

Bizzare Delusions : conceptual clarifications and two case studies

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ABSTRACT

*Bizzare delusions have always played an important role in the diagnosis of schizophrenia. Literature is sparse with regard to concepts that surround bizarre delusions. Here we discuss few pertinent psychopathological and conceptual issues related to bizarre delusions and we discuss two cases with respect to the same. *

Key words: *bizarre delusions, schizophrenia, psychopathology.*

INTRODUCTION

Bizzare delusions are part of the necessary criterion for the diagnosis of schizophrenia. In fact the diagnostic criteria of schizophrenia in the 4th edition of the Diagnostic and Statistical Manual for the Classification of Psychiatric Disorders (DSM-IV TR) [1] mentions that the presence of bizarre delusions on its own is sufficient to diagnose schizophrenia as long as the duration of illness criteria are met. Bizzare delusions in psychopathology have been neglected as is evident with the scarcity of detailed reviews and criteria for the same. In fact researchers have shown that only a small number of patients with schizophrenia receive their diagnosis due to the sole bizarre delusion criteria [2]. It has been shown by researchers that bizarre delusions show an overlap with first rank symptoms (FRS) in schizophrenia [3]. Many bizarre delusions may develop from FRS concepts like delusions of control, thought broadcasting, thought withdrawal and thought insertion [4]. It is worthwhile that FRS encompasses both delusional and hallucinatory processes while bizarre delusions make up pure delusional processes only [5]. There is a divided opinion amongst schizophrenia researchers when it comes to a valid, operational and consensual definition for bizarre delusions with many explanations being prevalent [6].

Some of the criteria used to diagnose bizarre delusions are as follows [7] – (a) apparent physical and logical impossibility (implying extreme implausibility), (b) presence of beliefs that are not consensually shared within a given social or cultural context, (c) absence of a historical or genetic understanding as to how

the thoughts may have emerged from relevant biographical antecedents, (d) incomprehensibility and a lack of static understanding to imagine the belief that exists and (e) the notion of the thought not being derived from ordinary life situations. It is also noteworthy that while the DSM-IVTR puts highest weight to the symptom of schizophrenia, ICD-10 [8] fails to even make a mention of the same.

We present herein 2 cases of bizarre delusions that presented to our out patient department. For the sake of this paper in both these cases, we shall focus on the bizarre delusional content that was presented rather than diagnosis and treatment discussions.

CASE 1

A 55 year old uneducated married female presented to our outpatient department, brought by her son with chief complaints of bizarre thoughts and talking things that were not possible. She was apparently alright two years prior to presentation when she had a fall from a ladder while cleaning the house. The fall was from a height of approximately 10 feet. She developed a minor swelling on the head but the head injury was insignificant with no loss of consciousness or seizures following the injury. She was seen by the local family physician who had prescribed some analgesics and told her that there was nothing to worry as there were no signs of a fracture or severe injury. Within 2 months of the event she started complaining of headache which was generalised, bilateral and would last the whole day. It was of a constricting nature and the pain was severe. She also started feeling that her facial bones were loose and was moving beneath the skin of her face. She began to feel that her brain had started to melt and that it would get mixed with her saliva. She also mentioned that she has tasted her brain and that she had swallowed some small parts of her brain. She also claimed that she had noticed small pieces of her brain that came out in her faeces and urine. The proof for the same was that her urine was whitish and milky while her stools were frothy. She visited multiple doctors like otolaryngologists, urologists and neurosurgeons and had undergone multiple investigations all of which were within normal limits. Due to no one agreeing to and providing her a solution to her complaints, she started developing sadness of mood, reduced interest in daily activities and crying spells. Her sleep also reduced with multiple intermittent awakenings. She was brought to us on the advice of her family physician. On mental status examination, her mood was conveyed as sad and she had thought disturbances in the form of bizzare delusions. We challenged the delusional content with scientific explanations but the patient refused to accept any of our suggestions remaining firm on her belief. We started her on antipsychotic medications like Risperidone 2mg per day in divided doses along with Escitalopram 10mg per day for her depressive features. The patient was lost to follow up and did not return for a check up.

CASE 2

A 44 year old uneducated married female presented to our outpatient department by her daughter with chief complaints of flames (*'chingari'*) coming out of her eyes since 1 year prior to presentation and being aggravated since 2-3 months. She was apparently alright a year back when she underwent a dental procedure details of which were not known. After the procedure, she started imagining impossible thoughts. She mentioned that the dentist must have used some machine to perform a procedure for which electricity was used. The current used had then passed through her teeth and reached her eyes. The same current remained in her eyes and got converted into flames from time to time. She further claimed that the flames originated from the

outer canthi of both her eyes and pass into the air. She also described that they fade and gradually after travelling some distance disappear. She said that more than 100 such flames come out throughout the day. She said that the flames are visible to her and could not be seen by other people. The flames aggravate when she strains her eyes like watching television or stitching while they reduce after sleeping. She said that the frequency of flames is highest in the evening. All the patient's relatives claimed that no such flames were visible to them but the patient refused to believe them. She visited 4-5 ophthalmologists but they denied of any ophthalmic pathology except a refractory error that she had due to age. The patient stated that since last 2-3 months she has started feeling sad throughout the day since no one believed her and had no interest in daily work. She showed decreased self care and stopped attending family and social functions. She would get irritable towards family members on trivial matters. She stated that the frequency and amount of flames coming out from her eyes had increased in past few months and she was constantly anxious about the same. She denied hearing of voices inaudible to others, suspiciousness, paranoia, suicidal ideation, substance abuse, head injury and any seizure episodes. She had undergone an operation for her cataract in her eyes 5 years prior to this episode and was on Atorvastatin 10mg for her raised cholesterol. There was no family history suggestive of psychiatric illness in her family members. On interview the patient was dressed in a burkha, wearing spectacles holding plastic bag full of files in hand. She was conscious, cooperative and interested in the interview. She was oriented in time, place and person. She maintained eye contact and was attentive. Mood stated was sad and affect was anxious. She stated that two flames passed out of her eyes during the interview and were visible only to her. She held the belief despite trying to contradict her or defy her. We even showed her a mirror and she mentioned that she saw the flames in the mirror while we could not see them. She denied any heat in the eyes when the flames came out. She was diagnosed as having delusional disorder somatic type with major depression and was started on Aripiprazole and Escitalopram. On follow up after 10 days she reported a decrease in the flames by 30%.

DISCUSSION

In the both the cases described above there were delusional thoughts that were not amenable to change even after large amount of reasoning and scientific explanations were provided. In both the cases above the definition of impossibility and implausibility are met. They qualify as bizarre delusions and thereby technically the patients above can be diagnosed as schizophrenia as per DSM-IV TR. Considering what we know about the phenomenology and symptoms of schizophrenia, would it be wise to diagnose patients like those above as schizophrenia which is in itself a diagnosis that is lifelong and stigmatizing. This brings us to the clinical question of whether bizarre delusions are alone sufficient to diagnose schizophrenia. Different clinicians may think otherwise and hence the diagnostic criteria of what is 'bizarre' in these delusions remains confounded. Rigorous studies across diverse sets of patients are needed to help us elucidate whether we can do away with the notion of bizarre delusions as stand alone criteria for the diagnosis of schizophrenia [9]. It is also important that bizzareness be viewed beyond the realm of delusions and seen from holistic phenomenological perspective where the general experiential dimension of the patient, perceptual orientation, familiarity, self awareness, bodily experiences and cognition as well as the notions of impossibility and implausibility from the patient's and examiner's perspective be addressed [10]. Conceptual understanding of grey areas in psychopathology like that

of bizarre delusions shall help clinicians improve specificity when it comes to using the symptom as diagnostic measure in schizophrenia.

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