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Dissociative Disorder in a Patient with Schizophrenia

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Abstract
The prevalence of dissociative disorders is around 10.2% among psychiatric in-patients. Presence of dissociative symptoms in Schizophrenia has been studied but co occurrence of both Dissociative disorder and Schizophrenia is rare. Our patient was a 32 year old Hindu housewife of Indian Origin, mother of one 7yr old boy, brought by her husband with complains of refusal to identify her husband and her son with child like behaviour for about six months. On detailed evaluation it was found that the patient had been behaving abnormally for about last two years. Patient had no history of any psychiatric illness in the past. Her family history was also insignificant. In Mental Status Examination, she was found to be apathetic and indifferent with decreased psychomotor activity and poor grooming and hygiene sense. She was found to be harbouring persecutory delusions and auditory hallucinations with impaired judgement and poor insight. She was diagnosed as per ICD-10 to be case of Schizophrenia with Dissociative disorder. Her positive symptoms had increased her vulnerabilities for dissociative symptoms and led to the emergence of such a rare clinical diagnosis.

Keywords: *Dissociative Disorder, Schizophrenia, Delusion, Hallucination, Judgement, Insight.*

Introduction

Dissociative disorders are characterized by disruption of and /or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control and behaviour [1]. Dissociative disorders involve segregation of any group of mental and behavioural process from the rest of the person□s psychic activity [2]. Overall the prevalence of dissociative disorders is around 10.2% among psychiatric in patients. [3] These disorders are also present as a comorbid condition in 15-20% of adult psychiatric patients. [4] Schizophrenia is characterized by disordered cognition, including again of function□ in psychotic symptoms and a loss of function□ in specific cognitive functions, such as working and declarative memory, but without the progressive dementia that character-

izes classical neurodegenerative disorders.[5]. Bleuler's original conception of schizophrenia as a "splitting" of the psyche was influenced by Janet's (1889) concepts of "association" and "dissociation." Bleuler also drew upon Janet's notion of psychasthenia as a basis for his theory about the primary symptoms of schizophrenia. [6] Presence of dissociative symptoms in Schizophrenia has been studied but co occurrence of both Dissociative disorder and Schizophrenia is rare. There are very few reported cases where dissociative order and schizophrenia have occurred together. We are reporting a case where Dissociative disorder has occurred in presence of Schizophrenia.

Case Description

Mrs. X, a 32 year old Hindu housewife of Indian Origin, mother of one 7yr old boy was brought by her husband to the Psychiatry outpatient department of a Tertiary Hospital of North East India with complains of refusal to identify her husband and her son with child like behaviour for about last six months. Initially she was thought to be a case of Dissociative Disorder but on detailed evaluation we found that the patient had been behaving abnormally for about last two years. She would remain withdrawn for most of the time with very less interaction with family members. She would keep staring aimlessly at vacant spaces for long periods without any effort to communicate with her family members. She refused to get intimate with her husband and would thwart his sexual advances saying she had no interest in such activity. Her work function and sense of personal hygiene also deteriorated significantly. She used to dress shabbily, did not take bath regularly and sometimes she would pass urine on her bed without showing much concern about hygiene or what others would say. Due to lack of caregivers in her husband□s home she was taken to her parents□ house where she was looked after by her own parents. Her husband would often visit her there with their son. However in the last 6 months, She also refused to recognise her husband and her son. She would act like a child and behave in the most childlike manner. She would often tell her father in a very childish voice that she is a small kid and marriage is only for elders like them. When her husband would come near to convince her, she would run away in fear and cling on to her mother and start crying like a child telling her that these are strangers trying to kidnap and take her to a bad place. With these symptoms patient was taken by her husband to a psychiatric institute for treatment, where all routine blood investigations and MRI of her brain was done. All her blood reports and the MRI (Brain) report came out to be normal (except her Haemoglobin 9.6 g/dl). She was diagnosed as a case of Depressive Disorder and put on Escitalopram 10 mg once daily and asked to come for follow up after 2 months. According to husband after taking this medication patient had slight improvement in her social interaction but the rest of the symptoms persisted without any improvement. After taking this medication for two months, patient discontinued it all by herself. She could not be taken for follow up because of financial problems. Later on, patient also developed odd behaviour like smiling for no obvious reason, talking meaninglessly about Lord Krishna and disrobing herself in front of her family members without any reason in the last 30 days before she was brought for treatment to our institute.

On further evaluation we found that the relation of the patient with her in laws was not cordial, there had been frequent altercations with her in laws in her husband□s home. She would be constantly pestered by her husband□s mother for being lazy and bringing bad luck to their family. Two years back, 15 days before the onset of symptoms patient□s husband had a fight with his younger brother. Her husband was being accused by his brother of being negligent towards their parents and the patient was being held responsible for all these. She was repeatedly brooding about these things to her husband in the last few days before her symptoms started although husband said she would never express her thoughts freely.

Patient had no history of any psychiatric illness in the past. Her family history was also insignificant. There was no history of any physical, mental or sexual abuse in her childhood, no history of use of psychoactive substance in. Premorbidly she was a shy and timid person, submissive in nature with low aspiration and preferred to keep her problems to herself rather than share them with others.

On General examination she was found to be anaemic but her vitals were stable and within the normal limits. Systemic examination was within normal limit. In Mental Status Examination, patient was found to be apathetic and indifferent with decreased psychomotor activity and poor grooming and hygiene sense. She was found to be having persecutory delusions and auditory hallucinations with impaired judgement and poor insight. She was diagnosed as per ICD-10 to be a case of Schizophrenia with Dissociative disorder. Patient was put on Aripiprazole 15 mg per day which was later increased to 30 mg per day after 2 weeks. Patient showed significant improvement in her psychotic symptoms after 4 weeks of hospitalization. For her dissociative symptoms, Family therapy was given to which patient and her family responded well. Gradually patient started acknowledging the presence of her husband and son. Her regression to childlike behaviour also resolved and she began interacting with her family members in her normal voice. Patient was discharged on Aripiprazole 30 mg per day and asked to come for follow up after one month. On her first follow up visit, patient□s husband informed that her psychotic symptoms had resolved and she was now staying with him. Patient was now able to discharge her duties as a housewife and a mother. She was asked to continue on Aripiprazole 15 mg per day and asked to come for monthly check ups.

Discussion

Schizophrenia and Dissociative disorders are typically thought of as unrelated syndromes □ a genetically based psychotic disorder versus a trauma based dissociative disorder. [7] However Schizophrenia and dissociative disorders share several common symptoms such as aberrant perceptual experiences and disruptions in reality testing and studies have shown considerable confusion in the diagnosis of Schizophrenia and Dissociative Disorders based on the presence of Schneiderian first rank symptoms that are present in both the disorders. They include auditory hallucinations, delusional thinking and thought insertion/withdrawal. [8] Our patient had positive symptoms like persecutory delusions and auditory hallucinations and it is seen that dissociative disorders occur more in schizophrenics exhibiting positive symptoms rather than those presenting with negative symptoms. [9] Her positive symptoms had increased her vulnerabilities for dissociative symptoms. Current thinking about the role of dissociation in the development, maintenance, and treatment of psychiatric disturbances continues to evolve and to challenge our traditional ideas regarding disorders such as dissociative identity disorder, schizophrenia, and brief reactive psychosis. In addition, the current system of diagnostic classification continues to be challenged by the work of contemporary researchers. Newly-proposed diagnostic schemas currently include the categories of reactive dissociative psychosis (Van der Hart et al., 1993) and of a dissociative type of schizophrenia (Ross, Anderson, & Clark, 1994). [10, 11]

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