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# Treatments for Delusional Disorder

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## Background

Delusional disorder is commonly considered to be difficult to treat. Antipsychotic medications are frequently used and there is growing interest in a potential role for psychological therapies such as cognitive behavioural therapy (CBT) in the treatment of delusional disorder.

## Objectives

To evaluate the effectiveness of medication (antipsychotic medication, antidepressants, mood stabilizers) and psychotherapy, in comparison with placebo in delusional disorder.

## Search Methods

We searched the Cochrane Schizophrenia Group's Trials Register (February 28, 2012).

## Selection Criteria

Relevant randomized controlled trials (RCTs) investigating treatments in delusional disorder.

## Data Collection and Analysis

All review authors extracted data independently for the 1 eligible trial. For dichotomous data we calculated risk ratios (RR) and their 95% CI on an intention-to-treat basis with a fixed-effect model. Where possible, we calculated illustrative comparative risks for primary outcomes. For continuous data, we calculated mean differences (MD), again with a fixed-effect model. We assessed the risk of bias of the included study and used the GRADE approach to rate the quality of the evidence.

## Main Results

Only 1 randomized trial met our inclusion criteria, despite our initial search yielding 141 citations. This was a small study, with 17 people completing a trial comparing CBT to an attention placebo (supportive psychotherapy) for people with delusional disorder. Most participants were already taking medication *and this was continued during the trial*. We were not able to include any randomized trials on medications of any type due to poor data reporting, which left us with no usable data for these trials. For the included study, usable data were limited, risk of bias varied, and the numbers involved were small, making interpretation of data difficult. In particular there were no data on outcomes such as global state and behaviour, nor any information on possible adverse effects.

A positive effect for CBT was found for social self-esteem using the Social Self-Esteem Inventory (1 RCT, $n$ = 17, MD 30.5, CI 7.51 to 53.49, *very low quality evidence,* table 1), however this is only a measure of self-worth in social situations and may thus not be well correlated to social function. More people left the study early if they were in the supportive psychotherapy group with 6/12 leaving early compared to 2/12 from the CBT group, but the difference was not significant (1 RCT, $n$ = 17, RR 0.33, CI 0.08 to 1.33, *moderate quality evidence*). For mental state outcomes the results were skewed making interpretation difficult, especially given the small sample.

## Authors' Conclusions

Despite international recognition of this disorder in psychiatric classification systems such as The ICD-10 Classification of Mental and Behavioural Disorders and Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, there is a paucity of *high quality* randomized trials on delusional disorder. There is currently insufficient evidence to make evidence-based recommendations for treatments of any type for people with delusional disorder. The limited evidence that we found is not generalizable to the population of people with delusional disorder. Until further evidence is found, it seems reasonable to offer treatments which have efficacy

**Table 1.** Summary of Findings of Single Study: CBT vs an Attention Placebo (Supportive Psychotherapy) for Delusional Disorder

| Outcomes | Illustrative Comparative Risks* (95% CI) | | Relative Effect (95% CI) | No. of Participants (studies) | Quality of the Evidence (GRADE) |
|---|---|---|---|---|---|
| | Assumed Risk | Corresponding Risk | | | |
| | Attention Control | CBT | | | |
| Global state: Clinically significant improvement | No study reported this outcome | | | | |
| Mental state: Delusions—clinically significant improvement | MADS reported in the single relevant small study, but not a clinical scale and no report of symptomatic improvement on delusions | | | | |
| Mental state: Depression (BDI); follow-up: 6 months | Average score 18.3 (*SD* 7.8, *N* = 6) | Average score 12.0 (*SD* 14.4, *N* = 11)[e] | Not estimable | 17 (1 study) | ⊕⊕⊖⊖ **low**[a,c] |
| Mental state: Anxiety (BAI); follow-up: 6 months | Average score 14.0 (*SD* 14.2, *N* = 6) | Average score 16.1 (*SD* 14.6, *N* = 11)[e] | Not estimable | 17 (1 study) | ⊕⊕⊖⊖ **low**[1,3] |
| Service use: Admission | No study reported this outcome | | | | |
| Social function: Self-worth—average score (Social Self-Esteem Inventory); follow-up: 6 months | The mean social functioning: self-worth average score in the intervention groups was **30.5 higher** (7.51 to 53.49 higher) | | | 17 (1 study) | ⊕⊖⊖⊖ **very low**[a,b,c] |
| Adverse event: Leaving the study early; follow-up: 6 months | **Low**<br>**100 per 1000**<br>**Moderate**<br>**300 per 1000**<br>**High**<br>**500 per 1000** | <br>**33 per 1000**** (8 to 133)<br><br>**99 per 1000**** (24 to 399)<br><br>**165**** (40 to 665) | **RR 0.33** (0.08 to 1.33) | 24 (1 study) | ⊕⊕⊕⊖ **moderate**[d] |

*Note*: BAI, Beck Anxiety Inventory; BDI, Beck Depression Inventory; CBT, cognitive behavioural therapy; MADS, Maudsley Assessment of Delusions Schedule. The 3 risk tiers (low,moderate, high) show what the corresponding risk of leaving early would be using the relative risk of 0.17 times the 3 differing assumed risk tiers.
[a]Risk of bias: rated "serious"—unblinded for subjective outcome, poor reporting for those who left early.
[b]Indirectness: rated "very serious"—measure reported self-worth rather than social functioning.
[c]Imprecision: rated "serious"—small trial, wide confidence intervals.
[d]Indirectness: rated "very serious"—leaving study may not be adverse effect or event. Reasons for attrition not reported.
[e]Data skewed.
*The basis for the assumed risk (eg, the median control group risk across studies) is provided in footnotes to the full review. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).
**Items showing corresponding risk of leaving the study early using a relative risk of 0.33 for CBT in varying degrees of assumed risk (low to high), with corresponding confidence intervals.

in other psychotic disorders. Further research is needed in this area and could be enhanced in 2 ways: firstly, by conducting randomized trials specifically for people with delusional disorder and, secondly, by high quality reporting of results for people with delusional disorder who are often recruited into larger studies for people with a variety of psychoses. Details are fully reported in the Cochrane review.[1]

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## Reference

1. Skelton M, Khokhar WA, Thacker SP. Treatments for delusional disorder. *Cochrane Database Syst Rev*. 2015;5: CD009785.