Schizophrenia masquerading as Dissociative Identity Disorder

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Abstract:

Dissociative symptoms can dominate the clinical picture in many psychiatric conditions and possess a huge challenge to the clinicians in management. We present a case report of a female with a strong family history of schizophrenia who initially presented with features suggestive of dissociative identity disorder, which is itself a rare clinical entity, was later diagnosed to have schizophrenia. Authors would like to emphasise that clinicians should have a high index of suspicion for schizophrenia when a patient with a strong genetic loading for schizophrenia presents with dissociative symptoms as early treatment enhances the prognosis.

Keywords: Dissociative identity disorder, Schizophrenia.

Introduction

Dissociative disorders are being recognized as increasingly significant psychiatric conditions. Not only is the primary diagnosis of dissociative disorders escalating, these disorders are also present as a comorbid condition in as many as 15-20% of adult psychiatric inpatients [1]. Moreover while dissociative symptoms occur in many psychiatric conditions, they can even dominate the clinical picture and possess a huge challenge for clinicians in the diagnosis and the management. Rarely dissociative symptoms constitute as the initial presentation of schizophrenia. Though there were few reported cases where a variety of dissociative symptoms preceded the typical psychotic features of schizophrenia [2], to best of our knowledge no case has been reported where an initial presentation has been dissociative symptoms suggestive of dissociative identity disorder (DID), which is itself a rare clinical entity, prior to the diagnosis of schizophrenia. We present such a case that initially presented with unique features, indicating a rare clinical diagnosis, hence delaying the diagnosis of schizophrenia.

Case Report

Miss B was a 39-year-old female teacher who presented to a psychiatric hospital with a change in behaviour of 3 months duration. She spoke in two different voices in addition to her own voice. She cried like a baby and whimpered in a kid's voice that she was a "stupid" baby. When she spoke like a baby she sucked her thumbs, bit her fingernails and at times she crawled and tried to cling on other people. These episodes lasted about a half to one hour before she switched to her own voice. She then abruptly switched to an adult male voice and shouted "Miss B was a timid and submissive person and "he" wanted to protect her from bad people". When she spoke like a male she pretended she was walking with a stick but did not assault or threaten any one. She shouted as she was arguing with a school principal scolding the principal in filth for harassing Miss B. The latter episodes too lasted more or less the same duration as the previous. On average she had about 5-7 "switches" to other personalities which were not preceded by any abnormal experiences or accompanied with any jerky movements of the body. Whenever she was in one personality she could not recall the identities and behaviour of others. She identified herself in different names during her switches to different persons and remained fully conscious and alert throughout all the personality states.

Corroborative history from the family members revealed she had a significant stressor as the loan sharks from whom she lent a sum of money were chasing her after for the last 3 to 4 months and she was hiding from them. Moreover family noted the switching occurred when she discussed about the stressor and distressed relatives promised to help her to relieve the financial burden whenever she switched to other personalities. She did not have affective or psychotic symptoms. She was admitted to the ward for further assessment and management and the staff acknowledged her switching to different personalities in regular intervals.

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Past psychiatric history revealed that she was treated with fluoxetine 20mg daily for a depressive episode 20 years ago and she defaulted the treatment after one to two months as she felt better. Significantly her deceased biological mother had schizophrenia. The childhood history revealed she was physically and emotionally abused by her stepmother since the age of 9 years. She had been working as a teacher till half a year ago when she stopped working due to the strained relationship with her superiors. Premorbid, she was a sensitive person who preferred to keep her problems to herself than discussing with others and never used psychoactive substances.

Before the admission to the psychiatric hospital, an organic workup was done in a general hospital and the investigations including renal, liver and thyroid profiles, fasting glucose, serum calcium and magnesium levels and the CT scan of the brain were normal. She was suspected to be suffering from Dissociative Identity Disorder (DID) and was treated accordingly with the help of a psychologist. All the staff in the ward designed a common approach in that whenever she spoke in her normal voice she should be rewarded with praise and meet her needs and not to pay attention to the occurrence of switching to personalities. The social worker explored with her the options to overcome her financial constraints. In spite of the management she continued to have the same presentation.

Nearly 2 months after her admission to the psychiatric ward, she spoke like a robot and claimed an unknown force controlled her voice. She spoke irrelevantly at times. Mental state examination revealed her mood was perplexed and had psychotic symptoms such as persecutory delusions, delusion of thought insertion and delusion of control or passivity. Risperidone 2 mg at night was initiated as the diagnosis was revised to schizophrenia owing to her new symptomatology, functional impairment and the strong family history. Patient improved dramatically in 4 weeks of administration of risperidone and continued to improve further in that she planned to restart her employment.

Discussion

Schizophrenia and dissociative disorders share several common symptoms such as aberrant perceptual experiences and disruptions in reality testing and several studies have reported considerable confusion in the diagnosis of schizophrenia and dissociative disorders (such as DID) based on the presence of Schneiderian first rank symptoms that present in both disorders . These symptoms include auditory hallucinations, thought insertion/withdrawal and delusional thinking [3]. Moreover dissociative experiences occur more commonly in schizophrenic patients with positive symptoms than in patients exhibiting negative symptoms [4]. This patient had positive symptoms such as delusion of control, delusion of thought insertion and persecutory delusions, which could have increased her vulnerabilities for dissociative symptoms.

There is substantial evidence linking child sexual and physical abuse to a range of mental health problems in childhood and adults [5]. Child abuse has also been shown to have a causal role in most adult psychiatric illnesses, including dissociative disorders and it is also related with concurrent dissociation among patients with schizophrenic disorder [6]. The symptoms that are significantly related to abuse in the order of the strength of the relationship are running commentary, ideas of reference, thought insertion, paranoid ideation, reading others' minds and visual hallucinations [7]. out of which this patient had thought insertion and paranoid ideation.

Evidence from early studies of first-episode schizophrenia suggested that a longer period of untreated illness is associated with a poorer prognosis [8]. Lappin et al found that temporal grey-matter reductions were more marked in patients with long duration of untreated psychosis [9]. These findings may reflect a progressive pathological process that is active prior to treatment and the antipsychotic treatment delays or prevents it [10].

Authors would like to emphasize that clinicians should have a high index of suspicion of the possibility of schizophrenia when a patient with a strong genetic loading for schizophrenia presents with dissociative symptoms as early treatment enhances the prognosis.

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