COMMENTARY

Atypical psychosis

Arnab Bhattacharya
Postgraduate Trainee of Psychiatry
at Silchar Medical College Hospital, Silchar

Definitions of psychosis

The term psychosis was given by Baron Ernst von Feuchtersleben in 1845. Karl Jaspers thought that psychosis were those psychic deviations which seized upon the individual as a whole and disrupted the person's normal way of thinking or behaving. Oxford English Dictionary defines psychosis as a mental derangement which cannot be ascribed to neurosis or organicity and is accompanied by hallucinations, delusions, confusion or loss of contact with external reality. The tenth edition of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) states that the term psychotic indicates the presence of hallucinations, delusions, behavioural abnormalities like gross excitement or retardation and catatonic behaviour. In the text revision of the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), the term psychotic refers to delusions, prominent hallucinations, disorganized speech or catatonic behaviour.

Historical views

Emil Kraepelin was of the opinion that the psychotic disorders fell into dementia praecox and manic depressive illness with a poor and good prognosis respectively. Eugene Bleuler viewed that the group of schizophrenias analogous to dementia praecox may not always be associated with a poor outcome. Wilhelm Griesenger forwarded the concept of 'unitary psychosis' or einheitpsychose by which he meant all psychoses pass through common similar stages. However there were certain entities which could not fit into the above categories and thus was felt the need for a third psychosis. Atypical psychosis designates psychotic conditions which cannot be easily classified into either psychotic mood disorders or schizophrenia.

Amentia and paranoia acuta

Concepts given by Theodore Meynert and Karl Westphal respectively. Illness comprised of confusion and perplexity, agitation, rapidly changing vivid hallucinations and delusions, misidentification phenomena, anxiety and apprehension. Association with physical illness was noted in few cases, and full recovery occurred within weeks. Freud chose this type of acute delusion and hallucinations for his psychoanalytic conceptualization of psychosis; however the terms are rarely used in recent days.

Oneirophrenia

The term was coined by Ladislas von Meduna in 1939. It was characterized by acute onset of confusion, nightmare or a dream like quality of all perceptions, extreme fear, anxiety, delusions and visual hallucinations. Meduna proposed an endocrinological basis for the entity. Prognosis is generally good with full recovery. In ICD 10 it is included under acute schizophrenia-like psychotic disorder (F23.2).

Reactive psychosis

Karl Jaspers is credited with the concept of reactive psychosis. According to him reactive psychosis: a) follows soon after a precipitating event capable of psychologically destabilizing most people, b) has a content which reflects the causative stressor, and c) resolves when causative stressor ceases. Jaspers felt that the psychosis manifested the patient's hopes, fears and wishes in delusion like ideas and hallucinations and serves as a defense, refuge, escape and a wish fulfillment. He classified reactive psychosis as per precipitating factors – prison psychosis, battle psychosis, psychosis of isolation and reaction of homesickness. Jaspers gave great stress over understanding the patient’s experience. August Wimmer from Scandinavia gave 'psychogenic psychosis' in which a psychotic disorder followed external stress. They occur later in life, have an acute onset, have good premorbid adjustment, have less bizarre features and better prognosis than schizophrenia. The prognostic validity of this entity has been investigated by Faergeman who followed up 113 Wimmer’s cases and found that 60% of cases kept the same diagnosis and 33% were reclassified as schizophrenia. ICD-10 includes it under acute and transient psychotic disorder (F23).

Rating instrument for reactive psychosis

Guldberg (1996) has devised a 'Reactivity of psychosis rating form' with 10 items. Items are: Severity of stressor / onset of stressor / duration of stressor / development of psychosis / meaning of psychosis / content of psychosis / duration of psychosis / perplexity / pre global assessment of functioning

(GAF) score / post GAF score. The instrument has been found to have good interrater reliability and validity.

Mitsuda psychosis

Hisatoshi Mitsuda in 1941 gave this concept in Japan. It was acute in onset. Relapsing course was seen. It was associated with alteration in consciousness, psychomotor activity and emotional disturbances. Prognosis was favourable with good recovery.

Hysterical psychosis

An American concept, given by Hollander and Hirsch in 1964. Usually seen in the background of a 'hysterical' personality. Symptoms are of a sudden and dramatic onset related to a profoundly upsetting event. Features include hallucinations, delusions, depersonalization and disorganized behaviour. Average duration is one to three weeks followed by good improvement.

Cycloid psychosis

Karl Kleist first gave the concept and felt this included acute psychoses in well functioning persons who recover after brief treatment sometimes even without hospitalization, mostly with no sustained impairment and may have a disbelief about the illness (Salvatore 2008). He initially gave two variants of it : a) confusional insanity (with contrasting phases of confused excitement and stupor), and b) motility psychosis (with phases of hyperkinesis and akinesis). Later Karl Leonhard from Berlin added yet another subtype called anxiety elation psychosis. This was characterized by an expansive mood and a grandiose mission to do good to the people. In each of these three subtypes Leonhard proposed alterations between a restricted-inhibited phase and an expansive-excited phase with changes in affect, thinking and behavioural arousal. Neurobiologically viral infections may be involved in the aetiology as it is significantly associated with first trimester maternal respiratory infections (Strober 1997). Strik et al. (1997) found higher than normal P 300 amplitudes in cycloid psychosis compared to normal controls. This finding was specific to cycloid psychosis and was explained by generalized cerebral hyperarousal. ICD-10 subsumes cycloid psychosis under acute polymorphic psychotic disorder with / without symptoms of schizophrenia.

Perris-Brockington criteria for cycloid psychosis

1. Acute psychosis of unknown cause starting at ages 15–50 years.

2. Sudden change from health to psychosis within hours to a few days.

3. At least four of the following:

(a) Confusion, from perplexity to severe disorientation, with derealization / depersonalization or puzzlement.

(b) Mood-incongruent delusions or paranoid features (ideas of reference, influence, or persecution).

(c) Hallucinations of any kind.

(d) Deep feelings of happiness or ecstasy, being at one with Nature or God.

(e) Pan-anxiety and fear that something terrifying is about to happen.

(f) Motility disturbances with increased or decreased activity.

(g) Particular concern with death or dying.

(h) Mood swings not sufficient to support a diagnosis of primary major affective disorder.

4. Shifting polymorphic symptoms, with opposite polar phases within an episode.

Bouffee delirante

Originally described by Valentin Magnan and Paul Legrain from France who thought it to be caused by modernization and urban lifestyle. Onset has been likened to 'a thunderbolt in a serene blue sky'. Psychosis begins suddenly in a person with no past psychiatric history. Features include delusions, hallucinations, depersonalization, derealization, confusion, mood changes and fluctuations of symptoms during course of illness. The person experiences complete improvement after the illness subsides. The diagnosis is still popular with French speaking psychiatrists in Europe, West Africa and Caribbean island. In ICD-10 system this is included under acute polymorphic psychotic disorder with / without symptoms of schizophrenia (F23). Charles Pull and colleagues have suggested a set of criteria for the above entity.

Pull criteria for bouffee delirante

Abrupt / acute onset of illness with no past psychiatric history. Absence of chronicity, relapse may occur but have complete interepisodic recovery. Symptoms of delusions, hallucinations, depersonalization / derealization and mood changes may occur from day to day or hour to hour. Insufficient evidence for organic or substance related aetiology. The true acute psychotic disorder occurs without associated psychosocial stress. If such stress is found then there is only a temporal link with the so called 'reactive' acute psychosis (Oxford Textbook of Psychiatry).

Schizoaffective disorder

Karl Kahlbaum is considered the first psychiatrist of modern era who placed schizoaffective disorders into a separate group called 'vesania typica circularis' in 1863. Jacob Kasanin used the name schizoaffective in 1933 in USA. Kraepelin also described cases 'in

between' dementia praecox and manic-depressive insanity sharing features of both. Kasanin's original cases had more similarity to 'bouffee delirante' or 'cycloid psychoses'. In modern psychiatric nosology schizoaffective disorder is an episodic illness in which both affective and schizophrenic symptoms are present simultaneously or within a few days of each other and neither affective disorder nor schizophrenia criteria are fulfilled (ICD-10). In DSM-IV criteria there is an uninterrupted period of illness at some time of which there is either a major depressive / manic or mixed episode concurrent with criterion A of schizophrenia (delusions / hallucinations / speech disorganization / disorganized or catatonic behaviour / negative symptoms). Also, mood symptoms criteria need to be present for a substantial period of the total illness.

Schizophreniform disorder

Gabriel Langfeldt of Norway gave the above concept. He thought of the condition as one with a sudden onset and occuring after an identifiable precipitant in a premorbidly well adjusted personality and which had a good outcome. Patients may present with a clouding of consciousness and mood disturbance. The term was adopted later in DSM III as a nonaffective psychosis with schizophrenic symptoms in which duration was less than six months, thus DSM III adopted the nomenclature given by Langfeldt but the concept differed from that of the pioneer.

Persistent psychotic or delusional disorders

These include paranoia, paranoid disorders, paraphrenia, delires chroniques (French concept), other types of delusional syndromes (Othello syndrome, Capgras syndrome, Cotard syndrome, deClerambault syndrome, sensitiver Beziehungswahn) and schizotypal disorder.

Paranoia and paranoid disorders

The term 'paranoia' is derived from the Greek 'para' meaning besides and 'nous' meaning mind. Kraepelin used the term to mean a group of psychoses with a permanent and unshakeable delusional system without hallucinations, with clear and orderly thinking, willing and acting. The term 'paranoid disorders' embraces paranoia, paraphrenia and various delusional syndromes. However the term 'paranoid' has been used differently in different languages. In German, it means all delusions relating to the subject. In English speaking nations it has been restricted to mostly mean persecutory delusions. In French the term 'paranoide' is used exclusively to designate the paranoid subtype of schizophrenia. In the current ICD-10 nomenclature the term delusional disorder has been used for this group of disorders.

Paraphrenia

This concept was also introduced by Emil Kraepelin in his Textbook. He differentiated paraphrenia from dementia praecox by the absence of deterioration despite a protracted course. He differentiated paraphrenia from paranoia by the fact that in paraphrenia prominent auditory hallucinations were present. Another entity 'late paraphrenia' was introduced by Roth (1955) as a well organized system of paranoid delusions, with or without auditory hallucinations existing in the setting of a well preserved personality and affective response. In ICD-10 system late paraphrenia is included under delusional disorder (F22.0).

Dellires chroniques

French psychiatrists use this term to designate chronic delusional states. They categorize them into three types: A) chronic interpretative psychosis (further subdivided into intellectual delusional states and emotional delusional states), B) chronic hallucinatory psychosis, and C) chronic imaginative (fantastic) psychosis.

Chronic hallucinatory psychosis

First described by Ballet (1911) as a disorder characterized by persistent hallucinatory activity, delusions of mostly persecutory type, presence of a clear sensorium, intact speech and absence of schizophrenic thought disorder. It has onset in middle or late life and relatively good psychosocial adjustment.

Chronic imaginative psychosis

Originally described by Dupre and Logre. It was characterized by magical thinking, fantastic and grandiose delusions, confabulatory delusional mechanism and good contact with reality which contrasted with the extravagance of the delusions. However this diagnosis is seldom used by French psychiatrists these days.

Delusional jealousy

It is featured by an abnormal belief that one's partner or spouse is unfaithful, the belief being based on illogical evidence. Also known by other names like Othello syndrome, pathological jealousy, conjugal paranoia, morbid jealousy. It is more frequent in men, alcoholics and may be present in some demented patients. Patients may become violent to partner as a consequence of the condition, hence it is important from forensic psychiatry point of view.

Folie a deux

First described by Lasègue and Falret (1877). In this the delusions held by a sick person are induced in

or shared by a healthy person. The disorder typically develops in people who are isolated from other persons. The primary psychotic person is the dominant figure and the person in whom the delusion is induced is a submissive person. The secondary person will improve when the pair is separated. Modern nomenclatures use 'shared psychotic disorder' in DSM-IV or 'induced delusional disorder' in ICD-10.

Capgras and Fregoli syndromes

Capgras syndrome (illusion des sosies) was described by Capgras and Reboul-Lachaux. The patient, usually a woman is convinced that an important person in her life e.g. husband has been replaced by a double (sosie) or a look alike imposter. It can appear in a variety of illness states like schizophrenia, organic lesions of brain (tumors, dementia), involutional depression, hysterical women. Neuroimaging results indicate right hemispheric frontal and temporal abnormalities and neuropsychological research implicate impairments in facial recognition which is a right hemispheric function. The syndrome of Fregoli involves the patient identifying a familiar person (usually his persecutor) in strangers.

De Clerambault syndrome

Also called erotomania or dèlires passionnels. The subject, usually a woman is convinced delusionally that another person, usually of high social status is in love with her. She may be confident initially that he will come out of hiding and offer gifts, make phone calls or write letters. Later the patient may become resentful, abusive, spiteful or even aggressive. The syndrome may also be seen in schizophrenia, depression, bipolar disorder and organic brain conditions.

Cotard syndrome

Also called dèlire de nègation by Cotard. Patients complain of having lost their money, social status, heart, blood, intestines and believe they are dead and nothing exists. It has become rarer in recent years possibly because it responds to pharmacotherapy before the complete forms of the syndrome develops. It is mostly associated with severe forms of depression and chronic forms may be seen in organic brain disease. Berrios and Luque classified Cotard syndrome into two types: type I - more of delusional than affective features and type II - anxiety, depression and auditory hallucinations ('mixed type'). Some authors have suggested abnormal right hemisphere disturbance to underlie Cotard syndrome.

Sensitiver Beziehungswan

Described by Ernst Kretschmer in 1918. It is a type of paranoia which develops in sensitive personalities when a precipitating event termed as a key experience (Schlüsselerlebnis) occurred at the correct time in the person's life. The person did not go on to develop schizophrenia and had a good prognosis. In ICD-10 this entity is subsumed under delusional disorder (F22.0).

Schihzotypal disorder

The term schizotypal was introduced to psychiatry after family studies in schizophrenia (Kety 1978). The disorder is more common among family members of schizophrenia patients and is a part of the schizophrenia spectrum. It is characterized by inappropriate constricted affect, odd behaviour, magical thinking, social withdrawal, paranoid ideas, obsessive ruminations, perceptual disturbances and occasional quasi psychotic experiences (ICD-10). They may show some focal cognitive impairment such as in working memory, verbal learning and sustained attention rather than generalized intellectual deficit. These patients show decreased temporal lobe volumes but intact frontal lobes thus are able to escape the severe social and cognitive deterioration of schizophrenia patients. It runs a chronic course with fluctuations and it's exact onset may be difficult to ascertain. DSM-IV places it under personality disorders and ICD-10 places it under atypical psychotic disorders (F21).

Culture bound syndromes (CBS)

It was first described by Yap. They are also known by various names like culture specific psychosis, ethnic psychosis, exotic psychosis. Two common features shared by most of them are: A) they were initially described in a particular population, and B) they are not easily accommodated in internationally used psychiatric classifications. In Indian context Dhat syndrome and Koro are two such entities which are classified under other specified neurotic disorders in ICD-10 (F48.8). Other conditions like pibloktoq (Eskimo), amok (Malayasia), brain fag (West Africa), ataque de nervious (Carribean) etc. are found in various parts of the world. It has been stated that CBS may be ethnically appropriate ways of expressing distress and hence management has to take consideration of local cultural values which may seem 'inappropriate' to outsiders.

Non-affective acute remitting psychosis (NARP)

NARP was first introduced by Ezra Susser and colleagues. Four criteria could be central to the classification of this condition (Susser et al. 1996):

a) Non-affective – does not meet criteria for mood disorder,

b) Acute onset – as defined in ICD-10 acute and transient psychotic disorder,

c) Brief duration – less than six months from onset to recovery,

d) Psychosis broadly defined.

NARP has a twofold higher incidence in women than men. It has a tenfold higher incidence in developing countries. It has a temporally stable course and when they relapse the subsequent episodes tend to be acute in onset and brief in duration. NARP is not included in either ICD-10 or DSM-IV systems but may be a potential candidate for future nosological systems.

Conclusion

Atypical psychotic disorders represent a heterogeneous but poorly understood group of problems. There seems to be some international consensus as to the classification of these disorders as separate from schizophrenia and psychotic mood disorders. However more research is needed in future to better comprehend these disorders which cause significant morbidity to the sufferers and their families.

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