Case Report

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Title: Differentiation of dissociative psychosis, delirious mania, and unspecified dissociative disorder in an adolescent case.

Short title: Dissociative psychosis, delirious mania, unspecified dissociative disorder.

Abstract

Dissociative psychosis is, it is a condition that usually occurs after a trauma when psychotic and dissociative symptoms occur together. In this process, disorganized behaviors increase, insight is lost, and hallucinations become worse. It usually results in sudden improvement over a period of several days to several weeks, and most patients remain amnesic into the dissociative psychosis phase. A sixteen-year-old female adolescent was brought in with severe manic and psychotic complaints that started suddenly a week ago. In the mental status examination, disorganized associations thought content, and auditory and somatic hallucinations were particularly striking. During the hospitalization process, passivity, delusional delusions of misidentification, and disorganized speech and behavior were also observed. The adolescent, whose complaints regressed in the fourth week, was amnesic during the episode. This study aims to present the differential diagnosis and treatment process of dissociative psychosis, delirious mania, and unspecified dissociative disorder in an adolescent female.

Keywords: Psychosis, dissociation, adolescent, mood disorder.

Makale başlığı: Bir ergen olguda dissosiyatif psikoz, deliryöz mani ve tanımlanmamış dissosiyatif bozukluğun ayrımı.

Kısa başlık: Dissosiyatif psikoz, deliryöz mani ve tanımlanmamış dissosiyatif bozukluğun ayrımı.

Öz

Disosiyatif psikoz; genellikle travma sonrası, psikotik ve disosiyatif bulguların bir arada oratya çıkmasıyla oluşan bir tablodur. Bu süreçte dezoganize davranışlar artar, iç görü kaybolur, varsanılar ağırlaşır. Genellikle birkaç günden birkaç haftaya kadar uzayan bir sürede aniden düzelme ile sonuçlanmaktadır ve çoğu hasta dissosiyatif psikoz dönemine amnezik kalmaktadır. On altı yaşındaki, kız ergen bir hafta önce aniden başlayan şiddetli manik ve psikotik yakınmaları ile getirildi. Ruhsal durum muayenesinde; dağınık çağrışımları, düşünce içeriği, işitsel ve somatik halüsinasyonları özellikle dikkat çekiciydi. Yatış sürecinde edilgenlik, sanrısal yanlış tanıma sanrılarının, dezorganize konuşma ve davranışlarının da olduğu gözlendi. Dördüncü haftada yakınmaları gerileyen ergen epizoda amnezikti. Taburculuk sonrası ilaçları kesilen ve nüks görülmeyen olguda disosiyatif psikoz, deliryöz mani, belirlenmemiş disosiyatif bozukluk ayırıcı tanı ve tedavi süreci sunulmuştur.

Anahtar kelimeler: Psikoz, disosiasyon, ergen, duygu durum bozukluğu.

Introduction

Hallucinatory experiences and delusions during adolescence are commoner than once thought. These symptoms can also be seen in disorders other than psychotic ones, including mood disorders, anxiety, attention-deficit/hyperactivity disorder, autism spectrum disorders, post-traumatic stress disorder (PTSD), and related conditions along with different psychopathologies or medical conditions [1]. Current studies have led to an increasing recognition of adolescents at risk for developing psychosis [1, 2]. These youth may have sub-threshold, heterogeneous symptoms (“prodromal symptoms”) and may progress to more severe disorders, including schizophrenia, during follow-up. As a result of studies on this subject, “Attenuated Psychosis Syndrome” was introduced in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) [3]. Although dissociative disorders, post-traumatic spectrum disorders, and psychotic disorders are evaluated in separate diagnostic categories in DSM-5, current opinion suggests that dissociative and psychotic symptoms may partially overlap and dissociative processes may mediate between early traumas and later developing psychotic symptoms [4].

“Dissociative Psychosis” (DP) is not included in current diagnostic systems and describes a syndrome that is widely used, especially among psychiatrists of European

origin [5, 6]. It is reported that the syndrome is not culture-dependent but occurs suddenly and unexpectedly after stressors that may vary depending on culture, can last for a short time (<3 weeks), and patients with good premorbid functionality may develop amnesia for the episode. Although the duration may vary, the relationship between the traumatic experience and dissociative characteristics is relatively constant. In cases, changes in the level of consciousness and pre-conscious phenomena may be observed, symptom severity and form may fluctuate, and although the appearance may resemble schizophrenia, mania, or organic cognitive disorders, the absence of affective blunting and a good prognosis is characteristic [5, 6]. It was thought that this diagnosis could explain the sudden recovery and amnesic period seen in our case. “Delirious mania” (“Bell mania”) is also a relatively little-known neuropsychiatric syndrome and is characterized by sudden onset delirium, mania, psychosis, and catatonic symptoms [7]. It is independent of general medical conditions, substance use, and other mental disorders and can be seen in up to approximately 15.0% of acute manic cases. Its severity may progress with delays in diagnosis and treatment, but it is reported to respond well to high-dose lorazepam and electroconvulsive therapy (ECT) [7]. In our case, the presence of findings suggestive of delirium in addition to manic symptoms may indicate delirium mania. However, this diagnosis could not be finalized because our case did not explain the amnesic period. In this study, we aimed to present the differential diagnosis and treatment process of rare but clinically similar dissociative psychosis, delirium mania, and unspecified dissociative disorder in an adolescent female patient and to help the diagnosis and treatment process of cases with uncertain diagnosis.

Case

A sixteen-year-old, 11th-grade female was brought to the clinic with complaints of “talking to herself in unintelligible speech, laughing, inability to spend time alone and not being able to recognize people around her”. It was learned that her complaints started suddenly about a week ago, her communication with the environment decreased about six months before the application, she reported a change in her religious beliefs after visiting a relative two months ago, her appetite was reduced, and she lost approximately 15 kg/month. From the past medical history, it was learned that she was a baby born with IVF, that she had no problems before, during and after birth, that she was a temperamentally docile baby, that her motor-mental development stages occurred on time, that she had no chronic medical diseases and no previous psychiatric applications. In the family history, it was determined that the mother had received treatment for a diagnosis of bipolar disorder Type I (BPI) and had been in remission for a long time and

that her grandmother had periodic tantrums and self-harming behavior but had never received treatment.

The mental status examination observed that the care of the adolescent girl, who showed age-appropriate physical development and partially communicated with the interviewer, decreased. It was observed that she alternately displayed defensive and regressive attitudes and made partial eye contact. Her orientation was fluctuating, and her consciousness was clear. Spontaneous - voluntary attention - concentration, working memory - short-term memory were evaluated as impaired and fluctuating. Long-term memory could not be evaluated. The speech was fast, disorganized, and pressured. The thought process is tangential/ circumstantial with loose associations, flights of ideas, the incoherence (“purple, orange, thank you”), neologisms (“shine is a code between me and my lover”, “I explain by coding”), perseverations and thought blocks. The thought content was poor. Delusions were compatible with her mood, unsystematic, bizarre, somatic (“she is pregnant”), erotomanic (“she has a lover”), grandiose (“only she can hear her lover”), persecutory (“they are trying to poison her”). Perceptual examination revealed auditory and somatic hallucinations consistent with mood. Affect was inappropriate and labile, mood was labile and exuberant. Psychomotor agitation, stereotypy, and mannerisms were observed. Sleep and appetite were decreased while libido was increased. Insight and judgment were impaired. She was admitted to the inpatient service to clarify her diagnosis and arrange treatment.

No organic pathology, intoxication, or withdrawal findings were detected in evaluations, including pediatric and pediatric neurology consultations, physical examination, laboratory tests including autoantibodies, electroencephalography (EEG), and cranial MRI. Young Mania (YMRS), Positive and Negative Affect Scale (PANSS), and Clinical Global Monitoring (CGI) scale scores [8] were 30 (significantly manic), 113 (Positive:41, Negative:72, General:113) and 6 (“Seriously ill”), respectively. As a result of the history, examination, and evaluations, she was preliminarily diagnosed with Brief Psychotic Disorder (Dissociative Psychosis), BP-I (Manic Episode, Delirious Mania), Unspecified Dissociative Disorder according to DSM-5 criteria and was started on risperidone 1 mg/ day, alprazolam 1 mg/ day, sodium valproate 250 mg/day treatment. Risperidone, alprazolam, and sodium valproate (VPA) doses were gradually increased to 4 mg/day, 1.5 mg/day, and 1000 mg/day in the second week.

During her stay, she continued to display regressive behaviors (e.g., wanting to hold the doctor’s hand while talking), labile affect, vague persecutory (rejecting the food served in favor of packaged foods), passivity (“What I write is written in blue”), delusional misidentification/ Fregoli/ Capgras delusions (“She disguised herself as Arif”, to the

doctor: “you can also be Arif” and “You are my mother”) [9], disorganized speech and behavior were observed.

In the first week of hospitalization, the VPA level was 100 µg/mL, and due to complaints of pain and nausea, valproate treatment was reduced to 250 mg/day, and risperidone was increased to 6 mg/day. YMRS, PANSS, and CGI scores [8] in the second week of hospitalization were 13 (insignificant manic symptoms), 93 (Positive:29, Negative:64, General:93), and 4 (“moderately ill”), respectively. On the twentieth day, the alprazolam treatment of the adolescent, whose complaints continued, was discontinued, and treatment with lorazepam 2 mg/day and olanzapine 5 mg/day was started, gradually increasing the latter to 10 mg/day. In the fourth week of hospitalization, the adolescent’s complaints were significantly reduced, and she reported for the first time that her complaints started after she had a row with a few friends she met online but had no recollection of what came after. The adolescent was discharged in the fifth week with risperidone 6 mg/day, olanzapine 10 mg/day, VPA 250 mg/day, lorazepam 1 mg/day, and biperiden 1 mg/day. YMRS, PANSS, and CGI scores [8] at discharge were 0, 0 (Positive:0, Negative:0, General:0), and 2 (“borderline mentally ill”), respectively. Lorazepam and valproate treatments were discontinued for the adolescent, who had no symptoms other than subthreshold depressive and anxiety complaints a week after discharge; olanzapine treatment was continued while risperidone was reduced to 3 mg/day.

In the second follow-up interview, the adolescent reported that she still did not remember the hospitalization period, that she had converted to another religion against her will, and that this might disturb her and cause her complaints. The risperidone dose was increased to 6 mg/day again, and 1 mg/day of biperiden was added. Then, the anxiety symptoms experienced in social communication were addressed in visits via cognitive-behavioral methods. Scores for Post-traumatic Stress Response Scale (PTSTS), Beck Depression Inventory (BDI), and Adolescent Dissociation Scale (A-DES) at the sixth visit were 55 (clinically significant PTSD symptoms), 32 (severe depressive symptoms), and 6.4 (dissociative disorder level symptoms), respectively. However, other than the argument with her peers, she recollected no significant trauma. Therapy sessions, therefore, are aimed at reducing anxiety, increasing assertiveness, and assuming age-appropriate responsibilities.

At the eighth interview, no active complaints were detected. Scores of 0, 0, and 2 were obtained from the YMRS, PANSS, and CGI scales [8], respectively. The adolescent, who was followed weekly until the eighth interview, was evaluated first every two weeks and then once a month for the next nine months. Since the symptoms did not

recur, all medications were tapered and discontinued. She is still free of symptoms a month after cessation of treatment.

Discussion

In this study, the differential diagnosis and treatment process of DP, delirious mania, and unspecified dissociative disorder in an adolescent female is presented. Schizoaffective disorder was ruled out due to a lack of significant psychotic symptoms lasting at least two weeks in the absence of mood symptoms and the absence of complaints after cessation of treatment. Substance abuse was ruled out with history and laboratory evaluations. PTSD with psychotic and dissociative symptoms was ruled out due to lack of exposure to actual or threatened death, serious injury, or sexual violence. In DSM-5, dissociative disorders occur with the division of functions such as consciousness, memory, identity, affect, perception, body schema, motor control, and behavior, which form a whole under normal conditions and are defined as dissociative identity disorder (DID), dissociative amnesia, depersonalization/derealization disorder, other specified and unspecified dissociative disorders [3]. In the presented case, DID was excluded due to impaired reality testing, the presence of additional symptoms, lack of two or more personality states, and recurrent episodes of dissociative amnesia. In the case, during the follow-up period, an inability to remember autobiographical information that could not be explained by normal forgetfulness, consistent with localized and selective dissociative amnesia, was observed, but the adolescent did not report subjective distress due to this symptom, and no dysfunction was detected. The differential diagnosis can also consider other specified dissociative disorders (acute dissociation in response to stressful events). For this diagnosis, symptoms typically last less than a month, sometimes emerging within hours/days of the stressor, level of consciousness changes with depersonalization/derealization, time is perceived as slowed with macropsia and similar perceptual disorders, microamnesias, transient somnolence and/or loss of sensory-motor functions can be seen [1]. In our case, this diagnosis was excluded because the duration of the symptoms was longer than one month; symptoms included hallucinations, delusions, and impaired reality testing. Delirious mania is ruled out due to the absence of catatonic symptoms worsening over time, psychotic/dissociative symptoms being independent of mood-related symptoms, and the relatively low dose of lorazepam used [7]. Dissociative psychosis is, it is a condition that usually occurs after a trauma when psychotic and dissociative symptoms occur together. In this process, disorganized behaviors increase, insight is lost, and hallucinations become worse. It usually results in sudden improvement over a period of several days to several weeks,

and most patients remain amnesic into the dissociative psychosis phase [10]. DP was considered due to the sudden development of symptoms, short duration, good premorbid functionality, post-episode amnesia, association with traumatic experience, absence of affective blunting, and the presence of noisy, waxing-and-waning, heterogeneous symptoms [5, 6]. Although social withdrawal and changes in religious beliefs in our patient could also be considered prodromal symptoms before schizophrenia or attenuated psychosis syndrome, the follow-up period does not support this view. Although PTSD was ruled out due to a lack of significant traumatic experiences, according to the adolescent's Report, it should be borne in mind that she had dissociative amnesia during the period of hospitalization. This may suggest that there might be other traumatic experiences for which she is currently amnesic, and those may resurface during longer follow-up.

The presented case may inform the clinicians in keeping the diagnosis of DP in mind among adolescent patients in whom dissociative, psychotic, and affective symptoms suddenly and dramatically emerge after a stressor.

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Authors' contributions to the article

A.C. wrote the article under the supervision of A.E.T. In addition, the authors discussed the entire study and approved the final version.

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