

Case Report

Neurosis Meets Psychosis: Case Series from a Tertiary Care Center in South India

Saumil Y. Dholakia, Chandramouleeswaran Susmita, Krishna Das Ranjit, Yogendra Singh, Deepa Braganza

ABSTRACT

The utility of the terms psychosis and neurosis in psychiatry have maintained their dichotomous stance since ages. Clinical observations and etiological hypothesis of psychiatric disorders have kept this polarity intact since the times of Freud and Jung. This case series attempts to revisit this perennial psychiatric controversy.

Key words: *Dissociation, neurosis, psychosis*

INTRODUCTION

The absence of a strong etiological model has maintained psychiatry as an observational science.^[2] Hence psychiatrists, unlike their more esteemed medical colleagues deal with illness more than the disease. Historically, observations of “behavioral illnesses” have given rise to the first dichotomy, the dichotomy of functional versus organic origin. This controversy has seemingly resolved with the observation that all body processes theoretically are and will be influenced through neural and humoral pathways.^[3] This observation was backed by physiology, which did show the autonomic link with emotions and their expressions.


The concept of neurosis follows this link, the broadest meaning being abnormal physiological reaction to situational problems. Hence, neurotic symptoms represent individual ways of reacting to perceived

stress. The individual may fail to cope with stress (as believed in the hypothesis for depression) or may do it mal-adaptively (as believed in some anxiety disorders, personality disorders and dissociation). What is sure in neurosis is that the individual preserves his/her link with reality, maintains an organization of personality, maintains the grasp over social relations and associations and has preserved the insight into the problems. Neurosis tends to represent an exogenous quality to its genesis. Its management progresses in the same line-“psychologically” helping patients change from maladaptive to adaptive ways of handling the situation.

Whereas psychosis represents total distortion of reality, distorted associations between situations, thoughts, emotions, and behavior with classically total lack of insight. Psychosis tends to represent the more endogenous quality^[4] to its genesis with management more in terms of “biological” treatment, medicines which can correct the underlying hypothetical change in neurotransmitters in the brain. Proponents of categorical diagnostic systems are discrete and unambiguous-Psychosis means denying the existence of

reality while Neurosis means an attempt to ignore/avoid/mal-adapt with the reality.^[1]

Dissociative illness, with its classic definition of “symbolic

Access this article online	
Website: www.ijpm.info	Quick Response Code 
DOI: 10.4103/0253-7176.162924	

Department of Psychiatry, Mental Health Centre Bagayam, Christian Medical College, Vellore, Tamil Nadu, India

Address for correspondence: Dr. Saumil Dholakia

Department of Psychiatry, Mental Health Centre Bagayam, Christian Medical College, Vellore, Tamil Nadu, India.

E-mail: dholakiasaumil@cmcvellore.ac.in

representation of an unconscious psychological conflict in the unconscious mind with a sole aim to keep the conflict out of awareness^[5] does represent the minor, less severe neurotic spectrum illnesses.

Schizophrenia with its classic form having delusions and/or hallucinations, disorganized thought, and behavior is representative of the major, more severe psychotic spectrum illnesses.

This case series reports three cases with an initial diagnosis of a dissociative illness which evolved into schizophrenia.

CASE REPORTS

Case 1

A 40-year-old female with possession episodes.

First seen in November 2009, Mrs. I was then a 40-year-old married housewife and mother of three children. There was no family history of the neuropsychiatric morbidity. She presented with 12 years history of episodes of possession and trance, wherein she adopted predominant male identities of her dead brother and religious deities. During the episodes, she had a distinct change to the male voice, verbalize words like “give me meat, give me alcohol.” These episodes would last for 10-15 min in clear consciousness without any fall, tongue bite, tonic-clonic movements, or incontinence. She would have a clear recollection of the episodes, and the episodes recurred on suggestion. She also reported fleeting hypnagogic hallucinations of male voices. Historically, these episodes were precipitated and perpetuated by verbal and physical abuse by father in law, probable unconfirmed reports of sexual abuse by brother in law and continued financial crisis within the family.

She was diagnosed to have dissociative identity disorder. Investigations revealed a low hemoglobin, subclinical hypothyroid state, and a normal electroencephalography (EEG). Treatment was initiated with two voluntary inpatient admissions, the first one was in November 2009, lasting 6 weeks with major focus being on nonpharmacological strategies, offering ventilation, face-saving measures to attempt symptom remission with individual sessions focusing on resolution of the areas of conflict. Pharmacologically, she was treated with tablet amitriptyline up to 75 mg and supplementation for low hemoglobin and subclinical hypothyroidism.

She showed dramatic improvement for the initial 2 months after the first inpatient stay with marked reduction in her dissociative spells. However,

subsequent course from March 2010 showed sudden worsening of episodes of dissociation with recruitment of new symptoms — auditory hallucinations of her in-laws voices telling her that they have died and she is responsible for the same. She also reported multiple dialogs inside her which included the conversations with the primary therapist all of derogatory content which she could hear; during one such experience she felt extremely distressed and attempted deliberate self-harm of low intentionality and low lethality as a way to relieve herself from the distress.

Initially, the auditory hallucinations were only present during times of extreme stress, however, later on, they continued throughout the course of illness. She also started reporting delusions of persecution against her husband that he had mixed something in the food to cause her harm and expressed delusion of infidelity.

The diagnosis was revised during the second inpatient stay to undifferentiated schizophrenia in view of the change in phenomenology. Pharmacological treatment was changed to risperidone, the dose of which was titrated to 8 mg. Mrs. I showed a gradual reduction in her positive psychotic symptoms and returned to functional recovery was achieved by August 2012. Until her last visit in May 2013, she has been doing well, with no relapse of positive psychotic symptoms, however, episodes of dissociation continue very occasionally in a frequency of once in 1-month.

Case 2

A 21-year-old male with dissociative convulsions and fugue.

When Mr. F first visited us in March 2013, he was a 21 years old single student into his 2nd year of graduation. There was no past or family history of neuropsychiatric morbidity or substance use. He presented with episodes of tonic stretching of his limb and neck muscles. These episodes occurred in a clear consciousness without any fall, incontinence or injury in a frequency of once-twice a month starting from 2004. These episodes had increased to ten-twelve per day since April 2013 with some correlation of increasing stress after working for a brief period of time in a call center; each episode lasting for around 10-20 min with Mr. F being well aware of the surrounding around him and able to recollect conversations around him during the episode.

There was one episode for around half an hour in which Mr. F had wandered out of the house to an unknown location and had to be traced and when found, was unaware of his whereabouts and how he had got there.

He underwent an awake EEG and a computed

tomography scan brain which showed normal results. He had been treated with a combination of antiepileptics and antidepressants with no improvement in his condition.

He was admitted in April 2013 on an involuntary basis and treatment was initiated with a major focus on nonpharmacological strategies, elicitation of stressors, and all his medications were tapered and stopped.

The episodes continued during an inpatient stay. He wandered out of the ward during one of his episodes and was not traceable for 24 h. He returned on his own and recollected that he had boarded a train and had gone to an unknown location, but was unable to recall what he did at that place or how did he maintain himself in those 24 h. He recollected that he was restless and had to go.

The resistance to therapy continued for nearly 3 weeks, until 1 day when he started reported fearfulness, persecutory delusions that a “shaitan” has done black magic on to him and auditory hallucinations of “Allah” calling him. He became extremely restless and agitated.

The diagnosis was revised to paranoid schizophrenia, and treatment was initiated with risperidone in therapeutic dosages. He is maintaining well till June 2013 and had resumed his studies.

Case 3

A 21-year-old male with dissociative amnesia and approximate answers.

Mr S, a 21-year-old single mason, presented to us first in May 2012. As a child, he had a mild delay in all his milestones, was described as poor in academics. He had dropped out of school by 5th grade. However, he had no peri-natal complications or other neuro-psychiatric morbidity. There was no family history of neuro-psychiatric illness. He was described as capable of functioning as a mason with sufficient monitoring and in a structured workplace — clinically suggestive of a mild intellectual delay.

He presented with a 1-week history of a low-grade fever accompanied by signs of an upper respiratory tract infection, for which he was receiving treatment locally. On the 5th day of the fever, he was noticed to have become increasingly aloof and irritable. The next day, he became violent suddenly without provocation and attacked his family with a heavy iron rod. Following this, he locked himself inside the house and attempted suicide by hanging. He was rescued by his family within 5 min and was resuscitated by a medical person on the scene. His vitals were stable, though he

was unconscious, and he was rushed to a government hospital. After regaining consciousness, he continued to be violent and irritable and occasionally claimed that he could see a goddess coming to attack him.

Following discharge from the hospital, he was directly brought to our center. At the time of presentation, his vitals were stable. He was well-oriented to time, place, and person. He denied any knowledge of the incidents of the last 2 weeks or any psychotic phenomenon. No other possible effects of neural damage due to hanging were present.

Computed tomography scan of the brain and an EEG for Mr. S were normal. A significant finding was his constant approximate answers to simple questions, which was not in keeping with his level of functioning or education. He gave wrong names for colors, commonly eaten food-stuffs, single digit mathematical calculations, and objects of daily use. However, his replies indicated that he understood the nature of the question asked and were not consistent over time. At the time of discharge, this phenomenon had significantly reduced, and he appeared free from any psycho-pathology. He was diagnosed to have a dissociative disorder and probable Ganser’s syndrome with mild mental retardation in view of periods of unawareness with intact consciousness and continued expression of approximate answers during serial mental status examination.

During the 2-week stay in hospital for observation, he continued to be quiet and was fully functional in self-care activities. In occupation therapy, he was found to be co-operative and participated adequately in group and simple individual activities. During individual sessions with the therapist he continued to deny any knowledge of events from the time of the fever. He was not placed on any medicines to better understand the phenomena.

One month following discharge, he was brought back by his parents, with a history of a week of agitation, violence, talking to self, and expressing fear that a goddess would attack him.

On the clarification, he described hearing fearful voices threatening him and a belief that the goddess would kill him. The diagnosis was revised to that of schizophrenia. He was placed on an appropriate dose of antipsychotic with which he showed a slow but gradual reduction of symptoms. After obtaining consent from his parents, electroconvulsive therapy was added to hasten recovery. On this combination, he recovered completely in 2 months. Following discharge, he was continued on antipsychotics with which he has functioned well over the last 1-year.

DISCUSSION

“Medicine is a science of uncertainty and an art of probability,” says William Osler.

These cases represent atypical presentations of typical syndromes, the probability of which is higher than typical presentations of atypical syndromes.

The search for truth: Atypical features

The phenomenology of Mrs. I, Mr. F, and Mr. S revisits the findings of Cheadle *et al.* who found neurotic symptoms more common and more disabling socially than delusions and hallucinations when they observed 190 patients with schizophrenia treated in the community.^[4]

The evolution of symptoms in both the cases began with two important atypical (and less common) features of dissociation: Chronicity and type. The cases had in common the rarer forms of dissociation — dissociative identity, dissociative fugue, and Ganser’s syndrome.

Diagnostic boundaries

The case reports question the erstwhile water tight compartments of psychosis and neurosis — are these categories discreet or are we seeing different parts of a single syndrome at different times which is continuous? Do we need more diagnostic categories to fit in the atypical or do we need to widen our existing diagnostic categories to accommodate these aspects of phenomenology?

Allen and Coyne (1995) cautioned against the theoretical concept “dissociative, therefore, nonpsychotic.” Case

reports^[6] have shown dissociative symptoms in psychotic individuals, perhaps the reverse is equally true.

Validity and reliability

Dimensional phenotypes of psychosis assume a multidimensional hierarchical structure,^[7] possibly that is true for neurotic spectrum disorders like dissociation as well. Predictive validity of categorically rarer forms of dissociation like identity and fugue may necessitate a review into a dimensional spectrum with the help long-term longitudinal cohort studies.

REFERENCES

1. James RK, Gilliland BE. *Theories and Strategies in Counselling and Psychotherapy*. 5th ed. Boston: Allyn and Bacon; 2002.
2. Helman CG. Disease versus illness in general practice. *J R Coll Gen Pract* 1981;31:548-52.
3. Peters J. Neurosis. *Calif Med* 1953;78:274-6.
4. Is schizophrenia a psychosis or a neurosis? *Br Med J* 1978;2:76.
5. Hollifield MA. Somatoform disorders. *Kaplan and Sadock's Comprehensive textbook of Psychiatry*. 8th ed. Philadelphia: Lippincott Williams and Wilkins; 2005.
6. Raja M, Azoni A. Long term atypical psychosis. *German J Psychiatry* 1999;2:34-48.
7. Russo M, Levine SZ, Demjaha A, Di Forti M, Bonaccorso S, Fearon P, *et al.* Association between symptom dimension and categorical diagnosis of psychosis: A cross sectional and a longitudinal investigation. *Schizophr Bull* 2013.

How to cite this article: Dholakia SY, Susmita C, Ranjit KD, Singh Y, Braganza D. Neurosis meets psychosis: Case series from a tertiary care center in South India. *Indian J Psychol Med* 2015;37:360-3.

Source of Support: Nil, **Conflict of Interest:** None.