MATHEWS

Case Report

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Mirror, Mirror on the Wall–A Case Report of Negative Autoscopy

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ABSTRACT

Autoscopic phenomena are considered as a psychic illusory visual experience consisting of the perception of the image of one's own body or face within space, this can be either internal or from an external point of view. Previous descriptions were based on phenomenological criteria to distinguish six types of autoscopic experiences such as autoscopic hallucination, he-autoscopy or heautoscopic proper, feeling of a presence, out of body experience, negative and inner forms of autoscopy. We report a patient who presented with negative autoscopy in the context of generalised anxiety disorder and major depression with comorbid post traumatic symptoms and psychosis, which did not respond well to treatment.

Keywords: Negative Autoscopy, Forensic, Anxiety, Trauma, Psychosis.

INTRODUCTION

Autoscopy describes visual experiences where the person perceives an image of their body or face in external space, viewed from within their own physical body [1]. Brugger described six types of autoscopy based on phenomenology [2]. Those types include autoscopic hallucination (parts of the double are seen in exact mirror image), heautoscopy (multimodal illusory reduplication of one's own body and self), feeling of presence (illusory experience of one's double at the fringe of vision), out of body experience (an experience of separation from one's own body and seeing it from elevated perspective), inner autoscopy (seeing inner organs of one's own body in the extra corporal space) and negative autoscopy. The last phenomenon, the subject of this report, refers to the failure to perceive one's own body or parts of it either in a mirror or when looked at directly [1]. Negative autoscopy is considered to be a rare form of autoscopy mostly seen in individuals with epilepsy [3,4]. Scientific literatures on negative autoscopy have been written by French, German and Italian authors between 1903 and 1967 [5-8]. Negative autoscopy is described as a transient inability to perceive one's visual body or reflection which is distinct from autotopagnosia, an inability to recognise or localise a part of one's own body occurring in left parietal damage or auto-prosopagnosia, an inability to recognise one's own face occurring in

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dementia, schizophrenia and port-traumatic stress disorder [9]. It is reported that negative autoscopy is often associated with depersonalisation, aschematia and other forms of autoscopy [2]. This can also affect only one side of the body [2].

METHODS

A written consent was taken from the patient for publishing the case study. Ethical approval was not required but every care was taken to ensure to protect life, health, dignity, integrity, right to self-determination, privacy, and confidentiality of personal information of research subject as per the Declaration of Helsinki Statement, permissions were taken from Justice Health for approval for publication.

CASE HISTORY

The patient was a 40-year-old single male who had been living with his parents and younger brother prior to coming into prison. He was on a disability support pension at the time. After being remanded to prison, he underwent a psychiatric assessment during the intake process, a referral was made to the consultant psychiatrist for intense episodes of anxiety.

When interviewed by the psychiatrist in prison, he presented with anxiety at most times which was pronounced in social situations. He complained of shortness of breath, chest tightness, cramping, and dry mouth associated with episodes of anxiety. He reported poor concentration and initial and middle insomnia complicated with nightmares. He described the sleep issues as longstanding but said the nightmares had intensified after his offending, and that the themes had been more violent and related to his index offence. He had been avoiding other people and isolating himself in the cell whenever possible. He did not report avoiding enclosed spaces.

Prior to coming into prison, he reported that he was using large quantities of alcohol (up to 20 cans of beer) and one joint of cannabis daily to cope with anxiety and to help with sleep. He denied the use of other drugs. He reported feeling low in his mood but denied significant disturbances in energy, motivation, and enjoyment. He denied any thoughts of self-harm. He reported guilt about what he was charged with but did not want to talk about it. He did not report persecutory thoughts or hearing voices initially, but at later interviews he reported hearing voices, or having loud thoughts in his head, and believing that other prisoners were talking about him. He described having command hallucinations which sometimes tell him to "do bad things" but said that he just tries to ignore them. He said that the voices tend to tell him to do bad things only to people who display anger towards him. He provided the example of a co-prisoner who was antagonistic and "a bully" to him and others. He was prescribed medication for his anxiety and was referred to the psychologist in prison. The main aim was to offer supportive therapy for his anxiety and for exploration of issues with a focus on grounding and mindfulness skills.

PHENOMENOLOGY

The patient reported that he cannot see his own reflection in a mirror. He just sees a shadow where his reflection should be and is therefore unable to do some tasks, such as shaving. He has been experiencing this since he was 20 years old. He reported that this is a continuous phenomenon and stated this is the reason he grows a beard. He does not comb his hair by looking in the mirror as he cannot see himself properly. He said he is always anxious when he looks into the mirror and does not know why this happens to him. He said that he is clearly able to see others' reflections in the mirror but not his own face. He also said that when he holds his hand up in front of him, sometimes he can see it clearly and sometimes it is blurry. Additionally, he described a heightened sense of smell, stating that he can strongly taste things he smells-e.g. when he smells roses he can also taste them. He does not have any out of body experiences. He said that he feels unable to gauge his grip and has to concentrate and check his grip when getting up to his bunk because his hand has slipped a few times. He prefers not to shake hands because he cannot tell how hard he is gripping.

He has never experienced any seizures but has fainted several times due to extreme anxiety when in crowds. He has not had any significant trauma to his head. He also reported seeing a black spot which is round in shape. This spot is about 10cm wide and moves when he moves his eyes and follows him when he looks any direction. This does not change when he closes both eyes alternately. He said it changes colour to blue at random times and that this is not under his control. He said that the spot is not constant, and he has no control over when it appears. He stated that he also sees floaters which move slowly when he moves and seems to settle down when he stops moving his eyes to the bottom (floaters can be a normal phenomenon). He denied any visual problems and said his vision is quite clear for both near and far vision. He has never needed glasses. He reported that he was supposed to have a neuropsychology assessment for his court case although this has not yet happened. He denied ever undergoing a CT, MRI scan or EEG in the past

but consented to having his eyes tested and to undergoing a scan or an EEG.

PSYCHIATRIC HISTORY

The patient reported that he was referred by his General Practitioner to the outpatient clinic of the local Area Mental Health Service in 2015, where he was seen by a psychiatrist. He was diagnosed with agoraphobia, panic disorder, and severe social anxiety and was treated with sertraline and amitriptyline to which his symptoms did not respond. He was also referred to a private psychologist in 2017. Treatment involved graded exposure therapy and relaxation training, which positively impacted his anxiety symptoms. He ceased going to therapy when the psychologist moved to a different practice. He also ceased seeing his psychiatrist due to having to use a lift at the clinic and the number of other patients also attending. He continued to take medication from his General Practitioner. He did not report ever attempting self-harm or suicide. He said he started to hear voices in high school, sometimes telling him to do things. He also said that he sometimes sees things that are not actually there. He seemed quite embarrassed about this and talking about it made him feel a bit down.

MEDICAL HISTORY

He described suffering a head injury at about 6 years of age where he lost consciousness. He said he would lose consciousness when in public due to his high levels of anxiety. He was not aware of any issues with his thyroid.

Drug and alcohol history

He commenced using alcohol and cannabis in his 20s and has used this to regulate his anxiety. He reports consumption of alcohol in large amounts but less of cannabis. He reported feeling less anxious and relaxed when using.

Family history

He said his mother and his maternal grandmother have suffered from anxiety.

Developmental and personal history

He said he was anxious as a child and hesitated to mingle with any others except for his family and relatives. He used to hide in his room when someone new entered his house. He said as an adult he could not do this any longer hence suffered immense anxiety. He reported hearing voices from the age of 9 or 10 years. He used to think this was normal and talked to the voices. His brothers observed him and used to ask whom he was talking to. He said he did not do well in school, requiring assistance from others, and that he can hardly read or writes. He was given assistance from a special teacher, who taught him separately in English, history, and maths. He said he struggled to concentrate or sit still so he was given tasks like building things with parts. This kept him busy in another room away from the rest of the class. He reported being bullied at school as he was an easy target. Other children used to call him a "wog". He managed to go to Year 12 but could not finish as he was too stressed and not able to cope with the work.

He discontinued school and commenced work as a panel beater, where he worked for four years before quitting due to being bullied at work. Following this, he became confined to his home and could not leave. He had limited social contact but was introduced to a friend who was very supportive of him. His friend used to pick him up from home every day to pack fruit which he did effectively sitting in a corner. His friend also took him out fishing and used to nag him to get out and do things. He said he never engaged in drug use with his friend. After 6 years his friend died of terminal stomach cancer within a month of receiving a diagnosis. This had a devastating impact on him-he could no longer work and was depressed during this time. He said he visited his friend's funeral but could not attend as there were too many people. He said he does not feel guilty as his friend would understand if he was alive. The friend's girlfriend continues to support him to the present time. When asked if he has death wishes, he denied this but said it would be good to catch up with his friend. He always thinks of him as being on a long vacation but not dead.

He said his symptoms have worsened over the past 10 years. He reported losing his temper growing up but does not like to hurt people. He said he has no memory of his index offence and that his parents have told him what he has done. This is his first time in prison, and he has not been in trouble with the law before being remanded.

Ongoing management

He had 11 sessions with a psychologist when at the remand prison and ongoing engagement with a psychologist when at the rehabilitation unit in prison. Along with this, he was commenced on antidepressant venlafaxine and mirtazapine for his anxiety, as well as olanzapine for his psychotic symptoms. Although with these interventions there has been some response to his anxiety, enabling him to work in the prison, there has not been any shift in his negative autoscopic experiences. During the course of pharmacotherapy, he experienced single-sided foot swelling of unknown aetiology and mirtazapine was discontinued

as a result. However, the patient's anxiety worsened, and he requested that he be put back on mirtazapine after the foot swelling subsided. There was no further swelling of the foot reported after recommencing mirtazapine. He was transferred to a psychosocial rehabilitation unit due to his mental health needs. He was also considered vulnerable to exploitation by other mainstream prisoners whilst he was housed in an open unit. He was commenced on Prazosin for the exacerbation of his nightmares. It was thought that the index offence had triggered posttraumatic stress symptoms. He reported that nursing staff and other prisoners on the unit were helpful, and he that he had commenced working as a laundry billet on the unit. Neurological examination and an EEG were within the normal range.

DISCUSSIONS

There are several kinds of literature that try to explain phenomena associated with mirrors. In our case study, the patient experiences negative heautoscopy refers to the failure to perceive one's own body either in a mirror or when looked at directly. Here this phenomenon seems to be consistent and continues and has been ongoing for years. However, it is noted that autoscopic hallucinations last only a few minutes or seconds and are often followed by flash-like reoccurrences. This was noted in French psychiatry literature in the 19th and 20th centuries that, the typical autoscopic hallucination was also labelled as "mirror hallucination" [8,10-13]. Furthermore, autoscopic hallucination lasts only a few minutes or seconds and are often followed by flash-like reoccurrences.

These experiences do not fit into the negative hallucinations that are characterized by a defect in the perception of an object or a person, or a denial of the existence of their perception. Negative hallucinations create blank spaces, due to both an impossible representation and incapability of investment in reality. They have a close relationship with Cotard's syndrome, a delusional theme of organ denial observed in melancholic syndromes in the elderly [11].

This can be a form of eisoptrophobia (Fear of Mirrors) specific phobia as part of his phobias or personality as self-awareness cues may be particularly salient to BPD patients due to their negative and shame-prone self-concept [14-18].

Yet another idea is in the context of psychological projection, can the person develop such guilt towards self from early sexual trauma by experiencing rejection of self which is the portrayal of his image in the mirror. Keppler notes that "The conscious mind tries to deny its unconscious through the mechanism of projection", attributing its own unconscious content to a real person or situation in the world outside; to the extent that it at times creates an external hallucination in the image of the content" [19] in this study a distortion.

CONCLUSIONS

There are several theories that were explored however none fit this picture and indicate that this is something new that is being observed in someone with intense anxiety, PTSD, and psychosis which responded to a combination of psychological and pharmacological intervention with no shift in the negative autoscopic symptoms. We do not suspect that this is part of malingering or part of approximate answer syndrome as the client is well aware that the treating team is independent of the outcome and procedures at court further there is consistency in reporting throughout the time period and with several clinicians.

DECLARATION OF INTEREST

None.

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