

Clinical Psychopathology During Covid-19 Pandemic

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ABSTRACT

The coronavirus disease 2019 (COVID-2019) pandemic and its consequences on individuals' social, economic, and familial lives have negatively affected mental health of the general population especially in a vulnerable individual. In this case reports, we aim to highlight the role of such psychosocial stressors related to COVID pandemic resulting in development of Acute Psychosis. In the first case the stressor is associated with fear of getting infected while in the second case fear of being put into Quarantine. Thus, health measures should be employed to address psychosocial stressors, particularly related to the use of isolation/quarantine, infection fear and vulnerability among the general population.

Keywords: clinical; COVID-19; pandemic, Nepal.

INTRODUCTION

The coronavirus disease 2019 (COVID-19) pandemic began at the end of 2019 in China and has quickly spread globally.^{1,2} Evidence from studies indicate that the COVID-19 pandemic has profound psychological and social effects.^{1,3} There are several factors which could increase risk of mental disorders. These include fear of infection, strict social distancing, travel restrictions, temporary unemployment, home-schooling children, working from home and sudden financial crisis which could lead to the increased stress levels.³ Various studies conducted across the globe have shown an increased prevalence rate of increased stress reactions, anxiety, depression, suicide, homicide, and psychosis among the people.^{4,8} Here, we report two cases of acute psychosis presented in the psychiatry department of a tertiary hospital in Bharatpur, without past or family history of mental illness and briefly discuss the relevant

literature on COVID -19 pandemic associated psychosis.

Case description: 1

45-year-old married female with well-adjusted premorbid personality with no past and family history of mental illness presented to Psychiatry outpatient department with a total duration of illness of 2weeks. Three weeks back, the patient had talked to one of her relatives over her mobile phone, who had returned from India recently. After one week, the patient came to know that her relative had been diagnosed as COVID positive. After hearing about this news, the patient started to appear fearful and avoided touching her mobile phone. She would express suspiciousness that a virus has entered through her phone and she has also become infected with coronavirus as she had spoken to the relative. She would also not allow family members to touch her phone. She would appear withdrawn to herself mostly, while restless at times. Her

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family members took her to a nearby hospital and performed her PCR test after 3 days. The report came out to be negative. However, the patient would not get convinced with her reports. She would not interact with family members and stay away from them saying viruses would get transmitted to them. Patient would not perform her household chores as before. Patient has been having difficulty in initiating her sleep and her appetite has also decreased than before. Patient denied hearing of non-existing voices. Physical examination revealed no pathological findings. Laboratory testing showed deranged thyroid function test showing features suggestive of subclinical hypothyroidism. Her BPRS score was 52 on admission.

A Course of Disease

Patient was admitted in our department and initiated Olanzapine 5mg optimized up to 15 mg/day and Lorazepam 2mg. Non pharmacological techniques such as Group therapy, Cognitive behavior therapy and activity scheduling were applied. This led to subsidence of symptoms and the patient was discharged after 1 week of inpatient treatment. Her BPRS score on discharge was 19. However, during the follow up after 2 weeks of discharge the patient started complaining of swelling of body and her blood report showed raised blood sugar. So, Olanzapine was cross tapered with Aripiprazole 15 mg. Patient had then maintained well on Aripiprazole 15 mg.

Case description: 2

A 53 years old female with well-adjusted premorbid personality with no past and family history of mental illness presented to the psychiatry outpatient department with a total duration of illness of one week. Patient had visited one of her neighbors two weeks back who had returned from abroad who was later diagnosed as COVID positive. During that period local authorities were given responsibility for contact tracing. Patient had heard that they would put

the asymptomatic positive cases in quarantine. After knowing about this, the patient started worrying that she would be put to quarantine. The following night the patient had difficulty falling asleep. Next morning the patient refused to come out of her room and appeared fearful. She would hide behind the door and express that local authority had come outside her house and expressed they would take the patient to quarantine. Family members tried to assure the patient that no one had come to their house but she insisted on hearing the voices say quarantine. The patient would also be found muttering to herself at times. When family members would be talking to themselves, she would become suspicious that they were also involved in sending her to quarantine. She refused to eat food given by the family members. So, she was forcefully brought to the Psychiatric outpatient department and got admitted. Her BPRS score on admission was 56. She was started on 2 mg of Risperidone and 1mg of Lorazepam along with group therapy and cognitive behavior therapy. There was subsidence of symptoms and the patient was discharged after 10 days. At the time of discharge her BPRS score was 18.

DISCUSSION

The cases reported presented with symptoms that met the diagnostic criteria of acute and transient psychotic disorder as per ICD-10. Both the cases discussed had short duration of illness and symptoms subsided in up to 10 days after admission to hospital. The triggering factor in both the cases was the concern about COVID-19 pandemic. In the first case, there was fear of getting infected by a virus. Studies have shown that fear responses in both the uninfected and infected may reach psychopathological levels that require psychiatric interventions.⁹ While in the second one there was fear of being put into quarantine. Quarantine separates persons who have been potentially exposed to an infectious agent and thus at risk for disease from the general

community. Evidence from previous quarantining during previous infectious disease outbreaks highlights negative psychological effects, including trauma and stress related disorder symptoms, confusion, and anger, especially in cases of long quarantine duration, infection fears, financial loss, stigma, and inadequate support, supplies, and information.¹⁰⁻¹³ Both case studies illustrate the psychological potential that the crisis caused by the COVID-19 pandemic has on at-risk groups of psychiatric patients. Research reports that stress can increase dopamine levels in the brain, causing psychosis hence postulating the role of psychological stress to trigger psychosis in vulnerable persons.¹⁴ Evidence indicates that women^{15,16} younger people¹⁷, and those with a poor sleep quality^{15,17} are at an increased risk for mental health problems during this pandemic. Both the cases reported in this study are women. According to CARE's Rapid Gender Analysis and the impact of the pandemic on men's and women's lives across 38 countries, the number of women who reported mental health impacts from COVID-19 was threefold that of men.¹⁸ In the context of Nepal women affected most were daily wage-workers, farmers, landless women, women working in the adult entertainment sector, women from Dalit and Madhesi communities, gender and sexual minorities, women from geographically disadvantaged locations, women with disabilities, adolescent girls, wives of migrant husbands, displaced women, and those living with HIV AIDS.¹⁹ Given the multitude and complexity of stressors contributing to varying psychological symptoms, addressing mental health during the COVID-19 pandemic has utmost importance. It will require a series of strategies aimed at prevention, surveillance, diagnosis, early intervention, continuity of care

for those with pre-existing conditions and mental and behavioral health crisis management. It is advisable to public health officials to employ quarantine as an infection control measure only when it is deemed necessary and to consider these primary stressors.²⁰ To reduce fear and panic regarding COVID-19 situation, it is essential that people hear the more sensible and authentic messages about COVID-19 and respond in a more measured way. Effective communication and knowledge sharing is important. It is recommended that support both short and long term approaches to COVID-19 should be gender-responsive and inclusive in order to ensure the needs, priorities of at-risk groups integrated in preparation, response, recovery and rehabilitation processes.¹⁹ Addressing the considerable increase in adverse mental and behavioral health during the COVID-19 pandemic serves as an opportunity to improve the accessibility, promotion, scale, and effectiveness of mental and behavioral health services that could save lives, reduce the social and economic consequences of adverse mental health and improve health and well-being during and beyond the pandemic.^{21,22}

CONCLUSIONS

This study on case reports shows that the emotional impact of stress and lifestyle related to the pandemic can have a severe effect on people who never had any contact with psychiatric services before. The emerging mental health issues related to this COVID 19 pandemic may evolve into long-lasting health problems. Thus, health measures should be employed to address psychosocial stressors, particularly related to the use of isolation/quarantine, infection fear and vulnerability among the general population.

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