



## Mood Disorder Masking Delusional Disorder

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### Abstract

This is a case of a 44 years old lady, married and working as a maid. She presented with prominent depressed mood in addition to feeling worthless. She was unable to sleep and felt lethargic during the day. She also expressed death wishes without active suicidal plans. She was treated for Major Depressive Disorder initially. However, her symptoms of depression did not resolve with trial of various antidepressants of adequate dosage and duration. Further exploration and collateral history from family members revealed that her mood symptoms were stem from paranoid delusion towards her husband and his family. As a result of her delusion, she also faced with difficulties in interaction and intimacy with her husband and his family and thus affected her marriage. She was started on antipsychotic, in which, she responded well to it.

**Keywords:** Delusional disorder, Mood disorder, Paranoid Delusion

### Introduction

Delusional disorder is under diagnosed as most patients with the disorder do not regard themselves as ill and therefore they are less likely to come into contact with psychiatric services. Patients with delusional disorder will however present themselves to a psychiatric facility either when they are severely affected by symptoms of common co morbid psychiatric disorders such as Major Depressive disorder or when their delusions causes severe disruption in their psychosocial functioning. However, presence of prominent symptoms of these common co morbidities may mask the latent delusion making diagnosis more difficult. This case gives an example of presentation of delusional disorders overshadowed by symptoms of depression.

### Case Presentation

This is a case of a 44 years old lady, who presented with depressed mood for the past 1 year and she began to feel that her life was meaningless. She became increasingly depressed for the past 2 months and this had lead her to seek treatment from psychiatry clinic at a tertiary centre for treatment of her symptoms. In addition to feeling depressed, she had frequent crying spells with feelings of helplessness and she wished she was dead at times. However, she did not have any active plans to commit suicide. Her appetite was affected as well. She found herself unable to sleep on most nights and hence felt tired during the day. There were no reported symptoms suggestive of a bipolar disorder. She denied any auditory or visual hallucinations. She reported having some difficulties with her husband whom she



perceived as inconsiderate and uncaring. However, she was reluctant to elaborate more on details of the marital issue. She had also refused to allow treating team to involve her husband in the management of her depression. Thus, collateral history regarding the extent of her marital problems was not available.

She managed to carry out house chores and activities of daily living independently previously and she was able to work as a cleaner despite having low mood. Nevertheless, since the worsening of depressed mood, she had difficulties concentrate on her work and there was deterioration in work performance as a maid.

At this point in time, she was diagnosed and treated for major depressive disorder secondary to marital disharmony. However, her symptoms of depression did not resolve with trial of various antidepressants of adequate therapeutic dosage and duration, namely, Fluvoxamine, Escitalopram and Dothiapine. She was not able to tolerate Mirtazapine.

Repeated effort has been made to involve patient's husband in the management of patient's depression in view that her depressive episode was due to marital disharmony. Patient had persistently refused to allow treating doctor to contact her husband or children. Patient did not think there was any need of involving her family in her treatment. Effort was made to improve therapeutic relationship via empathic validation to establish trust and rapport. Following much discussion and explanation on the benefit of involving her family for support, she finally allowed the treating doctor to contact her daughter.

Collateral history from her daughter revealed that she had prominent paranoid delusions towards her husband and in-laws for the past 6 years. She had a fixed false belief that her husband had arranged for someone to spy on her and to report her whereabouts to him because he believed that she was having an affair. Patient was constantly worried of being hit by her husband although both patient and her daughter reported that her husband had never been physically violent towards her. Patient also believed that her husband and in-laws were involved in a deviant religious group because she found many unfamiliar prayer materials at home and performed weird prayer rituals by making burnt marks on her husband's boxer. Patient also believed they had intentions of using black magic to control her. She also accused her husband and her in-laws for stealing her jewellery although she did not have actual evidence for the accusation. There were no hallucinations noted. Her daughter had confirmed that none of her beliefs were true and patient held on to the beliefs despite not having evidence to support the belief. Her marriage was greatly affected as she distant herself from her husband because of these beliefs. Her daughter observed that the patient was becoming increasingly sad with frequent crying spells due to the paranoid delusions for the past 1 year. Her diagnosis was revised to delusional disorder with co morbid major depressive disorder.

### **Investigations**

A normal full blood count, renal profile, liver function test, thyroid function test as well as urine drug screening exclude a possible organic cause for her psychotic and mood symptoms.



## Treatment

She was initially treated for Major Depressive Disorder with various antidepressants. She was started on Fluvoxamine, titrated up to 100mg ON. She was not able to tolerate higher dosage of Fluvoxamine due to daytime somnolence, thus was put on Escitalopram instead. There was no improvement of depressive symptoms with Escitalopram 20mg ON for a duration of 6 weeks. She was next started on Mirtazapine, of which caused her to feel hungry constantly. Dothiapine was then started, replacing Mirtazapine and was optimized to 125mg ON. There was improvement in her sleep but she was still persistently depressed. In addition, she also complained of difficulty waking up in the morning. She was then started on Sertraline and optimized to 200mg ON for a duration of 8 weeks. Upon revising her diagnosis to delusional disorder with co morbid depressive disorder, Olanzapine was started and titrated gradually to 20 mg ON.

## Outcome and Follow up

Over time, there was noticeable improvement in paranoid delusion as she reported less fearful towards her husband and his family. She believed she was no longer being followed and they no longer have intentions to control her with black magic. As a result, there was also improvement in the symptoms of depression.

## Discussion

Delusional disorder is characterized by presence of delusions without other psychotic symptoms. The prevalence of delusional disorder in the United States of America is estimated as 0.03% and accounts for 1-2% of

inpatient admission rates. (APA, 2013) Manschreck estimated the prevalence rate of delusional disorder in the general population as 24-30 per 100 000 (Sadock, Sadock, Ruiz, & Kaplan, 2000). The most frequent subtype of delusional disorder is persecutory type delusional disorder (Sadock et al., 2000).

Delusional disorder is less commonly studied as patients with delusional disorder often do not regard themselves as being ill and thus will not present themselves to psychiatric services, let alone agreeing to be involved in research studies (Sandeep Grover, Nitin Gupta, & Mattoo, 2006). In addition, delusional disorder may often be misdiagnosed due to the presence of symptoms of other psychiatric disorders which may be more prominent during initial presentation.

Studies showed that depression is highly prevalent in delusional disorders. (Hsiao, Liu, Yang, & Yeh, 1999; Saha, Scott, Varghese, & McGrath, 2010; Segovia, Calahorro, Jimenez, & Ballesteros, 2016) The prevalence of depression in delusional disorder was found to be 31.9% in one study. (Segovia et al., 2016) A replication study on National Survey of Mental Health and Wellbeing in Australia showed that delusional-like experiences was closely associated with Major Depressive Disorders and Anxiety disorders (Saha, Scott, Varghese, & McGrath, 2012). Another study showed that 57-80% of individuals who presented with psychotic-like experiences including delusional-like experiences were found to have at least one neurotic psychiatric disorder (Kelleher et al., 2012).

Depression is a common presenting complaint at first visit to psychiatry service in patients with delusional disorder. (Hsiao et



al., 1999) In addition, one study showed a dose-response relationship between major depressive disorder and delusional disorder i.e. the more severe the major depressive episode, the higher the odds of delusional disorder. (Saha et al., 2012) Thus, it is useful to look into the possibility of masked delusional disorder in patients with severe depression. A lack of improvement in symptoms of depression after trials of various antidepressants of adequate dose and duration is also an indicator for re-exploration of underlying stressor and to evaluate other possible co morbidities such as delusional disorder.

Patients with delusional disorder often do not think their delusion is pathological, hence, uncovering the delusion rely largely on careful exploration and confirmation via collateral history. This may be challenging especially in cases where collateral history is not readily available, such as in cases where patient denied consent for the treating doctor to contact the next of kin.

This is demonstrated in this case whereby patient presented to the psychiatry clinic to seek treatment for depressive symptoms, seemingly stemmed from marital problems. There was much resistance in patient to allow family involvement initially. It was only much later when patient finally consented to allow daughter to take part in the management of her illness, input from her daughter revealed an underlying delusion that helped identify the presence of paranoid delusion towards her husband and his family; hence a primary diagnosis of delusional disorder came to light.

Therapeutic relationship has been an essential element in mental health care. (Dziopa & Ahern, 2009; McGuire, McCabe,

& Priebe, 2001) Therapeutic alliance comprises of rapport, trust and warmth and it should channel towards managing patient's problem and needs. (Carlat, 2017) In situations where patient showed resistance in allowing history taking from a collateral informer, establishing a good therapeutic relationship play an even more important role in the management. Supportive therapeutic relationship imparts trust, facilitates negotiation of mutually acceptable management plans and allows reinforcement of positive behaviours. As demonstrated in this case, patient only allowed interview of her family following reinforcement of therapeutic alliance and repeated explanation on the benefit of allowing family involvement in her management.

In conclusion, patients with delusional disorder often do not present themselves to psychiatric services for treatment of the delusion as they do not regard their beliefs as pathological. Patients often only seek treatment when there are associated mood symptoms. However, the presence of mood disorder at initial consultation may mask the underlying delusional disorder, especially in cases where collateral history is not readily available. Good therapeutic alliance is essential in the treatment of any mental disorders and more so in the management of delusional disorders, to facilitate effective collaboration between patient and therapist.

#### **Reminder of important clinical lesson**

- Patients with delusional disorder often do not regard their delusions as pathological.
- Major Depressive Disorder is a common co morbidity of Delusional Disorder.
- Symptoms of Major Depressive Disorder may be a prominent feature on first



psychiatric consultation and may overshadow an underlying delusion.

- Careful psychiatric evaluation with collateral history is needed to identify a masked delusional disorder.
- A lack of response to various antidepressants of adequate dose and duration for the treatment of Major Depressive Disorder should act an indicator for re-exploration of symptoms and to evaluate the possibility of comorbidities such as delusional disorder.

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