Letter to the Editor

A Case of Obsessive-Compulsive Disorder Presenting as Dissociative Disorder: The Role of Sodium Thiopental Interview

To the Editor: Dissociative experiences have often been reported in obsessive-compulsive disorder (OCD)[1,2] without overt dissociative disorder. Patients with OCD and high dissociation are more likely to be checkers and arrangers than those with low dissociation.[2,3] Conversely, both obsessive and compulsive symptoms[4,5] have also been reported in dissociative disorders. We report the case of a young lady who presented with dissociative motor disorder and mutism and who was later diagnosed with OCD after a drug-assisted interview.

Case report. Ms A, a 24-year-old woman from a middle-class socioeconomic urban background, who premorbidly had a well-adjusted personality and had no past or family history of mental disorders, was brought to our hospital in 2009 with a 3-month history of frequent attacks of repeated nodding of the head and blinking of the eyes with absent speech lasting about 15–20 minutes each time, but with complete responsiveness and consciousness during the attack. Such attacks were noted to be occurring 3–4 times a week, with the patient denying existence of the attacks. A detailed history revealed that Ms A had been recently married (over a year before) and was having difficulties in interpersonal relationships with her in-laws. A complete physical and neurologic examination revealed no abnormalities, routine hemogram and biochemical investigations were negative for any findings outside normal limits, and electroencephalogram was uneventful. During serial interviews, Ms A avoided eye-to-eye contact and would deny the existence of any problem. She also had frequent episodes of rapid head nodding and blinking of the eyes, during which she would become completely mute and refuse to answer any questions. Initially, a diagnosis of mixed dissociative disorder (*ICD-10* Diagnostic Criteria for Research) was made, largely comprising dissociative motor disorder and dissociative mutism.

An attempt at individual psychotherapy was made consisting of removal of secondary gain and symptom reduction. However, Ms A continued to have attacks in spite of repeated therapist attempts, and therapy was declared largely unsuccessful. Since no more information was forthcoming from the patient at this time, a sodium thiopental interview was planned in order to delve into her conflict areas. After informed consent was obtained from the patient and caregivers, the interview was carried out. During the interview, the patient revealed that she had been having repeated blasphemous and homicidal thoughts about her in-laws with an obsessive quality. These were accompanied by compensatory mental compulsions of trying to abort such thoughts by forcible "amnesia," which led to her dissociative symptoms. After this information was obtained, Ms A was diagnosed as suffering from OCD, mixed type, with a Yale-Brown Obsessive Compulsive Scale (YBOCS)[6] score of 27/40. The patient was then started on sertraline treatment at a dosage maintained at 200 mg/d, and cognitive-behavioral therapy (CBT) was added later at the end of 4 weeks. At follow-up, Ms A showed substantial improvement of both dissociative symptoms and OCD (YBOCS score of 6/40).

A number of previous studies have observed a link between OCD and dissociative symptoms, but this patient demonstrated a rare example of OCD presenting as dissociative disorder. The value of the drug-assisted interview in reformulating the diagnosis cannot be overappreciated, as it led to a paradigm shift in the management plan. Little evidence exists as to causation, but some authors have suggested that disruptions of reality monitoring due to attempts at forcible "amnesia" by the patient[7] and the consequent distress may lead to dissociative symptoms. Further, sociocultural taboos of revealing the blasphemous and homicidal nature of her thoughts may explain why these obsessions were kept so secret. In addition to pharmacotherapy, to which the patient showed marked response, CBT may be tried in such cases despite reports of poor outcome.[2] To conclude, patients with OCD may present as having dissociative disorder due to the high levels of distress associated with the nature of the thoughts. A high index of suspicion may be essential to managing such a patient appropriately.

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Potential conflicts of interest: None reported.
Funding/support: None reported.
Published online: June 30, 2011 (doi:10.4088/PCC.10l01134).
Prim Care Companion CNS Disord 2011;13(3):e1