Case Conference

The journey from neurosis to psychosis

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Abstract : *Unexplained medical symptoms have been variously defined in last two centuries. Their mere presence, without associated str ors can lead to diagnostic and management dilemma. Here we present a case, where tients' only complaint was inability to open her mouth. The provisional diagnoses considered included dissociative disorder and depressive episode. However, pursuing management strategies as per these diagnoses, additional psychopa was elicited which led to a final diagnosis of schizophrenia. In the disc on that follows, we examine the relationship of dissociative symptoms with schizop ia.*

Keywords : *Dissociative Symptoms, Schizophrenia.*

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INTRODUCTION

Unexplained medical symptoms can present as single transient episode or as multiple changing symptoms with multi-systemic involvement.[1] Such symptoms have been variously defined under rubric of hysteria, dissociation, conversion and so on. The current version of ICD classifies dissociative-conversion disorders in the block of neurotic disorders.[2]

The diagnosis conversion-dissociative disorder has its fair share of limitations.[3] Firstly, the diagnosis needs exclusion of organic basis of symptoms but such symptoms are common in neurological settings where it is difficult to determine if symptoms are of functional origin. Secondly, the temporal relationship between stressor and symptoms is not always evident on multiple assessments. Thirdly, the symptoms are expected to be unconsciously mediated [as explained in glossary of ICD-10[2] and DSM-IV[4]] but it is often noted that on distraction (i.e. when focus of attention is changed) the symptoms tend to vanish.

Schizophrenia on the other hand is a prototypical psychotic disorder with multi-domain involvement. Presenting symptoms in schizophrenia vary from florid hallucinations and delusions (positive psychotic symptoms) or significant reduction in volition and speech with associated blunted affect (negative symptoms) or uncharacteristic oddities in thought and behavior. In clinical practice however, it is not unusual to see patients with multiple subtle symptoms and signs that do not suggest an underlying schizophrenic process. A careful evaluation of such symptoms with assistance from other diagnostic tools may reveal evolving psychotic phenomenology.

In this particular case for discussion, we were limited in the assessment of illness by the presenting symptom of the patient (i.e. inability to open mouth) and by the fact that patient had remained guarded regarding her experiences. With the limited available information a consensus regarding diagnosis could not be reached by the treating team.

The Case

Mrs K, 40 year old widowed female of rural background and lower socio-economic strata, presented to psychiatry OPD, with chief complains of inability to open the mouth since

last 15 months. Due to her inability to open her mouth, she was unable to eat and speak. The illness was acute in onset and episodic in course.

Illness started in July 2007, when without any apparent stressor or conflict patient became mute and stopped accepting meals. She made all necessary communications with family members by gesticulation. Family members did not notice any apparent change in her mood, sleep, self-care, socialization or reactivity to pleasant events and role performance. Patient's 18 year old son assumed that patient had started her 'maun-vrat (vow of silence)', which the patient had a custom of keeping for about 40 days after every 5-6 months since 1995. Her son, however, was surprised by the timing of current vrat and also because she did not inform him in advance, as was her habit. Patient's brother who visited her in between noticed this and brought home a faith-healer for consultation. The faith-healer declared that she was under some evil spell and following some procedure she started speaking again. She informed family members that indeed she had not planned any vrat and this time she simply was not able to open her mouth to speak or eat. She however, did not express any suspiciousness, belief of being under any external influence or hearing voices etc. and resumed her normal activities thereafter.

Two months later, without any apparent stressor patient relapsed to similar symptoms. Patient and her son went to same faith-healer who suggested a talisman for her problem. The talisman did not seem to benefit the patient and 2 days later she left home without informing anyone. Family members could not trace her for 2 days and then contacted the dera (religious congregation), of which she was a follower. Indeed, she had lodged herself there since two days and had verbally given her contact details at the time of registration. When family members reached there she was talking and eating normally. Her explanation given for leaving home was that she felt that the faith-healers' procedures had made the house impure. She was assured of no further visits to the faith-healer and she was brought back home.

She remained normal for another two and half months but relapsed again (December 2007) with no apparent stressor or evident conflict. This time family members noted that she made fewer efforts for communication even through gesticulation. She was usually alone during the day but family members were certain that she never consumed food as food items at home were unutilized. Also, the neighbourhood included many relatives, who reportedly never saw her going out of her home. Patient did consume small amounts of water/milk with spoon through the little space between her lips which she made with great effort. By around 15 days into this episode she had become weak and hence household work had to be done by her 14 year old daughter. When family members forced her to open her mouth she would clench her hands and teeth and shiver vigorously. Over next 7 days her health further deteriorated. Now she was not recognizing some of the family members and did not greet elders with touching of feet or namaskar as she always did. She suddenly started passing urine in her sleep and when asked to explain 'how did it happen?' she would point her finger towards the sky. She was brought to a physician who after investigations inserted a nasogastric tube and put patient on IV fluids. She was thereafter fed through the nasogastric tube and was asked to consult a psychiatrist. Family members refused consultation with psychiatrist. She was discharged with NG tube in-situ. She did not have any further episodes of incontinence.

Following this treatment by the physician, the patient continued to stay at home. She would now have all her meals through nasogastric tube and inform family whenever the protein powder was over. Whenever the nasogastric tube was blocked, the family would visit the physician to

get it replaced. Patient would go to neighbours or attend family functions with nasogastric tube in-situ. She however did not speak but communicated with gestures.

No expressed sadness of mood or anhedonia, decreased energy, self smiling or muttering behaviour was reported. No stressor could be elicited and no secondary gains were apparent. No catatonic sign was elicited. There was no history suggestive of co-occurring neurological or any other systemic disease. She had never been to a psychiatrist before. Family denied substance use, past psychiatric illness and family history of psychiatric illness.

Patient was uneducated and could not read/ write. She had lost her husband who served in the armed forces, 14 years back. She continued to stay with her in-laws and her relations with them were reported to be cordial. She however had occasional arguments with her brother-in-laws' wife which resulted in periods of non-communication. However relations with her were usually restored over time. General physical and systemic examination revealed no abnormality. When patient was asked to make effort to open her mouth, she was only able to part her lips and expose her teeth. She would cry when repeatedly asked to do so. No foul smell from mouth was noted.

On mental status examination, she was found to be ill-kempt, had depressed facies, psychomotor activity was reduced. She answered by nodding her head. She appeared to be aware of her surroundings and was cooperative during her assessment.

The differential diagnoses considered were dissociative disorder versus depressive episode. The point against dissociate disorder was that no apparent secondary gain or stressor was evident. On the other hand there was no self reported depressed mood and depressive cognitions during the entire duration of illness which further ruled out the possibility of depressive episode.

To rule out any organic basis of the presenting symptoms, she was examined in otorhinolaryngology department but since she expressed inability to open her mouth, she was examined under general anesthesia. Her mouth was opened and there was no rigidity. No structural abnormality was detected.

Aversion therapy was then attempted. She did make efforts to open her mouth but could open enough only to expose front of her teeth. She would cry while attempting to open her mouth, her body would become rigid as if she applied a lot of pressure. Aversion therapy was repeated again but patient could not speak beyond making some sounds. Her nasogastric tube was removed to encourage oral feeds but patient did not consume anything for one whole day. Nasogastric tube hence had to be reinstituted. Patient was then considered for a Pentothal interview. Repeated efforts however failed to produce any response.

In pursuance of the second differential diagnosis, Mrs K was put on SSRI and benzodiazepines but for an early anti-depressant response, modified electroconvulsive therapy was started. The medication was crushed and given through nasogastric tube. Family members and treating psychiatrist did not perceive any significant change until three ECTs i.e 10 days since admission. On the 11th day she suddenly started speaking. She appeared to be in elated mood, her socialization, self care and activity increased markedly. She thanked the doctors and the God multiple times for the relief she had. She denied any depressive mood, anhedonia or decreased energy. When asked to elaborate on her problem, she simply said that she was unable to open her mouth. Family members perceived her to be in pre-morbid self. Her medications continued and ECT was discontinued after 4th

session. The formal MSE at this time revealed euthymic mood, no abnormalities related to thought or perception. Apart from proverbs, which she was unable to understand due to her education, no significant abnormalities in cognition and higher mental functions were evident. Also, because of her dialect help had to be taken from her son for clarifications.

Patient was discharged on request and family members agreed for medication compliance and regular follow-up. Patient remained alright only for two whole days. On the third morning, when she got up, she was again mute and unable to open her mouth. Patient was brought back to psychiatry ward. No stressor could be elicited this time also. A decision was made to restart ECT and give a course of 6-8 ECTs. She responded after the 2nd ECT.

Regular sessions were started to improve rapport. She confided once that she felt as if someone or something was stopping her from opening her mouth. She was reluctant to inform about who could be doing this and why. Her general communication with treating team and family members was vastly improved. Twenty five days after her second admission she reported that she frequently had dreams in which she saw snakes that would bite her and cause pain to her. She was encouraged to discuss further but she did not have anything to say beyond that.

On the thirty fifth day of her admission (seven ECTs since second admission) she reported to the psychiatrist that often she felt that some evil spirit was always surrounding her and was making observations of her. She could feel it though she could not hear it or see it. Occasionally when she was in bed and about to sleep she felt as if the spirit is trying to have sexual intercourse with her. She did not understand what to do about it and found the whole experience unpleasant. She would feel the weight of evil spirit as well as something being inserted into her vagina. She further feared that the evil spirit might attempt the same with her young daughter. She believed it was this evil spirit that made her incapable of opening her mouth. An interpretation of somatic hallucinations, delusion of control and bizarre delusion was made. The diagnosis was revised to Schizophrenia, paranoid type.

In view of this information she was asked to co-operate for projective testing in the form of Rorscach ink blot test and all medications were discontinued. Her report showed an underproductive protocol, negative form level, tendency to over generalize, poor emotional control, ego disintegration and pathological signs of contamination, personal reference, morbid responses and perseveration of content. Psychometry was suggestive of psychoses and supported the diagnosis of schizophrenia.

In view of these findings it was decided that patient be started on anti-psychotics and ECTs be discontinued. Accordingly, tablet risperidone in a maximum dose of 8 mg in divided dose was given which she tolerated well. During her ward stay she reported a gradual decrease in frequency of her abnormal experiences and disintegration of bizarre delusion. Her final diagnosis at discharge was Schizophrenia. When she followed last, it was 12 months since discharge and she no longer reported any dysfunction or relapse of symptoms.

DISCUSSION

The reported primary complain of the patient was her inability to open her mouth. With no structural or neurological basis to account for the symptom, a possibility of dissociative disorder was expected. However consistent denial by family members of significant stressor or apparent secondary gain meant that alternative diagnoses had to be considered. Her symptoms and her inability to write further restricted any means of gathering more information. The failure of

abreaction left us with little options to pursue this diagnosis. In hindsight an additional differential diagnosis of mental disorder not specified would have been appropriate at this stage.

The second differential diagnosis (depressive episode) was in keeping with mental status examination. Information available on history did not give much support to diagnosis. Her response to electro-convulsive treatment on first admission made us reasonably convinced of this diagnosis. Her reluctance/ guarding to report sexual experience on improvement was possibly more because of social reasons. Additionally, since her experiences were related to sex, she could not have informed about them to her children who were our primary source of information. In the absence of depressed mood and depressive thinking, the possibility of depressive episode was elusive.

The use of electroconvulsive therapy in schizophrenia is generally restricted to treatment resistant cases with evidence of efficacy.[5,6] However our intent to use ECT in this case was for rapid anti-depressant response. It was likely that her first set of ECTs helped break her delusion and hence gave her relief. In the absence of anti-psychotic and continued ECT, this response was not sustained. After it became evident that patients' symptoms were outcome of a psychotic process, it was decided to put her on medications instead and discontinue ECT.

Based on patient's clinical history and mental status examination, a final diagnosis of schizophrenia was made as per ICD- 10 and DSM-IV criteria. Additional support for this diagnosis came from psychometric findings. The combination of contamination, low populars, deviant verbalizations, lack of logical thinking and other pathological signs are the most common indicators of schizophrenia. Research demonstrates that schizophrenia, in its overt as well as latent and borderline forms, is detectable on the Rorschach through an analysis of the patient's thinking. The thinking of the schizophrenic reveals highly personal, illogical, and bizarre associations to the blots.[7]

Systematic clinical surveys consistently show that about one quarter of patients with psychiatric diseases[8] (without regard to their diagnostic categories) and 15-20% of adult psychiatric inpatients have a substantial level of dissociative symptomatology.[9,10] Dissociative experiences are more common in psychosis but not as common as in borderline disorders and less than normal health individuals.[11]

It is not unusual for schizophrenia to present with dissociative symptoms with or without other psychotic symptoms. Symptoms generally reported are de-realization and depersonalization symptoms and dissociative identity disorder. However, a major problem with diagnosing dissociative disorders in schizophrenic inpatients is that these patients are often too symptomatic to be assessed properly.[9] Evidence also shows that the dissociative population may endorse Schneiderian first rank symptoms to a greater extent than do schizophrenics.[12] Some authors have hence speculated two pathways for positive symptoms in schizophrenia[13]: the biological pathway and childhood trauma-dissociation pathway. Others have proposed a dissociative subtype of schizophrenia that would benefit primarily by psychotherapy.[14]

Dissociative symptoms, when present in schizophrenia, are significantly correlated with delusions and hallucinatory behavior but not with other positive symptoms of schizophrenia or negative symptoms of schizophrenia.[15] Follow up studies have shown that significant number of patients with dissociative disorders are later diagnosed with personality disorders, depressive disorders and schizophrenia.[16,17] However, while interpreting these findings, it is important to understand that significant differences exist in

currently used classificatory systems.[3]

This case also highlights significant delay in treatment seeking for mental illness despite dysfunction.

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