

An Interwoven Case of Dissociation and Psychosis—Spotlight on Network Structure Model of Psychopathology: A Case Report

To the Editor,

Dissociative disorder (DD) and schizophrenia spectrum disorder (SSD) are two distinct diagnostic categories in the International Classification of Diseases (ICD-10)¹ and Diagnostic and Statistical Manual of Mental Disorders (DSM-5).² Categorization of psychiatric disorders attempts to “carve nature at its joints.” In the Bleulerian era, the current emphatic distinction between DD and SSD existed but was weaker.

Despite different “theoretical definitions” of DDs and SSDs, several studies have shown high co-occurrence of these diagnoses (not to be confused with true comorbidity).³ In total, 9%–50% of schizophrenia spectrum patients also meet diagnostic criteria for a DD. And, patients with DD have often had a previous diagnosis of SSD (between 27% and 41%).⁴

There have been many theories put forward for the seemingly high co-occurrence between DDs and SSDs. Historically, Dissociative reactive psychosis was diagnosed when traumatic events lead to emergence of psychotic symptoms. Furthermore, psychosis used to improve with uncovering of a traumatic event.⁵

More recently, the network structure model of psychopathology states that some psychopathological symptoms can cause other symptoms.⁶ For example, anxiety can cause sleep problems, which can lead to fatigue, which in turn can increase anxiety and cause feelings of depression. Another possibility is that dissociative detachment can lead to impaired reality testing, which in turn can cause psychotic symptoms.⁷

Many researchers have started questioning whether the categorical dis-

tinction between DDs and SSDs is clinically and scientifically the most useful approach to study psychopathology. Against this background, we discuss a case with both dissociative and psychotic symptoms, illustrating these queries regarding the relationship between dissociation and psychosis.

Case Report

A 46-year-old housewife, belonging to middle socioeconomic status and rural background, was admitted as an inpatient with three days history of episodes of barking continuously for a few minutes. A month ago, her daughter had got married against her wishes. A week before the onset of the symptoms, her relatives and neighbors had called her an “irresponsible mother.” Also, the next day of this altercation, the patient was allegedly bitten by a stray dog, following which she received three doses of antirabies vaccination. After three days, the family members noticed her barking in a loud manner continuously for a few minutes. The face appeared intense, the eyes were wide open, and the bark was unnerving. She responded to the stimuli in the surroundings during that time, and she had such “spells” 2–3 times per day. She had partial memory for the episodes. There was no other obvious history to suggest any organic cause for the symptoms.

There was no past or family history of neuropsychiatric illness. Personal history and the early developmental years were uneventful. Premorbidly, she was sensitive to criticism, with no other pathological personality traits. There was no history of significant interpersonal conflict among the family members or the possible presence of a model to her current behavior.

During the ward stay, initially, she also expressed a delusional thought that the dog that bit her had been sent by one of her neighbors on purpose. Also, she said she could feel herself being transformed into a dog only during the episodes, denying any metamorphosis in the inter-episode intervals. Gradually,

she started expressing suspicions toward the treatment, claiming that the doctors were plotting to kill her through injections as she was slowly transforming into a rabid dog. She insisted on leaving the hospital as she believed that her life was at stake. Because of her paranoia, it was difficult to build rapport and initiate any kind of conversation with her.

Blood investigations like complete blood count, blood glucose, liver function test, renal function test, and serum electrolytes were found to be within normal limits. The total Brief Psychiatric Rating Scale (BPRS) score was 51, and the mean Dissociative Experiences Scale (DES) score was 52%. After the diagnostic clarification, she was discharged on request as the family wanted to continue treatment on an outpatient basis.

She was treated with T. olanzapine 10 mg on an outpatient basis, and family members were psychoeducated to avoid indulgence in any activities that could promote secondary gains. Supportive-expressive psychotherapy sessions were effectively conducted. Over a period of three weeks, both the psychotic symptoms and the episodes of dissociation decreased. On follow-up after seven weeks, she was completely asymptomatic; the BPRS scale score was 28.

Discussion

Though dissociation and psychosis often coexist, in clinical practice, it throws up many conceptual and management dilemmas. In our case, both dissociative and psychotic symptoms were interknitted in the same episode, with the onset of the dissociative symptoms preceding that of the psychotic symptoms. We were curious to know if one aspect of illness, say psychosis, influences the other, namely dissociation. According to present categorical classificatory systems, this patient would be diagnosed to have acute psychosis with predominantly delusional symptoms, with comorbid DD. However, in this case, the striking and most important symptoms were those of dissociation. Also, our case fulfilled only one criterion (having dissociative

amnesia) out of the six criteria given for dissociative schizophrenia.⁸ In this context, we had the following management challenges and queries.

1. Dissociation is primarily understood to occur as an expression of internal conflict. In the present case, could the emergent psychotic symptoms add on to the “conflict” to cause more dissociative symptoms? In other words, could the presence of psychotic symptoms add on to become an additional “stressor,” leading to the persistence of dissociative symptoms? In such a case, what would be the primary management strategy? Is treating these patients with antipsychotics advantageous?
2. What is the prognosis of such patients? Do they relapse with only dissociative or only psychotic symptoms or both? Is early treatment with antipsychotics justified even if there are only dissociative symptoms in the next episode? What is the role of supportive psychotherapy in DD when the patient has psychotic symptoms?

It is imminent to address these therapeutic dilemmas as the treatment of choice differs strongly, with a primary focus on psychotherapy for DDs and pharmacotherapy for SSDs. This case report is intended to explore the impact of psychotic symptoms in a case of DD. This constellation of symptoms could warrant a separate diagnosis in the spectrum of DDs to ensure a better therapeutic approach. Some authors have already proposed a new diagnosis or a diagnostic subtype having characteristics of both SSDs and DDs.⁹ Dholakia et al. have also

mentioned the evolution of dissociative illness into psychotic symptoms in their case series. We emphasize on the co-occurrence of dissociative and psychotic symptoms and the kind of possible interaction between both symptoms and leading on to more dissociative symptoms.¹⁰ Some of these queries could possibly be explained by a spectrum conceptualization of DDs, which may provide a more parsimonious explanation for the unclear boundaries. Perhaps the time has arrived for an overhaul.

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