“IF YOU CAN SEE, LOOK. IF YOU CAN LOOK, OBSERVE” *: A CLINICAL CASE

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Objectives:

To reflect on diagnostic challenges of a complex clinical case.

Background:

We rely heavily on verbal communication to understand the workings of the mind. Nonconscious non-verbal communication, associated with more primitive brain areas, is perhaps even less easily understood and translatable. Socio-cultural factors impact both verbal and non-verbal communication and further contribute to misunderstanding human expressions of suffering.

Materials and Methods:

33 year old male patient, from Guine-Bissau, has lived in Portugal for several years, separated from his mother from age 9 to 18 years old, is admitted to hospital due to agitated disorganized behaviour and presents with periods of mutism/semi-mutism, grimacing, waxy flexibility, changing to periods of mutism with physical expression of severe abdominal pain, crying, spitting, in apparent response to emotional stressors, sometimes responding to simple commands, alternating with periods in which he appears to be well.

Prior psychiatric history reveals a brief hospital admission to inpatient unit due to agitated unusual behavior with discharge diagnosis of psychotic disorder due to substance use (cannabinoids) with full remission of symptoms and a second hospital admission to an inpatient ward a year earlier with a similar clinical presentation to the present episode, hypotheses of psychotic episode and catatonia and diagnosis at discharge of schizophrenic disorder and mild intellectual disability.

Neurological and general physical evaluation findings were considered not relevant (hepatitis B and C; fluctuating leukopenia with neutropenia and thrombocytopenia were thought to be associated with hepatitis).

Psychological evaluation was difficult and inconclusive. It was not possible to exclude physical, sexual or emotional abuse or neglect nor to gather information on pre-morbid personality and general functioning. Culture-specific rituals had apparently been of no benefit. A fellow patient on the ward, also from Guine-Bissau, commented that “only he and God know what wrong was done”. Figure1: Clinical reflections on the case.

Results and Conclusions:

Diagnostic hypotheses evolved from psychosis at admission, to catatonia, culture-related syndrome, dissociative disorder, mild intellectual disability, mood disorder, somatization disorder, back to hypotheses of cultural idioms or expressions of distress and dissociative disorder.

Faced with the paucity of communication through language, unusual behaviour is frequently attributed to psychosis, low IQ or hysteria, which may be associated with prejudice as to who is less likely to use language in a more sophisticated manner. Verbal communication and maybe even more so, non-verbal expressions of suffering, are often misunderstood. Cultural contexts add further layers of complexity due to differences in the expression of human suffering.

Dissociative symptoms may be related to childhood trauma, emerge as a regulatory strategy and may be mediating factors for psychosis or act as a defense against psychosis.

“The point is that one sees with different eyes at different times...This is why a motif can be seen in so many ways and this is what makes art so interesting.”

person/patient

Psychiatry/Psychology

Edvard Munch

Figure 1:
To be read from bottom center out and up.