# Clinical delusions

I aim to share the results of my practice in treating individuals with delusional ideas through two clinical examples: one diagnosed with paraphrenia and the other with schizophrenia. In both cases, the subjects had a high degree of success in maintaining their family and social lives and stable employment.

I met the first patient in the outpatient clinic of a hospital in the Buenos Aires metropolitan area about fifty years ago. Reason for consultation: His manic symptoms prevented him from working as a bricklayer, and he was the primary financial support for his family. It was a case of expansive paraphrenia: he experienced psychic hallucinations that convinced him he was a messenger of God. His belief was based on the idea that the number of letters in his name matched the number of letters in the message he had received.

To illustrate, let's assume his name was Ramón Hugo Rodríguez, which has 17 letters. He received a message: *I bring good news*, which also has 17 letters. When he consulted me, he noticed that my name and phone number added up to 17 letters. As he understood it, he told me: "It's obvious".

He also saw a golden crown with flowers around my head. The transference occurred abruptly –I became the Virgin Mary. If any student from that time reads this work, they will remember the *seventeen-letter patient*, who still occasionally calls me to ask if I want him to speak with a group of students. He felt very comfortable sharing his experience. From then on, I saw him at the hospital and later in my office, free of charge.

A first result of the treatment was that, with incisive antipsychotics, he no longer had hallucinations. *"It's OK Doctor, but you know what? I feel sad."* Figuratively speaking, a red flag went up in my mind. My professional goal was never to "cure diseases" but to make people as happy as possible and take advantage of the opportunities to enjoy life. So, I realized that in this clinical case, where the hallucinations were non-threatening, the ideal approach was for the patient to maintain enough clarity to be able to work, even if the psychotic phenomenon did not disappear entirely.

I spoke with his mother and wife and explained how to manage the medication so that the manic aspect –which was inhibiting his ability to work– would disappear while not worrying about the hallucinations that did not distress him but instead placed him in a privileged position as a messenger of God.

It worked, and at first, I continued seeing him every month; later, only when his family could visit me. It didn't matter that the patient faced the psychotic phenomenon because it did not involve aggressive content. From this person, I learned a great lesson: it became even clearer to me that "curing diseases" is not a rule but rather a tool to achieve the objective of my professional practice. It has been many months since he last called me –I don't even know if he is still alive.

The other patient, diagnosed with schizophrenia, was seen only 20 years ago after having undergone a year of psychoanalysis three times a week on the couch without any relief. He had only auditory hallucinations at three spatial levels, which caused him significant distress. In this case, as well, the patient was immediately treated with incisive antipsychotics. His distress also decreased, allowing us to work with greater ease. I tried not to discredit his previous experience. I continued seeing him three times a week without resorting to psychoanalytic interpretations described as mutative.

When I understood that our bond was strong enough, I began to increase my criticism and to suggest –more emphatically each time –that he argued with the voices, as he knew they did not come from outside but from within himself. Framed in this way, he had, on the one

[Editor's Note] This text is a brief letter to the readers written by the experienced psychiatrist and psychoanalyst Lía Ricón, who served as Head of the Psychiatry Department at the Hospital Italiano de Buenos Aires. As a mentor to multiple generations of psychiatrists, I aim in this communication to show young professionals that it is not always advisable to work against delusion but with delusion, as in some cases, it constitutes an integral part of the individual's identity structure.

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hand, a certain level of acceptance from me since he was arguing with someone, giving him the space to disqualify them. I also spoke with his parents, who had always been very supportive. Over the 20 years since I first saw him, the patient has developed as a businessman –he owns three businesses, has married, and is responsible for a daughter his wife had as a widow and another son they had together. He trains for his favorite sport, has friends, and enjoys a good social life. I see him once a month at his family's request. He has a therapist in his town since he lives far away. His general practitioner prescribes his antipsychotics. When I ask him about the voices, he tells me that he has started sending them his problems to discuss –he laughs and says it's okay.

In both cases, I was categorical in my criticism of the delusion. I must also say that, in both, my emotional commitment was very intense.

As a provisional conclusion and aiming to share my experience with younger colleagues, I would like to emphasize that all available resources should be used appropriately, in a contextualized and relevant manner –for example, psychopharmacology, psychoanalytic theory, and some aspects of behavioral therapy– to improve the overall quality of life of the patient. It is not necessary –sometimes not even possible– for the psychotic phenomenon to disappear; it is enough for the individual to be able to live according to their desires and possibilities. As a physician, I understand that this is not *restitutio ad integrum*, but it is a form of healing that reduces suffering and enhances the ability to enjoy life.

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