Case Report

Journal Homepage: http://crcp.tums.ac.ir

An Acute and Transient Psychotic Disorder in a Male Victim of Rape: A Case Report and a Nosological Question

Ruohollah Seddigh[1], **Amir-Abbas Keshavarz-Akhlaghi**[1], **Mahdieh Saeidi**[2]

1. Research center of addiction and risky behavior, Department of psychiatry, school of medicine, Iran University of Medical Sciences, Tehran, Iran.
2. Department of Psychiatry, School of Medicine, Iran University of Medical Sciences, Tehran, Iran.

Use your device to scan and read the article online

Citation Seddigh R, Keshavarz-Akhlaghi AA, Saeidi M. An Acute and Transient Psychotic Disorder in a Male Victim of Rape: A Case Report and a Nosological Question Case Reports in Clinical Practice. 2021; 6(Special Issue):298-302.

Running Title ATPD as an Adjustment Disorder

Article info:

Received: 28 November 2021

Revised: 11 December 2021

Accepted: 28 December 2021

Keywords:

Psychosis; Psychotic Disorder; Rape; Violence; Sex Offenses; Adjustment disorder

ABSTRACT

Stress has a significant role in developing Acute and Transient Psychotic Disorder (ATPD). The condition resolves after stress termination without relapse for long years in many cases. So this kind of psychosis can be different from other psychosis in terms of etiology and prognosis. We report an 18-year-old male patient with an acute and transient psychotic disorder who experienced a psychotic episode after a rape. His psychosis was remitted without any antipsychotic medications. This case raises an important question: Why should this kind of psychosis be classified under a psychotic branch of psychiatric disorders classification and not under more benign disorders such as adjustment disorder.

Introduction

Stress has been assumed as a risk factor for developing Acute and Transient Psychotic Disorder (ATPD). About two-thirds of non-affective remitting psychosis experienced significant stress in one month preceding the onset of symptoms [1]. On the other hand, compared to the other types of psychosis, it has a more benign course and about 30% experience no relapse over 15 years of follow-up [2]. This means a subtype of psychosis triggered by stress with no relapse over the years. Stress also has a significant role in preceding other disorders like adjustment disorder and Post Traumatic Stress Disorder (PTSD). But, there is a lack of research for explaining who is vulnerable to experiencing psychosis instead of adjustment disorder or PTSD after

*** Corresponding Author:**
Ruohollah Seddigh, MD
Address: *Spiritual Health Research Center, Iran University of Medical Sciences, Tehran, Iran.*
E-mail: *ruohollahseddigh@gmail.com*

stress. There is also the proper classification of ATPD among psychiatric disorders.

Case Presentation

An 18-year-old young man (single, high school graduate, employed, low socioeconomic status) developed persecutory and reference delusions along with auditory and visual hallucinations, incomprehensible speech, and a high level of anxiety three days after experiencing rape by three of his colleagues, all of them men. This was the main and only stressor of a patient during the last month. The content of his delusions and hallucinations did not relate to the event. In comprehensive assessments, there were no symptoms of mood disorders, no history of substance or medication use, no history of medical problems, no psychiatric illness history in himself and his family, and no history of childhood abuse. Laboratory data were unremarkable, including Liver, kidney, and thyroid function tests, complete blood counts, hepatitis B and C, syphilis, HIV tests, urine toxicology, and brain MRI.

Two different independent psychiatrists (associate professors of psychiatry) interviewed him to establish the diagnosis, and finally, ATPD was diagnosed based on ICD-10.

At the onset of admission, we prescribed 1 mg of clonazepam for insomnia. His symptoms disappeared for 2 weeks without any other interventions. In the follow-up to 1 year, there was no relapse. Two months after complete remission, we did Millon's Clinical Multiaxial Inventory-III (MCMI-III), Coping Scale Revised Checklist (CSRC), and Social Skills Inventory (SSI) for him. The following paragraphs are the results:

MCMI-III: "Mr. ….. Has personality disorder not otherwise specified with avoidant personality traits. Because of fear of rejection due to social disapproval, patients with this profile tend to isolate themselves physically and emotionally. Although they appear without problem, they experience ongoing conflicts internally. On the one hand, they want to have a relationship, and on the other hand, they are hypersensitive to disapproval. They are vulnerable to react to stress more intensely because of their hypervigilance to threats. They may have traumatic early childhood experiences like rejection and aggression."

CSRC: "His coping strategies are mainly emotional and ineffective compared with problems solving focused strategies. Among emotional and ineffective focused strategies, scores on denial, magical thinking, and searching for emotional support are high. His tendency for positive re-appraisal of negative events is high, but acceptance is low."

SSI: "His general social skills are low. Scores of five dimensions are medium but in the lower limit, including emotional expressivity, sensitivity and control, and social expressivity and control. The score of social sensitivity is low. This pattern means his skills in sending, receiving, interpreting, controlling, and regulating non-verbal messages are medium; and his skills in engaging others in social discourse and self-presenting verbally are medium, but his skill in interpreting the verbal communication of others and also sensitivity to and understanding of the norms governing appropriate social behavior is low."

Discussion

In our case report, we describe the case of a patient with ATPD shortly after rape in a healthy man without a previous psychiatric history. Pieces of evidence show that the rape of men by men is not rare [3]. We discuss our case in two dimensions: the relationship between stress and psychosis and a nosological discussion about psychosis after pressure.

The relationship between stress and psychosis: Until relatively recently, the research examining associations between stress and psychosis has focused mainly on stressful life events (e.g., loss of a family member, parental divorce, serious illness, the birth of a child, etc.), with particular attention to events that are uncontrollable and relatively independent of the patient's disease [4]. But more recently, some researchers have broadened the focus to examine the impact of minor stressors or "daily hassles" (e.g., rushing to meet a deadline, transportation problems, etc.) on patients with psychoses [5]. But there is little attention on rape as a traumatic event shortly before the onset of psychosis. Also, there is no report of psychosis resulting from rape in the literature review [6, 7]. There is no report of the rape of men in Iran.

On the other hand, there is mounting evidence that is experiencing childhood trauma, including exposure to sexual, physical, or emotional abuse, physical and emotional neglect, and loss of a parent renders individuals more vulnerable to developing psychosis later in life [8]. These traumas increase stress reactivity later in life, suggestive of an underlying process of behavioral sensitization [9]. Our patient didn't have any significant stress in his early childhood experiences and later life. This can explain why he went into remission fast.

The number of reported male rape appears to be higher among military personnel, prison inmates, and the gay and bisexual communities [10, 11]. On the other hand, men who experience sexual assault are more likely to report mental illness, poor life satisfaction, activity limitations, and lower emotional and social support than women who experience rape [12]. Considering these points, our case report highlights the importance of keeping rape in mind, psychiatrists in men, and intervening appropriately.

A nosological discussion about psychosis after the stress: In developed countries, the incidence rate of ATPD that remained diagnostically stable for 3 years is about 1.36 per 100,000 [13, 14], and in developing countries, tenfold higher (13 per 100,000) [15, 16]. These psychoses comprise 35% of all first contact non-affective psychoses in developing countries compared to only 6% in industrialized countries [17].

About 35.5% to 73.3% of patients with baseline ATPD retained their diagnoses in Asia over 3-12 years. Most individuals with polymorphic subtypes of ATPD in India and Hong Kong were re-diagnosed with bipolar disorder after 3-5 years. 31.2% of polymorphic cases in Japan were diagnosed as schizophrenia after 12 years of follow-up [18, 19]. Although there are inconsistencies in these reports, one can conclude that at least one-third of patients with ATPD remain diagnostically stable over the years. Considering the incidence rate of ATPD in developing countries (13 per 100,000), about 5 per 100,000 patients in developing countries who develop ATPD remain stable over the years.

Here raise an essential question: who is vulnerable to developing this kind of psychosis? Although the answer is unclear, different authors have answered these questions with other approaches. These patients have more hysterical and affective features, more vulnerable personalities, higher stress experienced in their life before illness, and relatively better prognosis [20].

Patients with ultra-high risk for developing psychosis are significantly more distressed by events, cope more poorly, and utilize ineffective strategies [21]. Some patients develop psychosis or experience symptom exacerbation when the number of stressful life events exceeds the patient's tolerable threshold (threshold effect). For example, a longitudinal population study revealed that recent adverse life events increased the risk of psychotic symptom presentation, but only in the group exposed to ten or more negative events [22]. Even minor stressors can mediate psychosis in persons with more significant emotional reactivity to stressors [23].

Behaviorally, psychotic patients use emotion-focused coping frequently, and effective coping correlates with less severe negative symptoms, greater perceived self-efficacy, social support, and greater use of problem-focused coping. Self-efficacy and social support predict the increased frequency of the use of problem-focused coping [24]. There are also unexpected findings: sometimes exposure to trauma decreases the incidence of psychotic experiences because of post-trauma positive changes or re-appraisal for successful adaptation [25]. Indeed, poorer premorbid adjustment during adolescence may predict a more inadequate response to antipsychotics in schizophrenic patients [26].

Evidence supports this hypothesis that teaching problem solving can be a possible candidate for a primary prevention program for major mental disorders [27]. Social skill deficits may also be a vulnerability marker for schizophrenia and other mental disorders [28, 29]. We didn't find these findings in ATPD, but theoretically, they can be generalized to other psychosis. Some patients develop psychosis after significant stress with the benign course that may go to remission without medication (like our case). They have some characteristics that vulnerable them to experience psychopathology along with some features that protect them from experiencing more severe pathologies. As if they react to stress with psychosis, they use their behavioral and cognitive repertoire to cope with it. This pattern is something like an adjustment disorder. Here, nosological questions about some kinds of ATPD raise: is it possible that this psychosis classifies as an adjustment disorder? For example, "adjustment disorder with a psychotic feature." Historically, reactive psychosis is the same. Research in this field should be done to answer this question.

Ethical Considerations

Compliance with ethical guidelines

All ethical principles are considered in this article. The participants were informed of the purpose of the research and its implementation stages. They were also assured about the confidentiality of their information and were free to leave the study whenever they desired. The research results would be available to them. Permission was granted to use participants' data for current research by obtaining informed consent in Persian language based on the Declaration of Helsinki.

Funding

This research did not receive any grant from funding agencies in the public, commercial, or non-profit sectors.

Conflict of interest

The authors declared no conflict of interest.

References

[1] Alaghband-Rad J, Boroumand M, Amini H, Sharifi V, Omid A, Davari-Ashtiani R, et al. Non-affective acute remitting psychosis: A preliminary report from Iran. Acta Psychiatrica Scandinavica. 2006; 113(2):96-101. [DOI:10.1111/j.1600-0447.2005.00658.x] [PMID]

[2] Möller HJ, Jäger M, Riedel M, Obermeier M, Strauss A, Bottlender R. The Munich 15-year follow-up study (MUFUSSAD) on first-hospitalized patients with schizophrenic or affective disorders: comparison of psychopathological and psychosocial course and outcome and prediction of chronicity. European Archives of Psychiatry and Clinical Neuroscience. 2010; 260(5):367-84. [DOI:10.1007/s00406-010-0117-y] [PMID]

[3] Black M, Basile K, Breiding M, Smith SG, Walters ML, Merrick MT, et al. National intimate partner and sexual violence survey: 2010 summary report 2011. Atlanta: Centers for Disease Control and Prevention; 2011. https://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf

[4] Holtzman CW, Trotman HD, Goulding SM, Ryan AT, Macdonald AN, Shapiro DI, et al. Stress and neurodevelopmental processes in the emergence of psychosis. Neuroscience. 2013; 249:172-91. [DOI:10.1016/j.neuroscience.2012.12.017] [PMID] [PMCID]

[5] Phillips LJ, Francey SM, Edwards J, McMurray N. Stress and psychosis: Towards the development of new models of investigation. Clinical Psychology Review. 2007; 27(3):307-17. [DOI:10.1016/j.cpr.2006.10.003] [PMID]

[6] Belik SL, Stein MB, Asmundson GJ, Sareen J. Relation between traumatic events and suicide attempts in Canadian military personnel. The Canadian Journal of Psychiatry. 2009; 54(2):93-104. [DOI:10.1177/070674370905400207] [PMID]

[7] Sundaram V, Laursen B, Helweg-Larsen K. Is sexual victimization gender specific? The prevalence of forced sexual activity among men and women in Denmark, and self-reported well-being among survivors. Journal of Interpersonal Violence. 2008; 23(10):1414-40. [DOI:10.1177/0886260508314305] [PMID]

[8] Varese F, Smeets F, Drukker M, Lieverse R, Lataster T, Viechtbauer W, et al. Childhood adversities increase the risk of psychosis: A meta-analysis of patient-control, prospective-and cross-sectional cohort studies. Schizophrenia Bulletin. 2012; 38(4):661-71. [DOI:10.1093/schbul/sbs050] [PMID] [PMCID]

[9] Scott JG, Ross CA, Dorahy MJ, Read J, Schäfer I. Childhood trauma in psychotic and dissociative disorders. In: Moskowitz A, Dorahy MJ, Schäfer I, editors. Psychosis, Trauma and Dissociation: Evolving Perspectives on Severe Psychopathology. Hoboken: Wiley; 2018. https://onlinelibrary.wiley.com/doi/book/10.1002/9781118585948

[10] Choudhary E, Coben J, Bossarte RM. Adverse health outcomes, perpetrator characteristics, and sexual violence victimization among US adult males. Journal of Interpersonal Violence. 2010; 25(8):1523-41. [DOI:10.1177/0886260509346063] [PMID]

[11] Sutton TE, Simons LG, Tyler KA. Hooking-up and sexual victimization on campus: Examining moderators of risk. Journal of Interpersonal Violence. 2021; 36(15-16):NP8146-NP8175. [DOI:10.1177/0886260519842178] [PMID]

[12] Grossman SF, Lundy M, Bertrand C, Ortiz C, Tomas-Tolentino G, Ritzema K, et al. Service patterns of adult survivors of childhood versus adult sexual assault/abuse. Journal of Child Sexual Abuse. 2009; 18(6):655-72. [DOI:10.1080/10538710903317265] [PMID]

[13] Addington J, Chaves A, Addington D. Diagnostic stability over one year in first-episode psychosis. Schizophrenia Research. 2006; 86(1-3):71-5. [DOI:10.1016/j.schres.2006.04.018] [PMID]

[14] Yoviene Sykes LA, Ferrara M, Addington J, Bearden CE, Cadenhead KS, Cannon TD, et al. Predictive validity of conversion from the clinical high risk syndrome to frank psychosis. Schizophrenia Research. 2020; 216:184-91. [DOI:10.1016/j.schres.2019.12.002] [PMID] [PMCID]

[15] Susser E, Wanderling J. Epidemiology of nonaffective acute remitting psychosis vs schizophrenia: Sex and sociocultural setting. Archives of General Psychiatry. 1994; 51(4):294-301. [DOI:10.1001/archpsyc.1994.03950040038005] [PMID]

[16] Stephen A, Lui F. Brief Psychotic Disorder. Treasure Island: StatPearls Publishing; 2019. https://www.ncbi.nlm.nih.gov/books/NBK539912/

[17] Cutler JL. Kaplan and Sadock's synopsis of psychiatry. Journal of Psychiatric Practice. 2016; 22(1):68-9. [DOI:10.1097/PRA.0000000000000126]

[18] Udomratn P, Burns J, Farooq S. Acute and transient psychotic disorders: An overview of studies in Asia. International Review of Psychiatry. 2012; 24(5):463-6. [DOI:10.3109/09540261.2012.715579] [PMID]

[19] Malhotra S, Sahoo S, Balachander S. Acute and transient psychotic disorders: Newer understanding. Current Psychiatry Reports. 2019; 21(11):113. [DOI:10.1007/s11920-019-1099-8] [PMID]

[20] Kapur R, Pandurangi A. A comparative study of reactive psychosis and acute psychosis without precipitating stress. The British Journal of Psychiatry. 1979; 135(6):544-50. [DOI:10.1192/bjp.135.6.544] [PMID]

[21] Phillips LJ, Edwards J, McMurray N, Francey S. Comparison of experiences of stress and coping between young people at risk of psychosis and a non-clinical cohort. Behavioural and Cognitive Psychotherapy. 2012; 40(1):69-88. [DOI:10.1017/S1352465811000397] [PMID]

[22] Lataster J, Myin-Germeys I, Lieb R, Wittchen HU, Van Os J. Adversity and psychosis: A 10-year prospective study investigating synergism between early and recent adversity in psychosis. Acta Psychiatrica Scandinavica. 2012; 125(5):388-99. [DOI:10.1111/j.1600-0447.2011.01805.x] [PMID]

[23] Docherty NM, St-Hilaire A, Aakre JM, Seghers JP. Life events and high-trait reactivity together predict psychotic symptom increases in schizophrenia. Schizophrenia Bulletin. 2009; 35(3):638-45. [DOI:10.1093/schbul/sbn002] [PMID] [PMCID]

[24] MacDonald EM, Pica S, McDonald S, Hayes RL, Baglioni AJ. Stress and coping in early psychosis: Role of symptoms, self-efficacy, and social support in coping with stress. The British Journal of Psychiatry. 1998; 172(S33):122-7. [DOI:10.1192/S0007125000297778] [PMID]

[25] Rossi A, Di Tommaso S, Stratta P, Riccardi I, Daneluzzo E. How much stress is needed to increase vulnerability to psychosis? A community assessment of psychic experiences (CAPE) evaluation 10 months after an earthquake in L'Aquila (Italy). European Archives of Psychiatry and Clinical Neuroscience. 2012; 262(3):265-8. [DOI:10.1007/s00406-011-0258-7] [PMID]

[26] Crespo-Facorro B, Pelayo-Terán JM, Pérez-Iglesias R, Ramírez-Bonilla M, Martínez-García O, Pardo-García G, et al. Predictors of acute treatment response in patients with a first episode of non-affective psychosis: Sociodemographics, premorbid and clinical variables. Journal of Psychiatric Research. 2007; 41(8):659-66. [DOI:10.1016/j.jpsychires.2006.05.002] [PMID]

[27] Falloon IR. Problem solving as a core strategy in the prevention of schizophrenia and other mental disorders. Australian and New Zealand Journal of Psychiatry. 2000; 34:S185-90. [DOI:10.1080/000486700242] [PMID]

[28] Pinkham AE, Penn DL, Perkins DO, Graham KA, Siegel M. Emotion perception and social skill over the course of psychosis: A comparison of individuals "at-risk" for psychosis and individuals with early and chronic schizophrenia spectrum illness. Cognitive Neuropsychiatry. 2007; 12(3):198-212. [DOI:10.1080/13546800600985557] [PMID]

[29] Tognin S, Catalan A, Modinos G, Kempton MJ, Bilbao A, Nelson B, et al. Emotion recognition and adverse childhood experiences in individuals at clinical high risk of psychosis. Schizophrenia Bulletin. 2020; 46(4):823-33 [DOI:10.1093/schbul/sbz128] [PMID] [PMCID]