Author's response to reviews

Title: A diagnostic dilemma between psychosis and PTSD: a case report

Authors:

Ricardo Coentre (Ricardo.Coentre@netc.pt)
Paddy Power (paddy.power@slam.nhs.uk)

Version: 2 Date: 11 July 2010

Author's response to reviews: see over
Dear Editor of Journal of Medical Case Reports,

Below we give a point-by-point response to the concerns addressed by the two Referees of our article entitled “A diagnostic dilemma between psychosis and PTSD: a case report”.
We hope to have made all the necessary changes according to the concerns of both Reviewers. We also hope this new version of the manuscript was upgraded regarding publication in JMCR.

Best regards,

The authors

Ricardo Coentre, MD

Paddy Power, MD

10 July 2010
Response to Reviewer Ross White

1. In the revised manuscript we corrected the grammatical errors indicated by this reviewer:

a) The sentence:
‘Our patient had PTSD symptoms, as recurrent distressing of the traumatic event, with markedly diminished…’

was replaced by the sentence:
‘Our patient had PTSD symptoms, as recurrent distressing image of the traumatic event, with markedly diminished…’

b) The sentence:
‘Psychotic symptoms are associated with more severe symptomatology and their present is also known to decrease the efficacy of conventional treatment [16], further indicating a possible role for antipsychotic treatment.’

was replaced by the sentence:
‘Psychotic symptoms are associated with more severe symptomatology and their presence is also known to decrease the efficacy of conventional treatment [16], further indicating a possible role for antipsychotic treatment.’

2. As indicated by this reviewer we replaced patient’s age by the year in which the event occurred in order to make it easier to piece together the chronological order of events.

3. We also made a psychological formulation of the case report aimed at accounting for the emergence and maintenance of the positive symptoms of psychosis and PTSD psychosis, illustrated by the following paragraph:

‘In a psychological point of view there is a relationship between pre-existing cognitive schemas of the individual and thought patterns emerging after the traumatic event. A maladapative cognitive processing style culminates into feelings of shame, guilt and worthlessness, which emerge during trauma acting in a positive feedback to enhance symptom severity and keep the subject in a constant state of psychotic turmoil. It is possible that under certain individual specific conditions the defense and coping mechanisms break down at a level of psychotic manifestations in the form of delusions and hallucinations. It has been hypothesized that trauma may produce a psychological vulnerability for the development of psychotic experiences. In our patient factors as unwanted pregnancy, potential homelessness, and a rejected asylum claim may have contributed and triggered the emergence of psychotic features in a preceding PTSD. Some authors underline the importance that both disorders are characterized by intrusions. In PTSD the interpretation of intrusive symptoms such as flashbacks is seen as central to the maintenance of the disorder and in psychosis hallucinations and delusional beliefs are interpretations of intrusions [9].’
To complete this psychological formulation we also reviewed evidence to psychological treatments of PTSD in psychotic diseases and included some discussion of psychotherapeutic interventions in these patients:

‘Several psychotherapeutic interventions have been studied in PTSD and psychotic illnesses, with a growing literature suggesting that they are feasible and effective. Waldfogel et al. report a case of a noncombat veteran man with PTSD with psychotic symptoms not successfully treated with antipsychotics and in which exposure therapy was successful in treating PTSD and psychosis [23]. Mueser et al. published a randomized controlled trial of cognitive-behavioral treatment of posttraumatic stress disorder in severe mental illness, which includes breathing retraining, education about PTSD and cognitive restructuring. Results showed that patients included in a 12- to 16-session CBT program improved more in PTSD symptoms, other symptoms, perceived health, negative trauma-related beliefs, knowledge about PTSD, and case manager working alliance compared with treatment as usual (TAU), where patients continued to receive the usual treatments they had been doing in local mental health centers [24]. Frueh et al. report an open trial in adults with PTSD and either schizophrenia or schizoaffective disorder treated via an 11-week cognitive-behavioral intervention, with 22 group and individual sessions for PTSD consisting of anxiety management therapy, psycho-education, social skills training and exposure therapy. Participants had significant PTSD symptom improvement and high treatment satisfaction [25]. Besides the psychopharmacological therapy, our patient will benefit from one of these psychotherapeutic programs targeting PTSD symptoms.’

4. In this revised version of the case report we make it clear that PTSD (emerged in 1999) preceded psychosis (emerged in 2003) in four years. This information is now clearer with the inclusion of the following sentence:

‘We describe a case report of a patient with PTSD with psychotic symptoms. Her PTSD developed soon after a severe traumatic experience associated with civil war in 1999: witnessing the murder of her nuclear family. In 2003 she developed psychotic symptoms, which included auditory and visual hallucinations and persecutory delusions.’

Both symptoms (PTSD and psychosis) became worse in 2009, months before instay. This information is now clearer with the introduction of the following sentence:

‘Few months before her first contact with mental health services in 2009, her psychotic symptoms and PTSD features became more frequent and intense.’

Information about the development of PTSD symptoms soon after the traumatic event associated with the murder of her nuclear family was obtained only by self-report. We recognize this as a limitation of our clinical approach. In this revised formulation of the
case report we included a paragraph underlining that all information was based on self-report:

‘Because our patient has no friends or family in UK, diagnosis was based only in self-reported information which is a less rigorous approach than using other sources of information to corroborate patient’s account.’

5. In this revised case report we give more details about the symptoms concerning ongoing PTSD symptoms after discharge from hospital:

‘She continues to have ongoing PTSD symptoms associated with the initial tragic event. Persistent remembering of the stressor event with recurring and vivid memories, nightmares, hyperarousal and initial insomnia are persistent PTSD symptoms present after discharge from hospital. She also avoids circumstances resembling the initial stressor event like wars and violence.’

6. Like we made clear in point 4 all information about symptom change was made based on self-report and unstructured clinical interviews. We included a sentence suggesting that the use of rating scales or structured interview is useful in clinical setting:

‘Structured clinical interview and the use of specific measure instruments could also help in rating symptoms and promote improvement in clinical daily routine.’

7. We made all the revisions necessary for publication proposed by the reviewer:

a) The revised manuscript includes a psychological formulation for the emergence of the psychosis (see point 3).

b) We make clearer the chronological order of the events and limitations associated with gathering this information (see points 2 and 4).

c) We gave more detail on symptom changes and how it was measured (see points 5 and 6).

d) The revised discussion is more conclusive about clinical implications of this case report, including: a) the psychological formulation; b) the importance of getting other sources of information to corroborate the patient’s account; c) the use of appropriate assessments and structured clinical interviews. Following sentences are illustrative:

‘Because our patient has no friends or family in UK, diagnosis was based only in self-reported information which is a less rigorous approach than using other sources of information to corroborate patient’s account. Structured clinical interview and use of specific measure instruments could also help in rating symptoms and promote improvement in clinical daily routine.’
Psychological formulation addressing potential causes of PTSD and psychosis that could be treated with psychological interventions (as CBT) is essential.
**Response to Reviewer Kim T Mueser**

1. In the revised manuscript we included a psychological formulation of the case report:

   ‘In a psychological point of view there is a relationship between pre-existing cognitive schemas of the individual and thought patterns emerging after the traumatic event. A maladaptative cognitive processing style culminates into feelings of shame, guilt and worthlessness, which emerge during trauma acting in a positive feedback to enhance symptom severity and keep the subject in a constant state of psychotic turmoil. It is possible that under certain individual specific conditions the defense and coping mechanisms break down at a level of psychotic manifestations in the form of delusions and hallucinations. It has been hypothesized that trauma may produce a psychological vulnerability for the development of psychotic experiences. In our patient factors as unwanted pregnancy, potential homelessness, and a rejected asylum claim may have contributed and triggered the emergence of psychotic features in a preceding PTSD. Some authors underline the importance that both disorders are characterized by intrusions. In PTSD the interpretation of intrusive symptoms such as flashbacks is seen as central to the maintenance of the disorder and in psychosis hallucinations and delusional beliefs are interpretations of intrusions [9].’

2. We included some discussion of psychotherapeutic interventions in PTSD that have been developed for patients with psychotic symptoms and we recognize that our patient will benefit from these besides the pharmacological treatment and CBT to psychosis:

   ‘Several psychotherapeutic interventions have been studied in PTSD and psychotic illnesses, with a growing literature suggesting that they are feasible and effective. Waldfogel et al. report a case of a noncombat veteran man with PTSD with psychotic symptoms not successfully treated with antipsychotics and in which exposure therapy was successful in treating PTSD and psychosis [23]. Mueser et al. published a randomized controlled trial of cognitive-behavioral treatment of posttraumatic stress disorder in severe mental illness, which includes breathing retraining, education about PTSD and cognitive restructuring. Results showed that patients included in a 12- to 16-session CBT program improved more in PTSD symptoms, other symptoms, perceived health, negative trauma-related beliefs, knowledge about PTSD, and case manager working alliance compared with treatment as usual (TAU), where patients continued to receive the usual treatments they had been doing in local mental health centers [24]. Frueh et al. report an open trial in adults with PTSD and either schizophrenia or schizoaffective disorder treated via an 11-week cognitive-behavioral intervention, with 22 group and individual sessions for PTSD consisting of anxiety management therapy, psycho-education, social skills training and exposure therapy. Participants had significant PTSD symptom improvement and high treatment satisfaction [25]. Besides the psychopharmacological therapy, our patient will benefit from one of these psychotherapeutic programs targeting PTSD symptoms.’
We also included in the revised manuscript references of psychological treatments for PTSD and psychosis as suggested by the reviewer:

