Atypical Delusional Content in a Case of Persistent Delusional Disorder: Freud Revisited

Jayaprakash Ramasamy, Shanmugiah Arumugam¹, Jaiganesh S. Thamizh²

ABSTRACT

Persistent delusional disorder is diagnosed when a person exhibits non-bizarre delusions of at least 1 month’s duration that cannot be attributed to other psychiatric disorders. Delusions are subdivided according to their content into various types. Here we report a case with unusual content of delusion.

Key words: Content of delusion, delusional disorder, Sigmund Freud

INTRODUCTION

Sigmund Freud believed that delusions rather than being symptoms of the disorder, are part of the healing process. In 1896, he described projection as the main defense mechanisms in paranoia. American Psychiatric Association (Diagnostic and Statistical Manual of Mental Disorders (DSM)-IIIR 1987) has revised the Kraepelinian concept of paranoia, but has given it the name of delusional (paranoid) disorder. Persons with these conditions do not regard themselves as mentally ill and actively oppose psychiatric referral because they remain relatively high functioning and experience little impairment. Along with schizophrenia and major mood disorders, paranoid or delusional disorders have traditionally been considered an important group of functional psychosis. Munro provided many clinical descriptions of DD. He pointed out the unique and striking features of DD in the way in which the patient could move between delusional and normal modes of thought and behavior. The description is of an encapsulated monodelusional disorder with several subtypes as follows: Erotomanic, grandiose, jealous, persecutory, somatic, and unspecified. However, if its varied presentations are appreciated it is not so rare and some of its forms are now amenable to treatment. Since paranoia is a circumscribed and definable disorder, it can be viewed as a kind of naturally occurring model psychosis and theories of etiology and treatment may be tested against it. Several competing and overlapping theoretical domains characterize psychoanalytic theory today. If paranoia were as rare as has been claimed, or as untreatable as it used to be, we could afford to go on neglecting it. The arrival of contemporary theories does not replace the older Freudian techniques rather they modulate certain Freudian concepts and also keeps on adding to the previous ones.

CASE REPORT

Mr. V, a 25-year-old male, who studied up to 12th standard, laborer by occupation has been brought by his mother with complaints of suspicion that his mother is making sexual advance towards him and also strongly believes that she manipulated his genitals. The complaint was advanced with great intensity and the patient was totally convinced of his belief despite...
all evidence to the contrary. Relatively his social and occupational functioning was adequate. When his belief was counteracted he would become irritable and would abuse and assault his mother. Also he had added suspicion that, his friend Mr. Z would kill him which developed secondary to the incident of an altercation with Mr. Z. But this belief does not predominate his delusional system. He was taken to various temples for magico-religious treatments. His appetite, sleep, and self-care were normal according to his parents. Because of frequent expression of his belief that his mother manipulated his genitals, his parents were ashamed and started to hate him. Mr. V also infrequently regrets about his thoughts whether a mother could manipulate her son’s genitals. Further questioning revealed that the patient while he was 14-years-old exposed his genitals in front of a girl belonging to his class. Later he repeatedly regretted for this act to his mother and also to that girl’s brother. He also frequently reads obscene sexually stimulating books and then he generalizes the acts done by the females in those obscene stories over every other female. Also when he was 20-years-old, he attended a prostitute once. He was using chewing tobacco for past 12 years and now has intense craving, tolerance (10 packs/day), inability to control its use, and using the substance even after knowing its harmful effects, satisfying the criteria for nicotine dependence. Previously he smoked Cannabis twice and uses alcohol occasionally. Born out of nonconsanguineous marriage, developmental milestones were normal. Premorbid personality was adjustable, sociable, and meticulous at work.

His physical examination revealed normal findings. MSE reveals presence of delusion that his mother manipulated his penis and nil psychopathology noted in other domains. After the interview the patient repeatedly entered the interviewing room and he idealized the interviewer and also repeatedly questioned the interviewer several times about the validity of his beliefs and tried to stimulate the interviewer’s counter transference reactions.

**DISCUSSION**

When viewed from psychoanalytic perspective, the patient’s symptomatology can be explained by following Freudian and other contemporary psychoanalysts theories.[7] Patient’s presentation that his mother manipulated his genitals may also be viewed as a result of projective identification in which this patient projects his internal urges and wishes over his mother.[7,8] In the Schreber case, Freud continues a theme which he initially developed in 1896 when he described paranoia as one of the neuropsychosis of defence.[9-11] Freud created the ground for ambiguity as to whether he considered psychosis a disease of ego deficit or of id-ego conflict. The concept of decathexis as a primary ego deficit constitutes a leading belief on the part of a group of analysts who approach the psychopathogenesis of psychosis as being caused by an ego deficit rather than by psychical conflict.[14] Arlow and Brenner[15,16] Boyer, and others view psychosis as due to psychical conflict, either between intrapsychic agencies of the psychic apparatus (id, ego, and super ego) or between internal objects and/or object representations based upon a nurture hypothesis, but they do not totally exclude the deficit conception.

Giovacchini acknowledge that a mother who does not properly nurse her child may constitute a nurture deficiency and comprise the basis for a psychical conflict. Jacobson also has left this area of nature/nurture in a state of ambiguity.[17,18] Nienderland has stated the concept of disorders of self-regulation which predicates that all psychopathology is due to either primary and/or secondary disorders of bonding or attachment and that the failure of bonding is predicated not only by maternal or paternal influences per se, but by factors which transcend the hereditary psychobiological disorders. Fantasies and delusions of persecution may be the transformed instincts through projective and introjective identification on the part of parents and other objects.[19,21]

**REFERENCES**

1. Munro A. Monosymptomatic hypochondriacal psychosis. Br J Psychiatry Suppl 1988:37-40.
2. Grover S, Gupta N, Mattoo SM. Delusional disorders: An overview. German J Psychiatry 2006;9:62-73.
3. Munro A. Paranoia revisited. Br J Psychiatry 1982;141:344-9.
4. Grover S, Biswas P, Avasti A. Delusional disorder: Study from North India. Psychiatry Clin Neurosci 2007;61:462-70.
5. Karasu TB, Karasu SR. Psychoanalysis and psychoanalytic psychotherapy. In: Benjamin SJ, Virginia SA, Pedro R, editors. Kaplan and Sadock’s Comprehensive Textbook of Psychiatry, 9th ed. Philadelphia: Lippincott Williams & Wilkins; 2009.
6. Haggard PJ, Furman AC, Levy ST, Dunn JE, Galatzer-Levy RM, Ginsburg SA, et al. Psychoanalytic theories, In: Tasman A, Kay J, Lieberman JA, First MB, Maj M, editors. Psychiatry. 3rd ed. Hoboken: John Wiley & Sons, Ltd; 2008.
7. Freud S. The neuro-psychosis of defence. Standard, 3rd ed. 1896. p. 43-70.
8. Further remarks on the Neuro-psychosis of defence. Standard, 3rd ed. 1896. p. 159-88.
9. Freeman T. Aspects of defence in neurosis and psychosis. Int J Psychoanal 1959:40:199-212.
10. Freeman T. Psychopathology of the psychosis. New York: International University Press; 1969.
11. Freeman T. Psychopathology of the psychosis, A reply to Arlow and Brenner. Int J Psychoanal 1970;51:407-15.
12. Wexler M. Schizophrenia: Conflict and deficiency. Psychoanal Q 1971;40:83-99.
13. Fairbairn W. A revised psychopathology of the psychosis
and psychoneurosis. In: Psycho-Analytic Studies of the Personality. London: Routledge and Kegan Paul; 1941. p. 3-27.

14. Arlow J, Brenner C. The psychopathology of the psychosis. In: Psychoanalytic Concepts of the Structural Theory. New York: International University Press; 1964.

15. Boyer LB. Working with the borderline patient. In: Boye LB, Giovacchin PL, editors Psychoanalytic Treatment of Schizophrenic, Borderline and Characterological Disorders. New York: Jason Aronson; 1980. p. 171-208.

16. Jacobson E. Contributions to meta-psychology of psychotic identifications. J Am Psychoanal Assoc 1954;2:239-62.

17. Jacobson E. The self and the object world. New York: International University Press; 1964.

18. Jacobson E. Psychotic conflict and reality. New York: International University Press; 1967.

19. Tustin F. Autistic Objects. Int Rev Psychoanal 1980;7:27-40.

20. Tustin F. Psychological birth and psychological catastrophe in do i dare disturb the universe? A memorial for Wilford B. Bion. In: Grotstein JS, editor. Beverly hills: Caesura Press; 1981. p. 181-96.

21. Tustin F. Autistic states in children. London: Routledge and Kegan Paul; 1981.

How to cite this article: Ramasamy J, Arumugam S, Thamizh JS. Atypical delusional content in a case of persistent delusional disorder: Freud revisited. Indian J Psychol Med 2014;36:431-3.

Source of Support: Nil, Conflict of Interest: None.