Delusional Disorder: An Unusual Presentation

Joseph Noel, Ranjit Krishnadas, Rajesh Gopalakrishnan, Anju Kuruvilla

ABSTRACT

Delusions with a sexual theme are rare, but when present are usually seen in patients with schizophrenia or other chronic psychotic disorders. We report a case of delusional disorder, with a single belief of a sexual theme. This report focuses on the management issues, wherein a combination of pharmacological and nonpharmacological interventions proved helpful.

Key words: Delusional disorder, sexual delusions, cognitive behavioral therapy

INTRODUCTION

Delusional disorder is an uncommon psychiatric condition characterized by nonbizarre delusions of a single theme, in the absence of other mood or psychotic symptoms.\[1\] It is differentiated from schizophrenia by the absence of bizarre delusions and impairment of functioning only in relation to the delusional belief. The lifetime prevalence rate is reported to be about 0.2% in the United States,\[1\] whereas in India rates of about 1% have been reported in a psychiatric clinic population.\[2\]

The disorder is divided into erotomanic, grandiose, jealous, persecutory and somatic subtypes based on the content of the delusion.\[1\] The most commonly reported subtypes are the persecutory subtype in western literature, whereas delusional parasitosis is most commonly reported in Indian literature.\[2\] Although delusions of a sexual nature are not unusual in schizophrenia and affective disorder, reports of this presenting as a delusional disorder are uncommon. We report a case of a young male who presented with a single delusion regarding his sexual physiology.

CASE REPORT

Mr. A is a 19-year-old single engineering student, from a middle socioeconomic background. Over the previous year and a half, he firmly believed that every time he assumed an upright posture, he attained penile erection. He believed that others were able to identify his physiological state by the appearance of his groin and therefore were laughing at him and making derogatory comments. He had made attempts to mask these perceived bodily changes by changing the way he dressed. Secondary to these beliefs he had also become socially withdrawn, was frequently absent from class and had had significant academic decline. The patient had even shifted colleges because of the perceived ridicule by others. He also avoided situations, which required him to stand upright, such as crowded buses, elevators, and shops. He had attempted self-harm a year earlier by slashing his wrist due to the distress related to his beliefs. These beliefs persisted though several attempts were made to persuade him otherwise. There were no other unusual beliefs or abnormalities of perception reported by the patient. There were no first rank symptoms of schizophrenia or obsessive compulsive symptoms. There was no history suggestive of seizures, other organic illness or substance abuse. The patient had been on fluvoxamine and risperidone for about 7 months at the time of presentation.

Department of Psychiatry, Christian Medical College, Vellore, Tamil Nadu, India

Address for correspondence: Mr. Joseph Noel
Department of Psychiatry, Christian Medical College, Vellore - 632 002, Tamil Nadu, India. E-mail: josephnoel@cmcvellore.ac.in

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Physical examination, including a detailed neurological and genital examination did not reveal any abnormalities. He was evaluated in the Department of Andrology where physical abnormalities were ruled out. Blood investigations including hormonal assays were within the normal limits. Mental status examination revealed a well groomed young man with normal psychomotor activity and speech. He was distressed by the sexual problems that he perceived he had, but denied suicidal ideation. He had a fixed belief that he attained penile erection whenever in an erect posture. This belief persisted despite evidence to the contrary. There were no other delusions or perceptual abnormalities. There were no obsessive compulsive symptoms or volitional abnormalities. He was alert and oriented with normal attention and concentration. His intelligence was estimated to be average; insight and judgment were poor.

The degree of conviction with which the patient held his belief despite evidence to the contrary suggested it to be a delusion, upon which he was acting. A diagnosis of delusional disorder was considered in view of the single delusional theme in the absence of first rank symptoms or affective features.

The management focused on establishing rapport with the patient along with eliciting and understanding the explanatory model for his beliefs. Supportive therapy was provided to reduce anxiety and reassure the patient. Cognitive and behavioral techniques were employed to modify the beliefs. Socratic questioning was used to identify negative thoughts and dysfunctional assumptions, which were reflected to the patient. A hierarchy of situations based on distress and avoidance were charted down and he was asked to expose himself to the least anxiety provoking situation. The patient was also encouraged to do some behavioral experiments in these situations to confirm or disprove his assumptions. The antidepressant medication was tapered and stopped, while the dose of risperidone was gradually increased to 4 mg/day. There was a gradual improvement in his symptoms with the above interventions.

DISCUSSION

Delusions with sexual content, although not as common as other delusions, have been reported in psychotic disorders such as schizophrenia,[4,5] depression,[6] and organic conditions.[7] The content of these delusions include that of self-mutilation,[7] delusional pseudotranssexualism,[4] bizarre sexual mechanisms,[8] threat to genitalia, variations of erotomania,[9] procreation,[10] and homosexuality.[11] In a qualitative review of bizarre delusions among a sample of patients with schizophrenia in India, De et al.[12] found that delusions with sexual content included false beliefs about sexual relationship between humans, animals and/or supernatural beings; forceful change in sexual gender or identity and threats to genitalia.

While sexual delusions are encountered as one among other types of delusions in schizophrenia, it is not commonly reported in the form of a delusional disorder. In this case, organic illness was ruled out and the delusional nature of the belief was confirmed. In the absence of other psychotic symptoms, the diagnosis of delusional disorder was made. The patient reported distress secondary to the belief and its consequences, and there was no evidence of a primary mood disorder or other psychotic symptoms.

Delusional disorder is managed with pharmacological and nonpharmacological strategies. In this case treatment with antipsychotic agents was combined with supportive measures along with cognitive and behavioural strategies, to allay the patient’s anxiety, acknowledge his distress, explore the consequences of his beliefs and modify them. This approach helped to produce symptomatic relief and restore the patient’s functionality.

CONCLUSION

Isolated delusions with a sexual theme are rare. As with any other delusional disorder, the treatment is challenging and involves both psychopharmacology and psychotherapy. Given the chronic nature of this condition, treatment strategies should be tailored to the individual needs of the patients with a focus on maintaining social function and improving quality of life.

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