

Clinical improvement of somatic and affective symptoms in a patient with complex trauma through the use of EMDR. Report of a clinical case

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Dear Editor,

Somatoform disorder is a diagnostic category first introduced in the eighties in the diagnostic manual DSM-III¹. It was maintained through successive versions of the manual until the recent DSM-5, in which it has been replaced by somatic symptom disorder². Somatic symptom disorders share, as a main characteristic, the presence of nonorganic physical symptoms that affect the patient's thoughts, emotions and behaviours³. Its prevalence is estimated to oscillate between 5-7% in the general adult population³, being more prevalent before the age of 30 and in women⁴, and may account for up to 25-50% of the non-explained physical symptoms seen in clinical practice².

On a clinical level, the relationship between psychological trauma and somatization has been growing in importance due to the high frequency of traumatic history present in these patients. Somatization has been observed to be closely related to the presence of trauma and to its severity⁵⁻⁷. However, the literature published so far on trauma-focused treatments in people with comorbidity between both medical conditions is scarce. A possible psychological approach to trauma is EMDR (Eye Movement Desensitization and Reprocessing) therapy, developed in the eighties by the North American Psychologist Francine Shapiro⁸ and recommended since 2013 by the WHO as treatment for post-trau-

matic stress disorder⁹. EMDR is an eight phase psychological treatment consisting of a standardized protocol applicable to both adults and children. The eight phases (patient history, patient preparation, evaluation of the primary aspects of the memory, desensitization of the traumatic memory, installation of the positive cognition, body scan, closure and reevaluation), and the past-present-future timeline protocol, facilitate a comprehensive evaluation of the traumatic memory image, as well as facilitating the preparation of the patient and the processing of past events forming the basis of the pathology, present situations causing distress and future possible stimuli or challenges that might trigger symptom appearance¹⁰. The protocol for its application, the hypothesis of how it works and a systematic review of its efficacy in the treatment of post-traumatic stress disorder can be consulted in the article by Novo and colleagues¹¹. The learning required for this approach is complex and, because of this, international EMDR associations have worked together to ensure that there is a standardized and homogeneous training in all countries. In recent years, the use of this therapy in clinical practice for treating traumatic events has increased exponentially due to its efficacy and safety in both general and psychiatric populations¹².

Taking into account the above, we present the case of a 64-year-old male who was admitted to the long-stay unit in October 2016 due to non-specific somatic symptoms, unstructured suicidal ideation and food restriction. At a psychobiographical level, it is important to emphasize that he was orphaned at the age of two, and that he spent all his childhood and adolescence (from 6 to 18) in a reformatory during the fifties and sixties, where he received negligent care, physical and psychological maltreatment¹³. When he was 18 and left the reformatory, he became involved in frequent criminal behaviors, mostly burglaries for which he ended up in prison, where he claims to have been a victim of torture. During the previous 10 years, the patient had made multiple visits to the emergency room and had been admitted eight times into a psychiatric ward for somatic complaints, having received various psychiatric diagnoses such as delusional disorder-somatic type (DSM-5 297.1 [F22]), borderline personality disorder (DSM-5 301.83 [F60.3]) and major depressive disorder (DSM-5 296.33 [F33.2]).

His medical history includes: arterial hypertension in treatment with amlodipine 5mg/day and dyslipidemia treated with atorvastatin 20mg/day. It is of note that in 2014 he presented a duodenitis with a positive result for *helicobacter pylori*, which was completely eradicated through treatment with clarithromycin.

The patient was transferred to the long-stay unit in October 2016, following a three-week inpatient stay in the acute psychiatric unit. In the initial psychopathological examination, he was conscious and oriented, with repetitive

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speech focused on past events which with difficult to redirect. His mood was slightly hypothyroid with a tendency towards irritability. He also presented symptoms of anxiety in the form of feelings of distress and tightness in the chest and explained the frequent presence of invasive and intrusive memories, flashbacks and nightmares related to past situations of abuse. He also presented repeated complaints of gastric pain, constipation and dizziness that limited his global functioning. Upon admission, a thorough assessment of traumatic life events was conducted through clinical interview, and a life timeline was created where all traumatic events mentioned by the patient were recorded. Given the nature of the symptoms the patient presented with and his previous history, the diagnoses were modified to: post-traumatic stress disorder (DSM 5 309.81 [F43.10]), somatic symptom disorder (DSM-5 300.82 [F45.1]), child physical abuse (DSM 5 995.54 [T74.12XD]) and child psychological abuse (DSM 5 995.51 [T74.32XA]).

At the beginning of his admission the pharmacological treatment was adjusted by: withdrawing quetiapine 200 mg/day due to lack of efficacy and poor tolerability; increasing venlafaxine from 150 mg/day up to 300 mg/day (as previous antidepressant treatments the patient had already received different SSRI antidepressants without a clear clinical response); and maintaining trazodone 100 mg/day, zolpidem 10 mg/day and clonazepam 1.2 mg/8 hours. Furthermore, because of dyspepsia, aerophagia and dysphagia, the gastroenterologist suggested starting treatment with ranitidine 150 mg/12 hours, alginate 1.5 g/8 hours, lactulose solution 10g/8 hours, simethicone 80 mg 3-4/day and sulpiride 25 mg/day. It should be noted that sulpiride is an antipsychotic drug that is used in somatoform disorders with favorable results and good tolerance¹⁴, but in our clinical case it had a very limited effect. Despite achieving a certain mood stabilization with pharmacological treatment, its effect was very narrow. Therefore, the decision was taken to use EMDR therapy to address the traumatic memories of the past and the present trigger situations. A total of 21 sessions were carried out over 9 months: 15 using the standard protocol and 6 using a protocol specific for pain. The EMDR treatment targets included: the physical abuse received in the reformatory, the prison punishment cell, gastric pain and, finally, an incident with the police (during his inpatient stay, while walking around the hospital grounds the police had stopped him and asked for his documentation, triggering strong psychological distress in the patient). Following the intervention with EMDR, there was a reduction in both the subjective discomfort and the affective and somatic symptoms associated with multiple traumatic events. During his inpatient stay, a gastroscopy was performed at the patient's insistence due to the presence of a persistent conviction of having a gastric ulcer, which was not modified by pharmacological treatment or the psychotherapeutic approach. The gastroscopy ruled out any gastric pathology, and following

this result he continued with the sessions of psychotherapy and psychoeducation and the pain disappeared after a few days.

Currently, the patient does not manifest any affective or traumatic symptoms related to the past. He presents with only fluctuating anxiety and somatic complaints in relation to environmental stressors and has adequate global functionality and is highly involved in occupational therapeutic activities. The digestive treatment is being progressively withdrawn and this is well tolerated by the patient. He is still an inpatient, awaiting the resolution of some economic debts acquired in the past before returning home.

Discussion

In our opinion, the results of this case show the importance of evaluating, diagnosing and treating the presence of psychological trauma in patients with somatic symptoms, due to the close relationship existing between both conditions.

Given the high prevalence of psychological trauma in the general population, and much higher prevalence in the psychiatric population¹⁵, the evaluation and detection of traumatic life events should be incorporated into the routine of clinical practice in order to be able to establish a better treatment strategy in patients with somatic symptom disorders.

Likewise, we consider that EMDR therapy, as an adjunct therapy to pharmacological treatment, could be a useful and promising alternative in the approach and treatment of these patients.

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Acute schizophrenia-like psychosis as major clinical presentation of Graves' disease successfully treated by radioiodine in combination with antipsychotics: a case report

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Dear Editor,

Graves' disease is an autoimmune disorder of the thyroid gland, typically characterized by a diffuse goiter, thyrotoxicosis, and circulating thyroid auto-antibodies in the blood. More than 170 years ago, Basedow first described psychotic disorder in a patient with Graves' disease¹. Although many other cases with psychotic symptoms have been reported since then²⁻⁸, schizophrenia-like psychosis, as a major presenting clinical feature of thyrotoxicosis, is still extremely rare.

Nonetheless, existing evidence suggested that the severity of psychosis usually reflects the severity of thyrotoxicosis. Also, the psychotic symptoms typically remit with successful reversion of the thyrotoxic state⁷. Previously, both anti-thyroid medications and thyroidectomy in combination with antipsychotics have been reported to eliminate psychotic symptoms in Graves' disease⁷⁻⁸. However, standardized treatment has not yet been well established due to its rareness.

We hereby reported a patient with schizophrenia-like psychosis as a major presenting clinical feature of thyrotoxicosis, who was successfully treated by radioiodine therapy (RIT) in combination with antipsychotics.

Case report

A 64-year-old woman suffering irritability, delusions of persecution, auditory hallucinations and irrational talking for 2 days was admitted to the department of emergency in our hospital in March 2016. She had no previous history of personal or family psychiatric disease. According to her family, no major event of her life had happened right before she developed these psychotic symptoms. However, she was diagnosed as Graves' disease 3 years ago based on elevated levels of thyroid hormones, suppressed levels of thyroid-stimulating hormone (TSH) and pretibial myxedem with no other characteristic symptoms of Graves' disease such as swelling neck, ophthalmopathy palpitations or tremor. She had been regularly taking methimazole until thyroid hormones returned to normal range 12 month ago. Her thyroid function had been since then constantly normal. The symptom of pretibial myxedem had disappeared before this admission. Therefore, physical examination found no characteristic symptoms of Graves' diseases. Mental state examination revealed a vigilant and uncooperative patient with poor eye contact. Perception examination revealed delusions of persecution (She suspected her daughter wanted to kill her) and auditory hallucinations (She heard voices of a fairy man talking directly to her, as if they were having a conversation). Her speech was coherent with logic, but irrelevant with the occasion. Cognitive assessment and neurological examination were normal.

The patient subsequently received brain computed tomography, electroencephalogram, analysis of cerebrospinal fluid, and drug use screening in searching of possible cause

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Table 1 Thyroid function of the patient at admission and follow up

Hormones	Value				Normal range
	Admission	At 5th day	At 26th day	At 60th day	
FT3, pmol/L	33.16	24.33	1.69	3.58	3.10–6.80
FT4, pmol/L	66.50	45.81	5.30	15.73	12.0–22.0
TSH, mIU/L	0.026	0.082	8.24	3.77	0.372–4.940
TgAb, UI/mL	162.40	182.24	120.37	128.42	<60
TRAb, UI/L	3.69	3.85	2.62	2.81	<1.75

of her psychotic disorders. However, both the psychiatrist and the neurologist found no pathological abnormalities. Blood test revealed elevated levels of thyroid hormones (FT3= 33.16 pmol/L, normal range, 3.10–6.80 pmol/L; FT4= 66.50 pmol/L, normal range, 12.0–22.0 pmol/L) and suppressed levels of TSH (TSH= 0.026 mIU/L, normal range, 0.372–4.940 mIU/L). (Table 1) Thyroid ultrasound showed slight swelling of the thyroid gland (right lobe: 48.3 mm×19.2 mm×15.5 mm, left lobe: 44.7 mm×19.5 mm×14.6 mm) and slightly increased blood flow. Thyroid scintigraphy demonstrated a diffuse and significantly elevated uptake of ^{99m}Tc-per technetate uptake in both lobe of the thyroid. Thyroid-stimulating antibodies were elevated. (antithyroglobulin antibody= 162 IU/mL, normal range, < 60 IU/mL; TSH receptor antibody= 3.69 IU/L, normal range, < 1.75 IU/L). (Table 1)

After collective assessment of this case, a diagnosis of schizophrenia-like psychosis, secondary to Graves' disease with thyrotoxicosis was established. We decided to firstly treat thyrotoxicosis, while stabilizing her psychotic symptoms using antipsychotics. Consequently, 15 mCi of radioiodine was administered to the patient. At the same time, aripiprazole (20 mg per day) and lorazepam (3 mg per day) was started. In the fourth day after RIT, the patient gradually begun to communicate with others and her psychotic symptoms were notably ameliorated. 25 days after RIT, all psychotic symptoms disappeared and aripiprazole was stopped. Thyroid hormones test revealed a hypothyroid state (FT3= 1.69 pmol/L, normal range, 3.10–6.80 pmol/L; FT4= 5.30 pmol/L, normal range, 12.0–22.0 pmol/L; TSH= 8.24 mIU/L, normal range, 0.372–4.940 mIU/L). (Table 1). Levothyroxine (100 µg per day) was introduced to treat the hormone deficiency immediately. Two weeks later, lorazepam was stopped and the patient was discharged from our hospital for follow-up. The psychotic symptoms did not re-emerge until her last clinic visit (12 month after RIT).

The clinical data was obtained with the patient's signature for use in the publication of scientific research papers.

Discussion

We reported a patient with no previous history of psychiatric disorder and a known history of Graves' disease who suddenly developed an acute schizophrenia-like psychosis. The patient has no characteristic symptoms of Graves' disease on physical examination. However, thyroid function test, thyroid ultrasound and thyroid scintigraphy confirmed her diagnosis of Graves' disease with thyrotoxicosis. Administration of 15 mCi of radioiodine, aripiprazole (20 mg per day) and lorazepam (3 mg per day) resulted in prompt remission of her psychotic symptoms. One year after discharge, she remained free of psychotic symptoms in spite of having stopped taking antipsychotics.

It is estimated that 9% – 20% of all cases of acute psychosis presented to emergency departments are due to general medical conditions. These include head trauma, intracranial and structural brain neoplasms, drugs and toxins, infections, vitamin deficiencies and thyroid dysfunction⁹. In our patient, the synchronization of the reversion of thyroid function and the remission of the psychotic symptoms suggests that thyrotoxicosis contributes to the etiopathology of the psychotic symptoms. The prompt remission of the psychotic symptoms after only 4 days of antipsychotics further reinforces this hypothesis. Moreover, the fact that the patient stopped antipsychotics after leaving the hospital and still remained free of psychotic symptoms 12 months after strongly support a secondary psychosis to thyrotoxicosis.

Despite many reports reinforcing the idea that psychotic symptoms were a direct manifestation of thyrotoxicosis, the exact mechanism underlying the development of psychosis in thyrotoxicosis is still not well understood. However, possible explanations may be as follows: (1) The massive thyroid hormone receptors localized in the brain, especially in the limbic system, could change functions in behavior, mood and long-term memory in the presence of excessive thyroid hormone; (2) Thyroid hormones could modulate the beta-adrenergic response to catecholamines

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in the central nervous system and may contribute to psychotic disorders; (3) Hyperthyroxinemia and psychotic disorders could also be synergistic with each other^{4,8}.

Schizophrenia-like psychoses in thyrotoxicosis have only been scarcely described in the literature. For example, Brownlie *et al*, in a retrospective study of 18 thyrotoxic patients with associated psychosis, only found two patients with schizophrenia-like psychosis³. Ugwu ET *et al* reported a case of schizophrenia-like psychosis in a patient with Graves' disease. In his case, psychiatric symptoms were successfully treated by anti-thyroid medications in combination with antipsychotics⁷. Häfner S *et al* also described a similar case. His patient remitted promptly after total thyroidectomy⁸.

Because of the low remission rate in Graves' disease and the inability to cure thyrotoxicosis with antithyroid drugs alone, radioiodine is increasingly used as first line therapy, and is the preferred choice for relapsed Graves' thyrotoxicosis. It has the merits of high efficiency, easy application and prompt control of thyrotoxicosis¹⁰. In our case, because our patient had a history of Graves' disease and her conditions did not allow for a surgery, a fixed, high dose of 15 mCi of radioiodine was administered to the patient. Although the utilization of a high dose lead to the occurrence of early hypothyroidism, it still proved to be a reasonable choice for promptly reversing the thyrotoxic state of the patient and consequently eliminating the psychotic symptoms.

Conclusion

1. Graves' disease with thyrotoxicosis, can present as schizophrenia-like psychosis. Particular attention should be paid to thyroid function in those patients with a known history of thyroid dysfunction; 2. RIT in combination with antipsychotics is efficient in reversing thyrotoxicosis and consequently eliminating psychotic symptoms.

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CONFLICTS OF INTEREST

There are no conflicts of interest.

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WPA Position Statement on Spirituality and Religion in Psychiatry

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Dear Editor,

The WPA and the World Health Organization (WHO) have worked hard to assure that comprehensive mental health promotion and care are scientifically based and, at the same time, compassionate and culturally sensitive^{1,2}. In

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recent decades, there has been increasing public and academic awareness of the relevance of spirituality and religion to health issues. Systematic reviews of the academic literature have identified more than 3,000 empirical studies investigating the relationship between religion/spirituality (R/S) and health^{3,4}.

In the field of mental disorders, it has been shown that R/S has significant implications for prevalence (especially depressive and substance use disorders), diagnosis (e.g., differentiation between spiritual experiences and mental disorders), treatment (e.g., help seeking behavior, compliance, mindfulness, complementary therapies), outcomes (e.g., recovering and suicide) and prevention, as well as for quality of life and wellbeing^{3,4}. The WHO has now included R/S as a dimension of quality of life⁵. Although there is evidence to show that R/S is usually associated with better health outcomes, it may also cause harm (e.g., treatment refusal, intolerance, negative religious coping). Surveys have shown that R/S values, beliefs and practices remain relevant to most of the world population and that patients would like to have their R/S concerns addressed in health care⁶⁻⁸.

Psychiatrists need to take into account all factors impacting on mental health. Evidence shows that R/S should be included among these, irrespective of psychiatrists' spiritual, religious or philosophical orientation. However, few medical schools or specialist curricula provide any formal training for psychiatrists to learn about the evidence available, or how to properly address R/S in research and clinical practice^{7,9}. In order to fill this gap, the WPA and several national psychiatric associations (e.g., Brazil, India, South Africa, UK, and USA) have created sections on R/S. WPA has included "religion and spirituality" as a part of the "Core Training Curriculum for Psychiatry"¹⁰.

Both terms, religion and spirituality, lack a universally agreed definition. Definitions of spirituality usually refer to a dimension of human experience related to the transcendent, the sacred, or to ultimate reality. Spirituality is closely related to values, meaning and purpose in life. Spirituality may develop individually or in communities and traditions. Religion is often seen as the institutional aspect of spirituality, usually defined more in terms of systems of beliefs and practices related to the sacred or divine, as held by a community or social group^{3,8}.

Regardless of precise definitions, spirituality and religion are concerned with the core beliefs, values and experiences of human beings. A consideration of their relevance to the origins, understanding and treatment of psychiatric disorders and the patient's attitude toward illness should therefore be central to clinical and academic psychiatry. Spiritual and religious considerations also have important

ethical implications for the clinical practice of psychiatry¹¹. In particular, the WPA proposes that:

1. A tactful consideration of patients' religious beliefs and practices as well as their spirituality should routinely be considered and will sometimes be an essential component of psychiatric history taking.
2. An understanding of religion and spirituality and their relationship to the diagnosis, etiology and treatment of psychiatric disorders should be considered as essential components of both psychiatric training and continuing professional development.
3. There is a need for more research on both religion and spirituality in psychiatry, especially on their clinical applications. These studies should cover a wide diversity of cultural and geographical backgrounds.
4. The approach to religion and spirituality should be person-centered. Psychiatrists should not use their professional position for proselytizing for spiritual or secular worldviews. Psychiatrists should be expected always to respect and be sensitive to the spiritual/religious beliefs and practices of their patients, and of the families and carers of their patients.
5. A tactful consideration of patients' religious beliefs and practices as well as their spirituality should routinely be considered and will sometimes be an essential component of psychiatric history taking.
6. An understanding of religion and spirituality and their relationship to the diagnosis, etiology and treatment of psychiatric disorders should be considered as essential components of both psychiatric training and continuing professional development.
7. There is a need for more research on both religion and spirituality in psychiatry, especially on their clinical applications. These studies should cover a wide diversity of cultural and geographical backgrounds.
8. The approach to religion and spirituality should be person-centered. Psychiatrists should not use their professional position for proselytizing for spiritual or secular worldviews. Psychiatrists should be expected always to respect and be sensitive to the spiritual/religious beliefs and practices of their patients, and of the families and carers of their patients.
9. Psychiatrists, whatever their personal beliefs, should be willing to work with leaders/members of faith communities, chaplains and pastoral workers, and others in the community, in support of the well-being of their patients, and should encourage their multi-disciplinary colleagues to do likewise.

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10. Psychiatrists should demonstrate awareness, respect and sensitivity to the important part that spirituality and religion play for many staff and volunteers in forming a vocation to work in the field of mental health care.
11. Psychiatrists should be knowledgeable concerning the potential for both benefit and harm of religious, spiritual and secular worldviews and practices and be willing to share this information in a critical but impartial way with the wider community in support of the promotion of health and well-being.

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