Panic psychosis: paroxysmal panic anxiety concomitant with auditory hallucinations in schizophrenia

Rev. Bras. Psiquiatr. 2017;39:85–86
BY-NC | doi:10.1590/1516-4446-2015-1690

Kahn & Meyers[1] has pointed to a link between classic paranoid schizophrenia and panic, suggesting a ''panic psychosis'' that is distinct from other schizophrenic diagnoses, much as psychotic depression is also distinct from schizophrenia. Veras et al.[2] described a cognitive-affective link between panic attacks and psychosis, pointing to the influence of the experience of helplessness on the symptoms of psychotic patients who experience highly intense auditory hallucinations and panic attacks. Freeman & Fowler[3] and Ruby et al.[4] described the importance of traumatic events as a common etiological element and connector between anxiety and psychosis. An important psychological contribution to psychiatric disorders is impaired psychological development during childhood. Infants and young children who experienced physical or psychological traumas during early development may be more susceptible to psychosis and panic anxiety in later life.[2]

In this case report, we highlight the importance of lifeime anxiogenic events as a trigger of paroxysmal psychotic episodes and an influence on hallucinatory content in a patient with schizophrenia and panic attacks.

A 53-year-old woman had her life marked by reported difficulties in her family relationship. Her mother was strict, and frequently required religious ''conversion'' to her own practices as a price for her daughter's wishes. Her father abused her mother in her presence, and she herself was sexually abused by him on one occasion. At 17, she developed physical and psychological symptoms of anxiety, consisting mainly of severe headaches. At 21, she was hospitalized due to worsening of those symptoms, retrospectively characterized as panic disorder according to DSM-5, characterized by short-term episodes of symptoms such as palpitation, derealization, and feeling of imminent death, despite absence of characteristic symptoms of agoraphobia. The patient was referred for psychiatric care and started on psychotropic medications.

Since adolescence, the patient used alcohol and marijuana, typically in the company of men who sexually abused her when she was intoxicated. Her relationships have never been stable, and she started to believe that men only approached her to take advantage of her. At 33, she experienced her first hallucinations, voices that accused her of being ''crazy, problematic, neurasthenic''; worsening of these symptoms caused repeated hospitalizations. She was given a DSM-5 diagnosis of schizophrenia due to persistent hallucinations and religious delusions and development of marked negative symptoms such as blunted affect, apathy, social isolation, and cognitive impairments on memory and attention. Initially, her panic attacks were characterized by recurrent episodes of severe anxiety, even with no psychotic symptoms. With progression of the disorder, the patient started to experience paroxysmal anxiety followed by hallucinations with persecutory and punitive content. Her present crises are characterized by subtle, offensive voices that curse and voices that threaten her through ''witchcraft,'' accompanied by physical symptoms such as palpitations, shortness of breath, tremors, feeling of impending doom, and derealization. Such crises, for which she often resorts to self-injurious behaviors, are usually triggered on Fridays and weekends, when ''everybody goes home'' while she remains in the hospital, anguished by the realization that she is an abandoned hospital resident without any close family contact.

The patient became more anxious and irritable when she learned she was pregnant by rape, although her harmful use of alcohol and drugs was also an influential factor in triggering anxiety symptoms. She was not able to raise the child, which was raised by her mother; this child, in turn, also became addicted to drugs during adolescence and began to live on the streets. The patient was often hospitalized intermittently, but ultimately became a full-time resident of the hospital after her mother's death 3 years ago, when other family members could not take over her care. Since then, the subtle auditory hallucinations became frequent, to the point that the patient has pierced her eardrum by introducing multiple foreign objects into her ears during crises.

Her punitive auditory hallucinations have made her focus on the traumatic framework of her life, and have been triggered by the revival of situations of aggression, invasion, and abandonment. A correlation between anxiogenic memories revived in crisis and onset of the break can be observed, highlighting that a multifactorial understanding of psychotic phenomena is required for their better management. It is clinically useful to examine the characteristics of these experiences, providing that some types of delusions or hallucinations may be a more severe manifestation of anxiety symptoms.[5] Indeed, these patients may do far better when anti-panic medication is added to their antipsychotic and combined with optimal psychotherapy.[1] In the reported case, although the patient did not tolerate augmentation with more than 1 mg/daily of clonazepam, after 12 weeks on psychotherapy and sertraline (increased from 50 to 150 mg/day), panic-hallucinatory episodes decreased and partial insight into psychotic symptoms developed. The antipsychotic dosage remained stable during the period.

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Submitted Oct 05 2015, accepted Jul 13 2016.

Disclosure

The authors report no conflicts of interest.

References

1 Kahn JP, Meyers JR. Treatment of comorbid panic disorder and schizophrenia: evidence for a panic psychosis. Psychiatr Ann. 2000;30:29-33.
2 Veras AB, Nardi AE, Kahn JP. Attachment and self-consciousness: a dynamic connection between schizophrenia and panic. Med Hypotheses. 2013;81:792-6.
3 Freeman D, Fowler D. Routes to psychotic symptoms: trauma, anxiety and psychosis-like experiences. Psychiatry Res. 2009;169:107-12.
4 Ruby E, Polito S, McMahon K, Gorovitz M, Corcoran C, Malaspina D. Pathways associating childhood trauma to the neurobiology of schizophrenia. Front Psychol Behav Sci. 2014;3:1-17.
5 Bermanzohn PC, Arlow PB, Albert C, Siris SG. Relationship of panic attacks to paranoia. Am J Psychiatry. 1999;156:1469.

Vortioxetine-induced manic mood switch in patient with previously unknown bipolar disorder

Rev. Bras. Psiquiatr. 2017;39:86
 | doi:10.1590/1516-4446-2016-2113

Vortioxetine is a new antidepressant (AD) recently introduced in Europe. With an action profile that extends beyond traditional serotonin (5-HT) reuptake blockade, it is considered a 5-HT_{3A}, 5-HT_7, and 5HT_{1D} receptor antagonist, 5-HT_{1B} partial agonist, 5-HT_{1A} agonist, and inhibitor of the serotonin transporter.[1]

Data on the safety of vortioxetine for treatment of depressive episodes in patients with bipolar disorder (BD) are still lacking. We found only one report of manic mood switch[2] and an episode of hypomania in a patient with unknown diagnosis of BD in an analysis of randomized placebo-controlled trials and open-label extension studies.[3]

We report a patient with previously undiagnosed BD who experienced a manic switch (MS) after initiating AD treatment with vortioxetine.

A 41-year-old male with at least two previous depressive episodes and paternal psychiatric family history of puerperal psychosis and recurrent depressive disorder developed a severe depressive episode. Vortioxetine (10 mg/day) was introduced with trazodone (50 mg/day) as a sleep inducer. One week later, the patient developed a MS consisting of elated mood, racing thoughts, disinhibition, irritability, and paranoid and grandeur delusions. Due to marked behavioral changes and lack of insight, the patient was involuntary admitted and AD treatment was discontinued. At admission, he scored 46 on the Young Mania Rating Scale and 13 on the Hamilton Depression Rating Scale. Blood tests including toxicological and serological screening were negative, and pharmacological treatment with olanzapine (20 mg/day) and valproic acid (1,000 mg/day) was initiated; the patient attained a provisional response after 17 days (scores reduced to 7 and 4, respectively) and was discharged to outpatient treatment with a diagnosis of BD – severe manic episode with psychotic features. At the time of writing, the patient had developed a depressive switch and been started on outpatient treatment with lithium (800 mg/day).

Even though low doses of trazodone are considered safe in BD,[4] a synergistic effect of its combination with vortioxetine inducing MS cannot be excluded. While vortioxetine appears promising as a second-line AD option, additional long-term data are still lacking,[5] and clinicians need to be aware of the possible risks of MS when prescribing this AD in monotherapy or in combination to patients with BD.

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Submitted Sep 13 2016, accepted Sep 28 2016.

Disclosure

SB was a Medical Affairs Manager for Janssen from 2010 to 2013. During the last 3 years, she has received honoraria for lectures from Lundbeck and Janssen. The other authors report no conflicts of interest.

References

1 Sanchez C, Asin KE, Artigas F. Vortioxetine, a novel antidepressant with multimodal activity: review of preclinical and clinical data. Pharmacol Ther. 2015;145:43-57.
2 Maud C. Vortioxetine in bipolar depression induces a mixed/manic switch. Australas Psychiatry. 2016;24:206-7.
3 Baldwin DS, Chrones L, Florea I, Nielsen R, Nomikos GG, Palo W, et al. The safety and tolerability of vortioxetine: analysis of data from randomized placebo-controlled trials and open-label extension studies. J Psychopharmacol. 2016;30:242-52.
4 Wichniak A, Jarkiewicz M, Okruszek Ł, Wierzbicka A, Holka-Pokorska J, Rybakowski JK. Low risk for switch to mania during treatment with sleep promoting antidepressants. Pharmacopsychiatry. 2015; 48:83-8.
5 Connolly KR, Thase ME. Vortioxetine: a new treatment for major depressive disorder. Expert Opin Pharmacother. 2016;17:421-31.