Prolonged Wahnstimmung (delusional mood) without development of a psychotic illness in a 50 year old male

Stone, Benjamin; Lepping, Peter

Indian Journal of Psychiatry

Published: 18/01/2018

Peer reviewed version

Prolonged Wahnstimmung (delusional mood) without development of a psychotic illness in a 50 year old male: a case report

Benjamin Stone[1], Prof Peter Lepping[2]*

Address: 1) Mr. Benjamin Stone, Medical Student, Cardiff University, 5th Floor Cochrane Building, Heath Park Way, Cardiff CF14 4YU. Tel: 07447437154. Email: benstone_17@hotmail.com

2) Prof. Peter Lepping, MRCPsych, MSc.
Consultant Psychiatrist (BCULHB), Honorary Professor (Bangor University Centre for Mental Health and Society and Mysore Medical College and Research Institute, India), Wrexham Community Mental Health Team, Betsi Cadwaladr University Health Board ,Tŷ Derbyn, Wrexham Maelor Hospital
Croesnewydd Road, Wrexham LL13 7TDTel: 01978-726752 (secretary), 726768 (clinical) or 727903 (academic); Fax: 01978-726600
E-mail: peter.lepping@wales.nhs.uk

Abstract

Delusional mood, or Wahnstimmung, is a prodromal feature of an impending psychotic illness. First described by Conrad, a delusional mood is characterised by a period of increasingly oppressive tension, a feeling that "something is in the air", which can last for days or months. It is sometimes described as "impending doom", although the tension can be positive excitation as well. It usually develops into full blown psychotic symptoms within days or weeks. In this case, the patient reports experiencing this sensation persistently since early childhood. Whilst he may yet develop psychotic illness, this seemingly unique case suggests that Wahnstimmung may persist for years without developing into full psychosis.

Mr X is a white British, 50 year old retired concrete manufacturer from North Wales. He presented to clinic with a feeling of excitement. Despite being referred for suicidal ideation, he described himself as "the happiest guy that I know. I wake up every morning feeling excited."

Whilst the phenomenon of delusional mood/Wahnstimmung is common in the early stages of psychosis, it rarely persists for as long as Mr X has experienced. This original case should highlight the possibility of this phenomenon in other patients. Ultimately, an understanding of why Mr X and similar patients do *not* progress to full psychotic illness may help improve our understanding of protecting factors in psychotic illnesses.

Introduction

Delusional mood, or Wahnstimmung, was first reported by "the great German psychiatrist"[1] Klaus Conrad in 1958.[2] Conrad proposed a stage model for psychotic disorders, including a prodromal delusional mood prior to the onset of delusions.[2, 3] It commonly involves a period, lasting days to months, of the patient experiencing an increasingly oppressive tension, "a feeling of non-finality" or expectation. The experience may vary between individuals, but generally involves a "feeling that something is in the air".[2, 4]

Conrad referred to this expectational phase as "Trema" (stage fright) due to the feeling that something important is about to happen.[2] This marks the moment the perceptual background takes a character of its own. The subject's internal motivational-emotional state is altered, and imbues the entire field of their experience with a "physiognomic" quality.[4] In essence, there is a sense of potential revelation or threat accompanied by affective tension. Yet, like an anosognomic neurological patient, the subject does not attribute their change in perception to a neurobiological cause, but externalises it to a yet to be understood process in the world.[2]

Usually, the subject's delusions or delusional system appears in an "Aha-Erlebnis" or sudden significant revelation.[2] This may be a delusional perception or other full psychotic symptom. It can bring relief, as the perplexing feeling, present during the delusional mood, is now explained. Conrad described this as a reflexive turning back on the self, as in the universe is experienced as "revolving" around them.[4] At this moment, the subject is unable to distance themselves from the experience, or unable to consider the situation from the perspective of others.[2]

Whilst delusional mood may, albeit unusually, last a number of years, there are no cases of lifelong symptoms.[2] The prevalence of Wahnstimmung in schizophrenia spectrum disorder is described between 1% and 8% .[5]

Case presentation

Mr X is a 50 year old, retired concrete manufacturer from North Wales. He presented to the secondary mental healthcare team feeling "excited". Mr X felt that the appointment would provide some explanation of his experiences. When questioned about his mood, he responded "I am the happiest guy that I know. I wake up every morning feeling excited". The feeling, he said, is "overwhelming". He is convinced to be chosen for something special that will transpire in due course.

Mr X vividly remembered feeling the same way when he was four years old, but until the age of 12 believed that everybody felt this way. Whilst he experienced some

illusions in childhood, Mr X denied any history of hallucinations, lability of mood or depressive symptoms. He searched for an explanation. Until he reached his 30s, he considered that he may be Jesus and would perform miracles. He never held this idea with delusional intensity. When he discovered that he was unable to perform these miracles, he looked for alternative meanings. Mr X first presented with these symptoms to mental health services in 1996. Whilst he indicated a feeling that others may know what he was thinking, he denied any passivity phenomena, thought broadcasting or hallucinations. There was no evidence of mania in his history. The working diagnosis at first presentation was a schizotypal personality disorder. There was no evidence of a narcissistic personality disorder. Follow-up was arranged, but Mr X was discharged after failing to attend.
Mr X's personal history was unremarkable. He was born into a family of four children, one brother and two sisters. The family was bad tempered, but there was no physical violence. Mr X's parents divorced when he was 19. He did not enjoy school, but achieved four GCSEs and began work as a labourer for the NHS after graduation. Mr X describes himself as always having been very sociable, with a good social network. There is a history of illicit drugs, beginning as a teenager and lasting until his early 20's. This includes extensive use of amphetamines (speed), cannabis and MDMA (ecstasy). He has been married four times and has been married to his current wife for 11 years. Mr X has four children from the three previous wives.

There was no history of previous mental illness, although Mr X is now retired following diagnosis with spinal stenosis. He takes Gabapentin and Ibruprofen. He smokes 30 cigarettes a day, drinks 23 units per week and committed an offence for police obstruction many years ago.

On mental state examination, Mr X appeared appropriately dressed, calm, maintained good eye contact and rapport was easy to establish. His communication was expressive. His speech was spontaneous and coherent, appropriate, but mildly pressured. It was normal in volume and rhythm. Mr X described his mood as "excited". Objectively, his mood was euthymic with no evidence of manic or hypomanic symptoms. His affect was excitable, albeit not labile, and congruous to his mood. There was no abnormality in the form of thought. The content of thought was abnormal, with a prevailing delusional mood/Wahnstimmung and the overvalued idea that he is destined for something special. This manifested itself as a desire for public recognition of his case during the consultation. He admitted that he is now enthusiastic about death, as he feels this will reveal the meaning of his symptoms. There were no overt abnormalities in perception. Cognition was normal: Mr X was well orientated, and attention, concentration and memory were not impaired. There was no evidence of suicidal or homicidal ideation, intent or plans. There was partial insight into the possibility of mental illness, albeit driven by a need for an explanation to his feelings.

To help manage these symptoms, Mr X was offered Amisulpride 200mg. Whilst he revelled in the sensation of excitement, he agreed to trial anything at this stage. Two days later, the mental health team were informed he had ceased taking his medication.

Discussion & Conclusion

Whilst the phenomenon of delusional mood/Wahnstimmung is common in the prodromal stages of psychosis, it rarely persists for as long as Mr X has experienced. This raises two clinical concerns; firstly, 'what is Mr X's risk of developing psychosis?' and secondly 'what is the best way to relieve Mr X's symptoms and prevent progression?'

We were unable to identify any studies that specifically looked at the treatment of Wahnstimmung. Generally, authors interpret it as a prodromal symptom of schizophrenia and therefore suggest anti-psychotic treatment. Attenuated (subclinical) psychosis and transient psychotic episodes are shown to increase an individual's risk of future clinical psychosis.[6] Research has suggested that prodromal symptoms may be present in up to 25% of non-psychotic psychiatric outpatients.[9] High risk individuals may be protected from psychosis by clinical interventions. A randomised-controlled trial of 58 high risk patients demonstrated a narrowly significant reduction in mean PANSS at 12 months following cognitive therapy ($p = 0.49$), albeit there was no significant effect on function and distress scores.[6] At 3 year follow up, cognitive therapy significantly decreased anti-psychotic prescribing and transition to psychosis after controlling for baseline factors.[7] A double-blind, randomised controlled trial assessing the protective effect of olanzapine in patients with psychotic prodromal symptoms demonstrated a non-significant decrease in conversion to psychosis. Despite a relatively large effect size (HR = 0.4), the sample size (n = 60) may have underpowered the result.[8] Nevertheless, these studies propose two possible treatment avenues to prevent prodromal psychosis from developing into clinical illness.

This case report demonstrates a rare, chronic presentation of prodromal psychosis. Whilst there is no clear understanding of why certain individuals progress to psychosis, clinical interventions may be effective at reducing the risk of progression. Indeed, the efficacy of cognitive therapy and anti-psychotic medication suggest that particular psychological coping mechanisms may prove to be protective in high risk individuals, and warrant further investigation.

Abbreviations

HR – Hazard Ratio
PANSS – Positive and Negative Syndrome Score

Consent

Written informed consent was obtained from the patient for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal.

The authors would like to thank Jade Jones for her contribution to this case. Without her valuable and thorough investigations, this case may not have been highlighted for a number of years.

References

1. Berrios GE. The history of mental symptoms: descriptive psychopathology since the nineteenth century: Cambridge University Press; 1996.
2. Mishara AL. Klaus Conrad (1905–1961): Delusional Mood, Psychosis, and Beginning Schizophrenia. Schizophrenia Bulletin. 2010;36(1):9-13.
3. Hambrecht M, Hafner H. ["Trema, apophany, apocalypse"--is Conrad's phase model empirically founded?]. Fortschr Neurol Psychiatr. 1993;61(12):418-23.
4. Conrad K. Die beginnende Schizophrenie: versuch einer Gestaltanalyse des Wahns: Thieme; 1966.
5. Blom JD. [The delusion of world catastrophe. Is this classic symptom still relevant today?] Tijdschr Psychiatr. 2015;57(10):730-8. [Article in Dutch]
6. Morrison AP, French P, Walford L, Lewis SW, Kilcommons A, Green J, et al. Cognitive therapy for the prevention of psychosis in people at ultra-high risk. Randomised controlled trial. 2004;185(4):291-7.
7. Morrison AP, French P, Parker S, Roberts M, Stevens H, Bentall RP, et al. Three-Year Follow-up of a Randomized Controlled Trial of Cognitive Therapy for the Prevention of Psychosis in People at Ultrahigh Risk. Schizophrenia Bulletin. 2007;33(3):682-7.
8. Thomas H. McGlashan MD, Robert B. Zipursky MD, Diana Perkins MD, Jean Addington PD, Tandy Miller PD, Scott W. Woods MD, et al. Randomized, Double-Blind Trial of Olanzapine Versus Placebo in Patients Prodromally Symptomatic for Psychosis. American Journal of Psychiatry. 2006;163(5):790-9.
9. Horneland M, Vaglum P, Larsen TK. The prevalence of DSM-III-R "prodromal" symptoms of schizophrenia in non-psychotic psychiatric outpatients. Nord J Psychiatry. 2002;56(4):247-51.

Competing interests

The author(s) declare that they have no competing interests

Authors' contributions

PL contributed to the case by taking the history, examination and providing sufficient note taking. PL edited the initial draft of the case. BS summarised the subject's notes into case form for first draft.