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Psychogenic psychosis

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In 1916, Wimmer described psychogenic psychosis as psychosis secondary to mental trauma.

Psychogenic psychoses are currently included in acute and transient psychotic disorders (F23) in the ICD-10 and in the brief psychotic disorders (298,8) in the DSM-IV-TR.

We present a case report of psychogenic psychosis in a 39 year-old female and analyze it with the predisposition-trauma mental model.

Key words:
Psychosis. Psychogenic. Mental trauma.

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Psicosis psicogénica

En 1916 Wimmer describió las psicosis psicogénicas como psicosis secundarias a traumas mentales.

Actualmente, las psicosis psicogénicas se incluyen en los trastornos psicóticos agudos y transitorios (F23) de la CIE-10 y en los trastornos psicóticos breves (298.8) del DSM IV-TR.

Presentamos un caso de psicosis psicogénica en una mujer de 39 años y se analiza desde el modelo predisposición-trauma.

Palabras clave:
Psicosis. Psicogénica. Trauma mental.

INTRODUCTION

We need to go back to Sommer[1], the author who in 1894 first used the term psychogenic, although without clearly establishing its limits, in order to understand the historic evolution of psychogenic psychoses. Afterwards, Jaspers (1913) and Wimmer (1916) defined the concept more exactly[1,2]. However, as Lewis stated, this did not prevent it from being used vaguely and variably in the literature, thus giving rise to confusion[3].

In current classifications, psychogenic psychoses are included in the chapters and acute and transient psychotic disorders (F23) of the ICD-10[4] and within brief psychotic disorders (298.8) in the DSM IV-TR[5].

CLINICAL CASE

A case report of a 39 year-old married woman with a university degree is presented. She worked as a librarian and had no known psychiatric background. She is described as an introverted, shy, distrustful, insecure, sensitive person with low self-esteem, overprotective with her children, rigid, perfectionist, with tendency to doubt things and extremely concerned about order and cleanliness. There was a background of affective disorders in her family on her father's side.

After global insomnia for 5 days related with an important stress factor (her son was diagnosed of meningitis 5 days earlier), she developed psychotic symptoms.

She stated that on the morning prior to her admission, she suddenly felt «full of energy, and wanted to help a girlfriend of her daughter who had been sad for some time». In the afternoon, while in the hospital room with her ill son, she observed that another parent was with his son in the same room. From the parent's tone of voice («at first abrupt, then whispering and seductive...») and by the content of the conversation («they spoke about the son going to the bathroom...»), she first had the feeling and then was sure that this father abused his son, and felt sudden tachycardia and great anxiety. She called the nurses with the excuse that they should see her son and commented what she believed was happening with them so that they would watch the father «although they did not notice anything unusual».

The father began to read stories to his son. She interpreted this as a sign, reflecting on the idea that her own hus-

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band could be abusing her daughter. At dawn, she telephoned her husband, asking him if he was abusing their daughter and even asked him if his father had hurt him «he gave me a non-specific answer, which I interpreted as affirmative. After, she called her sister-in-law, commenting on what was happening, so that the family member came to the hospital alarmed. According to her, the patient had sudden changes of affective tone, going from laughter to crying, and with partial insight of the situation. Finally she agreed to go home to sleep, her husband remaining to take care of her son.

Once at home, the patient looked for signs that would confirm her suspicion. She thought that her husband could not only be abusing her daughter but also her son «which is why he asked for me when he had a fever». She found a diaper of the child in the garbage «as if hidden to hide something...» which confirmed her suspicion. She called a taxi to return to the hospital («it was taxi number 69 and the taxi driver had the same name as my husband... another unmistakable sign that verified my suspicion»). When she saw her husband, she insulted him, accusing him of abuse, so that the family member took her to the emergency service.

In the initial psychopathological examination, the patient was conscious and self and allopsychically oriented. She was suspicious, anxious and labile, with spontaneous, fluid and coherent speech, verbalizing interpretative type delusional ideation in relationship with sexual abuses to children. She showed no sensorial-perceptive alterations and had not criticism regarding the situation.

It was decided to admit her to psychiatry and a complete blood test, biochemistry test, coagulation, ECG, chest X-ray and brain CT scan were performed, no abnormalities being found. Treatment with risperidone (4 mg/day) and lorazepam (3 mg/day) was prescribed.

On the first day of admission, the patient maintained delusional ideation, then had partial insight of her ideas at some time. On the third day, the delusional theme disappeared completely. During this period, her son was transferred from the Intensive Care Unit to the Pediatrics ward. Initially, she was released on the weekends, with good adaptation to the family setting, and with no reappearance of the psychotic symptoms. Thus, when she returned to the unit, she was discharged with the diagnosis of psychogenic paranoid psychosis (ICD-10. F23.3)

DISCUSSION

In 1916, Wimmer described psychoses reactive to psychic traumas. On the contrary to Kraepelin, who considered that psychogenic caused psychoses only appeared in individuals with mental predisposition, Wimmer maintained that this is not an essential condition for the appearance of psychosis[1].

For him[2], psychogenic psychoses are a group of clinically independent psychoses whose main characteristic is found in the fact that its appearance, generally based on a predisposing constitution (defined), is precipitated by mental causes («mental traumas») in such a way that these determine the initial time of the psychosis, its fluctuations (remission, intermediate episodes, exacerbations) and very often its termination. He also indicates it as a characteristic associated to the absence of deterioration. For this author, mental trauma and not predisposition is the condition that is necessary for these psychoses to appear, although the latter often exists.

In our case, precipitating factor is the admission of a child with meningitis in an intensive care unit. After several days without sleep, the patient had sudden psychotic symptoms in relationship with the stress factor that disappeared with its resolution (clinical improvement of her son).

On the other hand, the vulnerability is seen in the patient's previous personality where sensitive-paranoid and obsessive traits seem to exist. This, together with the stress factor, seems to contribute to the sudden appearance of the psychosis in form of reaction in the Jaspers sense.

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