

Dissociative Disorder Psychosis-Like or Imaginative Obsessions – Clinical and Therapeutic challenge

Brindusa Ecaterina Focseneanu¹

¹Consultant psychiatrist, Assistant professor Titu Maiorescu University, Bucharest, Romania;
“Prof.Dr.Al.Obregia” Clinical Psychiatric Hospital, Bucharest, Romania
Corresponding Author: Brindusa Ecaterina Focseneanu

Abstract

BACKGROUND

Obsessive-compulsive disorder (OCD) is an anxiety disorder in which people have unwanted and repeated thoughts, feelings, images, and sensations and engage in behaviors or mental acts in response to these obsessions. A person's level of OCD can be anywhere from mild to severe, but if left untreated, it can limit his or her ability to function at work or school or even to lead a comfortable existence at home or around others.

AIM

The paper presents the case of a patient whose atypical clinical symptoms have raised more problems of differential diagnosis, the pursuit in the dynamics of evolution being decisive in the elucidation of the psychiatric diagnosis.

METHOD

This paper describes the case of a male patient, aged 34, who was the follow up for 18 months since the first presentation to the hospital with the challenges raised up by all dynamics of symptoms, psychotropics, and psychotherapy in order to clarify the diagnostic and proper therapy and to avoid the social stigma.

CONCLUSION

This paper emphasizes the diagnosis related controversies and the psycho-dynamic hard work needed to find a suitable therapeutic conduct and to rehabilitate the patient from a social and cultural point of view.

Keywords: psychosis-like symptom; obsessions; psychodynamics; Adlerian psychotherapy

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I. Background

It is easy to diagnose OCD in the presence of overtly manifested obsessions and/or compulsions. However, recognizing it in particular, atypical clinical contexts verging on a psychotic spectrum disorder as a psycho-pathological form becomes a challenge, especially when the patient's insight is ignored by the strong activity of the unconscious psychic sector.

AIM

Our paper deals with the case of a young patient who initially is thought to have the symptoms of a psychosis-like dissociative disorder and whose thorough approach in dynamics led to the elucidation of the OCD diagnosis.

II. Method

This paper describes the case of a male patient, aged 34, who first came to our psychiatric hospital 18 months ago, where he was also hospitalized, presenting an apparently psychotic symptomatology which had started all of a sudden 6 months before. The patient is brought to the hospital by his wife, who is worried about the persistence and the aggravation of the clinical picture during the last month. She tells the medical staff that her husband has changed his behaviour in the last 6 months, has secluded himself, refuses to find a job, he is not interested in his family life and social responsibilities. He spends a lot of time at home, reading religious books and listening to religious radio stations while lying in bed. The communication with him is difficult, being focused only on the strange sensory experiences which he frantically tells his wife about.

INITIAL ASSESSMENT

The patient grew up in an organized familial group. He benefited from a normal familial climate; his mother was a teacher, his father a worker; he was the youngest of the family's three boys. He had a good school

record, good communication and social skills. Thanks to his pleasant physical appearance and promising sports results, he gained and maintained his popularity throughout his entire school years.

After finishing high school, we notice an oscillating occupational route, with periods of professional integration, followed by resignations justified by a stressful working environment or by the lack of personal performances. Subsequently, the patient graduates from university (1 year before the illness episode breaks out). However, he fails to attend his degree examination (“I was not ready, I had not studied enough”). The patient has been married for eight years, he doesn’t have any children; he has a stable domicile. According to him, his marital relationship is good, his wife is a supportive person, although a bit “nagging”.

The onset of the symptomatology coincided with the patient’s resignation from the position of manager of an oil company. The patient justifies that his decision was the consequence of pressures at the workplace. Despite the various irregularities found, the patient feels forced to put off his clients, to conclude orders which later are not accomplished by the company, as well as other financial troubles. The patient also speaks about the lack of support from his elder brother (former reverend, currently a businessman), partner of the same company. The patient’s resignation was doubled by an anxiety attack activated by strong inner conflicts connected to morality and fairness, non-accomplishment and depersonalisation experiences and the isolation in the study of the orthodox religion.

We mention that the patient’s development was strongly influenced in his childhood by his mother’s religiousness, who excessively got involved in his orthodox education in particular, of all three children (“As a child I used to chase shadows – bad genies – which I chased holding the cross in one hand and my prayer book in the other”). The interview with the patient does not show physical or sexual abuse; however, we cannot exclude the emotional abuse exercised by his mother in his childhood.

The patient’s anxiety, guilt complex, the reactivation of primitive mystical beliefs and fears through reading triggered, on the occasion of a great Christian holiday, some perceptual experiences which were unusual to the patient. “Last Easter I felt the crucifixion, I felt each nail piercing my palm, my hand bleeding”, “painful thorns on my head”, “I felt my skin burning, from my soles to my neck”, “I felt the Saviour and Saint John beyond regular knowledge and, at the same time, I felt the pure love, knowledge, tenderness, but also the pain of the crucified Saviour”. “I was going through changes but at the same time I came to a standstill”. Subsequently, the clinical picture expanded on a daily basis with other unusual sensory experiences which gradually conquered the patient’s mind and behaviour. Thus, the patient became an actor and a viewer at the same time, turning away more and more from the duties and the tasks of the real life and daily existence (“I was enslaved by these experiences”, “I did not like the bad things, I liked the good things”, “I was searching for an answer to the question: why me? What for? It seemed to me that I was a debauched person, that I had made more mistakes than other people...”).

The psychiatric examination at the time of the hospitalization reveals that the patient has a suitable outfit, he cooperates easily, he has a good temporal and spatial, self and allopsychic orientation, he is lucid, but he does not realize that he is ill. His countenance is cheerful, in sharp contrast to the contents of his accounts, his look is lively, he makes few gestures. We notice muscular tension, constant eye contact. The psychical relationship between the patient and the examiner is too excessive on the patient’s part, which requires great effort for the examiner. It is easy to have a dialogue with the patient and to maintain it throughout the interview. The patient has a dissociation of the attention of concentration with hypoprosexia of general concentration and thematic hyperprosexia, fixing hypomnesia and evoking hypermnesia centred on the psychically stressful events and on the intensely lived unusual perceptual experiences. His mood is dysthymic; he reacts to pleasant stimuli and he has a free-floating anxiety. The patient denies the presence of suicidal ideation or suicidal behaviour either at present or in his personal life history. His ideatic and verbal pace is slightly slow; his ideatic flow revolves around the interpretations of his new perceptual experiences. The patient is highly suggestible, he has magical beliefs (“I believe in telepathy, I feel certain states which are unseen and which I can transmit”); he tells us about trance and possession experiences, bodily scheme modifications (“I sometimes feel that persons enter and exit my body as if I were a door”, “It seems to me that I have another body over my body and through this body I seem to perceive and feel something else”, “I feel from my head that, seemingly, someone else is also eating with me while I am eating”, “I feel like a soul made up of water droplets is being drawn over my head”, “on the right side of my chin I seem to have another mouth, which signifies justice, and on the left side it gives me the feeling that I have a broad smile and this signifies love”, “I felt that my right hand was heavier”, “I felt that the left side of my body was trying to devour the right side”, “I felt fangs growing in my mouth”, “I felt that another face was glued from my face”).

Due to hypoprosexia, the patient has difficulties in establishing the analysis/synthesis, abstractisation/generalisation ratio. The amount of knowledge is activated according to the patient’s educational level. His calculation capacity is maintained. His capacity to organize and plan his own activities is diminished. His discourse is somewhat vague; it contains derailments, Ganserian elements, digressions. The patient has a high tendency for symbolic thinking. He has pseudo-hallucinatory perception disorders at olfactory

level (“I felt the smell of dead bodies, urine, food”), tactile level (“I felt my skin burning as well”, “I wake up in the morning as if I were burning on the outside”), interoceptive level (“sometimes my lungs catch fire”, “at times I feel that the food reaching my stomach is contaminated or that I myself transmit something evil to the world and to the objects around me”). The patient’s self-esteem is high, and he has grandiose delusions (“maybe I have a special mission on Earth”, “I felt I had the power to cure myself, by myself, by using my brain”, “I have the power to heal myself”).

The patient’s professional performance is absent, his social relationships are disturbed, the patient has isolated himself passively; the social meetings he attends at his wife’s insistence are described as rather formal; the patient expands his sensory experiences to the physical presence of the people around him as well, and he describes expressively how he can see the “auras” or the distorted faces of the people around him, which distract him from the conversation and sometimes amuse him.

The patient’s food instinct is diminished, his sleep seems unaffected, his sexual appetite is present. However, the patient describes pseudo-hallucinatory “universal orgasm” experiences with all the women around him, but, paradoxically, he feels shame when having normal sexual intercourse with his wife, which he avoids. The patient admits that he has occasionally consumed alcohol and marijuana as anxiolytics over the last month. As to the patient’s familial antecedents, none of his family members have suffered from significant psychiatric or neurological disorders. According to the patient’s personal medical record, seven years ago the patient had a loss of consciousness crisis due to a minor traumatic brain injury, which was not examined by the physicians.

DIAGNOSIS AND THERAPEUTIC MANAGEMENT

In order to make a diagnosis and to initiate therapeutic conduct, the patient was recommended paraclinical and laboratory investigations. The electrocardiogram was normal, except for a mild sinus tachycardia, the electroencephalogram showed a route within normal limits, with alpha mixed activity, expressed in OPT bilateral derivations, moderately responsive to hyperpnea. The neurological examination showed normal limits. So did the computed tomography of the brain. The laboratory analyses showed a mild eosinophilia (5.6%; normal values: 2-4.00%) as well as slight increases in the hepatic transaminases (GPT: 57 U/L; normal values: 0-45 U/L and GGT: 73.16 U/L; normal values: 0-38.00 U/L). The clinical examination of the apparatuses and systems did not reveal any anomalies, the lower edge of the liver was below the costal arch, un-palpable spleen, the abdominal and pelvic echography was within normal limits. The patient admitted to having recently consumed cannabis and alcohol, but the toxicological samples were negative at the time of the hospitalization.

The psycho-metrical assessment using the Hamilton scales for depression (1) and anxiety (2) showed the following scores: 22 for depression (moderate) and 25 for anxiety (severe).

As a result of these investigations, when making the diagnosis of the current psychiatric condition we excluded an organic causality and we focused on the pure psychiatric pathology. We considered the possibility that the patient might suffer from NOS dissociative disorder, given the mixture of non-accomplishment, depersonalisation symptoms as well as the data offered by the psychological assessment: a predominantly demonstrative personality structure, the patient’s tendency to find refuge in illness, his high capacity of suppression and adaptation, his need for attention, the suppression of the painful feeling triggered by the conflict between morality and guilt and the exacerbation of defensive intellectual mechanisms. The episodes of trance and possession in which the patient finds psychological comfort and which he describes with indifference are disturbing, since they are accompanied by slight perplexity, by high self-esteem in connection to the accounts and the ascendancy of the self in the context of a present moment lived in a “special” way. On the other hand, the persistent modifications of perception that have a rather pseudo-hallucinatory, predominantly visual, olfactory, somatic nature, and are justified by the patient in a rather delirious, persecutory or xenopathic way, along with his tendency to give up in most of his functioning areas (albeit oscillating), the period exceeding more than 6 months during which the psychiatric illness manifests, all this suggests a disorder of the schizophrenia spectrum.

Certainly, the two types of psychiatric conditions have different evolutionary, therapeutic and prognostic implications, but the perspective of a dynamic assessment under hospitalization conditions and of the observation of the reaction to the treatment was our first and foremost decision.

The initial therapeutic scheme consisted of the association between an atypical antipsychotic (risperidone solution 2ml/day, gradually increased to 4ml/day, in the evening), an anxiolytic (clonazepam 2 mg/day, in 2 doses of 1 mg in the morning and in the evening), and, since the HAMD score showed a moderate depression, we added an antidepressant with activatory properties (venlafaxine 75mg/day, subsequently increased to 150 mg/day, in 2 doses, in the morning and in the evening). Since the evolution was favourable in general and the patient’s state of health improved considerably, after 3 weeks we decided to discharge him, the temporary diagnosis being “NOS dissociative disorder”, but we did not exclude a psychotic disorder.

EVOLUTIONARY DYNAMICS

FAVOURABLE

After 6 weeks of treatment, the HAMD score dropped significantly to 12, the patient partially regained his interest in his social and professional activities, he started helping his wife with the chores, his capacity to concentrate and his memory improved, and his anxiety reduced slightly (HAMA score: 17). However, he maintains his preoccupation with his “special experiences” during several moments of the day. Also, he makes stereotypical movements with his hands bilaterally. His wife considers them to be the result of the antipsychotic treatment, but the patient is not affected by their presence. A few weeks later, the patient starts working as a driver, but after only 2 months he resigns because his “states prevent him from focusing on the job”.

UNFAVOURABLE

After another 2 months the patient decides to stop taking his medicine because he does not want to be stigmatised, he is rehired as a driver but after a few days he resigns, and, quite quickly, his psychical state worsens, he starts to neglect his personal hygiene, his food appetite decreases dramatically, he loses weight significantly (6 kg in one month), he seldom leaves the house and his “experiences” become more powerful. He comes back to the hospital for a psychiatric examination at his wife’s insistence, who is worried that he might suffer from schizophrenia, the patient’s discourse being centred on his wish to get rid of the tiredness generated by the thoughts which invaded his conscience during his special perceptual experiences. He is anxious, he has onychophagia, and the stereotypical movements of his hands are maintained in the absence of the antipsychotic. Although the insight is weak, we notice pervasive obsessional notes in the clinical picture, the pseudo-hallucinatory experiences are re-identified as imaginative obsessions, the patient is aware that their origin is in his own mind (although partially egosyntonic), and the diagnosis is reoriented towards an obsessive-compulsive disorder with a poor insight. The presence of these elements led to a different approach of the interview with the patient, since his perception disorders are reconsidered as obsessive images that trigger rationalization and intellectualization psychological defence mechanisms, secondarily leading to avoidance behaviour and compulsions for reducing the intra-psychic tension at the level of the upper limbs. The patient’s awareness that these obsessions belong to his own mind is weak. However, he takes this fact into account, but he constantly has doubts about the origin of the images (total score Y-BOCS: 28, severe)(3).

The patient and his wife declined the hospitalisation in our psychiatric hospital, but they agreed with frequent visits to the hospital for monitoring. We decided to modify the therapeutic scheme, and the patient received another atypical antipsychotic, aripiprazole 10mg/day, as well as an antidepressant, venlafaxine 75mg/day. Our purpose was to restore the patient’s emotional tonus, to increase his energy and to annihilate his obsessive ideas. The therapeutic benefits became visible soon (total score Y-BOCS decrease to 19), and the aripiprazole dose was increased to 20mg/day, after 3 weeks.

FAVOURABLE

The patient was monitored by means of weekly visits during which he was clinically evaluated and benefited from psycho-education and Adlerian psychotherapy sessions.

During the sessions, the therapist and the patient talked about the patient’s lifestyle, the convictions that intertwine with his development, the solutions to the various personal and social challenges that he has chosen throughout his life, as well as the psycho-dissociative solution chosen at present in order to regain his self-esteem (he admitted to having had feelings of inferiority towards people from his past who have currently found their purpose in life more or less and which they pursue with confidence and conviction, while he does not know who he really is, what he wants, whether he feels well in his marital relationship, whether a certain type of job would make him feel satisfied, whether he is smart enough, whether he could handle the birth of a child as a father). As the patient seemed to hide behind his sentences about his bizarre experiences to the detriment of a mental effort to find intelligent explanations to the topics of discussion, we used metaphors that immediately relaxed the patient and disclosed the world of his ideas about the world, himself, the others, his purpose and wish to be accepted for his mere existence, but also to be noticeable and self-assertive by means of the overcompensation offered by the attributes of the “disease”. The patient’s most telling childhood recollection is that of offering money to his elder brothers in order to notice him, to play with him. Perhaps that is why his relationship with financially remunerated work has not been assumed entirely, being often underrated and leading to psychic discomfort. The trust only movement invigorated the patient, who realistically reconsidered his attitude to his work and his relationship with financial income, but also with the people around him, and accepted that the relationship between how much he can offer and receive in exchange in every moment of his existence is a dynamic one.

The amplitude and the duration of the symptoms diminished gradually, the obsessive effort to justify the “experiences” reduced considerably; the patient regained his self-confidence and self-esteem, his social and familial functioning improved substantially. The patient realised the persistent emotional pressure he had felt in

his childhood as trigger of certain obsessive-compulsive manifestations such as onychophagia, doubts and uncertainties, checks and twitches presented during certain periods of his life. The patient's family has been supportive throughout the intense diagnosis related, pharmacotherapeutic and psychotherapeutic work, and the spectre of the stigma of a chronic psychotic disorder removed. The insight on OCD improved considerably; the patient declared that those experiences "seemed so real, but they are not...", "I absorbed everything I read like a sponge absorbs water", "I think in my case, everything started thought by thought...like a sort of communication with another inner self", "I decided to leave everything aside because otherwise things get even more complicated and time passes by...when you are constantly thinking and trying to find explanations you get separated from the real world...it's hard to be present both here and there", "I was tormenting myself, I felt all those states coming out of me and I wanted to believe that they weren't mine, that they came from somewhere else, from God and that they had meaning...I was lying to myself without knowing why".

At present the patient is responsibly involved in social activities, he has a stable job, he is studying for his degree examination, the level of obsessionality is diminished considerably, the patient is compliant with the treatment (he receives only aripiprazole 20 mg/day), he makes efforts to understand the intimate mechanisms of human psychology and he says he is more relaxed, at peace with himself and the others, he can identify stressors and he has shown receptiveness to the useful modification of coping strategies.

III. Discussions

Some studies have offered relevant data that supports the association between dissociative and traumatic experiences in patients with different psychiatric disorders, including PTSD, food disorders, borderline personality disorder, dissociative identity disorder, OCD or trichotillomania (4). Although dissociative symptoms are frequently reported in patients who suffer from OCD, some OCD symptoms can also feign dissociation in some patients, and in the same way OC symptoms have been reported in the clinical picture of dissociative disorders.

On the other hand, dissociative thinking and the similar concept of inferential confusion seem to be the key predictors of OCD (5). Although the dissociation process where patients mistake reality for their imagination, and the inferential confusion that involves imperative, obsessive doubt feelings have not been previously reported as being connected to OCD, some studies have reported their role in a clinical population, after the control of some negative emotional states such as depression and anxiety.

Paradis at al.(5)also conclude that inferential confusion and dissociation were the predictors of OCD symptoms; hence they reiterate and extend the results of Aardema and Wu (6). These results offer clues about the processes that drive patients to the transition from realistic thinking to the absorption in a thinking pattern based on unrealistic beliefs, the so-called "OCD bubble".

Unlike the pain described by a patient suffering from classic OCD, the progressive evolutionary route of common OCD symptoms, our patient suddenly developed a clinical picture which is hard to differentiate from the psychotic one, with abandonment of most functioning areas, but with the superficial dissociation of internal psychic structures.

Despite the fact that the previous studies have noticed a connection between OCD and dissociative symptoms, the latter being presented as mechanisms that are intrinsic to the former, our patient has shown a rare example of OCD, initially presented as a psychosis-like dissociative disorder, with no insight or clear OCD features. The bizarre perceptual phenomena described by the patient initially made us consider even a disorder of the schizophrenia spectrum, whereas the dissociative notes, twitches, onychophagia, the associated obsessions and compulsions subsequently orientated us towards the OCD diagnosis, changing the phenomenological theme and the therapeutic approach and last, but not least, removing the stigma associated to a debilitating psychotic condition.

IV. Conclusion

OCD is still an enigma to many healthcare professionals, being much under-diagnosed in the general population. Even psychiatry specialists can be misled, and the elucidation of the diagnosis can be delayed, sometimes at the cost of years of psychopharmacological trials, diagnosis errors, suffering and disability for the patient and his/her family.

As it has been proved that subtle dissociative experiences trigger the obsessive phenomenology, the case presented above lays emphasis on the fact that, sometimes, the dissociation can have an amplitude which conceals what it actually generates – the OC picture.

The close monitoring of these cases removes the diagnosis related uncertainty, and the support offered by the involvement of the family in the therapeutic and psychological treatment increases the compliance in the relationship between the therapist and his/her patient and offers the premises of the latter's confidence in the help provided.

In addition to pharmacotherapy, to which our patient showed marked response, Adlerian psychotherapy may be tried in such cases.

No conflict of interest.

Highlights:

- for diagnosis of the psychiatric condition we excluded organic causality
- the patient might suffer from NOS dissociative disorder
- the pseudo-hallucinatory experiences are re-identified as imaginative obsessions
- the persistent emotional pressure was trigger of obsessive-compulsive manifestations
- In addition to pharmacotherapy, Adlerian psychotherapy may be tried in such cases

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