Review

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Functional Confusion in Psychiatry

Psikiyatride Fonksiyonel Konfüzyon

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ABSTRACT

In this paper, functional confusion defined as clinical condition which is the patient can not focus on a certain issue, reply the questions and explain his/her story during psychiatric interview is focused. It is hypothesized that functional confusion seem most prevelant in patients with borderline personality disorder and somatic symptom and related disorders. Relationship between inability of mentalization, dissociation, cognitive disturbances and functional confusion seen in patients with borderline personality disorder is emphasized. Similarities are explained between alexitimia and can not expression of emotional complaints in the patients with somatic symptoms and related disorders. Relationship between somatoform dissociation and confusion has been discussed. In the article, also it has been argued that childhood traumatic experiences might play a role on vulnerability to functional confusion. Functional confusion may contribute to emergence of clinical conditions and severity of illness in adulthood period. Patients with functional confusion should be treated with psychotropic medications including low dose antipsychotic drugs rather than psychotherapeutic interventions.

Keywords: Functional confusion, borderline personality disorder, dissociation

ÖZ

Bu yazıda psikiyatride görüşme esnasında hikâyesini anlatmakta zorlanan, belli bir konuya odaklanamayan ve sorulara amaca yönelik cevaplar veremeyen hastalarda görülen klinik tablo olarak tanımlanan fonksiyonel konfüzyon üzerinde durulmuştur. Fonksiyonel konfüzyonun en sık borderline kişilik bozukluğu ve bedensel belirti ve ilişkili bozuklukları olan hastalarda görüldüğü öne sürülmektedir. Borderline hastalarda görülen fonksiyonel konfüzyonun zihinselleştirme kapasitesindeki yetersizlik, disosiyasyon ve bilişsel bozukluklar ile ilişkili olabileceği vurgulanmıştır. Bedensel belirti ve ilişkili bozukluklarda hastaların duygusal yakınmalarını sözel olarak tanımlayamaması ile alexitimi arasındaki benzerlik üzerinde durulmuştur. Somatoform disosiyasyon ve konfüzyon arasındaki ilişki ele alınmıştır. Yazıda ayrıca çocukluk çağı travmalarının fonksiyonel konfüzyon için yatkınlaştırıcı bir rol oynayabileceği ileri sürülmektedir. İleri dönemde klinik tabloların ortaya çıkmasında ve semptomların şiddetinde fonksiyonel konfüzyonun etkili olabileceği ifade edilmektedir. Fonksiyonel konfüzyonu olan hastalarda tedavide psikoterapötik müdahalelerden önce düşük doz antipsikotik eklenmesini de içeren psikofarmakolojik müdahaleler önerilmektedir.

Anahtar sözcükler: Fonksiyonel konfüzyon, borderline kişilik bozukluğu, disosiyasyon

In psychiatry, confusion state in which purposeful answers to the questions cannot be obtained in the mental state examination of the patient, and the orientation to place and time is disturbed can be seen most often in elderly patients, in delirium (Raj 2015, Thom et al. 2019). In addition to cognitive impairment, many different symptom comorbidities can be seen in delirium, including psychotic, depressive, anxiety, mood, and even dissociative symptoms (Salawu et al. 2009). In addition to these diseases, drug intoxication and withdrawal symptoms should also be taken into consideration in the differential psychiatric diagnosis. Confusion can also be seen in psychiatry, particularly in acute psychotic disorders. Patients with primary psychiatric conditions, medical conditions, drug intoxication and withdrawal may confront with delirium and psychosis (Griswold et al. 2015). Furthermore, confusion at certain degrees may confront as a symptom in reversible psychotic conditions such as cycloid psychosis (Liappas et al. 2001, Peral and Cuesta 2005, Griswold et al. 2015). Again, in depression with psychotic characteristics, there may be confused patients with prolonged time of reply to questions and are confused (Griswold et al. 2015). Regardless of being a certain stress factor or not, confusion is a manifestation that can be recognized in brief psychotic disorders. 2000, Liappas et al. 2001, Griswold et al. 2015). In postpartum psychosis, disorientation, confusion and delirium-like symptoms can be seen in addition to affective symptoms (Işık 2018).

In psychiatry, in addition to all these, we may see patients who have difficulty in telling their stories, cannot focus on

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a certain subject, confuse the topics that they tell, and cannot give purposive answers to the questions during the interview almost in every day. In such patients, we may recognize from the beginning of the interview that the patient cannot tell his/her experiences as a whole, cannot form sentences regularly; and that s/he cannot verbally describe both of his/her physical and psychological complaints. This situation that we can refer to as confusion in the simplest terms can be defined as functional confusion.

Functional Confusion Concept

In neurology, confusion means mental fog, failure to establish cooperation (communication) with the patient, and failure to establish place, time, and person orientation. The neurological examination of the confused patient can be recorded as confused, non-cooperative and disorientated (Acar et al. 2018). The functional concept is referred to as 'functional neurological symptom disorder' in conversion disorder in DSM 5 (The Diagnostic and Statistical Manual of Mental Disorders, 5th edition). Here, it is stated that the symptoms of conversion disorder are functional (due to abnormal central nervous system functionality) or psychogenic (due to possible causes) (APA 2013). Confusion is stipulated in Dissociation disorders in DSM 5. Dissociation is mostly recognized after a trauma, and the sense of confusion is affected by the degree of trauma. The confusion here is used in the meaning of astonishment and includes the closest meaning to the concept that we define as functional confusion. The condition that we define as functional confusion is maybe a dissociation with the fullest meaning. Depending on the severity of dissociation, the severity of confusion may increase.

Functional Confusion in Psychiatry

Orientation disorders is the failure to recognize time, place, or people. Sometimes the person cannot describe these verbally, but can describe them behaviourally. S/he can show the intended person with his/her hand, writes the place and time correctly, exhibits purposive behaviours. The disorientations can be short- or long-term; alternating or permanent; partial (one, time orientation, or both, time and place orientation) or all (all three, time, place, and person orientation). Although most forms of orientation disorders are organic, some forms can also be seen in functional psychiatric disorders, too. Time orientation may be impaired in major depression (pseudodementia), mania, major anxiety, dissociative, and psychotic disorders (Berrios 1982, Berrios 1983). Along with time orientation, the place orientation may be impaired in cases such as dementia. The place, time, and person orientation disorder may be observed in organic psychiatric disorders and sometimes in acute psychotic conditions (Berrios 1983).

Confusion condition may be observed in neurological meaning in the patients who received differential organicity diagnosis in psychiatry inpatient services or undergone major somatic treatments such as ECT. In this article, the functional confusion that is observed in patients with Borderline personality disorder and Somatic symptoms and associated disorders as we may encounter more frequently in outpatient conditions is handled. Therefore, it is aimed to accelerate decision-making process in these cases, and to help diagnose and to regulate the treatment.

Functional Confusion in Borderline Patients

In daily psychiatry polyclinics, functional confusion may be observed frequently in patients who have borderline personality disorder. From the beginning of the interview with these patients, it can be recognized that these patients skip topics and cannot tell their personal stories. In this respect, although there is different diagnosis such as depression, somatization, obsessive-compulsive disorder (OCD), panic disorder, or other anxiety disorder in the symptom cluster of the patient, borderline personality disorder may immediately come to mind in confused patients who have difficulty in telling their story. For these patients, functional confusion may be a finding of examination to help diagnosing faster than any other diagnostic method or structured interview graph.

Here, it should also be emphasized that the confusion of the patient may also be associated with resistance. At most of the times, the patient may come to the examination unintentionally due to the insistence of the relatives of the family or other conditions that force him/her. Since s/he has no insight and sees the problems around him/her, s/he can always give marginal answers to the questions. The functional confusion that is observed in borderline personality organization may be closely associated with the failure to ensure identity integrity in these patients. As a matter of fact, it is not expected from a patient who does not have an identity integrity to have story integrity. In this respect, the functional confusion may be a trait characteristic in borderline patients and may cause the patient to disintegrate under stress; it may be preparing position for agitation, dissociation, and even a brief psychotic reaction.

While functional confusion prevents the patient from telling his/her story, it can also give some important clues about the clinic of the patient too. The presence of a significant confusion in the patient may indicate the significance of the clinic, deterioration in psychosocial functioning areas, and a relatively increased risk of attempt to suicide. The suicidal thoughts s/he planned behind his/her confusion may also contribute the patient's prolonged time to reply to questions, slowdown of associations, and increase in dysphoria. In this respect, the presence of a significant confusion may also affect the treatment approach. In this kind of a case, pharmacological interventions may be considered initially instead of psychotherapy. For example, administration of low-dose antipsychotics and benzodiazepine for a certain period of time in addition to the antidepressant to a borderline patient who applies with depression condition may ensure the recovery of the patient in a shorter time.

In borderline psychopathology, together with all these, it is seen that the patient cannot objectively evaluate and give a meaning to his/her experiences. Therefore, it is understandable that the patient has difficulty in explaining something that s/he cannot

comprehend. Just at this point, it can be said that the treatment helps the patient to understand his/her story. The functional confusion observed in the borderline patient may improve after a successful treatment process by means of psychotherapeutic interviews in addition to symptomatic pharmacotherapy. As the patient tells his/her story over and over, s/he begins to understand the experiences that s/he could not comprehend at the beginning, to integrate the sentences and events that seem unconnected with each other; and the gaps of the memory begin to fill. While evaluating the situations, starts to see the distorted points, exaggerations and contradictions, and so his/her awareness will expand and have his/her all buttons. In this way, the personal story of the patient will become more fluent and transparent.

Mentalization and Functional Confusion in Borderline Patients

The failure of the patient to explain his/her experiences as a whole, to form sentences regularly; to verbally describe both physical and psychological complaints may be associated with the failure in the mentalization capacity. Mentalization is the ability of the person to evaluate him/herself and others as a whole, to think about his/her intrinsic moods and to establish communication (Allen 2013). Mitrani (1995) attributes the deficiency in the mentalization ability to the inhibition of the symbolization ability by the traumatic experiences -as prevalent in trauma- that develop due to the lack of capacity of the parents to care particularly as of the early childhood, neglect and even emotional, physical and sexual abuse, and calls these kinds of experiences as "unmentalized experience". Unmentalized experiences mean the failure to transform the intrinsic or extrinsic data into mental representations, to organize, or integrate. The intensity of such experiences that cannot be put into words is a significant risk factor for the development of borderline personality disorder in the future.

The neurobiological explanation of mentalization is done as follows. When a threat and danger is encountered, the functional patterns of the brain pass from flexibility to automatic due to the neurochemical change resulting from increased emotional stress. Passed from relatively slow high-level functions occur by means of the prefrontal cortex to faster intuitive and habitual behaviours interceded by posterior cortical (parietal) and lower cortical structures (amygdala, hippocampus, and striatum). During this process, mentalization becomes passive as defences (escape, fight, freeze) are activated. The time of this transition from high-level functions (mentalization) to automatic responses (escape-fight), in other words the transition threshold, varies from person to person (Judd 2005, Fertuck and Stanley 2006, Allen 2013, Brand and Lanius 2014).

Dissociation and Functional Confusion in Borderline Patients

It is considered that the functional confusion observed in borderline patients is associated with dissociation. It is known that borderline patients experience transient psychosis-like dissociative attacks when they are under stress (Judd 2005, Zanarini et al. 2013, Brand and Lanius 2014, Schultz and Hong 2017). When the close relationship between psychotic conditions and confusion are taken into consideration, functional confusion can be expected in borderline patients. Furthermore, past traumatic experiences that are currently active and dissociative experiences associated with this may also impair the recalling of near and far-life cases as a whole through impairing the attention and memory processes of the patient (Judd 2005, Fertuck and Stanley 2006, Skrzypinska and Szmigielska 2015, Krauze-Utz et al. 2017).

It can be asserted that the functional confusion seen in borderline patients is a conclusion of cognitive dysregulation associated with emotional and behavioural dysregulation (Figueroa and Silk 1997, Brand and Lanius 2014, Choudhary and Thapa 2017). Dysfunctional pathways, functional brain abnormalities, impaired neurobiological mechanisms, neurochemical irregularities, and neurocognitive deficits in certain brain regions that are indicated in neuroimaging studies been performed in borderline patients may play a role to predispose to functional confusion that is suggested to be observed in these patients (Dell'Osso et al. 2009, Krauze-Utz et al. 2017). It has been reported that amygdala and left cingulate gyrus activity and glutamate levels in anterior cingulate cortex are higher in relation to the severity of dissociative symptoms in borderline patients (Krauze-Utz et al. 2017). Furthermore, it is known that N-methyl D-aspartate (NMDA) antagonists and cannabinoids can trigger dissociative symptoms. These pathophysiological processes may be effective in functional confusion asserted to be observed in borderline patients.

Severe or pathological dissociation and various dissociative experiences associated with childhood sexual traumas can be observed frequently in borderline personality disorder (Judd 2005, Brand and Lanius 2014, Krauze-Utz et al. 2017). It is stated that dissociation plays a role of mediator for the psychopathology that is observed in borderline personality disorder (Judd 2005, Krauze-Utz et al. 2017). Dissociation plays a significant role in emotional dysregulation, identity disturbance and dementia in these patients (Judd 2005, Brand and Lanius 2014, Krauze-Utz et al. 2017). Furthermore, dissociation may interrupt information processing processes and personal memory (Judd 2005, Krauze-Utz et al. 2017). It can be said that these data have connection with confusion that is observed in borderline patients.

Cognitive Disorders in Borderline Patients

In the literature, there are articles that defend the presence of cognitive disorders at the centre of borderline psychopathology (Judd 2005, Fertuck and Stanley 2006, McClure et al. 2016, Gica et al. 2021). In numerous studies carried out in patients with borderline personality disorder, it has been reported that there is impairment in attention and memory functions, learning skills, executive functions such as planning and problem solving, and language functions such as verbal fluency (Burgess 1990, Dinn et al. 2004, Ruocco 2005, Ruocco et al. 2014, McClure et al. 2016, Kaplan et al. 2020). Attention deficit hyperactivity

disorder, traumatic brain damage, learning disorders, and other organic conditions that may accompany borderline personality disorder support the cognitive impairment observed in these patients (Burgess 1990, Dinn et al. 2004, Judd 2005, McClure et al. 2016). Furthermore, it has been reported that childhood traumas are associated with disorders in cognitive functions. It has been detected that cognitive disorder in borderline patients with a history of sexual abuse is higher than in borderline patients without a history of sexual abuse (Fertuck and Stanley 2006, Gica et al. 2021). Cognitive problems may adversely affect their academic and professional success, daily functioning, and social relationships (Ruocco et al. 2014). These data that support functional confusion indicate that cognitive dysregulation is a dimension of borderline symptomatology (Judd 2005).

Somatization, Alexithymia and Functional Confusion

It is in question that the patients are unable to verbally describe their psychological complaints in psychological disorders that are handled in the somatic symptom and associated disorders cluster in DSM-5. These patients are unable express their feelings and use complicated expressions. Theorists such as Sifneos and McDougal name this phenomenon as secondary alexithymia, "disaffectation", and "affect deficit". McDougal (1984) describes psychosomatic patients (affectless or dis-affected) as those who are cold, emotionally unresponsive, dissimulative, and have lack emotional experience. The alexithymia term can be translated into Turkish as 'the absence of words for feelings' (Dereboy 1990). It is known that people with alexithymia may have difficulties in recognizing and defining their feelings and in imagining (fantasy). During the interview, it can be seen that these patients have difficulties in understanding the similarities in metaphors and establishing connections between the concepts.

As a result of the observations carried out on psychosomatic patients, it was reported that these patients are not aware of their emotional life, have a mental inability to verbalize their emotions, and cannot relieve their tension verbally or symbolically. The discussion on whether alexithymic characteristics are permanent or temporary (state) has revealed the primary and secondary alexithymia concepts. It has been stated that primary alexithymia is a significant factor causing predisposition to the emergence and persistence of physical disorders in psychosomatic diseases; that secondary alexithymia is a condition that can occur temporarily or permanently in people who experience severe diseases or traumas (Dereboy 1990).

The common characteristic of somatic symptom disorder, illness anxiety disorder, and conversion disorder is the presence of significant stress-related somatic symptoms and dysfunction. Mind-body dichotomy comes from the inability to explain a somatic symptom medically. Confusion or functional confusion observed in the patient may also be associated with this conflict. Besides genetic and biological factors, the early trauma experiences, attention focused on the illness, and non-somatic manifestations of stress may be effective in the emergence of somatic symptom and associated disorders (American Psychiatric Association 2013). These individuals may focus on somatic symptoms too much and experience intense anxiety. Therefore, it may be difficult to direct them to another subject. This case may play a role in the condition we define as functional confusion. When it is taken into consideration that somatic symptom disorder is more common in individuals with lower education level and socioeconomic status, and who have recently experienced stressful life events, it can be said that these factors may also contribute to functional confusion.

During the examination, it can be recognized that patients with health anxiety experience intense anxiety and confusion. It can be observed that the patient's reply time to the questions prolongs, associations slow-down, decision-making processes are affected, and in some patients, s/he almost approaches psychosis. In the treatment, for these reasons, it may be appropriate to add low-dose antipsychotics for both anxiolytic purposes and rigidity of thought approaching to delirium. Antipsychotics can also help regulate sleep and appetite. Olanzapine (2.5-5 mg/day), sulpiride (50-100 mg/day), trifluoperazine (stylizing 1-2 mg/day), haloperidol (10-20 drops, 1-2 mg/day), quetiapine (50-100 mg/day short-acting or XR forms), and risperidone (1-2 mg/day) can be used in the form of single dose or divided doses. The use of benzodiazepines in somatic symptom disorders is quite limited (Kleinstauber et al. 2014).

Somatoform Dissociation and Confusion

It has been reported that both somatoform and psychoform dissociation are associated with childhood traumas (Nijenhuis 2000, Şar et al. 2004, Kienle et al. 2017, Farina et al. 2019). Somatoform dissociation refers to medically unexplained functional somatic symptoms that occur as a result of the reactivation of dissociative states (Kienle et al. 2017, Nilsson et al. 2019). Somatoform dissociation is the disruption of the integration of the somatic compounds' functions, perceptions, and reactions (Nijenhuis 2000, do Espirito Santo and Pio-Abreu 2007, Kienle et al. 2017, Nilsson et al. 2019). It has been reported that there is a high rate of sexual abuse in patients who have Somatoform disorder such as conversion disorder, somatization, and pain disorder (Nijenhuis 2000, El-Hage et al. 2002, Şar et al. 2004). Dissociation, somatization, and affect dysregulation are closely associated with the childhood traumas (Nijenhuis 2000, Şar et al. 2004). Traumatic experiences may lead to confusion by disrupting the integrity of mental functions (Farina et al. 2019).

It has been reported that somatoform symptoms are common in patients with dissociative disorder and even somatoform symptoms are the most common dissociative symptoms (Nijenhuis 2000, El-Hage et al. 2002). Dissociative phenomena and a history of sexual abuse were found to be frequent in female patients with unexplained somatic symptoms, chronic pain, and pseudoepileptic seizures (El-Hage et al. 2002). Comorbidities of dissociative disorder, somatoform disorder and borderline personality disorder can be observed frequently (Mai 2004,

Deville et al. 2014). These patients may also experience psychosis-like symptoms accompanied by confusion (Deville et al. 2014). It has been stated that identity confusion (confusion) observed in borderline patients is the best predictor for depression, anxiety, and somatoform dissociation (Nijenhuis 2000).

Conclusion

Regardless from the presence of a psychosocial burden factor, it can be said that psychopathology is associated with a disintegration and chaos in the mental organization (Özdemir et al. 2012). Impaired mental balance may appear as confusion in the patient. As discussed above, it is predicted that functional confusion may be associated with symbolization, mentalization, emotion regulation, alexithymia, and dissociation concepts. In addition to this, it can be suggested that childhood traumatic experiences may play a role on vulnerability to functional confusion. In the late phase, functional confusion may be effective in the emergence of clinical conditions and in the severity of the symptoms, particularly in patients that have borderline and somatic symptom disorders. Before psychotherapeutic interventions in patients that have functional confusion, psychopharmacological interventions and anxiolytic drugs, particularly low-dose antipsychotics, are recommended. Furthermore, for these patients, the interviews may be organized with the relatives of the patients (Özdemir 2020). So, the relatives of the patients can understand the points in which the patient has difficulty in comprehending, have more information about the disease and can ensure the regular use of the drugs.

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