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A case of organic psychosis: the therapeutic interventions and challenges in a structured Rehabilitation setting.

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Introduction

Psychotic disorders involve aberrations in one or more of the following categories: delusions, hallucinations, disorganized speech (thought), grossly disorganized or abnormal motor behavior (catatonia included), and negative symptoms. Organic psychosis specifically applies to psychotic features resulting from a recognized physiological disorder affecting the brain, such as neurological disorders, infections, metabolic derangements, or the use of substances. These conditions can cause profound changes in perception, cognition, affect, and behavior, usually needing a multidisciplinary therapeutic approach to manage them effectively.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) identifies organic psychosis as a type of "psychotic disorder due to another medical condition." Organic psychosis necessitates the identification of a causative medical condition with a temporal association with the onset of psychotic symptoms. The course, prognosis, and treatment plan may significantly differ from those for primary psychotic disorders such as schizophrenia because of the underlying organic cause.

This case report discusses the clinical presentation, diagnostic process, and therapeutic management of a 33-year-old male patient diagnosed with organic psychosis. It demonstrates the role of early detection, pharmacological management, and psychological intervention in the restoration of functioning and enhancement of quality of life. Through this report, we hope to draw attention to the intricacies involved in diagnosing and managing psychosis with an organic cause, underlining the necessity of a biopsychosocial approach.

Case Presentation

The patient, under the pseudonym XYZ, is a 33-year-old unmarried male who was admitted to the psychiatric hospital by his family because of the presence of profound behavioral changes, disorganized thoughts, and prominent functional deterioration during the past few months. XYZ had no previous psychiatric history and was otherwise well-functioning in his occupational and social life.

Based on collateral history presented by his parents, XYZ started showing changes around five months before his admission. Early signs were social withdrawal, irritability, and sleep disturbance. Thesegradually evolved into frank psychotic symptoms like paranoid delusions, auditory and visual hallucinations, and disorganized behavior. The family noted that XYZ often complained of neighbors and relatives conspiring against him, talked to himself, and sometimes showed violent behavior without any reason.

Upon admission, a thorough clinical and neurological assessment was conducted. XYZ was unkempt, with poor eye contact and compromised reality testing. He was fearful and confused, often scanning the surroundings as if reacting to internal stimuli.

His speech was circumstantial and incoherent, and his mood was apprehensive with an affect that was limited but labile. He showed limited insight and judgment and did not recognize the pathological quality of his experiences.

With the acute onset of symptoms in a previously healthy adult, together with some neurological findings such as occasional tremors and slight disorientation, further investigations were undertaken to exclude an underlying organic cause. A comprehensive medical work-up, including laboratory evaluation and neuroimaging, disclosed abnormalities indicative of an organic brain disorder being a cause of the psychotic presentation. A diagnosis of Psychotic Disorder Due to Another Medical Condition (Organic Psychosis) was thereby made, in line with DSM-5 criteria.

It was always verbally hinted that the symptoms began appearing after the patient was once kidnapped which led to a brain injury.

The patient was hospitalized in the inpatient psychiatry unit for stabilization, close observation, and initiation of treatment.

Assessment and Diagnosis

At admission, XYZ was subjected to a thorough biopsychosocial evaluation, including clinical interview, mental status examination (MSE).

Mental Status Examination (MSE):

Appearance & Behavior: The patient was disheveled, with poor grooming and hygiene. He was restless and hypervigilant, often looking around the room.

Speech: His speech was spontaneous but tangential, with loose associations and frequent derailments.

Mood & Affect: XYZ reported feeling "anxious and confused." His affect was constricted but labile, alternating between fear and anger.

Thought Process: Disorganized, with flight of ideas and circumstantial evidence.

Thought Content: Characterized by persecutory delusions (e.g., neighbors following him) and second-person commanding auditory hallucinations.

Perception: Auditory hallucinations featured most prominently. No visual hallucinations or hallucinations of a tactile nature reported.

Cognition: Oriented to person but not to time and place. Attention and concentration were compromised.

Insight & Judgment: Poor insight. Grossly impaired judgment, usually functioning on the basis of delusional beliefs.

Physical and Neurological Examination:
Mild tremor and unsteadiness of gait were the only neurological signs. Gross motor examination did not reveal any deficits. No signs of head injury or frank systemic disease were noted at presentation.
Investigations:
Neuroimaging (MRI Brain): Detected cortical atrophy and slight enlargement of the ventricles suggesting a baseline neurodegenerative or organic process.
EEG: Demonstrated non-specific changes with intermittent slow-wave activity.
Blood Tests: Routine biochemical and hematological investigations were within normal limits. Infection, autoimmune, and thyroid function screening was uneventful.

Diagnosis:
Following clinical presentation, collateral history, neuroimaging results, and exclusion of primary psychiatric disorders, the diagnosis was made as:
Psychotic Disorder Due to Another Medical Condition (Organic Psychosis)
(As per DSM-5 criteria; ICD-10 Code: F06.2)

The organic cause was highly indicated by the concomitant late onset, unusual presentation, cognitive impairment, and neuroimaging findings. The patient reported or presented with neither prior psychiatric history nor drug use.

Therapeutic Intervention

XYZ was initiated on Risperidone (titrated to 3 mg/day) for psychotic symptom management, and short-term Clonazepam for agitation and insomnia. Supportive psychotherapy involved reality orientation, emotional stabilization, and involvement in structured daily activities. Cognitive stimulation activities and simple occupational tasks (e.g., art and light exercises) were introduced progressively. Family psychoeducation was carried out to enhance understanding of the disorder and adherence to medication. Ongoing interdisciplinary reviews were conducted to assess progress.

Process and Outcome

During the span of three weeks, XYZ showed significant improvement in several areas. In the first week, he showed a decrease in agitation and paranoid ideation. His sleep pattern stabilized, and he started responding to simple questions with lesser resistance. Towards the end of the second week, his speech was more goal-oriented, and he could follow simple directions in therapy sessions.

Group activity participation improved over time. He started to engage in art therapy, basic cognitive activities, and gentle physical activities with minimal prompting. His self-care and hygiene also improved with regular support. Although residual delusional beliefs remained, their severity decreased significantly, and he started to show insight into the effect of his symptoms.

By week three, XYZ was more compliant, had good eye contact when interacting, and showed better social behavior. His mother felt more confident to provide his care at home after the psychoeducation sessions. A plan for discharge was established with ongoing antipsychotic medication, outpatient visits, and home-based occupational and cognitive activities.

Discussion

This case illustrates the complicated and frequently forward direction of organic psychosis, especially when it is linked to neurological susceptibility and stress-related precipitants. XYZ exhibited characteristic symptoms of organic psychosis, such as dominant paranoid delusions, visual and auditory hallucinations, major cognitive disorganization, and loss of insight. His history of head trauma and previous neurological symptomatology indicate a probable neurobiological etiology, consistent with the insidious onset and chronicity of symptoms.

The therapeutic outcome seen in XYZ demonstrates the significance of early drug stabilization coupled with organized, low-demand psychosocial treatment. Risperidone was effective in alleviating the severity of hallucinations and delusions, while Clonazepam facilitated initial control over behavior and sleep. The enhancement of social interaction and daily functioning within a brief rehabilitation period implies a good prognosis with continued treatment.

Family psychoeducation was instrumental in enabling recovery, particularly in the promotion of treatment adherence on a consistent basis and lowering expressed emotions at home—a recognized factor affecting relapse in psychotic disorders. This is in accordance with previous research that emphasizes the role of caregiver participation in the management of chronic psychiatric illnesses.

The case also highlights the importance of treating comorbid cognitive impairment and psychosocial deterioration in patients with organic psychosis. Organized routines, reality-oriented tasks, and supportive therapeutic relationships provided a stabilizing context in which gradual re-engagement in self-care and interpersonal functioning was possible.

Although XYZ experienced considerable clinical improvement, persistent impairment in judgment and abstract thinking would suggest the requirement for ongoing follow-up, with potential incorporation of neuropsychological rehabilitation. Outcome over the longer term would likely be contingent upon ongoing medical management, social support, and planned psychosocial input.