Dissociation or Psychosis? : A Case Report

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Abstract

Dissociative disorder is a common diagnosis in day to day psychiatric practice and may be sometimes mistaken as psychotic feature. We report a case of youth having seizure disorder and mild mental retardation having non-epileptic psychogenic seizure (NEPS). He reported distinct episodes during which he ‘saw and heard a chudail’ abusing and threatening him leading to extreme distress. Detailed interview revealed psychological stress in real life in context of family conflict with a neighbor woman. When patient could connect the stressful event and the episodes, his NEPS as well as the episodes of seeing and hearing chudail disappeared. Thus even a person with mental retardation can have dissociative disorder which can be mistaken as psychotic disorder.

(Keywords: dissociative disorder, mental retardation, psychosocial stress, NEPS-Non-Epileptic Psychogenic Seizure)

Introduction

Psychogenic nonepileptic seizures (NEPS) or pseudoseizures are paroxysmal episodes that resemble and often misdiagnosed as epileptic seizures; however, NEPS are psychological (i.e. emotional, stress-related) in origin. NEPS are common at epilepsy centers, where they are seen in 20-30% of patients referred for refractory seizures. NEPS are probably also common in the general population, with an estimated prevalence of 2-33 cases per 100,000 population.¹

If NEPS are not recognized, extensive, expensive sometimes harmful investigations are done. Antiepileptic drugs do not control NEPS and may actually harm. We report a case in which generalized tonic-clonic seizures had comorbid conversion disorder. Visual and auditory hallucinations independent of seizure and conversion disorder posed a diagnostic problem.
Case Report

An 18 years old boy was brought by parents and several relatives in psychiatry department in emergency hours. He had loss of responsiveness and difficulty in breathing; but no frothing at mouth, involuntary passage of urine or stool in clothes or typical tonic clonic limb movements. His vitals as well as reflexes were normal. He was unresponsive for half an hour. According to his parents and the available documentations, he was a known case of seizure disorder, Generalised Tonic Clonic (G.T.C.S) type, since his age of 9 years but he was non-compliant for treatment since last 5 years and had seizures once or twice in 15 days. Mother reported that recent attacks were different than what patient used to get thus far. Besides general medicine consultant on emergency had sought psychiatry referral with a note of ‘‘Not an episode of Convulsion’’.

Following this the patient was interviewed alone. The unresponsive patient was asked in a loud voice to open eyes and tell his problems as we wanted to help. He started moving his limbs, making some vocalizations and after a couple of minutes he got up and sat in the chair. He mentioned that he was working as a load lifter on the railway station and his parents were forcing him to work for earning some money. Though later mother mentioned that he does not do any productive work, and no one in the family expected him to earn because he was ‘innocent’. After the interview, diagnosis of conversion with coexisting G.T.C.S. was made. He was hospitalized under psychiatry unit and was given Clonazepam 1.5 mg per day in three oral divided doses. By the next day, he had 6 to 7 similar non-epileptic seizures, each episode lasting for 10 to 15 minutes. On the same day he had one typical G.T.C.S. as well.

On the next day, the interview revealed that patient had to discontinue schooling as the teachers were afraid of the child having seizures in the school. School authorities asked parents not to send him to school. Patient could hardly study upto 4th standard. As both parents were textile mills workers, they could not bring child to hospital for regular follow up and medication was discontinued though parents continued to be afraid that he might get injured during episode of G.T.C.S. He used stay at home and do simple household chores like washing utensils, clothes, cleaning the home etc.

He was having some vague fear and discomfort in his day to day routine. During psychiatric interview he said, ‘‘she is following me everywhere since last 4 years. She scolds me as well. Once she had slapped me very badly’’ When we asked who she was, he became panicky and had conversion episode. The session was terminated and was scheduled for the next day.

On the next day, when encouraged to describe about the woman, he said, ‘‘she is very bad, asks me to leave the home. She follows me everywhere I go. She puts on a silk saree, stands very close to me and verbally abuses me. Only I can see her, none of my family members can see or hear her. To get free from her troubles, we have changed our rented home twice but she follows me everywhere. She constantly harasses me and does not allow me even to eat. She is a chudail, around 40 years of age, she stands near my bed threatens me and asks me to leave my place of residence.’’ He was also afraid that the chudail may kill him. Once he reported that as he saw the
chudail he ran for his life to railway station, so that in public place someone may save him. His mother also confirmed that because of patient’s fear of the chudail (and as a traditional healer had also advised) they had changed their residence twice over last four years.

Patient spoke in a childish way in a very low tone, answered with many pauses and often repeating the same sentences twice or thrice. His abstract thinking was poor. He could not do simple calculations or handle money, or recognize colours. Clinically he had sub-average intelligence and formal psychological testing confirmed mild mental retardation his I.Q. was 55 to 60 on Bhatia Battery of Intelligence Test.

His E.E.G. showed ‘neuronal hyperexcitability noted in temporal lobe’. Neurophysician advised continuation of phenytoin 300 mg. a day and his seizures were controlled well. However he continued to have 6 to 7 conversion episodes every day.

The patient was the youngest of three sons. The eldest son had separated from this family since many years. Patient’s other elder brother, 23 years old, was living with them till 4 years back. An auto rickshaw driver by occupation, he earned good money. He used to visit a neighbour, 40 years old separated woman with two children to watch cricket match. They grew closer and began spending more time together which was not approved by both of their families. The man was unmarried and the neighbour was a separated woman with two children, such a liaison jeopardized the family prestige in their traditional community. Patient’s parents had exchange of words with the woman regarding her relations with their son, they asked her to leave the place. ‘Instead you all leave the home if you want to’ shouted the woman. She cursed and abused and threatened more severe consequences. Witnessing these exchanges, patient was much distressed.

The woman asked patient’s brother to leave his family and live with her. He agreed and started living with the neighbour.

After this traumatic experience for patient’s family members, they stopped communications with the son who deserted them and relocated themselves away from the couple. The woman continued to visit patient’s new home, sometimes ... in absence of patient’s parents, abused them and threatened adverse consequences.

Patient was unhappy about his brother’s separation from the family as well as angry and fearful of the woman who took away his earning brother. He was tired of staying whole day at home doing nothing and was willing to work to help the family.

After narrating this, he improved markedly, the conversion episodes stopped, there was no ‘vision’ of the chudail. The seizures were controlled with antiepileptics. He was discharged and was advised strict adherence to antiepileptic medication and regular follow up.

He complied with the medication regimen, came for follow up regularly. After 6 months of the initial presentation, he started moving out and began work at a tailor shop as helper. He was in regular contact with his brother telephonically.


**Discussion**

Patient’s Presentation initially seemed like that of typical delusion and hallucinations for 4 years in a mentally retarded youth with epilepsy. Probable comorbid non-epileptic psychogenic seizure led to further exploration of stressor.

Persons with mental retardation also are affected by family stress. In this case, the family stress was in form of unmarried, earning brother leaving family with a separated woman after strong exchange of words and threats from the woman.

In the dissociative state, patient saw and heard a woman very similar to the threatening neighbour, in age and appearance. It is a common cultural belief that *chudail* is a dissatisfied woman without a mate who seduces young men and possesses them. Though the visual and auditory hallucinations and secondary delusion like phenomena raised possibility of psychotic disorder, their short duration and episodic nature was suggestive of flashbacks of the Post Traumatic Stress Disorder. However the woman in the experience was not the neighbour but someone like her, a supernatural being, a *chudail*. Alternatively as later reported by mother she had addressed the woman as *chudail* during verbal exchanges as an abuse. It is possible that a person with mental retardation can easily copy this verbalization, and may mimic the family members in using the term.

Moreover as the patient revealed the traumatic experience and could connect with the real life stress his conversion episodes and ‘visions’ of *chudail* remitted completely.

Adults with mental retardation are at increased risk of developing mental disorders due to the complex interaction of biological, psychological, social and family factors. Prevalence studies have consistently shown that 20-40% of people with mental retardation also have some form of mental disorder. Clinicians sometimes inappropriately attribute signs of a mental disorder to a person's mental retardation per se – a phenomenon known as 'diagnostic overshadowing'. Generally, the signs and symptoms of mental disorders presented by adults with mild mental retardation and reasonable verbal communication skills are similar but less complex than those presented by adults with normal intellect. The possibility of underlying mental illness in mentally retarded patients presenting with newly arisen behaviour disturbance must be considered.

An individual may present with overlapping signs and symptoms of two or more related mental disorders at a given time. Classic symptoms are usually present but may be difficult to identify and be masked/overshadowed by atypical features, which can lead to diagnostic problems in schizophrenia and paranoid psychosis. Hysterical symptoms, pseudo-seizures, and visual hallucinations are common.²

U.K. Study of adults with mental retardation found point prevalence of mental disorders 15.7% (DSM–IV–TR). The most prevalent type was problem behaviours. Mental ill-health was associated with more life events, female gender, type of support, lower ability, more consultations, smoking, incontinence, not having severe physical disabilities and not having immobility; it was not associated with deprived areas (geographic regions with overcrowding, high unemployment in men, lack of car – a measure of deprivation used in UK by Castrairs and Morris) no occupation,
communication impairment, epilepsy, hearing impairment or previous institutional residence.³

We need to remember that stressful life events can affect people with mental retardation and can be a contributing factor in onset of psychiatric disorder. Hastings et al (2004) in a county district in North-east England conducted a study of people with mental retardation found that within the 12 months before data collection, Overall, 46.3% had experienced one or more significant life events in the previous 12 months and 17.4% had experienced two or more life events.⁴

Another study concluded that rather than life events traumatic events may be more important role in psychopathology than life events.⁵

It is possible that for the patient with mild mental retardation a moderate stressor can also take the severity of traumatic event due to cognitive limitations.

Though conversion disorder is becoming uncommon diagnosis in the developed world it is still common in India. Recent study found pseudoseizures as the most prevalent presentation, present in 87.5% patients.⁷

As mental retardation has mostly been an exclusion criteria for most of the studies conducted till date on non epileptic seizures, many patients of mental retardation presenting with non epileptic seizures might have been overlooked accounting for relatively lesser reports of the same amongst these patients. Increasing awareness about the possibility of presence of co morbid non epileptic seizures in patients with mental retardation among psychiatrists is the need of hour in order to provide more effective and all inclusive service to these patients.

References


Sources of support: None
Conflict of interest: None

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