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Original Research

The Psychosomatic Veil: Case Studies of Psychogenic Blindness

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Abstract
Psychogenic sensory disorders, often referred to as psychogenic sensory disturbances or conversion disorders, are a subset of somatic symptom disorders characterized by the presence of sensory abnormalities without discernible organic pathology. These disturbances can manifest as altered perceptions of touch, pain, temperature, proprioception, or vision, among others. Here, we provide an overview of the key features, diagnostic challenges, and treatment approaches for psychogenic blindness. We discuss the complex interplay between psychological factors and sensory experiences, emphasizing the need for a holistic biopsychosocial approach to assessment and management. We also highlight the potential for symptom resolution through psychotherapy and other psychosocial interventions. The understanding and management of psychogenic sensory disorders continue to evolve, necessitating ongoing research to improve our knowledge and patient outcomes. **Categories:** Psychiatry

Keywords: selective serotonin reuptake inhibitor, supportive therapy, dependency, psychological issues due to stress, psychogenic blindness

Introduction

Conversion disorder is a psychiatric disorder characterized by symptoms that interfere with sensory or motor functions. These symptoms are not consistent with the patterns of known neurological diseases or medical conditions. Conversion disorder has no biological basis. However, the symptoms have a significant impact on a person's capacity to function. Furthermore, the symptoms are not controllable at will and are not thought to be feigned on the patient's part. Functional neurological symptom disorder (FND) is another name for conversion disorder.

The term conversion disorder was coined by the Austrian neurologist and founder of psychoanalysis, Sigmund Freud (1856-1939). The word conversion refers to the substitution of a somatic symptom for a repressed idea [1][2].

Freud believed functional symptoms that could not be explained by neurologic diseases or other underlying medical conditions reflected an unconscious conflict [2]. In this context, conversion refers to replacing a somatic symptom with a repressed idea. The understanding of conversion disorder is still limited and continues to evolve [3].

Case Presentation

CASE A:

A 19-year-old married Hindu woman reported a sudden, painless loss of vision that had persisted for three days. The woman was from a low

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socioeconomic background and lacked formal education. The woman was 16 weeks pregnant and had frequent conflicts with her husband because he lived and worked in another city for three to four months each year. Her obstetric history included a previous spontaneous miscarriage approximately one and a half months ago, which was followed by a fall in her bathroom while she was alone in her house when her husband was working in another city. She reports being blamed for the miscarriage by her in-laws, which only mildly lessened after she conceived for the second time. This led to her presenting with a low mood, anhedonia, and apprehension. Two days before her hospital admission, after experiencing a panic attack, she complained of a complete inability to see. During this period of blindness, she could perceive bright light sources but had difficulty clearly distinguishing objects or individuals in her surroundings. She did not report headaches, vomiting, appetite changes, or significant alterations in sleep patterns. Notably, there was a history of interpersonal conflicts with her in-laws. No prior bodily injuries, diplopia, tunnel vision, or hemianopia were reported, and there was no history of hypertension or diabetes mellitus. Upon examination, the patient was in fair general condition, and her vital signs were stable. A systemic examination did not reveal any abnormalities except for her 16-week pregnancy. An ophthalmologist's opinion was obtained, and any organic causes were ruled out. The menace test produced a positive response. Routine blood and urine tests yielded results within the normal range. In terms of hermental state, the patient displayed an anxious affect and worrisome thoughts that were changing into ruminations regarding her current symptomatology and her foetus's safety. Her preexisting personality traits included dependency.

A diagnosis of psychogenic blindness was established and communicated to both the patient and her family members. The psychological origin of the condition was explained to her and her in-laws, and methods to manage it were suggested. Ventilatory sessions were also held. The patient received reassurance and was educated about in-hand coping skills as well as the stages of labor and the expected normal outcome of her pregnancy. It was emphasized that her fetus was medically normal, and a favourable outcome was anticipated. Within a day of this intervention, her vision began to improve, with approximately 90% of her normal vision returning by the following morning.

CASE B:

A 21-year-old female class-nine graduate who had been married for three months and came from a middleclass background was brought to a psychiatry clinic by her husband. She presented with complaints of intermittent hyperventilation that had been ongoing for three months. Additionally, she experienced a sudden and profound loss of vision in the past two months.

The patient reported discovering her husband's extramarital affair one month after her wedding. She stated that she stumbled upon evidence of her husband's affair, which led to an intense argument between them. Amid the argument, she suddenly lost her vision. She has been experiencing two to three episodes per month ever since. She reported experiencing significant emotional distress following the discovery of the affair. She expressed feelings of humiliation, worthlessness, and a belief that her life had fallen apart.

Her physical health remained stable, although she was found to be having frequent crying spells and appeared dull and withdrawn, with frequent ruminations about her conflicts. Her pupils reacted normally to light. Her visual acuity, as measured by Snellen's chart, was remarkably impaired. However, ophthalmological tests revealed no organic basis for her vision loss.

A diagnosis of psychogenic blindness was made. Her condition was successfully managed with low-dose benzodiazepines, supportive psychotherapy, and psychoeducation for both the patient and her husband.

CASE C:

A 24-year-old female college student living in a nuclear family presented herself at the emergency department due to a year-long history of recurring episodes of loss of vision and a three-month history of headaches. After undergoing relevant tests and investigations that ruled out organic causes, she was subsequently referred to the psychiatry department. One year ago, the patient had been well, but she had experienced relentless bullying from her classmates regarding her appearance. Over time, she started to feel sad and shared her concerns with her mother, though they were not taken seriously. She began experiencing episodes of blindness, which had a gradual and insidious onset. She would complain to her teachers about not being able to see the blackboard, following which she would be sent home. These episodes occurred two to three times per week. An ophthalmology evaluation did not reveal any abnormalities or a history of diplopia, tunnel vision, or hemianopia.

The patient consulted multiple physicians and underwent relevant tests, including a fundoscopy, which revealed no abnormalities. Following this, she was referred to our psychiatry department. Rapport was established, and a therapeutic alliance was made.

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Over the course of the interview, the patient reported feeling that she was overweight. She also believed that losing weight would stop her friends from making fun of her, and she admitted to sometimes suffering from episodes of anxiety during bullying, following which she would lose her ability to see. There was no history of psychiatric illness in the patient's family, and her birth and development history were unremarkable. She performed well in her studies, slept well, and maintained a good appetite. Upon general physical examination, the patient appeared moderately built but poorly nourished, with a body mass index (BMI) of 16.8 kg/m². A diagnosis of psychogenic blindness was made, and she was successfully managed with selective serotonin reuptake inhibitors, supportive psychotherapy, and psychoeducation for both the patient and her mother. She continued to show improvement during follow-up appointments.

Discussion

Psychogenic sensory disorders, also known as psychogenic sensory disturbances or conversion disorders, represent a fascinating yet challenging aspect of psychosomatic medicine. These disorders are characterized by sensory abnormalities that cannot be explained by any known organic pathology. Instead, they are rooted in psychological factors, making them a topic of significant clinical and research interest.

The diagnostic criteria of psychogenic blindness have not been established. In 10th edition of theInternational Classification of Diseases' Diagnostic Criteria for Research, it comes under F44.6 dissociative anesthesia and sensory loss, respectively [4]. In the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, it is under the rumination syndrome of F98.21 without any psychological factors [5].

One of the fundamental aspects of psychogenic sensory disorders is the altered perception of sensory stimuli. Individuals with these conditions may report a wide range of sensory disturbances, including changes in touch, pain, temperature perception, proprioception (awareness of one's body position), or vision. These alterations can be highly distressing and have a profound impact on a person's quality of life.

Between 45% and 78% of patients experience complete resolution of all visual symptoms [6]. Good prognostic indicators include young age and the absence of any associated psychiatric disease [6].

Conclusions

Psychogenic sensory disorders serve as a striking example of the intricate interplay between the mind and body. While these conditions can be perplexing and challenging, they underscore the importance of a holistic biopsychosocial approach in modern health care. Newer developments in research and a broad understanding of the psychological underpinnings of these disorders will continue to refine our diagnostic and treatment approaches, ultimately improving the lives of those affected by these conditions.

Additional Information

Disclosures

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References

1. Freud S, Strachey J, Freud A. London: Hogarth Press and the Institute of Psycho- Analysis; 1962: The Neuro-Psychoses of Defense, Institute of Psychoanalysis editors. The Standard Edition of the Complete Psychological Works of Sigmund Freud; pp. 45:61.
2. Blitzstein SM: Recognizing and treating conversion disorder. Virtual Mentor. 2008, 10:158-60. 10.1001/virtualmentor.2008.10.3.cprl1-080
3. Ali S, Jabeen S, Pate RJ, et al.: Conversion Disorder-Mind versus Body: A Review . InnovClinNeurosci. 2015, 12:27-33.
4. ICD-10 (International classification of diseases: tenth revision), author Classification of Mental and Behavioral Disorders: Clinical Descriptions and Diagnostic. 1993.
5. American Psychiatric Association, ed. (2022: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision. Washington, DC, USA: American Psychiatric Publishing; 9780890425756.
6. Merskey H: Conversion and Dissociation. In Gelder. GM, Lopez-lbor JJ, Andreason N, editors. New Oxford Textbook of Psychiatry. First edition. Oxford.Oxford University Press. 2003,