Persistent delusional disorder in a 32 year old male

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Abstract

Background: Persistent delusional disorder is a permanent, unshakable and encapsulated delusional system, developing insidiously in middle or late life with no impairment in other mental functions. This paper reviews a case of persistent delusional disorder.
Methods: The case record of a 32 year old man who said nothing was wrong with him but whose wife said he has been suspicious that several people around him were planning to harm him was reviewed.
Results: The long history of his suspiciousness of several people despite no evidence that anyone is planning to harm him, lack of evidence of an organic mental disorder or the use of alcohol or drugs, the criteria for schizophrenia was not fulfilled, the preservation of other mental functions in this patient, his ability to continue to function effectively and his lack of insight conform to the ICD 10 diagnosis of persistent delusional disorder (persecutory type).
Conclusion: Cases of persistent delusional disorder (persecutory type), though very rare do occur in our environment.

Key words: persistent delusional disorder, persecutory type, male

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Introduction

Persistent delusional disorder (persecutory type) is a delusional system that develops insidiously in a person with suspiciousness as its predominant feature. The diagnosis is based on the typical presentation in the history and mental state examination which usually reveals no other abnormalities except the delusional system and a poor insight. It typically presents in the middle to late years of life with a slight female preponderance[1]. Men are more likely to develop paranoid delusions [1]. The prevalence is less than 30 per 100,000 population[2]. The later age of onset than schizophrenia may support the case initially put forward by Kraepelin that delusional disorder is the result of 'the influence of the stimulus of life' . The course of the disorder is variable and can become chronic and relapsing. There are various subtypes of delusional disorder occurring with different frequencies. It can present as persecutory delusions (57%) , delusions of jealousy(19%), self-referential delusion (8%), hypochondriacal (7%), grandiose (3%), erotomanic (3%) and others (3%). It is the content of the delusion that determines the subtype. This presentation is a case of persistent delusional disorder, persecutory type.

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Case Report

Mr B.A, a 32 year old married Marghi Christian, policeman presented to the Federal Neuropsychiatric Hospital, Maiduguri in company of his wife and elder brother. The patient said he had no complaints and wondered why he was brought to the hospital; however, the complaints from the wife were that he was unduly suspicious that people around him were planning to harm him which has been going on for four years.

Before his transfer to Maiduguri, he served in various locations with no obvious difficulties. However, four years prior to presentation, he was said to have mentioned to his wife that some of his colleagues were unfriendly and not trustworthy. A few weeks later, he complained about "a sinister plot against him to tarnish his image" by those colleagues. In the months that followed, his wife noticed that he had become more vigilant in his actions and was easily startled. Whenever he returned from work, he was noticeably suspicious and would frequently strain his ears to listen to neighbors' conversation which he suspected was about him. Despite his wife's reassurance that there was no cause for alarm, he abruptly secured an alternative accommodation and 'commanded' his wife to pack their things to the new house. His reason for relocating was 'safety'. He felt that his former neighbors were not to be trusted. He however continued to function well as a policeman. One year prior to presentation at the hospital, he was said to have requested for transfer to his State of origin. He said he felt relieved, when he was posted back home close to his relations. A few months at his new duty post, he again

began to complain that his colleagues in the office were after him. One day, he told his wife he was off duty and did not go to work for several days. On enquiry from his office, she discovered that he was not permitted to stay away from work. When she confronted him, he told her that he felt his life was in danger, and that he will 'never go back to that office'.

It was at this point that he was brought to the hospital. His colleagues reported no disagreements between him and anyone in the office. No history of any physical illness or any stressful life events preceding the onset of the illness. He denied history of hearing voices in clear consciousness, no history of feeling as if his thoughts or actions were being controlled by external forces.

There was no previous history of mental illness in the patient who is the second of five full siblings in a monogamous Christian family. His father died several years ago but mother is alive and well. There was no family history of mental illness.

Patient's birth, primary and secondary education were uneventful. He got married after enlisting into the police force. There was no history of alcohol or other psychoactive substance use in the patient. He was described as a quiet and reserved person premorbidly.

Mental state examination revealed a young, appropriately dressed man who was well groomed, calm and co-operative. His speech and thought process were essentially normal except his belief that his colleagues wanted to end his life. There was no perceptual abnormality and his cognitive function was essentially normal. He however had no insight into his illness. Physical examination revealed no abnormality.

A diagnosis of persistent delusional disorder (persecutory type) was made. He was admitted against his wish and Haloperidol tablets and Fluphenazine decanoate injection were administered. He became relatively stable in the ward. On a number of occasions, he made statements which seem to imply that he thinks the police have enlisted the support of his doctors in actualizing their evil plan against him. On one occasion, during the ward rounds, he accused his elder brother of having an affair with his wife. He wondered if his brother who travels regularly over a distance of over 150 km to attend the ward rounds had no ulterior motives.

Discussion

In persistent delusional disorder, the delusions are non-bizarre in that they can occur in real life and conform to societal norms e.g, relatives planning evil, partner's infidelity etc. The nature of the delusion is a key factor in distinguishing the disorder from schizophrenia[3]. There must be no evidence of an organic mental disorder or the use of alcohol or drugs, and the criteria for schizophrenia must not be fulfilled[3]. Often patients appeared entirely normal until the subject of their delusional belief is raised. The belief develops into an encapsulated, consistent delusional system which is often chronic. The individual usually continue to function well and the delusional intensity of the belief may vary. The patient lacks insight into his condition. Manschreck[4] described the general characteristic features of persistent delusional disorder patients as 'anger, irritability, attention to small details, guardedness, evasiveness, litigiousness, hostility, secretiveness, humourlessness, self-righteousness, hypersensitivity, sullenness, and suspiciousness.

It has been debated whether delusional disorder is a distinct diagnostic entity, a subtype of schizophrenia or a subtype of bipolar affective disorder. Paranoid personality traits were found to be increased in the first degree relatives of delusional disorder probands compared with controls.[5] There is a general family tendency towards psychopathology in patients with delusional disorder. Munro et al[6] found 20% of family members of delusional disorder probands had psychopathology. Many evidences indicate that delusional disorder is a diagnosis on its own right and not a subtype of schizophrenia.[7] The prevalence of schizophrenia was significantly lower in 1st and 2nd degree relatives of delusional disorder probands (0.6%) than in the first and second degree relations of patients with schizophrenia (3.8%)[8]. Some patients with delusional disorder have been shown to have had avoidant and paranoid premorbid personality traits[9]; they were often oversensitive, with what Kretschmer[3] described as a sensitive personality (sensitive Beziehungswahn). It has also been suggested that delusional disorder is caused by defective social vigilance mechanisms and responses.[2] Suspicion and anxiety carry a selective advantage in evolutionary terms, but when misapplied or inappropriately regulated on account of adaptive hypersensitivity may result in delusional disorder .[2]

During assessment, the psychiatrist should maintain a good relationship. He should approach the patient in a relaxed and friendly manner and should try to avoid provoking suspicion in the patient. He should avoid statements that may portray him as taking sides during assessment when the patient disagrees on any matter with his relations/ informants and should show compassionate interest in the patient's belief, but without condemning them or colluding in them.

Psychological and physical methods are useful in management although psychological management is frequently difficult. The patient may be suspicious and distrustful, and may believe that psychiatric treatment is intended to harm him. Even if he is not suspicious, he is likely to regard his delusional belief as justified, and may see no need for treatment. Considerable tact and skill are needed to persuade patients with persistent delusional disorder to accept treatment. Sometimes this can be done by offering to help non-specific symptoms such as body aches or lack of sleep. If voluntary admission is refused, compulsory admission is often justified to protect the

patient or other people, although this is likely to add to the patients' resentment. Interpretative psychotherapy and group therapy are unsuitable because a suspicious patient can easily misinterpret what is being said.

In this disorder, symptoms are sometimes relieved by antipsychotic medication. Probably the commonest reason for failure of treatment in these patients is their failure to take their medication either because they suspect it will harm them or they feel nothing is wrong with them to warrant medication. It may then be necessary to prescribe a long acting preparation such as Fluphenazine decanoate. There are reports that antidepressants especially SSRIs have been successfully used to treat this disorder [4]. The course and prognosis of the disorder varies in individuals. The outcome is better in reactive (clear precipitant) delusional disorder than non reactive delusional disorder[9]. Reclusive personality, poor premorbid history, onset six months or longer before admission, gradual onset, lack of insight and lack of precipitating factor are poor prognostic factors [10]. This patient has several poor prognostic features. However, the global outcome for delusional disorder has been shown to be better than for schizophrenia. There is need for doctors to have a high index of suspicion should they come across such a case.

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