Specified may be the most
appropriate diagnosis.

Diagnostic criteria for 295.70 Schizoaffective Disorder

A. An uninterrupted period of illness during which, at some time, there is either a Major
Depressive Episode, a Manic Episode, or a Mixed Episode concurrent with symptoms
that meet Criterion A for Schizophrenia:

   Note: The Major Depressive Episode must include Criterion A1: depressed mood.

B. During the same period of illness, there have been delusions or hallucinations for at
least 2 weeks in the absence of prominent mood symptoms.

C. Symptoms that meet criteria for a mood episode are present for a substantial portion
of the total duration of the active and residual periods of the illness.

D. The disturbance is not due to the direct physiological effects of a substance (e.g., a
drug of abuse, a medication) or a general medical condition.

Specify type:

   Bipolar Type: if the disturbance includes a Manic or a Mixed Episode (or a Manic
or a Mixed Episode and Major Depressive Episodes)

   Depressive Type: if the disturbance only includes Major Depressive Episodes

297.1 Delusional Disorder

Diagnostic Features

The essential feature of Delusional Disorder is the presence of one or more nonbizarre
delusions that persist for at least 1 month (Criterion A). A diagnosis of Delusional
Disorder is not given if the individual has ever had a symptom presentation that met
Criterion A for Schizophrenia (Criterion B). Auditory or visual hallucinations, if
present, are not prominent. Tactile or olfactory hallucinations may be present (and
prominent) if they are related to the delusional theme (e.g., the sensation of being in-
fested with insects associated with delusions of infestation, or the perception that one
emits a foul odor from a body orifice associated with delusions of reference). Apart
from the direct impact of the delusions, psychosocial functioning is not markedly impaired, and behavior is neither obviously odd nor bizarre (Criterion C). If mood episodes occur concurrently with the delusions, the total duration of these mood episodes is relatively brief compared to the total duration of the delusional periods (Criterion D). The delusions are not due to the direct physiological effects of a substance (e.g., cocaine) or a general medical condition (e.g., Alzheimer's disease, systemic lupus erythematosus) (Criterion E).

Although the determination of whether delusions are bizarre is considered to be especially important in distinguishing between Delusional Disorder and Schizophrenia, "bizarreness" may be difficult to judge, especially across different cultures. Delusions are deemed bizarre if they are clearly implausible, not understandable, and not derived from ordinary life experiences (e.g., an individual's belief that a stranger has removed his or her internal organs and replaced them with someone else's organs without leaving any wounds or scars). In contrast, nonbizarre delusions involve situations that can conceivably occur in real life (e.g., being followed, poisoned, infected, loved at a distance, or deceived by one's spouse or lover).

Psychosocial functioning is variable. Some individuals may appear to be relatively unimpaired in their interpersonal and occupational roles. In others, the impairment may be substantial and include low or absent occupational functioning and social isolation. When poor psychosocial functioning is present in Delusional Disorder, it arises directly from the delusional beliefs themselves. For example, an individual who is convinced that he will be murdered by "Mafia hit men" may quit his job and refuse to leave his house except late at night and only when dressed in clothes quite different from his normal attire. All of this behavior is an understandable attempt to prevent being identified and killed by his presumed assassins. In contrast, poor functioning in Schizophrenia may be due to both positive and negative symptoms (particularly avolition). Similarly, a common characteristic of individuals with Delusional Disorder is the apparent normality of their behavior and appearance when their delusional ideas are not being discussed or acted on. In general, social and marital functioning are more likely to be impaired than intellectual and occupational functioning.

Subtypes

The type of Delusional Disorder may be specified based on the predominant delusional theme:

**Erotomanic Type.** This subtype applies when the central theme of the delusion is that another person is in love with the individual. The delusion often concerns idealized romantic love and spiritual union rather than sexual attraction. The person about whom this conviction is held is usually of higher status (e.g., a famous person or a superior at work), but can be a complete stranger. Efforts to contact the object of the delusion (through telephone calls, letters, gifts, visits, and even surveillance and stalking) are common, although occasionally the person keeps the delusion secret. Most individuals with this subtype in clinical samples are female; most individuals with this subtype in forensic samples are male. Some individuals with this subtype, particularly males, come into conflict with the law in their efforts to pursue the object of
their delusion or in a misguided effort to "rescue" him or her from some imagined danger.

**Grandiose Type.** This subtype applies when the central theme of the delusion is the conviction of having some great (but unrecognized) talent or insight or having made some important discovery. Less commonly, the individual may have the delusion of having a special relationship with a prominent person (e.g., an adviser to the president) or being a prominent person (in which case the actual person may be regarded as an impostor). Grandiose delusions may have a religious content (e.g., the person believes that he or she has a special message from a deity).

**Jealous Type.** This subtype applies when the central theme of the person's delusion is that his or her spouse or lover is unfaithful. This belief is arrived at without due cause and is based on incorrect inferences supported by small bits of "evidence" (e.g., disarrayed clothing or spots on the sheets), which are collected and used to justify the delusion. The individual with the delusion usually confronts the spouse or lover and attempts to intervene in the imagined infidelity (e.g., restricting the spouse's autonomy, secretly following the spouse, investigating the imagined lover, attacking the spouse).

**Persecutory Type.** This subtype applies when the central theme of the delusion involves the person's belief that he or she is being conspired against, cheated, spied on, followed, poisoned or drugged, maliciously harassed, or obstructed in the pursuit of long-term goals. Small slights may be exaggerated and become the focus of a delusional system. The focus of the delusion is often on some injustice that must be remedied by legal action ("quarrelous paranoia"), and the affected person may engage in repeated attempts to obtain satisfaction by appeal to the courts and other government agencies. Individuals with persecutory delusions are often resentful and angry and may resort to violence against those they believe are hurting them.

**Somatic Type.** This subtype applies when the central theme of the delusion involves bodily functions or sensations. Somatic delusions can occur in several forms. Most common are the person's conviction that he or she emits a foul odor from the skin, mouth, rectum, or vagina; that there is an infestation of insects on or in the skin; that there is an internal parasite; that certain parts of the body are definitely (contrary to all evidence) misshapen or ugly; or that parts of the body (e.g., the large intestine) are not functioning.

**Mixed Type.** This subtype applies when no one delusional theme predominates.

**Unspecified Type.** This subtype applies when the dominant delusional belief cannot be clearly determined or is not described in the specific types (e.g., referential delusions without a prominent persecutory or grandiose component).

**Associated Features and Disorders**

Social, marital, or work problems can result from the delusional beliefs of Delusional Disorder. Ideas of reference (e.g., that random events are of special significance) are common in individuals with this disorder. Their interpretation of these events is usu-
ally consistent with the content of their delusional beliefs. Many individuals with Delusional Disorder develop irritable or dysphoric mood, which can usually be understood as a reaction to their delusional beliefs. Especially with the Persecutory and Jealous Types, marked anger and violent behavior can occur. The individual may engage in litigious behavior, sometimes leading to hundreds of letters of protest to government and judicial officials and many court appearances. Legal difficulties can occur in Delusional Disorder, Jealous Type and Erotomanic Type. Individuals with Delusional Disorder, Somatic Type, may be subject to unnecessary medical tests and procedures. Hearing deficiency, severe psychosocial stressors (e.g., immigration), and low socioeconomic status may predispose an individual to the development of certain types of Delusional Disorder (e.g., Paranoid Type). Major Depressive Episodes probably occur in individuals with Delusional Disorder more frequently than in the general population. Delusional Disorder may be associated with Obsessive-Compulsive Disorder, Body Dysmorphic Disorder, and Paranoid, Schizoid, or Avoidant Personality Disorders.

Specific Culture and Gender Features
An individual's cultural and religious background must be taken into account in evaluating the possible presence of Delusional Disorder. Some cultures have widely held and culturally sanctioned beliefs that might be considered delusional in other cultures. The content of delusions also varies in different cultures and subcultures. Delusional Disorder, Jealous Type, is probably more common in men than in women, but there appears to be no major gender difference in the overall frequency of Delusional Disorder.

Prevalence
Delusional Disorder is relatively uncommon in clinical settings, with most studies suggesting that the disorder accounts for 1%–2% of admissions to inpatient mental health facilities. Precise information about the population prevalence of this disorder is lacking, but the best estimate is around 0.03%. Because of its usually late age at onset, the lifetime morbidity risk may be between 0.05% and 0.1%.

Course
The age at onset of Delusional Disorder is variable, ranging from adolescence to late in life. The Persecutory Type is the most common subtype. The course is quite variable. Especially in the Persecutory Type, the disorder may be chronic, although a waxing and waning of the preoccupation with the delusional beliefs often occurs. In other cases, full periods of remission may be followed by subsequent relapses. In yet other cases, the disorder remits within a few months, often without subsequent relapse. Some evidence suggests that the Jealous Type may have a better prognosis than the Persecutory Type. When the Persecutory Type is associated with a precipitating event or stressor, it may have a better prognosis.
Familial Pattern

Some studies have found that Delusional Disorder is more common among relatives of individuals with Schizophrenia than would be expected by chance, whereas other studies have found no familial relationship between Delusional Disorder and Schizophrenia. There is limited evidence that Avoidant and Paranoid Personality Disorders may be especially common among first-degree biological relatives of individuals with Delusional Disorder.

Differential Diagnosis

The diagnosis of Delusional Disorder is made only when the delusion is not due to the direct physiological effects of a substance or a general medical condition. A delirium, a dementia, and Psychotic Disorder Due to a General Medical Condition may present with symptoms that suggest Delusional Disorder. For example, simple persecutory delusions (e.g., “someone comes into my room at night and steals my clothes”) in the early phase of Dementia of the Alzheimer’s Type would be diagnosed as Dementia of the Alzheimer’s Type, With Delusions. A Substance-Induced Psychotic Disorder, especially due to stimulants such as amphetamines or cocaine, cross-sectionally may be identical in symptomatology to Delusional Disorder, but can usually be distinguished by the chronological relationship of substance use to the onset and remission of the delusional beliefs.

Delusional Disorder can be distinguished from Schizophrenia and Schizoaffective Disorder by the absence of the other characteristic symptoms of the active phase of Schizophrenia (e.g., prominent auditory or visual hallucinations, bizarre delusions, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms). Compared with Schizophrenia, Delusional Disorder usually produces less impairment in occupational and social functioning.

It can be difficult to differentiate Mood Disorders With Psychotic Features from Delusional Disorder, because the psychotic features associated with Mood Disorders usually involve nonbizarre delusions without prominent hallucinations, and Delusional Disorder frequently has associated mood symptoms. The distinction depends on the temporal relationship between the mood disturbance and the delusions and on the severity of the mood symptoms. If delusions occur exclusively during mood episodes, the diagnosis is Mood Disorder With Psychotic Features. Although depressive symptoms are common in Delusional Disorder, they are usually mild, remit while the delusional symptoms persist, and do not warrant a separate Mood Disorder diagnosis. Occasionally, mood symptoms that meet full criteria for a mood episode are superimposed on the delusional disturbance. Delusional Disorder can be diagnosed only if the total duration of all mood episodes remains brief relative to the total duration of the delusional disturbance. If symptoms that meet criteria for a mood episode are present for a substantial portion of the delusional disturbance (i.e., the delusional equivalent of Schizoaffective Disorder), then a diagnosis of Psychotic Disorder Not Otherwise Specified accompanied by either Depressive Disorder Not Otherwise Specified or Bipolar Disorder Not Otherwise Specified is appropriate.

Individuals with Shared Psychotic Disorder can present with symptoms that are similar to those seen in Delusional Disorder, but the disturbance has a characteristic
etiology and course. In Shared Psychotic Disorder, the delusions arise in the context of a close relationship with another person, are identical in form to the delusions of that other person, and diminish or disappear when the individual with Shared Psychotic Disorder is separated from the individual with the primary Psychotic Disorder. Brief Psychotic Disorder is differentiated from Delusional Disorder by the fact that the delusional symptoms last less than 1 month. A diagnosis of Psychotic Disorder Not Otherwise Specified may be made if insufficient information is available to choose between Delusional Disorder and other Psychotic Disorders or to determine whether the presenting symptoms are substance induced or the result of a general medical condition.

It may be difficult to differentiate Hypochondriasis (especially With Poor Insight) from Delusional Disorder. In Hypochondriasis, the fears of having a serious disease or the concern that one has such a serious disease are held with less than delusional intensity (i.e., the individual can entertain the possibility that the feared disease is not present). Body Dysmorphic Disorder involves a preoccupation with some imagined defect in appearance. Many individuals with this disorder hold their beliefs with less than delusional intensity and recognize that their view of their appearance is distorted. However, a significant proportion of individuals whose symptoms meet criteria for Body Dysmorphic Disorder hold their beliefs with delusional intensity. When criteria for both disorders are met, both Body Dysmorphic Disorder and Delusional Disorder, Somatic Type, may be diagnosed. The boundary between Obsessive-Compulsive Disorder (especially With Poor Insight) and Delusional Disorder can sometimes be difficult to establish. The ability of individuals with Obsessive-Compulsive Disorder to recognize that the obsessions or compulsions are excessive or unreasonable occurs on a continuum. In some individuals, reality testing may be lost, and the obsession may reach delusional proportions (e.g., the belief that one has caused the death of another person by having willed it). If the obsessions develop into sustained delusional beliefs that represent a major part of the clinical picture, an additional diagnosis of Delusional Disorder may be appropriate.

In contrast to Delusional Disorder, there are no clear-cut or persisting delusional beliefs in Paranoid Personality Disorder. Whenever a person with a Delusional Disorder has a preexisting Personality Disorder, the Personality Disorder should be listed on Axis II, followed by “Premorbid” in parentheses.
298.8  Brief Psychotic Disorder

Diagnostic Features

The essential feature of Brief Psychotic Disorder is a disturbance that involves the sudden onset of at least one of the following positive psychotic symptoms: delusions, hallucinations, disorganized speech (e.g., frequent derailment or incoherence), or grossly disorganized or catatonic behavior (Criterion A). An episode of the disturbance lasts at least 1 day but less than 1 month, and the individual eventually has a full return to the premorbid level of functioning (Criterion B). The disturbance is not better accounted for by a Mood Disorder With Psychotic Features, by Schizoaffective Disorder, or by Schizophrenia and is not due to the direct physiological effects of a substance (e.g., a hallucinogen) or a general medical condition (e.g., subdural hematoma) (Criterion C).

Specify type (the following types are assigned based on the predominant delusional theme):

- **Erotomanic Type**: delusions that another person, usually of higher status, is in love with the individual
- **Grandiose Type**: delusions of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person
- **Jealous Type**: delusions that the individual's sexual partner is unfaithful
- **Persecutory Type**: delusions that the person (or someone to whom the person is close) is being malevolently treated in some way
- **Somatic Type**: delusions that the person has some physical defect or general medical condition
- **Mixed Type**: delusions characteristic of more than one of the above types but no one theme predominates
- **Unspecified Type**