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Диссоциация, «ОКР наоборот» и несостоявшаяся шизофрения. Случай Алсу Б.

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АННОТАЦИЯ

В статье приведено описание редкого клинического случая тяжёлого гистрионического расстройства личности с проявлениями нетипичного обсессивно-компульсивного расстройства («обсессивно-компульсивного расстройства наоборот»), приведшего к ошибочной диагностике шизофрении и определению нетрудоспособности пациентки. За восьмилетний период психиатрического наблюдения девочке выставляли множество различных диагнозов в ведущих российских и зарубежных клиниках — от соматоформного, ипохондрического и обсессивно-компульсивного расстройства до шизофреноформного, биполярного аффективного расстройства и параноидной шизофрении с эмоционально-волевым дефектом. В статье обоснованы диагноз гистрионического расстройства личности и ошибочность иных диагнозов. Приведён краткий обзор литературы по коморбидности диссоциативных и обсессивно-компульсивных расстройств.

Ключевые слова: *диссоциативные расстройства, гистрионическое расстройство личности, шизофрения, обсессивно-компульсивное расстройство, диагностика психических расстройств.*

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Dissociation, “OCD IN REVERSE” and unfulfilled schizophrenia. Case Alsu B.

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ABSTRACT

The article describes a rare clinical case of severe histrionic personality disorder featuring manifestations of an atypical obsessive-compulsive disorder (“obsessive-compulsive disorder in reverse”), which led to an erroneous diagnosis of schizophrenia and classification of the patient as disabled. Over an eight-year period of psychiatric observation, the girl was given many different diagnoses in leading Russian and foreign clinics — from somatoform, hypochondriac and obsessive-compulsive disorder to schizophreniform disorder, bipolar affective disorder and paranoid schizophrenia with an emotional and volitional deficits. The article substantiates the diagnosis of histrionic personality disorder and the incorrectness of other diagnoses. The article also provides a brief review of the literature regarding the comorbidity of dissociative and obsessive-compulsive disorders.

Keywords: *dissociative disorders, histrionic personality disorder, schizophrenia, obsessive-compulsive disorder, diagnosis of mental disorders*.

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The clinical case of 21-year-old Alsou attracted our attention because during observation in leading Russian and international clinics, psychiatrists made various diagnoses of the girl, from somatoform and hypochondriacal disorders and obsessive–compulsive disorder (OCD) to schizophreniform and bipolar affective disorders and paranoid schizophrenia with emotional–volitional defect. Over the past years, Alsou has had a first-degree disability due to a mental disorder (schizophrenia). However, no pathological dynamics of her mental state were noted, as is the case with schizophrenia, and the assessment of the dominant psychopathological syndrome requires rethinking.

Alsou is 21 years old. At this time, she asked doctors to prescribe her α-blockers because she had increased adrenaline levels and suffered from mental disorder attacks. The therapist then referred the patient to a psychiatrist.

Anamnesis vitae and case history. Heredity does not aggravate mental disorders and genetic diseases. The patient was born full-term and was the only child in the family. Her parents are philologists; however, her mother is currently not working because she has to take care of her sick daughter who requires her constant presence and strict following of the rituals she has developed. Family relations are formally good.

It was her mother's first pregnancy, which was desired and had a normal course (her mother underwent an ovarian resection before pregnancy). Natural delivery was at week 39. The Apgar score was 7/8 points; during birth, umbilical cord entanglement around the leg occurred. After birth, the patient was put on mechanical ventilation because of hypoxia that developed during passage through the birth canal. The birth weight was 3200 g, and height was 52 cm. The patient and her mother were discharged from the maternity hospital on day 5.

During the first 3 months, Alsou was a restless child, screaming piercingly for a long time. She began to speak her first words at 18 months old. She attended preschool institutions from the age of 3 years, but not for long because she often had catarrhal diseases. Her mother and grandmother took care of her. From the age of 5 years, she attended music school for piano. In her free time, she loved to film herself, impersonate a correspondent, and parody popular singers; she grew up in an atmosphere of benevolence, love, and indulgence of her whims and needs. While walking outside, she made friends with her peers and willingly communicated with them. However, the patient stated, "I didn't have a good relationship or love for my mother. For example, it was disgusting for me to hug her since childhood."

At aged 7 years, she started attending a specialized (with advanced study of English) school. She did not adapt there easily. According to her mother, she often came home scared after the teacher raised his voice. In elementary school, she studied "excellently," received praise from teachers, and made progress in mastering languages. She spent her time free from studying under the supervision of her mother and was freed from performing simple everyday duties (e.g., washing dishes, making the bed). She further stated, "My mother took great care of me; she accompanied me to school until grade 7 because dogs were running in the yard and could attack me. She dedicated her whole life to me, but she didn't save me from illness." When communicating with her peers, Alsou showed obsequiousness and courtesy; however, she treated her mother discourteously, reproaching her and making various claims.

In addition to her good performance at school, she was awarded diplomas at competitions, for example, for the best poetry. According to teachers and members of the competition commissions, her poems had depth and meaningfulness. She wrote poetry in different languages (Russian, Tatar, English). Moreover, she participated in literature academic competitions, taking first places ("I was happy then, I won them, I felt better than the rest").

At music school, she took first place in competitions, believed that she had no right to be worse than others, and raised the bar: "It cost me a lot; concerts are stressful; I was afraid to let you down and disgrace myself." In addition to the piano, she studied singing, "But I was always put behind… from grade 3 of study at a music school, competition began, someone was singled out, I was deprived, when I had to sing a difficult duet, the teacher said that it was not mine, I still haven't gotten over it, but in grade 8, I expressed all my grievances in a message to the teacher, I wanted to evoke a feeling of guilt, the teacher asked for forgiveness."

By nature, her mother called her "perfectionist, bright, and energetic." As a child, she had some minor obsessions; she wanted to spin clockwise, and then counterclockwise, because she felt like a thread was tangled around her. At 6 years old, she obsessively wanted to touch the iron: "What if it was hot…I wanted to make sure that it had cooled down so that my brain would calm down." Once she touched the iron that was still hot and had a blister on her palm. At age 10, obsessive thoughts began to appear, such as "When flushing in the toilet and the sound of water is heard, you cannot listen to it so as not to vomit, and therefore, when flushing, I covered my ears with my hands."

Additionally, she compulsively counted the letters in names and emblems ("While we're driving by, if I don't have time to count, something will happen, I could vomit, I felt nauseous"). A panicky feeling of nausea occurred one night when her mother turned off the lights. She behaved "strangely"; she tilted her head forward, blinked, and opened her mouth. Since then, she began to feel hatred toward her mother and "the whole world" and she began to conflict with her mother and had a conflict with her father; he beat her in response to the fact that Alsou offended her mother, after which the rude behavior disappeared. She visited a psychologist who did not find any mental pathology.

Since grade 5, she had a friend, and her "heart lightened," because she had no enough time for friends before. However, she noted that internally, she was getting worse every year.

She graduated with honors from music school.

"Bouts of cleanliness" appeared, and she wanted everything to be in its place. "If it was dirty, I brought everything to perfection, wiped the table with a damp cloth." She began to feel the need to be in order ("Everything had to lie flat. The wrinkles in my pants were annoying. I was constantly straightening my ponytail [hair]"). She would turn the volume on and off on the TV many times because she needed to hear the words "00 minutes."

During a trip to Germany, she was "poisoned by tea"; her body temperature increased, vomiting occurred, and she thought that someone put poison in her tea. While on vacation in Turkey, she had a rotavirus infection and had loose stools and low-grade body temperature, experienced severe anxiety and weakness, and was "afraid of being sick." It was in Turkey that she realized she had to cry to relieve tension, at least for a short time, but with her mother.

After recovery, it was difficult for her to attend school; throughout grade 6, she missed school, wanted to sleep, had no appetite, had no strength, had throat ache, often had sore throat and high fever, complained that she felt unwell, "Dad was unhappy because the teacher didn't believe that I was sick, but I studied well with my last strength."

The patient was examined by a cardiologist, neurologist, and endocrinologist; however, no somatic diseases were identified. Aminophenylbutyric acid was prescribed, after which the patient felt better.

From age 12, she became irritable, complained of loss of strength and pain in the projection of the sternum, and switched to home schooling. From that time on, inappropriate behavior appeared in the form of a piercing, loud, prolonged scream at moments when she needed something from her mother. At first, this happened exclusively at night. After the scream, she needed to cry and for her mother to hold her hand. She began to leave the house less often, spent whole days watching TV, expressed complaints about her "serious condition" and "as if her soul was wounded," and openly declared her unwillingness to live.

An even greater deterioration in the condition occurred a year after the graduation party at the music school, "I was constantly upset, everything was bad, I had no strength, I felt fright, fear of death, what would happen if I died, it seemed that I had cancer, what if cancer, appendicitis or problems with the gall bladder."

The patient was first examined by a child psychiatrist at age 13. She complained of poor sleep; an irresistible desire to scream at night, which she herself called "making yelling"; and increased conflict with her family, especially with her mother. At the appointment, she asked the doctor to suggest the best way to commit suicide. For urgent reasons, she was hospitalized in the children's department of a psychiatric hospital, where she stayed with her mother for 3 days. Upon admission, she spoke of the desire to cry loudly. She asked permission to leave the room and scream and cry, "Because I'm bursting here," pointing to the chest area. She was fixed on this desire. During hospitalization, she appeared neat, was fussy, made stereotypical movements with her hands,

coughed, periodically wrung her hands, and raised her eyes upward.

Her mother refused the proposed medications. The girl begged her to be discharged, saying that she was feeling extremely bad, "You can't even imagine how! It's terribly hard here in my soul…Everything is wrong here, I need to go home, why are you torturing me?" Simultaneously, she suddenly raised her voice, broke into a scream, and behaved extremely rude with her mother, which never happened with the staff. "I've been feeling bad for a year now, I don't even know, there's something pressing on my soul here in my chest, and I scream at night because I feel so bad." During the day, she kept her mother close by. During hospitalization, the patient took benzodiazepines and antipsychotics. She was discharged with a diagnosis of psychasthenic neurosis with mixed somatoform (in the form of autonomic nervous system dysfunction) and hypochondriacal symptoms as part of the pathocharacterological development of personality with hysteroidal traits. Then, she visited a psychiatrist on an outpatient basis and took sulpiride and milnacipran.

After discharge, she considered her father a traitor who had put her in a psychiatric hospital and demanded that he leave her and her mother. Her parents decided to take up residency with her mother separately from her father in a rented cottage. Her mental state, despite the move, did not stabilize; hence, her parents decided to have her hospitalize in a private psychiatric clinic.

In the hospital, she screamed for 5 days in a row with an "inhuman voice" because she needed to perform rituals and cry and because her mother was not beside her. She was transferred to a day hospital and was administered risperidone, chlorprothixene, and depakine. She said that she felt very bad and that her thoughts were constantly ordering her to do something. She was repeatedly hospitalized at the same clinic. She received haloperidol, benzodiazepine, and clopixol, which, in her opinion, only led to increased yelling. One month after taking trifluoperazine, terrible aggression began, and the drug was replaced with amisulpride. During the first week, aggression disappeared, and she had the desire to meet with friends and go for walks; however, crying and other rituals did not disappear. She began to enjoy going to school for individual meetings with teachers. During this time, she lived with her mother in a rented cottage, but the neighbors complained about the screams and threatened to evict them through court action.

The deterioration occurred unexpectedly without any external reasons, and one day she had a fight with her mother. According to her mother, "It was like the child had been replaced: endless screams, aggression, she raised her hand against me, said that she was afraid of swallowing pills."

Six months later, she was again hospitalized in a psychiatric hospital, where she stayed for 2 months, for schizophrenia; childhood-type, continuous course, paranoid form, hallucinatory–delusional syndrome with compulsive disorders; and severe emotional–volitional defect. She was referred to the hospital by a local psychiatrist, at whose appointment the patient said that in her head, there were "creatures" that mentally commanded her to do bad things (e.g., hit her grandmother, throw herself in front of a train) and to which she resisted and did not do what they told her to do.

In the admission ward, she screamed at the top of her voice, beat herself on the head with her fists, ran into another room, and called her father and asked him "to save her." She complained to the attending physician about a constant feeling of expansion of an incomprehensible energy in her chest with a desire to scream and make noise, cry, and hit a punching bag or her mother; thoughts that something bad would happen to her if she did not scream or cry; and thoughts that tell her that she needs to do something to herself or to her mother and about the "creatures" threatening her. She presumed that other people's thoughts told her that she had to scream loudly and cry to not "break apart," and then an irresistible desire to scream, fight, and cry occurs. Thoughts suggesting trouble came more often. During hospitalization, the patient received clozapine, haloperidol, chlorpromazine, diphenhydramine (Dimedrol), pipofezine, carbamazepine, and benzodiazepines.

School character reference for Alsou, a grade 9 student. Throughout the entire period of study, she mastered academic subjects well. She was flexible, disciplined, calm, and friendly. However, starting from grade 7, there was deterioration in academic performance in many disciplines. Teachers began to notice rapid fatigue and an inability to concentrate on assigned tasks. Alsou had difficulties mastering

exact sciences; she had problems with mathematics, physics, and chemistry. Regarding humanitarian subjects, she had problems memorizing educational material. Social activity became insufficiently high, and Alsou showed herself to be a good performer and willingly performed assignments but did not occupy a leadership position in class. She became more withdrawn and did not have close friendships with anyone.

Hospitalization 3, with a diagnosis of **schizophrenia, childhood-type, continuous course, and hallucinatory–delusional syndrome**, was conducted by ambulance. The deterioration occurred within a week when, against the maintenance therapy (olanzapine, amisulpride, haloperidol), she became tense, conflicted with her mother, began to scream, beat her mother, experienced disturbed sleep, and felt that incomprehensible forces were tearing her to pieces.

In the department, she complained of poor sleep and a desire to scream, cry, and fight. During the conversation, she would jump up from her seat, start screaming for 5–6 minutes, howl loudly, and jump until the floor shook. She did not yield to persuasion, saying that an incomprehensible force was tearing her apart that she had to scream, cry, and jump. In the department, she said, "I want to cry and scream, but I need my mother for this, I want my mother to be with me." She complained about the feeling in her head of "her own and other people's thoughts," which she perceived as a "voice" but without sound. It was these thoughts that ordered her to make noise, scream, and fight. "Sometimes I want to die, I want to throw myself under a subway train or a car; I'm overwhelmed with energy, it's tearing me apart, and medications don't help me." In the department, she received diazepam, chlorpromazine, diphenhydramine (Dimedrol), haloperidol, trifluoperazine, quetiapine, valproic acid (Depakine Chrono), and clozapine. After discharge, clozapine, trifluoperazine, and clomipramine (Anafranil) were prescribed.

Character reference of Alsou according to her father. Before the acute phase of the illness, the patient was kind and fair in her relationships with her parents, relatives, and friends. After disease onset, especially during the attacks, she behaved extremely defiantly and aggressively. The exceptions were short periods between attacks. In communicating with friends, she was completely normal; she tried to restrain herself with older relatives, realizing that it was uncivil to scream for rasp in their presence. However, as soon as the friends left, she burst into a full screaming, shaking the walls and the five apartments of the neighbors around.

During calm periods, she enjoyed watching music programs, especially "Voice," and dreamed of performing in this competition. She regretted that the teachers at the music school, for objective reasons, did not allow her to develop a solo career. The father especially noted that Alsou's sense of humor was absolutely adequate.

Over time, Alsou has had many rituals. The ritual of saying goodbye to her mother was and remains especially frequent, even when she simply went to the store for a few minutes. It was necessary to say "bye" several times, with different voice volumes, synchronously, etc. Sometimes she fantasized, imagined herself as a dog, and asked to communicate with her accordingly. The reason for the onset of the "yell" was often the fact that she ("Doggie") was scolded by the owner for the fact that it chewed her slippers or, in a particularly bad mood, its (Doggie's) ears were cut off. This provided basis for the onset of her attack. From time to time, a habituation effect occurs. There was no longer such a feeling of "resentment," and she fantasized about new "weeping" images and situations.

She behaved normally with teachers and strangers in accordance with her age and situation. In the months preceding her last visit to psychiatrists for advice, Alsou had attacks of aggression toward her family, mainly her mother, approximately every 2 hours. She sought a reason (or even without a reason) to humiliate her mother, tyrannized over her, yelled, broke furniture, and, thus getting worked up, reached an emotional peak. If at that moment somebody began to educate her and point out the inadmissibility of such an attitude toward her family, Alsou could set upon the offender with blows. Warnings about the possible legal consequences of attacking her mother made her even more aggressive.

After reaching an emotional peak (having ensured that her humiliation was "swallowed"), she began to sob, asked to feel sorry for her at this time, and felt relieved for a while. She understood regretting as forgiving the insults she had just caused.

Alsou refuses to do anything around the house or take care of herself. Her mother acts as her constant servant. She looks for any reason to start a conflict, such as a need for moral sadism, but only in relation to a family member because she knows that no one else can tolerate this and will fight back. Because attacks of aggression occur almost every 2–3 hours while awake, her father assumed that she lacks some hormones, and in this way she injects adrenaline into her blood or "burns" it in this way.

They sought medical advice from a doctor who is both a psychiatrist and an endocrinologist; however, she did not observe hormonal abnormalities in Alsou and said that she did not notice schizophrenia in her but discovered **bipolar affective disorder**. Thus, mood stabilizers and antipsychotics (lamotrigine, quetiapine, sertindole) were prescribed. With the new treatment regimen, aggression attacks became less pronounced. Alsou is a creative person who composes music and poetry, records her own songs in a studio, and studies well at a music college.

At the very onset of the disease, relatives turned to alternative medicine methods, namely, "pulling out the essence." Alsou liked a female kinesiologist who "released stress through points." Alsou sympathized with her, felt not alone, and conceived an affection for her, even hugged her, saying that she would like to get into her (she explained her phrase by saying that she felt comfortable with her that she wanted to be completely inside her). However, the kinesiologist's behavior somehow changed dramatically; she stopped answering telephone calls and refused further sessions. It turned out that this woman's dog died, and she was grieving because of this, but Alsou believed that it was her essence, which settled in the kinesiologist that killed the healthy animal.

Subsequently, her mental state deteriorated again. Alsou was in a fog, she behaved strangely, she screamed in the school yard, she did not understand anything, and her brain shut off. Later, they tried other methods of alternative medicine—visited old ladies who cast spells. Supporters of alternative medicine said that her adrenal glands were not functioning properly. She began to think that her behavior was related to the metabolism of adrenaline and read special literature and decided that she needed α-blockers. She came to the medical center with exactly this request to prescribe the appropriate medication. She stopped aripiprazole on her own and did not visit the local psychiatrist, and the treatment regimen was not changed for a long time.

At 18 years old, Alsou was *consulted in Geneva* by Dr. Ardamondo. During the examination, marfanoid signs and extrapyramidal symptoms (akathisia, muscle rigidity, difficulty swallowing, tremor) were noted, the cause of which apparently was a high dose of antipsychotic drugs.

Alsou looks younger than her age and is neat. During a conversation, she behaves with restraint, is aloof, and weakly maintains contact with the interlocutor. The ability to be oriented in space and time was preserved, but increased distractibility was noted. During the conversation, she demonstrated ritualistic impulsive behavior and repeatedly reported a desire to scream, which she associates with obsessions ("Something bad could happen if I don't scream"), but restrained herself. General psychomotor slowing and reduced motor activity were observed. Gestures and gait were slow. Facial expressions were poorly expressed. Speech was relatively disorganized. She often got confused about the topic of the conversation, demonstrated the deficiency of associations, and lost the course of the conversation. In general, speech retardation and thinking deficiency were recorded (confirmed by the translator).

Alsou denies the presence of delusional ideas and changes in the perception of reality. Emotional inadequacy and a tendency toward emotional indifference were noted. This tendency decreases in the presence of her mother when Alsou's mood becomes dysphoric, especially against frustration. No symptoms of depression or suicidal tendencies were identified. Awareness of the disease was limited. **OCD with problems of consciousness (F42) accompanied by schizophreniform disorder without signs of a good prognosis in remission (F 20.81)** was diagnosed.

There was significant weakness at the cognitive level, requiring a full cognitive assessment in her native language (without an interpreter). The complexity of the clinical presentation is associated with many somatic components, which gives reason to suspect probable genetic or metabolic disorders.

The need for consultation with a geneticist, gynecologist, neurologist, and endocrinologist was discussed with the patient's mother, as well as the

need for hospitalization to gradually wean off current medications and administer aripiprazole. After assessing effectiveness, a second drug (selective serotonin reuptake inhibitor or mood stabilizer) can be added. Alsou can be hospitalized in Russia or Switzerland (at the request of the parents). Cognitive behavioral therapy of Alsou and psychoeducation of parents were recommended. A treatment regimen with aripiprazole, levomepromazine, and biperiden was selected. Alsou canceled the proposed scheme on her own, citing problems with swallowing pills ("I stopped swallowing, I needed someone to squeeze my hand").

Upon arrival in Russia, **the disability second group and then the first group for mental illness were registered for Alsou for an unlimited term.**

Despite the independent withdrawal of drugs, Alsou's mental state improved significantly, and she was able to graduate from school (mediocre) and enter a music college. She obtained excellent marks in the solo folk singing department. In college, she became friends with one of the students who helped her in situations when she was very hungry but could not eat because of problems with swallowing. At this time, her friend took her hand, and she managed to do it. She started attending group yoga classes. Her relatives noted that she behaved correctly in the presence of strangers. "No one believes us that she was sick." During the same period, Alsou **began to suggest the need to cancel the diagnosis**.

Somatic anamnesis. No history of allergies to medications was noted. The patient denied having had tuberculosis, infection with the human immunodeficiency virus, hepatitis, skin and sexually transmitted diseases, and traumatic brain injuries. She denied having undergone surgeries, blood transfusions, sleepwalking, sleep talking, and convulsions. Past diseases included urinary tract infection, dyspepsia, myocardial dystrophy, sinus tachycardia, mild anemia, sex infantilism, and delayed sexual development. Menstruation started at the age of 17, lasts for 7 days, and is painful and regular. She is not sexually active. The patient denies the use of alcohol or psychoactive substances.

Neurologist. No focal neurological pathology was observed. *Electroencephalography* showed mild changes in the bioelectrical activity of the brain, namely, disorganization of the basic rhythm. There were no regional changes. When conducting functional tests, short bursts of polymorphic activity without epileptoid changes were observed. No epileptiform activity was recorded at the time of recording.

Mental status. The patient is neat, she takes care of her appearance, her hair is neatly gathered in a ponytail and straightens it in conversation, and her nails are neatly trimmed. When discussing topics that are emotionally significant to her, she gesticulates abundantly, fidgets in her chair, and interrupts the doctor. She is smiling and polite, with sufficient eye contact.

She is fixated on the manifestations of her illness, especially on the rituals that she is forced to perform with her mother. Nonetheless, she believes that rituals are associated with the activity of the adrenal glands, although she does not insist on this. She is critical of rituals (screaming and some others) and understands that these are signs of mental pathology. She notes the cyclical nature of changes in state ("Screaming, tears, sobs, then I calm down"; "I don't behave like that at school, I control the screams, I can rarely run out of the class, ask for time off"; "It seems to me that something is being developed, accumulated, adrenaline causes screams, tears"; "It used to be as if someone was ordering me, something was sitting in my head, for example, throwing myself under the subway, I felt a urge to do something").

The patient systematizes the existing *rituals*.

– A ritual in which you need to wash your face three times, since this reflects a certain washing pattern (if you have not done something, it will not be good).

– A ritual associated with the swallowing process, when it is required to hold the mom's or dad's hand to swallow food while pressing on the hand in a strictly defined manner. It requires clapping, turning your back, and saying, "Alla," and then the mother has to stand up. Sometimes the ritual would change: "When I eat, my mother should wish me a bon appetit (in a certain way), then I should sit up straight, hold my hands in front of me and start saying 'holy.' My mother should answer 'Cow!' as quickly as possible."

– The ritual is to pronounce a "swear word," to which the mother must answer.

– The ritual of combing hair in the evening before going to bed is when it is required first to throw out

the comb, lie down in the middle of the bed, and ask the mother, “Straight?” She must answer to this, “Straight.” Then, it is required to say, “Let’s start,” and the mother answers, “Let’s start,” and must cover Alsou with a blanket and check with her hand whether the blanket lies evenly and in the middle. Then the mother must bend the blanket in a special way (corner to corner). There are days when they have to perform this ritual three times and redo it if something does not correspond to the established plan.

– The “Doggie” ritual is done when Alsou asks to call her “Doggie.” She feels very sorry for herself, and she demands to take pity of her. Her mother must fulfill all the requirements of the “game.” Sometimes “fantasies” arise in which Doggie is put down and beaten, and the tears do not come without hysteria.”

– The ritual of a fight with the father after they drive up each other to the flaming is when he says, “Why are you tyrannizing over your mom?” Alsou becomes furious and then wails and starts a fight with her father.

– The ritual associated with clothing is when it is required to stay at home only in a T-shirt without panties and lie on the sofa naked in a blanket, as clothes are annoying.

– The “Bon appetit” ritual 3–4 times a day, before each meal) is wherein it is required to tell her mother, “Sit down! Sit down!” (the mother does not move, freezes), and then Alsou must sit on a chair nearby, straighten her clothes (so that everything is smooth, does not infuriate), and raise her “paws like a dog” (the mother is allowed to move). Then, Alsou begins to conduct and the mother must immediately say, “Bon appetit,” and then “Very, very, very... bon appetit-tit-tit...” (to fade out). After, the mother must hold her hand without asking any questions and then say, “Well done, comrade Doggie, smart girl!” To this, Alsou must make faces, showing the pitch of the sound. If her mother suddenly does something wrong, Alsou has to beat her with a whip, which always lies nearby at the ready.

When asked if she really considers herself a “Doggie,” Alsou replies with a grin and would say that she is not and that she just plays this game. Her mother must completely obey her and fulfill all requirements. “I save myself by swearing at my mother, but I am lost without her, fatigue causes aggression, then I cry, she needs me to feel better, she takes it easy.” “My obsession is that I take a rag, pants, and if something goes wrong, it deviates from the ritual, I spank my mother, and I feel better; if I resist this, it gets worse; the disease is stronger than me; I grab her, throw her on the sofa, I wait for what will happen next, my fate, when my mother dies or stops tolerating.” “I do not control these states; rituals arise against my will, ritual is life.” “There is nothing to compare them with; these are tears, sobbing sounds, emotions, everything comes out, I have a physical need, then relief, a sigh, I lie down for 15 minutes, and everything is normal, I don’t care, anxious thoughts are carried away, I lose strength, but not for long.”

“I am now completely sure that OCD needs to be eliminated that it is progressing greatly, my whole life is a continuous ritual, I can’t use the phone now, it leaves all sorts of crap in my brain, I type SMS on the phone, and keep my finger on the ‘send,’ on the new phone it’s stronger, I come home, I ask my mother to hide the phone, I leave, I ask for an SMS about what I can’t write to the teacher, with thoughts that I won’t do this, my heart is pounding, my hands are sweating. The most important thing about using a phone is that everything needs to be done correctly with it. Ritual with a laptop is that if I press the wrong button, I have to do everything again; if I did it right, I immediately forgot everything, if I think I did it wrong.”

She describes in detail the times when painful sensations appear for no reason—the cycle of rage–anger–aggression, but always in different ways. The painful sensations themselves are accompanied by a feeling of melancholy and thoughts about the future and the past, and she urgently needs to throw out emotions: “Feelings are primary here” and “Thoughts are eating me up, even to the point of suicidal thoughts; this has been accumulating for many years, in the evening it accumulates, in the evening, I feel extremely bad.”

Criticism of her behavior toward her mother is ambivalent; she is convinced that her mother should strictly fulfill her demands, but at the same time, she understands that she is tormenting her mother and is afraid of losing her. Further, she becomes excited when talking about her hobbies. Particularly, she gladly allowed to play a studio recording of her musical composition and gratefully accepted compliments.

She is oriented correctly in place, time, and personality. Her thinking is at a normal pace, without

signs of disturbance. She did not experience delusions or perceptive deceptions and has no suicidal thoughts.

Psychologist's report. During conversations and when performing test tasks, the patient enters communication and working interaction at a sufficient level. During the initial meeting, she at first appeared wary, not knowing what a meeting with a psychologist could lead to, and she was constrained. Subsequently, she readily responded to the interlocutor's interest in clarifying the actual state of affairs; when answering questions, she preferred a direct answer, and if she found it difficult, she tried to find a more accurate description. She spoke about something proactively and commented on something.

At the beginning of the meetings and in some situations after warming up, she emphasized her anxious and tense attitude toward testing or individual tasks, directly linking it with the fear of disappointment due to possible failures in her efforts to be successful. In general, she was correct in her behavior and quite consistently followed generally accepted socially approved norms. In one of the situations, when commenting on some forms of her reactions in behavior, intonation, and facial expressions, she said that she felt comfortable when she was treated like a child. When asked about the reasons for such an assessment, she answered kindly and simply, "It is convenient." During long-term functional loads, she was generally patient and relatively enduring; when reporting fatigue, she, if necessary, raised up resources to complete a new task.

In interpersonal relationships during testing, she was mostly friendly. In communicative facial expressions, a low-amplitude background of mobile minor facial expressions with microfacial expressions prevailed, which always remained mobile, corresponding to interaction and emotional and personal responses to the situation that arose or to one's intentions, motives, claims, expectations, and associated assessments. She understood and assimilated instructions for test tasks at a normal level, and maintained a sufficient level with rare episodes of slight instability and elements of practical simplification. These phenomena were probably associated with a slight unevenness in the level and direction of her activity (e.g., with the fear of failure, she became more tense and somewhat inhibited, and in attempts to overcome these changes and distraction, she became more energetic and harsh until the short "finish" explosiveness). She worked at a rather fast pace.

Attention. Generally, she performed simple psychometric tests at a sufficient level with the phenomena of instability of voluntary concentration and switching (Schulte 32"—41"—55"—33"—48"). She performed the Munsterberg test at a sufficient level. However, the style of her activity was remarkable. To succeed, at the end of one of the Schulte test tables, she acted overly excited, loud, abrupt, and with intense effort in her hand movements and voice (after emotional support, there were no more such outbursts in testing). In the Munsterberg test, preferring to work quickly, she found the correct words somewhat superficially, and having reached the end of the letter rows, she immediately looked more closely at the material in the opposite direction, finding many words previously missed.

In working on the "Black–Red Table" test, during the period of interference of rows, she became noticeably more tense; however, with a strong-willed effort, she maintained the established order of switching, and a little later, she was distracted by doubts about the correctness of her actions, made a mistake, and turned to a psychologist for feedback and comments, and having switched attention to other activities, she was faced with the need for a new warming up, which practically stopped the dynamics of standard work with the test.

Memory. Direct memorization is at the normal level with phenomena of instability of the level of reproduction (5—8—7—10 words out of 10). Memorizing a sequence of six words was at a borderline level, and memorizing words and syllables of trigrams without interference was sufficient. Against the homogeneous interference, she reproduced the words at a borderline level, and syllables were reproduced with the loss of the stimulus material of the task when its volume increased to three syllables.

Operational memorization of the digital series of the Wechsler test in direct reproduction was at the normal level, whereas in reverse reproduction, it was reduced (both tasks with five figures were reproduced with omissions and substitutions).

Visual retention in the Benton test was sufficient. Indirect memorization was at the borderline level.

Thinking. The ability to compare, search for analogies, generalize, mediate, and understand the

socially significant context of test situations was generally sufficient. These were used mainly with sufficient spontaneity, relatively ordinary emotional and personal involvement, and correct motivation for cognitive activity, but at the same time, with episodes of borderline and slight unevenness in the level of productivity, focus, and preference for signs of a culturally common semantic core. It is significant that the frequency and influence of these effects were only partially associated with cognitive uncertainty, since they were almost not noted when good work was combined with a favorable affective–motional background of activities and relationships and with sufficient spontaneity of the individual in understanding her position and mature implementation.

In performing the "Pictograms" test, comments on the created images mainly reflected emotional and personal interpretations of the stimulus topics. In the graphic style of the drawings, manifestations of rough subjective-rigid, formal, or subjective-amorphous influences were irrelevant, whereas cultural, age-related, and personal influences were often noted as background. In the graphic style of working with the Benton test (where she had to draw complexes of figures), the influence of the individual was aimed at achieving the desired quality with the use of some systematization and elements of pedantry.

In the "Third is odd out" test, while correctly naming all the depicted objects, she grouped them only by shape. In the constructive praxis test, she searched for solutions to spatially complex problems, including by "mechanically" enumerating options for the position of elements. The combination of slight inertia (organoid type) in guessing about a solution method with claims of high success with the apparent simplicity of tasks occasionally provoked fussiness with a slight anxious tension.

In performing individual proposed tasks of the tests "Discrimination of the properties of concepts" and "Fourth is odd out" (verbal and nonverbal versions), she relied primarily on significant culturally common, private, practical, and emotionally and personally selected characteristics. The actualization of weak and random signs arose sporadically (e.g., which occurs in borderline states), and in response to additional stimulation, it was mostly overcome with access to correct judgments.

Personality. In the shortened "Mini-Mult" test, the structure of the valid profile, scales 6, 4, and 7, clearly dominated at the borderline level (75T, 71T, and 66T, respectively), reflecting the difficulties of spontaneous discharge of accumulated affects against the conflict between the desire for free and decisive unhindered self-realization and psychasthenic tendency to consider everything and double-check, calculate comprehensively, and weigh all the pros and cons to be confident in the correctness of her decision and to feel right in her actions (scores on the obsessiveness and compulsiveness scales were markedly high).

The fundamental difficulties of reconciling obsessively forced and spontaneous tendencies exacerbated her sensitivity to criticism and led to a feeling of exhaustion from the excited tension and intolerance toward any additional demands. The test data showed, in difficult situations, an excessive tendency to inhibit her behavior in response to the risk of punishment or deprivation of the expected reward. This made her avoid even favorable opportunities and contacts that were objectively available to her, preferring a subjective search for compensation for her suffering from the anxiety she was experiencing (while her personal readiness to engage in the struggle persisted at a sufficient level).

After 3 months, Alsou became noticeably more free and confident to be interested in her personality and her impressions, motives, relationships, and judgments; this was reflected in the MMPI[1] test profile with a borderline increase in scale 8 score (72T) and with lower scores in scales 6 and 7 (64T and 63T) and almost the same scale 3 rating (61T). This "legalization" of her individuality and the relevance of her own world allowed her to do so without dissimulative distortions of her condition and revealed quite clearly the actual complexities of both the inner world and real interpersonal relationships and social adaptation.

In the absence of external support and assistance (mainly psychotherapeutic), these completely natural and living interests of her in difficult circumstances may again be replaced by an increased but unproductive focus on herself and her problems,

[1] MMPI: Minnesota Multiphasic Personality Inventory.

creating subjective adaptation difficulties. Acquiring more diverse and deeper healthy personal experience can become crucial for preserving her greater well-being under various options for further development.

Thus, the presented clinical case, which reflected an 8-year medical history, including repeated hospitalizations in a psychiatric hospital, disability, spontaneous fluctuations in mental state, and alternating periods of pronounced social maladaptation with periods of successful study and self- actualization as a creative person, should be considered diagnostically ambiguous.

During psychiatric observation, Alsou was given various mutually exclusive diagnoses of both neurotic and psychotic levels, from somatoform, hypochondriacal disorder, and OCD to schizophrenia-like, bipolar affective disorder and paranoid schizophrenia with an emotional–volitional defect.

The dynamics of her condition were not and are not progressive in nature, and it can be argued that the psychopathological presentation of her disorder has not undergone significant changes over the years of observation and therapy. Some symptoms appeared and disappeared, particularly the clinical signs of "voices," which were always accompanied by criticism and were considered by Alsou to be part of the "rituals" that tormented her. Other symptoms were somatoform, such as vegetative phenomena in response to stressful situations, which arose exclusively at disease onset and subsequently stopped.

Psychopathological symptoms that have determined the clinical presentation for several years should be recognized as gross behavioral disorders manifested by attacks of unmotivated, heart-rending, "inhuman" screaming and rigid (fixed) forms of interaction with relatives, which the patient herself calls "rituals." Moreover, Alsou and her father believed that the observed attacks and actions aimed at humiliating the mother were based on physiological reasons, particularly hormonal dysfunction.

According to an analysis of the clinical presentation of her condition, Alsou did not show any signs of schizophrenic spectrum disorders. Neither psychopathological nor experimental psychological examination revealed symptoms and signs of thought disorders, apathetic–abulic symptoms, cognitive dysfunction, and emotional regression typical of schizophrenia.

Theoretically, one could regard unmotivated bouts of screaming and corresponding foolish behavior as hebephrenic; however, this behavior was not characterized by uncontrollability or involuntary behavior. The patient "demonstrated" similar behavior in strictly defined situations and circumstances. This behavior was always addressed to loved ones, most often to her mother. In the clinical presentation of Alsou's disease, no clinical signs met the diagnostic criteria for bipolar affective disorder. Therefore, the diagnoses of endogenous mental disorders were rejected, although Alsou is a first-degree disabled patient with schizophrenia.

The most difficult clinical phenomenon to qualify is a set of behavioral stereotypes, which the patient herself calls "rituals" within the framework of OCD. Analysis of this phenomenon in the presented clinical case shows that some rituals can be classified as obsessive–compulsive, whereas others should be interpreted differently.

OCD should include not only and not so much a statement of the presence of obsessive thoughts and actions but also strictly defined clinical manifestations, which are considered mandatory diagnostic criteria for OCD. These include the fact that in OCD, the individual must try to resist obsessions ("struggle of motives") that the implementation of compulsive acts and obsessive thoughts themselves should not cause pleasant sensations, and that obsessions or compulsion should lead to distress or interfere with the patient's social or individual activity.

If we compare the diagnostic criteria for OCD with the clinical presentation of Alsou's disease, we can conclude that the patient did not have the desire to resist obsessions. In contrast, with almost sadistic pleasure, she strived to perform certain forms of behavior, choreographed to subtleties, and demanded this from those around her. The "ritual" was not aimed at relieving anxiety; it was self-sufficient and focused on achieving other goals, primarily selfish ones. The patient stated that she could not help but perform "rituals," such as not screaming, but in reality, she did not scream or perform "rituals" in situations that she regarded as inappropriate.

Conventionally, rituals associated with swallowing, washing her face, and pronouncing swear words could be classified as obsessive–compulsive. However, Alsou never (as happens

with OCD) reported that these rituals were based on fear, for example that of choking (in the case of swallowing), getting infected with something (in cases of washing), and punishment for "blasphemy" (when uttering swear words). The remaining "rituals," which were performed not by the patient herself but by her relatives, usually by her mother, did not carry any signs of anxiety, fear, or any other pathological emotional state in their psychopathological basis. Their implementation gave Alsou pleasure. That is, she did not perform any rituals herself, but forced her mother to do it.

At the base of the "rituals" (games) developed and implemented in life, for example, with Doggie or wishing her bon appetit, there are no obsessions, compulsions, and phobias, that is, no anancasms.

Particular attention should be paid to the system of punishments developed by Alsou for failure by the mother to follow the established procedure. In case the mother does something wrong, a whip was prepared, and such punishments were not isolated. Additionally, a phenomenon that cannot be explained by obsessive–compulsive mechanisms should be recognized as attacks of heart-rending, uncorrectable screaming aimed (according to the patient) at relieving an unbearably hard emotional condition.

Notably, the parents (primarily the mother) came to terms with their fate and were convinced that all this needed to be done, since it was not Alsou who required this, but her illness. However, this clinical phenomenon also had its own characteristics ("I want to cry and scream, but for this I need my mother, I want my mother to be with me"). There is no reason to recognize this phenomenon as either impulsive, since it was controlled by the patient and did not manifest itself outside of certain situations, or compulsive.

From our viewpoint, the features of Alsou's pathological behavior and destructive reactions correspond to the phenomenon that we call "reverse OCD." Its essence was the patient's desire to benefit from her rituals and create conditions under which everyone around her would fulfill her whims. That is, the dominance of a dissociative radical in Alsou's personality can be stated, as confirmed by psychological research. Thus, we come to the diagnostic conclusion that in the case of Alsou, we are dealing with severe histrionic personality disorder combined with obsessive–compulsive symptoms (F60.4).

Recent studies show considerable evidence of the high comorbidity of dissociative disorders and OCD [1–8]. Belli et al. [1] revealed that OCD is combined with dissociative depersonalization. In the case of Alsou, the presence of elements of dissociative depersonalization can be assumed, particularly in the description of a feeling of expansion of an incomprehensible energy in her chest, which led her to the idea of the need to scream, cry, and hit a punching bag or her mother. From the same perspective, it is permissible to interpret Alsou's statements about the presence of periods in her life of her own and other people's thoughts, which she interpreted as a "voice," but without sounding with full criticism. Playing "Doggie" could be considered a form of pathological dissociative fantasy and manipulation of others.

It can be assumed that the patient alienated part of her mental functions and attributed them to external forces. A systematic review and meta-analysis on the relationship between dissociative disorders and OCD [2] showed that the frequency of comorbidity of these types of pathology was 17%–32%. Another study [4] noted the role of dissociative experiences in the development of OCD.

A study based on an analysis of 60 clinical cases concluded that perfectionism (tendency to obsessiveness) in patients with OCD may be associated with a higher tendency to "preoccupation with imaginary events" of their lives [9]. This enables us to take a look at the problem of reflection of OCD patients in relation to their own anancastic symptoms.

Another study showed that OCD is a debilitating mental condition in which patients become obsessed with possible harm, error, and bad luck and compulsively lead to repetition of mental and behavioral rituals to neutralize these possibilities [10]. This tendency to make predictions based on unlikely rather than more likely possibilities is called "inference confusion" and can lead to immersion in possible worlds, accompanied by a sense of dissociation between knowing and doing and imagination and reality and between the authentic and inauthentic self. These experiences of OCD dissociation may indicate that experiences such as derealization and depersonalization that occur in OCD should be interpreted as dissociative.

Thus, the clinical case of a mental disorder of 21-year-old Alsou represents a rare case of severe

histrionic personality disorder with dissociative depersonalization manifested by “reverse OCD,” which led to an erroneous diagnosis of schizophrenia and the determination of the patient’s disability.

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