

Dissociative Disorder Presenting as Catatonia

P. Sarkar*¹, B. Patra², F.A. Sattar³, K. Chatterjee⁴, A.Gupta⁵, T.S. Walia⁶

ABSTRACT

Three cases of dissociative disorder presenting with catatonia are described. Catatonia is generally believed to be associated with schizophrenia. However, many other conditions are also known to cause catatonia. A brief review of literature is provided. All the cases improved rapidly with a few ECTs. This report aims to highlight the presentation of dissociative disorders with catatonia. It also seeks to bring to notice the need to avoid lumping all non-organic catatonics under the rubric of schizophrenia so as to ensure proper treatment.

Key words: Catatonia, dissociative disorder, electroconvulsive therapy.

Introduction

Catatonia refers to a broad group of movement abnormalities usually associated with schizophrenia, but also found in other disorders such as mania, depression, many neurological disorders (especially those involving the basal ganglia, limbic system, diencephalon and frontal lobe), systemic metabolic disorders, toxic drug states and periodic catatonia (Yager et al. 2000). Kahlbaum's seminal description of catatonia included motor signs (catalepsy, rigidity, waxy flexibility), psychosocial withdrawal or excitement, combative agitation, mutism, stupor, staring, negativism, impulsivity, and bizarre repetitious behaviour (mannerisms, stereotypies, echophenomena and command automatisms) (Rummans et al. 2000). Taylor in 1990 noted that the presence of any one or two of the classical features has as much diagnostic and treatment significance as the presence of seven or eight features (Taylor 1990).

Many psychiatrists consider catatonia a subtype of schizophrenia (Joseph 1999). Almost all major textbooks of psychiatry have discussed catatonia in their chapter on schizophrenia. The tenth edition of the International Classification of Diseases (ICD - 10) and fourth edition of the Diagnostic and Statistical Manual (DSM - IV) also are no exceptions in this respect (World Health Organisation 1992, American Psychiatric Association 1994). However, several investigators have drawn attention to the fact that catatonia is neither a disease entity nor just a subtype of schizophrenia, but is a non-specific syndrome (Ahuja 2000). Classically catatonia has been described in schizophrenic

patients. Depressive stupor may occasionally manifest with catatonic features and differentiation can be difficult, but the posture and expression are sometimes indicative of sadness and silent tears may be shed (Lishman, 1998). Even with a broad view about the aetiology of catatonia, an extensive search of related literature hardly reveals any other cause except organicity, schizophrenia and mood disorders. Dabholkar reported a case of hysterical catatonia responding to electroconvulsive therapy (ECT) (Dabholkar 1988). Jagadeeshan et al. have reported two cases of obsessive compulsive disorder presenting with catatonic features, of which one patient had dissociative symptoms. (Jagadeeshan et al. 2002) Here we report three cases of dissociative disorders presenting with prominent catatonic features.

CASE - I

A 23 year old male, was brought by his family members with history of abnormal behaviour of six weeks duration manifesting with remaining mute, not responding to verbal and physical stimuli, poor self care and reduced sleep and appetite. Onset was abrupt immediately after a significant stress and progress static. There was no history suggestive of organicity. He belonged to a poor rural joint family of hereditary priests and was the eldest of five siblings. He studied up to high school. Married two years back. Pre-morbidly sincere, sensitive and sociable. Physical examination revealed marked anxiety features. Initial mental state examination showed an unkempt, uncooperative individual with poor rapport, staring look, complete

¹Classified Specialist and Associate Professor in Psychiatry, CH (SC), Pune - 411040.

²Senior Adviser and Associate Professor in Psychiatry, CH (EC), Kolkata

³Senior Adviser in Psychiatry, Command Hospital, Pune - 411040.

⁴Graded Specialist in Psychiatry, Department of Psychiatry, I.N.H.S. Asvini, Mumbai.

⁵Graded Spl Psychiatry, Dept. of Psychiatry, CH (AF), Bangalore

⁶Graded Spl Psychiatry, Dept. of Psychiatry, 167 MH

*Correspondence

muteness, catalepsy and waxy flexibility. He was admitted to psychiatric ward and treatment started with Tab. Lorazepam 2mg 8th hourly. By that evening, the patient responded dramatically, became cooperative, spoke relevantly with normal prosody. He said that his mind had become completely blank and had dissociative amnesia of all events of the previous six weeks. This normal state lasted for two days and he returned to catatonic state thereafter. But this time he ate and slept normally, partially attended to self-care, obeyed instructions and his mutism was selective. He had La-belle indifference. There were no features of psychosis or any syndromal depression. Essential investigations including MRI brain and EEG were normal.

A provisional diagnosis of dissociative disorder with catatonic features was made. Lorazepam was reduced to 1mg twice daily after three days and low dose Imipramine started for anxiety features. Repeated interview was carried out for eliciting the precipitating stress factor, but he remained mute, communicated by signs, walked with an unstable gait being supported by others but ate and slept well. When asked to write his replies, wrote only his name and on persuasion, did a few simple calculations. When his condition did not improve further after 17 days of hospitalisation, modified brief-pulse unilateral ECT was started. After the first ECT he started speaking small sentences and became completely asymptomatic after the second ECT.

He then revealed that after his marriage there was a financial crisis in their joint family. He gave up priesthood, joined a private bank and was tasked with recovering pending loans. He did not receive any pay or commission over one year and his employers kept deferring his requests. He had spent substantial sums of his own money while carrying out his job. On the day of onset he had deposited his collections at the bank headquarters and had hoped that his dues would be cleared. He was again rebuffed with the explanation that his papers were not ready. On this he felt extremely frustrated and abruptly developed symptoms on his return home that night. He was subsequently discharged to home and followed up for three months and he remained symptom free.

CASE - II

A 26 year old soldier had accidentally suffered bilateral above knee amputation when he fell under a train while crossing railway tracks. In the surgical ward, three days later, he refused food and tried to jump from his bed. Psychiatric examination revealed a withdrawn, uncooperative individual, speaking little, irritable and gloomy, who displayed negativism. He expressed anger towards

self and stated that it was better to die than to live in that condition. Sleep was reduced. Physical examination and essential investigations were non contributory. He was diagnosed to be suffering from grief reaction and started on treatment with Fluoxetine 20mg daily along with supportive psychotherapy. After two months he was transferred to Artificial Limb Centre at Pune for fitment of prostheses. He remained asymptomatic and was helping other patients cope with their difficulties.

One day, when he heard that he was to be sent home to Uttar Pradesh where the whole family was staying, he abruptly became mute, uncooperative and refused to eat, drink or take medicine. He remained withdrawn, threw away medicines, kept his lips pressed together to prevent his mouth being opened and was not amenable to suggestion or persuasion. Physical examination revealed marked autonomic arousal. After Ryle's tube feeding for three days, when his symptoms did not improve, he was given modified brief-pulse bilateral ECT. After two ECTs he improved significantly and ECTs were stopped .

He remained completely symptom-free for three weeks thereafter. Again when asked for discharge from hospital, he abruptly developed catatonic symptoms over a few hours. He exhibited total mutism, negativism, rigidity and refusal of food and water which continued for 3 days till he was again administered ECT. He became asymptomatic after one ECT.

There was no past or family history of mental illness. He hails from a rural agrarian background. Married ten years back, had five healthy children. Pre-morbidly was a shy, sensitive loner and prone to emotional outbursts in the face of stress. There were no features of psychosis or pervasive depressed mood.

While the initial presentation in the aftermath of the accident showed features of grief reaction, the two subsequent episodes were clearly dissociative in nature, manifesting with catatonic symptoms immediately preceded by understandable stress of facing family and friends for the first time in a handicapped state. The two catatonic episodes responded dramatically to ECT.

CASE - III

A 20 year old recruit with about 1yr of training was hospitalised following sudden onset of unresponsiveness while standing in the summer sun for an hour during a training exercise. Initial examination revealed low grade

fever and an abscess over the left side of his face. He gave a vague staring look, responded slowly to verbal commands and remained confined to bed. He was admitted to ICU with the provisional diagnosis of septicaemia and treated with abscess drainage, antibiotics and supportive measures. His fever subsided after two days but his mental state remained unchanged. He kept lying in bed, with vacant look, muteness and unresponsiveness. He did not eat nor pass urine, was fed by Ryle's tube, catheterized and his hands had to be bandaged to prevent him from pulling out the tubes. Posturing was noted and he was occasionally agitated without apparent reason. On a few occasions he spoke briefly but relevantly and once suddenly attacked a nurse when she was attending to his tubes. Gait was unsteady and he was indifferent to his symptoms. Assessment including, MRI brain and EEG were within normal limits. When his condition remained unchanged for a few days after his fever subsided, he was shifted to the psychiatric ward, where all his bandages and tubes were removed and he was encouraged to stand, walk, talk and eat. His condition dramatically improved within a short period and he walked slowly from his bed, sat outside in the shade of a tree and had lunch. However catatonic symptoms returned that evening and he was started on lorazepam 2mg thrice daily. He showed improvement within two days, was cooperative and attended to self care. Thereafter he showed periods of normalcy with intermittent dissociative behaviour when he would give a vague look, speak at slow pace with incomplete and brief replies and walk with an unsteady gait, all worsening when observed by psychiatrists. His catatonic symptoms relapsed significantly soon after his father came to meet him. He was then treated with modified brief pulse unilateral ECT and became completely asymptomatic after the first ECT.

There was no past or family history of mental illness. Hailing from a poor rural agrarian background, eldest of three siblings, educated up to 8th class. Detailed evaluation revealed multiple stressors immediately prior to onset. His father had repeatedly asked for money since he started earning and a week before the onset, father had demanded Rs 12,000/- to purchase a cow, when he could spare only Rs 2,000/-. He was also due to depart on his first posting within a week, leaving his state for the first time. He was ailing with the abscess and fever for a few days, but was continuing his rigorous training despite the suffering. His symptoms finally precipitated after prolonged standing in the summer sun.

At no stage were there any psychotic symptoms or pervasive depressed mood. His presentation was

dissociative in nature with prominent catatonic symptoms. He was discharged after psychotherapy and has remained completely asymptomatic over three months of follow up.

Discussion

Lishman states that hysterical and psychogenic stupors usually occur in a situation of stress and superficial motives may be discerned. Signs of conversion hysteria are commonly in evidence. The condition is more likely than others to wax and wane and there may be marked emotional reaction when sensitive subjects are discussed. The patient may show signs of irritability and annoyance when moved against his wishes (Lishman, 1998). All the three patients developed catatonia in the presence of acute and significant stress. Along with catatonia they manifested features of dissociation (hysteria). Onset was sudden and the clinical picture changed abruptly with periods of normalcy in between. The waxing and waning of symptoms was mainly related to external factors. All of them showed annoyance when their condition was interfered with. They were indifferent towards their symptom. At no stage were there any hallucinations or delusions and there was no evidence of syndromal mood disorder. They responded quickly to suggestion and lorazepam, but significant improvement was seen after ECT. Only one or two ECTs were required for complete recovery.

Catatonic symptoms in cases of dissociative disorder merit discussion. Catatonia has been reported in cases of obsessive compulsive disorder (Jagadeeshan et al. 2000). Girish et al. have reported that dissociation may produce catatonia. (Girish et al. 2003) Interestingly, Payee et al. in a series of 30 cases of catatonia have reported diagnoses of transient psychotic disorder in 40% and psychosis NOS in 33.3% of the cases (Payee et al. 1999). The psychosis NOS group closely resembled idiopathic catatonia described by Benegal et al. where no other psychotic syndrome could be clearly identified after the resolution of catatonia (Benegal et al. 1992). The psychosis NOS and idiopathic catatonia cases did not have any other psychotic features apart from catatonia (Catatonia as such was considered synonymous with psychosis!). If catatonia is not considered equivalent to psychosis, as described in DSM - IV and ICD - 10, some of those cases could have possibly been diagnosed as dissociative disorder.

Till recently we tended to diagnose most non-organic catatonics as schizophrenics. But when we analysed the first patient as a case of dissociative disorder presenting with catatonic features, within the next few months we

found two similar cases. The diagnoses were validated by three experienced psychiatrists after prolonged in-patient observation, evaluation of treatment response and follow-up. There possibly are more cases of dissociative disorder presenting with catatonia which end up being diagnosed differently.

References

- Ahuja, N. (2000). Organic catatonia: a review. *Indian Journal of Psychiatry*, 42, 327 - 346.
- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th edition) American Psychiatric Association, Washington D.C.
- Benegal, V., Hingorani, S., and Khanna, S. (1992). Idiopathic Catatonia: Validity of a concept. *Psychopathology*, 26 (1) 41 - 46.
- Dabholkar, P. O. (1988). Use of ECT in hysterical catatonia. *British Journal of Psychiatry*, 153, 246 - 247.
- Girish, K., and Neeraj, S. G. (2003). Electroconvulsive therapy in Lorazepam non-responsive catatonia. *Indian Journal of Psychiatry*, 45 (1) 21-25.
- Jagadeeshan, K., Nizamie, S. H., and Thakur, A. (2002). Catatonia in Obsessive Compulsive Disorder. *Indian Journal of Psychiatry*, 44, 179 - 182.
- Joseph, A. B. (1999). Catatonia. In *Movement disorder in neurology and neuropsychiatry*. (2nd edition) Joseph, A. B., and Young, R. R. Editors, Oxford, England.
- Lishman, W. A. (1998). *The Psychological Consequences of Cerebral Disorder. Organic Psychiatry*. (3rd edition) Blackwell Science, Oxford, England. 155.
- Payee, H., Chandrashekhara, R., and Raju, G. V. L. (1999). Catatonic syndrome: Treatment response to Lorazepam. *Indian Journal of Psychiatry*, 41, 49 -53.
- Rumans, T. A., and Philbrick, K. L. (2000). Recognition and management of neuroleptic induced reactions in the medically ill. In *Psychiatric care of medical patients*. (2nd edition) Stoudemire, A., Fogel, S. B., and Greenberg, D. B. Editors, Oxford University Press, Inc. New York. 409 - 413.
- Taylor, M. A. (1990). Catatonia: A review of behavioural neurological syndrome. *Neuropsychiatry, Neuropsychology and Behavioural neurology*, 3, 48 - 72.
- World Health Organisation (1992). *ICD - 10. Classification of Mental and Behavioural Disorders*. World Health Organisation, Geneva.
- Yager, J. and Gitlin, M. J. (2000). *Clinical Manifestations of Psychiatric Disorders*. In *Comprehensive Textbook of Psychiatry*. (7th edition) Sadock, B. J., and Sadock, V. A. Editors, Lippincott, Williams and Wilkins, Philadelphia. 819 - 820.