Original Research Paper

Volume-7 | Issue-11 | November-2017 | ISSN - 2249-555X | IF : 4.894 | IC Value : 79.96

Psychiatry

A PECULIAR CHALLENGING CASE OF SCHIZOPHRENIA PRESENTING WITH DISSOCIATION TO A TERTIARY CENTRE

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ABSTRACT Dissociative state in a setting of an acute psychotic state can be very challenging to the physician. It not only allows the physician to address the treatment challenges of schizophrenia and its entire gamut of rehabilitation and cognitive behavioural therapy but also the doctor is required to address the issues of dissociative states. Depersonalization is state of unreality which at times is infrequently encountered in patients with schizophrenia. Although it is extremely hard to elicit these symptoms readily in a functional case of schizophrenia , especially when they present in an acute setting, it nevertheless presents a persistent challenge to the treating physician to address all the problems not only related to schizophrenia management but also he would need to address the symptomatology of depersonalization in such cases.

KEYWORDS : Depersonalization, schizophrenia. Management, cognitive disturbances, antipsychotics, unreality

INTRODUCTION:

Depersonalization is a dissociative disorder in which an individual experiences a disconnection between body and self. Although this type of mental disorder is mainly the product of perceptual and cognitive dysfunction, symptoms of depersonalization disorder can sometimes be used to diagnose more severe mental illnesses such as schizophrenia. Depersonalization is a subjective state of unreality in which there is a feeling of estrangement, either from a sense of self or from the external environment. Frequently, it is accompanied by the symptom of derealisation, a term denoting a similar feeling of unreality with regard to awareness of the external world. Depersonalization is the term used to designate a peculiar change in the awareness of self, in which the individual feels as if he/she is unreal (Sedman, 1972). It is best to reserve the use of the word to this as if feeling rather than the experience of unreality that occurs in psychosis. A more comprehensive definition has been given by Ackner (1954).

Definitive features are: depersonalization is always subjective; it is a disorder of experience the experience is that of an internal or external change characterized by a feeling of strange-ness or unreality the experience is unpleasant any mental functions may be the subject of this change, but affect is invariably involved insight is preserved. Excluded from depersonalization are: the experience of unreality of self when there is delusional elaboration ,the ego boundary disorders of schizophrenia ,the loss or attenuation of personal identity.[1]. Depersonalization is difficult for the doctor to portray; more important, it is also extraordinarily difficult for the patient to describe Depersonalisation and schizophrenia. Depersonalization disorder may be caused by a hypoactive sympathetic nervous system. Electrodermal response studies and measurement of blood flow through the forearm are used to study the activity level of the sympathetic nervous system. By measuring blood flow and the skin's conduction of electricity based on the amount of moisture present, researchers have shown that patients suffering from depersonalization disorder have low basal recordings and skin conductance, conveying that the sympathetic nervous system's arousal level is poor.

Another theory about the etiology of depersonalization disorder states that symptoms are caused by dysfunction in the prefrontal cortex, mainly characterized by inhibition of certain structures. Researchers rationalize this theory by stating that mental inhibitory actions serve protective purposes which makes sense on both a psychological and evolutionary perspective. This theory makes sense psychologically because dissociative disorders are self-preserving and protective in nature. Patients with depersonalization disorder feel disconnected from their bodies, and while that sensation in itself is abnormal, they retain full consciousness and are aware of both their body and their mind- they just don't recognize them as a synchronized unit.

Depersonalisation has long been thought of as essential component of Schizophrenia; these were based on the circular arguments which emphasised depersonalisation like symptoms as cardinal features of Schizophrenia. One school of thoughts still believe that lasting depersonalisation is mainly manifestation of Schizophrenia spectrum disorders.[3] Depersonalization per se is rarely a presenting feature of Schizophrenia

CASE STUDY:

55 Yrs old mother of serving officer presented on own volition for psychiatric evaluation. The patient is a known case of Schizophrenia off medication since five yrs. The presenting complaints were: Feeling as if her body is occupying the whole available space around for 8-9months

Body is being twined and un twined constantly for 8-9 months. Detailed history revealed that for last 8-9 months, the patient started feeling as if her body is getting expanded to fill up whole the available space, for example if she is out in football field , she is all over the field. She would be having difficulty managing herself as she won't be able to reach her body. This will make her extremely uncomfortable and distressful. She would feel comfortable in bathroom as the expansion of the body will be limited by the size of the bathroom. She would also feel as if her body is being twined and getting untwined. She could feel the wrinkles on the dress and firmly attributed it to the process of getting twined and untwined.

Detailed longitudinal history revealed that the individual was apparently alright for around 2 yrs. when she started getting slowed down in her routine activities which initially was attributed to her post retirement phase. She started keeping aloof, very much keeping to herself, getting confused before taking any decision even in routine matters like whether to push button 3 or 4 in lift to reach the desired floor, even after reaching the floor, which way to walk etc.

Her sleep started getting reduced and when she visited Psychiatry department of local hospital, her sleep was between 2-3 hrs a day. She would wander aimlessly in house, if asked, won't be able to pin point the reason although she would be having clear consciousness History further revealed that the Individual is a known case of Schizophrenia diagnosed around 28 yrs ago. She had abnormal behaviour, lack of self-care, unprovoked aggression, aloofness , behaviour suggestive of delusional perceptions, irrelevant speech and overvalued ideas. She was managed initially by local physicians at hospital, followed by Psychiatrists at specialized centre in tertiary hospital. She had most of her symptoms ameliorated with treatment and after continuously taking treatment for few years, stopped treatment on her own. She had two relapses which were managed at hospital.

She stopped medicines around 5 years ago again citing posting to a small place and amelioration of symptoms. There was no History suggestive of hallucinations , depression or obsessional thoughts and no history of substance abuse in dependable pattern. No h/o medical/ surgical illness. Past history revealed no history of psychiatric illness or other medical/surgical illness. Personal history was not relevant. In

the Employment history, patient was employed as sanitation officer in the Govt., retired after completing her tenure successfully. Family history revealed that she belonged to an agrarian background and was 5th among 7 siblings with no history of psychiatric history in other family members. There was good interpersonal relation among family members. Both parents had expired. She was married to a farmer and had three offspring which included two sons and one daughter.

General examination revealed a Conscious, afebrile person, pulse 80/min, BP 130/78 mm hg, No pallor/cyanosis/ icterus/ lymphadenopathy

Systemic exam was normal.MSE revealed Kempt , Cooperative, well-groomed, adequate confidence, maintained eye contact with ease, Normal speech, normal PMA. Mood revealed that she was preoccupied/Distressed. Affect was Dysphoric, with normal reactivity and range, with Congruous Thought. She had Delusional perception in the form of wrinkles on the clothes attributable to she being twined and untwined.

Ambivalence in the form of difficulty taking decisions like pushing correct buttons in lift, Social withdrawal, self absorbed attitude, aimlessness

There were No Hallucinations/illusions. Depersonalization was present in the form of her body occupying all the available space and as if her body is being twined and untwined. Sensorium was clear with intact memory, judgement, abstract thinking ,sustained concentration and emotional insight. Bio drives revealed reduced sleep and appetite

Psychometry was done and it revealed BDI score of 05, MMSE: 26, Rorschach test showed colour shock indicating psychotic process.

Patient was managed with Tab Risperidone 6 mg OD,(Gradually titrated from 2 mg to 6 mg).She was also put on injection Risperidone consta 50 mg IM, She developed extrapyramidal symptoms, which was managed with Inj Lorazepam and tab Pacitane, and Tab Rispereidone was tapered down and stopped later. After about 45 days she was put on Inj Paliperidone Palmoate 100 mg/month**.**

Current status:

The symptoms of body getting twined and untwined is reduced to bare minimum and the feeling of her body occupying all the available space is also reduced to minimum. Her ambivalence has ameliorated completely. She interacts more and her sleep has been restored to great extent. She is now complaining of giddiness which may be explained as postural hypotension. Over all there is improvement in the symptoms and general outlook of the individual.

Conclusion:

The prevalence of depersonalisation in Schizophrenia is between 6.9% to 11.1% as found in one study (Hunter et al ;2004.). In another study comparing Schizophrenia with and without depersonalization symptoms , it was found that the former had more propensity for cognitive disturbances, more lability for stress and more chances of alexithymia. In this case the Individual has depersonalization as the predominant cardinal manifestation which is rare. The initial symptom of the depersonalisation has reduced . As per the available literatures the symptoms of depersonalisation is difficult to ameliorate.

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