Psychological Interventions in Patients with Delusional Disorder

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Abstract: Although most of the studies suggest that delusional disorder is treatment-resistant, antipsychotics have been considered the treatment of choice. Psychological interventions seem to reach the highest level of evidence (e.g. randomized controlled trials). Available evidence makes difficult to reach definitive conclusions and clinical recommendations; however, in our point of view, these non-pharmacological interventions should be considered in combination with pharmacological therapies.

Keywords: Delusional disorder, Psychosis, Psychological interventions, Neurocognition.

LETTER TO THE EDITOR

Although there is no strong evidence to reach definite conclusions, delusional disorder (DD) has been traditionally considered a treatment resistant disorder and antipsychotics the treatment of choice [1]. However, recent research pointed out that evidence for the pharmacological treatment of DD is low [2]. A recent systematic review collected evidence on the use of first-generation antipsychotics (FGAs) and second-generation antipsychotics (SGAs) for the treatment of DD. Studies were only included if they used clinician-rated scales, and primary outcomes were presented into two response groups: (1) response of at least 50% and (2) response less than 50% [3]. Although the authors did not find significant differences in response rates between both groups, FGA were found to be slightly superior to SGA. Pimozide, which has been widely recommended for patients with DD somatic type, was not found to be a safe antipsychotic medication [3,4]. More recently, in a further step, some authors have tried to identify mediators and moderators of poor treatment response in DD, in an attempt to explain for whom treatments work best, how they work and when antipsychotics work [5]. Several moderators were identified: gender, reproductive status, age, comorbid psychiatric disorders and medical diseases, as well as baseline brain abnormalities, biochemical factors and genetic variants of genes encoding for liver enzymes and neurotransmitter receptors in the brain. Mediating variables were found to be functional brain changes, antipsychotic plasma levels and hormone concentrations. The authors concluded that patients with DD may respond to psychotherapeutic interventions, highlighting, particularly, the use of cognitive behavioral therapies [5].

When focusing on the use of non-pharmacological interventions to treat patients with DD, evidence is sparse, but points out to the use of psychological interventions [2]. This recommendation has been also replicated by Skelton and co-workers (2015) who carried out a systematic review on relevant randomized controlled trials (RCTs) investigating medications and psychotherapy to treat DD [6]. Only 1 randomized trial was found to be eligible. This was a 24-week randomized controlled trial comparing cognitive-behavioral therapy (CBT) with supportive psycho-therapy (attention placebo) for individuals with DD. CBT showed a positive effect on social self-esteem, and it seems to impact on affect relating to belief, strength of conviction and positive actions on belief [7].

Few other studies have investigated the effectiveness of psychological interventions in DD. Two decades ago, Turkington and colleagues (1996) carried out a case-series collecting 8 outpatients who received cognitive therapy (CT) [8]. Psychopathological symptoms were assessed by using the Comprehensive Psychopathological Rating Scale (CPRS) and the global measure of delusional severity (GSDS). CT demonstrated to be effective in reduction in belief conviction [8]. On the other hand, Sharp and colleagues (1996) conducted a case-series formed by 6 outpatients and suggested that CT was effective in reducing belief conviction [9]. The authors suggested that preoccupation and acting were found to act independently from belief conviction.

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E-ISSN: 2310-8231/20 © 2020 Synergy Publishers

Furthermore, a recent study investigated neurocognitive deficits in patients with DD with the main aim of assessing the impact of neuropsychological performance on psychological functioning [10]. Deficits in verbal memory and executive functions were associated with higher disability in patients with DD, suggesting the relevance of treating cognitive dimension. Neurocognitive deficits seem to be an important target to treat in patients with DD. Therefore, the potential role of cognitive interventions in treating these populations should be further studied.

Another important issue is the treatment of DD in the late period of life span. Certainly, pharmacological therapy with antipsychotic medications is still the primary line of treatment. Nonetheless, taking into account the available evidence, it seems crucial to personalise treatments for each individual case with cautious consideration of the comorbidities. Thus, minimising the adverse-effect profile, considering the interactions with other medications, and using medication only for an appropriate period of time might be indeed essential in these patients [6]. Regarding psychological treatments in late-life delusional disorders, no specific studies has been reported yet. However, psychological treatments for psychotic disorders in late life have shown an acceptable level of efficacy as previous studies had confirmed [11]. In these particular population psychological treatments should include cognitive skills training, functional adaptation skills training, social rehabilitation, supported employment, and work rehabilitation.

In conclusion, although some evidence in favour of the efficacy of psychological treatments has been reported, there is insufficient evidence to make a general recommendation of their use in patients with DD. Nonetheless, in the interim of more evidence being available, to offer psychological treatments in combination with pharmacological strategies in more resistant and severe cases seems reasonable.

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Received on 04-04-2020 Accepted on 15-04-2020 Published on 19-04-2020

DOI: https://doi.org/10.12970/2310-8231.2020.08.01

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