Comorbidity of delusional disorder with bipolar disorder: Report of four cases

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Background: Although it is accepted that patients with delusional disorder can show co-existing depression, comorbidity with bipolar disorder is not a recognised feature.

Method: Case report of patients who showed both delusional disorder and mania or hypomania. The patients were examined using lifetime structured psychiatric interview where possible.

Results: Four patients are described who met criteria for delusional disorder, with durations ranging from 2 to 15 years, and also experienced one or more episodes of mania or hypomania.

Limitations: Case reports cannot quantify a clinical association.

Conclusions: These cases suggest that there is an association between delusional disorder and affective disorder which goes beyond the occurrence of depressive symptoms in the disorder.

Following Kendler’s (1980) review of the concept, delusional disorder is now accepted as a distinct clinical entity. Nevertheless, doubts remain about its independence from other major psychiatric disorders. For example, in a recent follow-up study, Marneros et al. (in press) found that 6 of 33 (18%) patients meeting ICD 10 and DSM IV criteria for delusional disorder underwent a conversion to schizophrenia, on average after 7–8 years of illness.

Kendler’s (1980) original criteria for delusional disorder excluded the presence of a full affective syndrome. This requirement has since been relaxed with respect to depression, with both DSM IV and ICD 10 stating that mild depressive symptoms and even a full major depressive episode can be present intermittently (although DSM IV requires that it should be relatively brief). Comorbid bipolar disorder, however, remains an exclusion: DSM IV implies that presence of mood elevation should lead to a dual diagnosis of psychotic disorder NOS and bipolar disorder NOS.

This article presents four patients who showed typical presentations of delusional disorder but who had also, at some point in their lives, experienced clear-cut episodes of mania or hypomania.

Case 1. After a theft at his workplace, a 28-year-old single printer started to believe that his bosses and colleagues suspected he was involved. He noticed his coworkers talking about him and giving him looks, and found that the settings of his press machine were changed when he was not there. He eventually came to believe that his bosses were monitoring him with cameras and microphones. He moved to a different job and the symptoms stopped. Some months later, however, after a previous workmate appeared in the workplace, they started again, and he became convinced that attempts were being made to poison him. The patient went on to change his job several times. When he did not work in the printing industry he did not experience any symptoms. However, he was often attracted back by the high salary he could earn, and then the symptoms always returned.

Four years later the patient was admitted with a two-week history of expansive mood, irritability, decreased need for sleep, increased speech and disinhibition. He was diagnosed as manic...
and improved on treatment. He did not persist with treatment and two years later, he was re-admitted with similar symptoms. Since then he has remained well on lithium and olanzapine. He works full time and has recently obtained higher qualifications. He has a long-term girlfriend who he lives with.

Lifetime structured psychiatric interview using the Present State Examination, 9th Edition (Wing et al., 1974) revealed referential beliefs, plus a fixed persecutory delusion that his original bosses wanted to harm him. He denied ever having experienced hallucinations or first-rank symptoms. The patient accepts that he has bipolar disorder but is convinced that this was caused by intentional poisoning.

Case 2. At the age of 33 a secretary overheard a remark at work and realised that an event that took place six years previously, where she thought she was being suspected of cheating in an examination, had gotten back to her current place of work. From then on she started noticing her colleagues making comments about her being promiscuous and sleeping with her teachers in order to pass exams. They would refer to her indirectly by using the name of a cheap brand of tampons or by repeating the slogan from a TV advert. At one point someone at work commented ‘Your husband wears glasses, doesn't he?’, which she took to mean that the person was implying that her daughter was not her husband’s. She was treated with olanzapine but remained symptomatic.

Ten years later she stopped all treatment. Her paranoid symptoms became worse, but then she became overtalkative and irritable. She started writing pages every day while listening to music and singing loudly. She was admitted and was noted to show pressure of speech and flight of ideas; she also described feeling that she was the best typist in the world and was unusually sexually attractive. She was treated with risperidone and slowly improved.

She underwent structured psychiatric interview four months after discharge. She accepted that her previous grandiose ideas were unfounded, but continued to experience the previous persecutory and referential beliefs. She denied past or present hallucinations and there were no other symptoms of schizophrenia.

Case 3. This 34-year-old woman developed symptoms of morbid jealousy two years previously. At home, she noticed that things were being moved when she was out, and found long black hairs on the floor (her hair was blonde). She called her husband repeatedly at work, checked his clothes for perfume, investigated what telephone calls he had made, and once went to a neighbour’s house to accuse her of being her husband’s lover. She had two admissions over this period and received treatment with olanzapine.

Structured psychiatric interview revealed a fixed delusion of infidelity and referential delusions related to this. She also described two periods of mild to moderate depressive symptoms during the previous two years; however, neither of these met criteria for major depressive disorder. She had never experienced hallucinations or other psychotic symptoms. When asked about hypomanic symptoms at any point in her life, she described that 11 years previously, two months after breaking up with a boyfriend, she started feeling euphoric without a reason. She felt very healthy and full of energy, and some nights didn’t sleep at all. She spent a lot of money on clothes, bought a car she could barely afford and, although normally a shy person, she became very talkative. She also had multiple casual sexual relations with men, something she had not done before or since. At work, she felt she was the fastest and the best, and noticed everything was going too slowly for her. Her parents felt she was acting strangely. The episode terminated spontaneously after around four months.

Case 4. This 44-year-old single man was first admitted at the age of 27, with a two-week history of hyperactivity and decreased need for sleep. He described a feeling of well-being and believed he was a famous psychiatrist. Objectively, he showed disinhibition, irritability and pressure of speech. He improved rapidly on treatment with lithium. He had three further episodes with similar symptoms at the ages of 28, 43 and 44; all of these occurred after he stopped lithium or took it irregularly. Between admissions he continued to work as an administrator.

At the age of 40, the patient stated that he fell in love with a TV presenter the first time he saw her reading the news. He started writing letters to her and believed that she was answering them through smiles and hints in what she said on TV. His letters to her became increasingly sexual, and eventually the presenter took legal action to prevent him having any kind of contact with her. He interpreted this as proof of her love for him, and resumed writing to her.

The patient was interviewed towards the end of his most recent admission for hypomania. No affective symptoms were evident at this time. He was absolutely convinced that the TV presenter reciprocated his love. He described a number of referential delusions relating to her appearances on TV, but denied ever having experienced auditory or other hallucinations, or first rank symptoms. He stated that he had a good knowledge of psychology, as a result of having done a correspondence course, and became guarded on further questioning about this, raising the suspicion that he continued to hold pathological beliefs in this area.

1. Discussion

The four patients described here all showed typical pictures of delusional disorder, yet they also experienced unequivocal episodes of mania or hypomania. Schizophrenia/schizoaffective psychosis does not appear to be a credible alternative diagnosis, given the patients’ absence of psychotic symptoms other than delusions and their lack of decline in functioning over 2–15 years. The fact that three of them experienced delusions for long periods when they were euthymic also makes any argument that they were really suffering from psychotic forms of bipolar disorder difficult to sustain.

Two studies of paranoia in the pre-DSM III era found that 6% (Retterstol, 1966) and 3% (Winokur, 1977) showed evidence of major affective disorder at follow-up. Later, Akiskal et al. (1983) described five patients with delusional disorder who responded to antidepressant treatment. One of these cases later went on to have a manic episode. Recent surveys of patients meeting diagnostic criteria for delusional disorder also point in the same direction: Maina et al. (2001) found that 23 of 64 patients qualified for an additional lifetime diagnosis of major depression, and that the mood disorder preceded the onset of the delusional disorder in
approximately one-third of cases. Grover et al. (2007) found that one of 88 patients had a previous history of mania. de Portugal et al. (2011) found that 21 of 86 patients had experience one or more episodes meeting criteria for major depression and two had a past history of hypomania.

Taken together, the findings suggest that there is a genuine clinical association between delusional disorder and affective disorder, which includes not just major depression but also bipolar disorder. One might even speculate that the higher frequency of major depression than mania associated with the disorder simply reflects the higher frequency of unipolar major depression than bipolar disorder in the general population.

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Conflict of interest
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