Fact Sheet: Delusions, Delusional Disorder, and Competency to Stand Trial

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Introduction:

Delusions and the diagnosis of delusional disorder are a common source of confusion in psychiatric treatment and have been a topic of debate within the forensic literature. In the landmark case of *Sell v. United States, 539 U.S. 166*, while the medicolegal conclusion of primary focus relates to involuntary treatment with psychotropic medication; in Sell, a major psychiatric treatment issue related to treatability of delusional disorder. Particularly, it was argued by Robert Cloninger, M.D., the defense's expert, and former chairman of the Department of Psychiatry at Washington University in St. Louis. that Sell suffered from delusional disorder, which was a condition that would not be expected to respond to treatment with antipsychotic medications, while James Wolfson, M.D., the prosecution's expert, believed that antipsychotic medication was medically indicated to treat the petitioner's psychotic symptoms[1].

After Sell, the issue of treatability of delusions, and restorability of patients with delusional disorder has been further studied, and the latest available data tends to suggest that individuals with delusional disorder have symptoms that are responsive to antipsychotic medications, and in most cases can be successfully restored to trial competency with treatment[2].

Definition of Delusions

Examining the technical definition of delusion utilized by psychiatry, it is important to recognize that delusions have two core components. Firstly, delusions require the presence of a false or incorrect belief. The second component of a delusion is the inflexibility, or persistence of the belief. The definition of delusion from the DSM 5-TR provided within the glossary of technical terms:

"A false belief based on incorrect inference about external reality that is firmly held despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary[3]."

The two-component definition of delusion is important to consider because the two-components of delusion do not resolve equally with medications. Rather, when tracking clinical improvement of delusions, the typical course is that the second component (i.e., inflexibility) improves first, while the first component (i.e., the content disturbance) improves later. In many cases, the content disturbance never fully resolves[4].

As this pertains to competency restoration, the acceptable treatment endpoints with delusional disorder, or in situations where delusions are competency limiting, would be:

a. False beliefs completely resolve (less likely)
b. That delusions reduce in scope such that they are well circumscribed and no longer impact reasoning related to task of adjudication (more likely)

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c. That delusions soften sufficiently in terms of flexibility, such that the defendant is now able to rationally reason and function around delusions, but the false beliefs persist (most likely). The delusion most often improves to the point of becoming an over-valued idea, but individuals achieve sufficient flexibility such that they are less compelled by the core idea of the belief.

Course of Treatment with Delusions

One of the primary challenges in treating delusions is that it is known delusions have a substantial chronological delay to improvement relative to other classes of symptoms[5]. This is well demonstrated by a paper published in the American Journal of Psychiatry from 2005, that specifically looked at the time to improvement of delusions in patients with first-episode psychosis. While the specific time estimates are not applicable to our target population, the conclusions from the paper that we can generalize to the IST population are as follows:

1. For delusions we are typically looking at response times on the order of weeks to months.
2. There is a high degree of individual variability.
3. The time to response substantially increases as a function of duration of untreated or undertreated psychosis.

These observations translate into several treatment implications, namely:

1. It is necessary to use other symptoms (such as disorganization, and hallucinations) as a proxy measure of symptom improvement in the near term for making decisions regarding medication titration.
2. It is important to rule out potential confounders to treatment response early because a lack of clinical improvement in delusions will not be readily apparent until months later.

Restorability Considerations:

As alluded to previously, post-Sell there have been studies that have explored the issue of restorability in patients with delusional disorder. In the most notable study, which was conducted by Herbel [2], the authors reviewed the records of all incompetent defendants with the principal diagnosis of delusional disorder who had undergone involuntary medication treatment for competency restoration during a 13-year period at a federal psychiatric prison hospital. The study found that 77% of defendants with delusional disorder improved sufficiently for the forensic evaluators to opine that they had been restored to competency after involuntary treatment with antipsychotic medication, which were noted to be similar to the published rates of competency restoration for incompetent defendants diagnosed with schizophrenia. A recent California Department of State Hospital study on the effectiveness of antipsychotic medication in restoration of trial competency found patients diagnosed with delusional disorder had a 93.8% restoration rate and achieved competency in a shorter timeframe, average of ~ 3 months, compared to patients with schizophrenia, average of ~ 5 months[6].

On the topic of delusional disorder, another area of confusion relates to the generalizability of treatment strategies for treatment-resistant Schizophrenia to individuals with delusional disorder who do not respond adequately to treatment with usual first-line antipsychotic medications. Finnish data from Jari Tiihonen's group support that clozapine and long-acting injectable (LAI) antipsychotic medications are associated with better functional endpoints, and this observation is consistent with our clinical experience[7]. Namely, switching to clozapine, or an LAI, can be associated with further clinical improvement in delusional disorder patients who fail to respond to usual first-line antipsychotic agents.

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