Case Report

Delusion of Grandiosity Incongruent With Mood In Schizophrenia: A Rare Phenomenon

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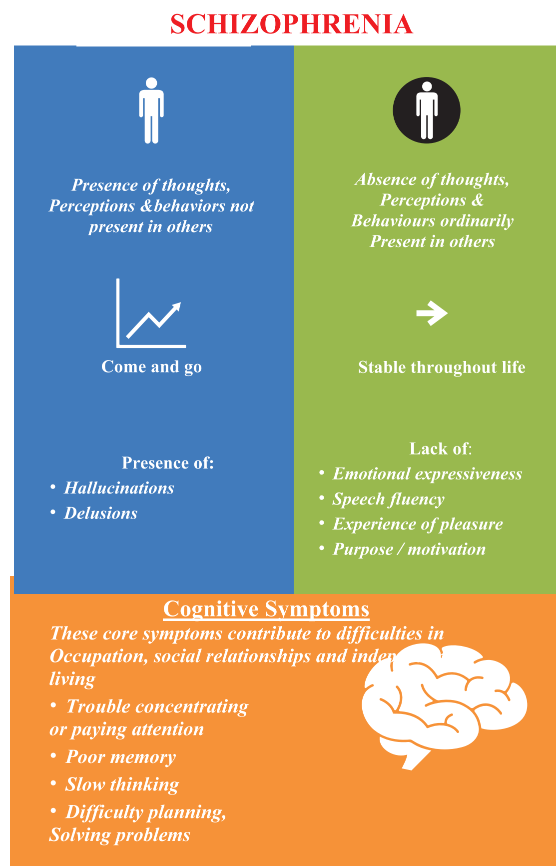
ABSTRACT

Schizophrenia is a known as a severe, chronic psychiatric disorder which affects a person's thoughts, perceptions, feelings and behaviour. The causal relationship between psychiatric disorders and chronic cannabis use is a debatable topic. Cannabis use has shown to affect a person's mental health, often presenting with symptoms resembling schizophrenia or mood disorders. There are evidences in its support but the connections are not completely understood. This article reports a case of a young adult presenting with depressive symptoms, which further evolved into psychosis, perhaps secondary to an underlying use of cannabis for a long period of time. This also discusses the rare phenomenological presentation of delusion of grandiosity in the absence of accompanying mood symptoms in the background.

Keywords : Depression, Mania, Cannabis, Schizophrenia, Grandiosity

INTRODUCTION



Mood disorders primarily influence one's emotional wellbeing through experiences of long periods of significant sadness, happiness, or both. Transient mood changes are normal, but symptoms must be

present for longer periods (weeks or months) to be diagnosed with a mood disorder. Mood disorders can adversely affect a person's routine, as well as occupational or interpersonal functioning. Depression and Bipolar Disorder are the most common mood disorders. Depression usually presents with sadness, loss of interest or pleasure, feelings of guilt or low self-worth and disturbed sleep. Mania presents as increased, rapid and big talk, decreased need for sleep, distractibility, more goal-directed activities and psychomotor agitation.[1,2] Similar presentation can however, be also observed in the initial phase of schizophrenia. About 75% of people with schizophrenia experience a prodromal phase, lasting from few weeks to even several years. This presentation can be similar to depressive illness when symptoms of memory problems or difficulty with attention and staying focused are found. Other symptoms can be mood swings, feelings of anxiety or guilt or mistrust in others. Suicidal thoughts can also be occasionally present. Other signs of prodrome include lack of energy or interest, sleep problems or reduced socializing, along with impairment in work or school performance. There could be noticeable changes in how a person looks and keeping up with hygiene might become an issue. The first rank symptoms of psychosis like auditory hallucinations or thinking that other people can hear their thoughts can be present.

Grandiosity is a core symptom of bipolar disorder, wherein a person often feels larger-than-life and harbours a feeling of superiority over others. Grandiosity is seen as an exaggerated state of one's importance, power or identity, despite little supporting evidence. Around two-thirds of bipolar disorder patients are known to experience grandiose delusions at some point of time. However, about half of those diagnosed with schizophrenia and many suffering from substance use disorders also experience grandiosity as an illness manifestation.[3] In this case, a polymorphic presentation of all the above symptoms created a diagnostic dilemma on cross sectional examination. Longitudinal assessments later helped with postulating the mood symptoms to be a part of prodrome of an evolving schizophrenic illness.

CASE PRESENTATION

An 18-years young man presented to the OPD with symptoms of increased worrying and decreased sleep since past 2 months, followed by anger outburst, irrelevant talk, crying and laughing spells and suspiciousness, for 5 days. The apparent stressors at the onset were heavy workload at his first job/ working experience and his mother not approving of his relationship with his girlfriend. The patient was apparently alright 2 months back when he started working at one of his father's businesses. According to the patient's father, the boy felt out of place, was constantly worried about not being familiar with work and not able to do things on his own. He seemed to have lost his confidence when co-owner constantly complained to his father about him being not good enough in Hindi language while most of the work required Hindi reading and writing skills. He often compared himself with his elder brother. These difficulties lasted for about 2 months following which he started experiencing sleeplessness. His sleep has reduced to 3-4hrs/day since last 5 days which was earlier 8-9hrs/day. He had problems in both initiating and maintaining sleep. The father added that since last 5 days he also started talking excessively and most of his talks did not make much sense. For example, when his mother would ask him to do some chores, he would reply with “hari hari om”. It was also noticed that he would laugh and cry without any apparent reason. When enquired from the patient, he mentioned he felt suspicious about something wrong happening with him, but the context was not specified. He said he often talks to himself about these wrong-doing sand he apologises to God. He added that he felt like he is supreme and has become very intelligent since last few days. He stated “mai sach jaan gaya hu, mai kuch krna chahu toh kar sakta hu”. He said he was able to read minds of people sitting next to him and also said that people can read his thoughts. His father further added that he would become aggressive without any significant provocation. A day before consulting with us, he got up in the middle of night with a knife in hand, pointing towards his family members. He was standing in a boxing posture, with protruding eyes and grimacing teeth and hopping movements. This lasted for nearly 30 seconds and nobody was hurt during this episode. This incident prompted his parents to consult in the Psychiatry OPD. Further enquiry revealed a history of substance use. He started using cannabis and alcohol under peer pressure, when he was 16years old. Since past 1 year, he had been smoking cannabis on a daily basis and in the last 2 days he had smoked in greater quantities than usual. He would typically drink a few beers on the weekends (varying amounts). His father reported about his occasional vomiting after drinking in binges. No history of passing out or withdrawal seizures or hospital admissions for the same was reported. He denied any other illicit drug use. The patient's functioning was impaired on social, occupational and interpersonal grounds. Before the onset of illness, he was described as a friendly person who enjoyed company of his friends and family get-togethers. However, his parents were unhappy with his social life and late-night outings. He used to avoid conversations with anyone when angry and used to keep things to himself. He enjoyed playing sports like boxing and swimming.

On examination he was conscious, calm, cooperative and well oriented to time, place and person. His eyes appeared to be red and he was frequently yawning. He appeared to be of his stated age. He was built athletically, tall, well-nourished but not groomed very well in context of his social setting and cultural background. His demeanour was guarded and rapport was built with difficulty. Throughout the interview he established eye contact, but did not sustain it. His psychomotor activity was reduced. His speech and language was non-spontaneous, comprehensible, and coherent and varied from relevant to irrelevant. Tone volume and pressure of speech were decreased. He reported his mood to be sad. Although his affect was euthymic and reactive, the range was labile and tearful at times. He had inappropriate smile during the interview and affect was incongruent to the thought content shared by the patient. His stream of thought was reduced and thought content included delusions of grandeur (I am very intelligent; I can read minds of people) and persecution (something wrong is happening with me). He denied inconsistently about experiencing auditory and visual hallucinations. He had poor insight into the reason behind these recent experiences but was willing to accept our help with the same (2/6).

On follow up, the parents observed that he felt nearly 50%

better on the prescribed medications but shared an incident wherein the patient spoke suspiciously of relatives in a recent family function, blaming them for pointing fingers at him, looking at him with protruding eyes and growling at him. He further added that the relatives were whispering and the context of conversation was that they wanted him to leave the place and disliked his presence in the gathering. Further conversation with the patient elicited absence of the delusion of grandiosity previously noted.

On the basis of history and examination, differential diagnoses of Prodromal Schizophrenia, Major Depression (with psychotic features), Substance-induced Psychosis and Bipolar Disorder (mania with psychotic features) were considered. The points in favour of prodromal phase of schizophrenia were the depressive mood, sleep disturbance, irritability, anger outburst and irrelevant talk. Although the major criteria for a depressive illness were met, this diagnosis was ruled out in the presence of frank positive symptoms of psychosis (delusions and hallucinations, including first rank symptoms). Substance-induced psychosis was ruled out due to lack of firm evidence of a temporal correlation with symptomatology and ongoing withdrawal period. Mania was a likely differential, but ruled out due to absence of sustained accompanying euphoric or irritable mood.

TREATMENT

When presenting to our OPD, the patient reported to have illness symptoms since approximately 2 months, with increase in severity for last 5 days. He was prescribed oral Olanzapine 7.5 mg at night and Clonazepam0.5mgon SOS basis for 15 days on his first visit. The family members were educated about the patient's illness, treatment options and expected course and prognosis. On the following visit, no adverse effects were reported and the treatment response was noted to be satisfactory. Treatment adherence and regular follow up were emphasized.

DISCUSSION

The concept of schizophrenia is an extremely old concept. Consistent with Emil Kraepelin's delineated symptomatology (1850) there is a standard course and outcome for the entity that he called as dementia precox. Later, Eugene Bleuler coined the term “schizophrenia” for the same clinical presentation. Schizophrenia is conceptualised as a neuro-developmental disorder that has an onset way before the particular presentation with frank psychotic symptoms. This period between latent onset and frank clinical presentation of symptoms is understood as the prodromal phase of schizophrenia. It is characterized by various changes or deterioration in the subjective experience or behaviour of a person and precedes the onset of actual psychotic symptoms. The concept of prodrome is retrospective, i.e. we cannot define it until there is an overt emergence of psychotic illness. These prodromal symptoms of schizophrenia could be often overlooked as they have a close resemblance with depression. Furthermore, social withdrawal, increased anxiety, difficulty concentrating, lack of motivation, changes to normal routine, neglect of personal hygiene and increased irritability may also indicate co-occurrence of multiple underlying psychopathologies. In this case, the onset of illness was with a similar presentation, confirmed to be a prodromal evolution of schizophrenia on longitudinal assessments.

The role of prolonged and concurrent psychoactive substance use in the form of cannabis smoking in this case can also not be overlooked. Cannabis use has been associated with both mania and acute psychosis through several studies, with grandiosity and irritability as the most prominent symptoms. [5-8] However, whether or not cannabis can cause schizophrenia and depressive disorder is debatable. The endo-cannabinoid system regulates neurotransmitters in the brain. Cannabis consumption potentially can disturb this regulation, causing inappropriate neuroplastic changes in the wiring of neurotransmitter circuits. Cannabis can cause complex interactions in transmission of dopamine, gamma amino-butyric acid (GABA) and glutamate in the brain, which can precipitate psychotic symptoms in vulnerable individuals.[7,8] An acute intoxication can present with redness of eyes, dry mouth, increased appetite and paranoia which was present in this case. Although the patient had no apparent genetic predisposition, smoking of cannabis since an early age was a risk factor for precipitating psychosis. The history of depressive symptoms earlier in the illness onset might have progressed to psychotic features due to the concurrent substance use, used as a coping method to allay his distress.

CONCLUSION

The above case intends to highlight the rare phenomenon of delusion of grandiosity without congruent mood changes, typically but rarely seen in Schizophrenia. Symptoms suggestive of different psychiatric illnesses (depression/ mania/ psychosis/ substance intoxication) were simultaneously present in this case, making it a unique clinical presentation. This report is an attempt to highlight the importance of identifying a delusion of grandeur in Schizophrenia, differentiating it with the grandiosity of a typical mood disorder, and optimizing the treatment accordingly, in view of early intervention and maximizing prognostic implications.

CONFLICTS OF INTEREST: None.

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