A CASE OF UNSPECIFIED NON ORGANIC PSYCHOSIS WITH DEPERSONALIZATION SYMPTOMS

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Abstract: Depersonalization - Derealization are alterations in the perception of self and the environment respectively. In this, as if, phenomenon, the affected person is not delusional convinced about the alterations and the reality testing is intact. Only when it overlaps a psychotic disorder in which reality testing may not be intact, does it create a clinical dilemma. These experiences could be primary or secondary. Though common in clinical and general population, these phenomena are usually missed. It is mandatory for the treating psychiatrist to enquire about this entity specifically to all psychiatric patients, irrespective of their diagnosis.

Keyword: depersonalization, derealization, psychosis, secondary depression. Depersonalization – Derealization symptoms involve an unpleasant, chronic and disabling alteration in the experience of self and the environment. The evolution of this unique syndrome dates back to 1872 when Krishaber described Cerebrocardiac Neurosis in some patients who complained of a strange and unpleasant alteration in the perception of themselves and their surroundings. Despite the term having been coined a century ago by Dugas and clearly defined in 1940s by Shoronov and in 1950s by Ackner, the phenomenon is still both misunderstood and misdiagnosed. Depersonalization is a subjective experience of unreality and detachment from the self. It is often accompanied by Derealization, the sensation that the external world and other people appear strange or unreal. DSM IV includes the entity under Dissociative disorders, whereas, ICD 10 includes it under other neurotic disorders. Both identifies the core symptoms to be the same – intact reality testing or insight. The phenomenon can occur as part of a symptom complex, either a primary or a secondary disorder. Transient experiences are common in normal and clinical populations. They are the third most commonly reported psychiatric symptom after depression and anxiety, but usually missed due to its variable clinical profile and course of the illness. Depersonalization symptoms can occur in a variety of situations including – mentally healthy persons suffering from acute stresses, fatigue or drug use; neuropsychiatric conditions like temporal lobe epilepsy, migraine, traumatic brain injury, encephalitis, tumour, chorea, carbon monoxide poisoning, cerebrovascular accidents; and psychiatric disorders including depression (most common), Post Traumatic Stress Disorder, generalised anxiety disorder, panic attacks, Agoraphobia, obsessive compulsive disorder, eating disorders and schizophrenia. Triggers for first episode include psychological stressors, substance abuse, physical and situational stressors, social / relationship problems and trauma. Depersonalization and Derealization are commonly reported in the general population and in patients with a variety of psychiatric disorders. The symptoms tend to be transient and of short duration; however, they may persist and develop into the syndrome of Depersonalization disorder, which can be diagnosed when persistent or recurrent episodes of Depersonalization cause distress to the individual and occur in the presence of intact reality testing. Presence of these symptoms in psychotic disorders is not as common as in mood or anxiety disorders. They are common in substance induced or withdrawal psychosis.

CASE REPORT
This is a case report of a young male presenting with significant depersonalization symptoms along with psychotic disorder, unspecified, which is not so common in the clinical settings in the absence of substance abuse. Mr. S., a 30 year old married male, a painter by occupation was brought to the outpatient department by his father with a 6 month duration of complaints, which initially started with being dull and withdrawn, preoccupied with his own thoughts and sleep disturbances. His self care deteriorated and he started going for job irregularly. Gradually he was found to be talking to self and being frightened at times. When enquired, he complained of hearing voices of unknown persons screaming and shouting at him. He was at times found to be agitated, wandering aimlessly in the streets. After about two months, unable to cope, he attempted suicide by hanging but was saved by his neighbours and was taken for psychiatric consultation. He was started on antidepressants and Benzodiazepines. Illness details were not available with the patient. His sleep alone improved with the medications, rest of the symptoms persisted and worsened. One month later, he suddenly felt as if his mind went blank, he was unable to feel any emotions, especially the fear associated with the threatening voices. He was not able to react to the events happening around him. He felt that his thinking process had slowed and came to a halt. He felt as if the whole world had changed and that he were two different persons. He did not derive pleasure from the dose of alcohol that he usually consumed (90 – 180 ml). Since he stopped reacting to the voices, he seemed apparently better to his family members. But he felt himself detached from self and the surroundings. Though he did not express sadness, he frequently expressed...
suicidal wishes and made two suicidal attempts over the next three months. He remained aloof, not interested in doing routine activities and his food intake also reduced. He continued taking alcohol in the usual dose which he previously used to take, but started smoking excessively. He was then brought for consultation to our hospital as the rest of the symptoms worsened. There was no history of seizures or any other medical or surgical illnesses. There was no history suggestive of obsessional or manic symptoms.

His past and family history did not reveal any significant findings. His personal history was uneventful. Premorbidly, he was typified as sociable, ambivalent, cheerful, hard working with good interpersonal relationship and no deviant traits. His general and systemic examination including vital signs were within normal limits. On mental status examination, he was guarded. Rapport was difficult. He appeared anxious and distressed. Subjectively, he termed his emotional state to be “blank”, but he expressed his inability to feel sad about his present state and of not being able to express his emotions. His speech was relevant. He expressed ideas of depersonalization, worthlessness and suicidal wishes. His cognition was intact. A provisional diagnosis of Unspecified Non organic Psychosis with Depersonalization- Derealization and Depressive symptoms was made and the patient was admitted. He was started on antipsychotics and low dose antidepressants. His PANSS score was 54 with high values on negative and general psychopathology subscales. His psychometric evaluation revealed high scores in depression, Paranoid ideation and negative symptoms. He was evaluated for organicity – CT Brain, EEG, blood glucose, metabolites and thyroid status. The results were found to be negative, thereby, almost favouring a psychiatric diagnosis. He was continued on antipsychotics, antidepressants and Benzodiazepines. [ T. Olanzapine 5 mg 1-0-2, T. Escitalopram 10 mg 0-0-1 and T. Lorazepam 0-0-2]. He showed improvement gradually. After 20 days he was discharged, with depressive symptoms completely resolved and his psychotic symptoms reduced, but his depersonalization symptoms persisted. He continued medications and after two months, felt better. He felt that his emotions were returning. He has been on regular follow up for the past 6 months. He earns his livelihood and takes care of his family.

DISCUSSION:

In this patient, the presence of psychotic, depressive and depersonalisation symptoms led to the diagnostic dilemma. Three possibilities were taken into consideration apart from organicity – Unspecified non organic psychosis, Depression with Psychotic symptoms and Primary depersonalization disorder. Based on the chronology and evolution of symptoms, the current diagnosis was made. Depersonalization – Derealization symptoms are relatively more common in general and clinical settings. It could be a main or secondary. Primary depersonalisation is a rare phenomenon. But studies report that it is often missed in clinical practice or misinterpreted as a different phenomenon. In this patient, the domain predominantly involved is “Deaffectualisation” – diminution or loss of emotional reactivity: emotions seem to lack spontaneity and subjective validity; this may affect intimate relationships.11. Emotional numbing13 is the most commonly reported symptom followed by an overall sense of emptiness in depersonalization disorder 16. These could be mistaken for the apathetic affect in Schizophrenia or anhedonia / lack of mood reactivity in depressive disorders. The depressive symptoms found in this patient could be occurring secondary to the psychotic or the depersonalization symptoms. In depersonalization there is difficulty in the optimum integration of mind and body. The patient could be “cognitively depressed” due to the inability to be “affectively depressed” for these altered experiences.5. Studies show that secondary depersonalization occur commonly in neurotic disorders especially in depressive and anxiety disorders. The separate diagnostic entity is included under dissociative disorders in DSM IV and in other neurotic disorders in ICD 10. Presence of these symptoms in psychosis is relatively less common and are primarily transient. In this patient, these symptoms persisted in the clinical picture over the last few months. There are very few studies, case reports, review articles or meta-analysis in literature regarding the presence of these symptoms in psychotic disorders, other than few reporting them to be present in Schizophrenia. These phenomena are reported to occur transiently in patients who use psychoactive substances, especially cannabis, ecstasy, marijuana and alcohol. They occur during the phase of intoxication or withdrawal along with the accompanying psychotic disorder. Raja et al9, 1992, in one of their journals, reported seven case reports of people who presented with a clinical picture of Atypical psychoses. Among them three had features of Depersonalization and Derealization along with other psychotic symptoms like paranoid delusions, magical thinking, catatonic symptoms and visual and auditory hallucinations. A recent study on patients with schizophrenia suggests that the presence of depersonalization symptoms mediates an established relationship between self-focus and auditory hallucinations.8 Whatever may be the diagnosis, it is important for the treating psychiatrist to enquire all psychiatric patients for the presence of these symptoms during the initial presentation and follow up as it is frequently missed, but has important diagnostic implications. The course of depersonalization symptoms is variable – being transient in secondary settings or in the initial stages of the primary disorder. In this patient, these phenomena were present continuously and negatively symptomatic. The treatment should ensure regular long term follow up to see treatment response. Presence of these symptoms is a poor prognostic sign in mood disorders and points towards treatment resistance according to few studies. The diagnosis of a primary disorder is to be kept in mind as retrospective studies show that patients diagnosed with this disorder were initially diagnosed with schizophrenia or depersonalization/complex partial seizure disorder, Complex Partial Seizure4,11. There is no definitive treatment yet for this syndrome13, both pharmacological and non pharmacological. There is some evidence for SSRIs(Fluoxetine15, Clomipramine). These are useful in the presence of comorbid or depression, but no randomised controlled trials have been published yet. Sertraline, along with SSRIs have better efficacy.17. CONCLUSION: It is important to differentiate between primary and secondary depersonalization – though it is difficult to do so. Treatment should be wholistic, not only being focussed on the predominant clinical diagnosis or comorbid symptoms. Long term follow up is necessary. It is important for the treating psychiatrist to enquire specifically, all patients including those with atypical psychosis, about this symptom which is mostly neglected due to important for the treating psychiatrist to enquire specifically, all patients including those with atypical psychosis, about this symptom which is mostly neglected due to lack of standardised rating scales and effective treatment.