SUMMARY

Twenty-two cases who fulfilled the criteria of having atypical manifestation at any stage of illness and had minimum follow up of three years were studied in detail. Their family history and follow up was analysed. The findings of the present study suggest that the cases showing admixture of schizophrenic and affective symptoms are probably a variant of affective disorders although a possibility of their being a third independent psychosis cannot be ruled out.

Ever since the subdivision of functional psychoses into Dementia Praecox and Manic depressive insanity by Kraepelin (1921) there have been described cases which on clinical grounds do not meet the criteria required to be included in one group or the other, or show a combination of symptoms characteristic of both major categories. There have been several reports of cases with primarily affective symptomatology who on follow up developed a schizophrenic picture (Hoch and Rochtin, 1941) whereas on the other hand several authors, e.g. Ziskind et al. (1971), Lipkin et al. (1970) have described patients who initially presented with schizophrenia like episodes but subsequently developed typical manic depressive attacks.

It is again a matter of daily observation that in many patients the clinical picture is mixed or impure, since they exhibit an admixture of schizophrenic and manic depressive symptoms, in varying amounts with acute onset and good prognosis. Numerous terms have been used by different authors to describe such cases, e.g. good prognosis schizophrenia (Fowler et al., 1972), remitting schizophrenia (Vaillant, 1965), reactive psychoses (McCabe and Stromgren, 1975), acute schizoaffective psychoses (Kasanin, 1933), atypical psychoses Mitsuda, 1965), Cerrolaza and Cleghorn (1971) and Procci (1976) have recently published excellent review of literature of such types of psychoses and the problems inherent in the use of this diagnosis.

The present study was undertaken with an aim to review the clinical picture, course and family history of patients presenting with a mixed schizoaffective or atypical psychoses, and of patients who undergo change of diagnosis from schizophrenia to manic depressive psychoses and vice versa on a subsequent admission.

MATERIAL AND METHODS

Case records of all patients attending the Psychiatry Department of Rajendra Hospital, Patiala, during the year 1975 were reviewed and all those cases who fulfilled the following criteria were taken up for detailed study:

1. All patients diagnosed as suffering from an atypical or schizoaffective illness at the time of index admission in 1975.
2. All those who had a change of diagnosis i.e. they had been labelled as schizophrenic on a previous or present admission (index) and were diagnosed as primary affective disorder on a second admission during the follow-up period or vice versa.
3. Only those cases were included who...
had a follow-up for a minimum period of three years.

In addition to a detailed psychiatric history and mental state examination a detailed family history was taken and where possible all first degree relatives were personally interviewed.

**Criteria for clinical categorization into subtypes:**

The diagnosis of schizophrenia and primary affective disorder was made as per criteria in I.C.D. 8th ed. (1967).

**Schizoaffective disorders:**

This diagnosis was made according to the criteria suggested by Welner et al., (1974).

It was further divided in two subtypes:

1. **Schizo-manic:** In this subtype, the patient should have enough symptoms to meet the criteria for mania under criteria No. 1 of Welner et al. (1974).

2. **Schizo-depressive:** In this subtype the patient should have enough symptoms to meet the criteria for depression under criteria No. 1 of Welner et al. (1974).

Final diagnoses of all cases were made by the consultant at all stages.

**OBSERVATIONS**

A total of thirty cases were found in records for 1975 who were either labelled as atypical or schizoaffective psychosis or whose clinical features suggested a change in diagnoses during two successive illness episodes. Eight of the total of thirty cases did not report to the clinic nor did they respond to letters sent to their home addresses for follow up after their discharge from the hospital and hence have been excluded from the present analysis. Thus the present paper is based on a total of 22 subjects who were available for follow up and fulfilled criteria (1, 2, 3) given above.

Table 1 shows their age and sex distribution. The age range was from fifteen years to fifty years, the majority (59.1%) of the patients were in the 15-24 years age group. Sex distribution shows an excess of females over males in the ratio of approximately 3:2.

| Age group in years | Number of patients (N=22) | % | Male | Female |
|--------------------|---------------------------|---|------|--------|
| 15-24              | 13                         | 59.1% | 6 | 7 |
| 25-34              | 4                         | 18.2% | 1 | 3 |
| 35-44              | 4                         | 18.2% | 1 | 3 |
| 45-50              | 1                         | 4.5% | 1 | 0 |
| **Total**          | 22                        | 9(40.9) % | 13(59.1)% |

Table 2 shows the presenting clinical diagnosis and the diagnosis given at the time of previous illness episodes. Of the twenty-two subjects, six patients presented with a schizophrenic picture, three were diagnosed as primary affective disorder (1 manic, 2 depressive), while the remaining thirteen cases had an admixture of both schizophrenic and affective symptoms i.e. schizoaffective psychosis (five being aschizomanic and eight schizodepressives).

A previous history of mental illness was obtained in thirteen of the twenty-two subjects. Of the six schizophrenics, one had a previous history of schizophrenic illness, two had a history of a manic attack and one had a depressive episode while in the remaining two patients there was no history of any previous psychotic illness. Out of three patients of affective group, two had previous attacks of affective disorders and one had no history of previous mental illness. Out of thirteen patients of schizoaffective group six had no previous history of any mental illness, four had a previous episode of primary affective illness, while in three there was history suggestive of a schizophrenic illness.

A list of the most frequently occurring schizophrenic symptoms seen during the
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Table 2—Showing the diagnosis at Index Admission and during a previous episode

| No. | Presenting picture | Number | Schizophrenic | Affective | Schizoaffective |
|-----|-------------------|--------|---------------|-----------|-----------------|
|     |                   |        | Manic         | Depressive| Schizomanic     | Schizodepressive| Nil     |
| 1.  | Schizophrenic     | 6      | 1             | 2         | 1               |                 | 2       |
| 2.  | Affective (N=3)—  |        |               |           |                 |                 |         |
| (a) | Manic            | 1      |               |           |                 |                 |         |
| (b) | Depressive       | 2      |               |           |                 |                 |         |
| 3.  | Schizoaffectives (N=13)— | 5 | 2             | 1         |                 |                 | 2       |
| (a) | Schizomanic      |        |               |           |                 |                 |         |
| (b) | Schizodepressive | 8      |               |           |                 |                 | 4       |
|     | Total             | 22     | 4             | 3         | 6               |                 | 9       |

Acute illness episodes are shown in Table 3. It is seen that paranoid features were most common, followed by primary delusions and auditory hallucinations and inappropriate bizarre behaviour. Evidence of thought disorder and catatonic features were elicited in six cases each, and, interestingly, two cases showed presence of a “Capgras” syndrome.

Table 3—Type of Schizophrenic Features

| Schizophrenic symptoms | Number of cases |
|------------------------|-----------------|
| 1. Paranoid features   | 16              |
| 2. Primary delusions   | 12              |
| 3. Auditory hallucinations | 11          |
| 4. Inappropriate-bizarre behaviour | 9       |
| 5. Catatonic features  | 6               |
| 6. Thought disorder    | 6               |
| 7. Inappropriate affect | 5                |
| 8. Delusions of control |                |
| 9. Illusion of doubling (Capgras syndrome) | 2 |

History of mental illness in the families of all probands of atypical psychosis is shown in Table 4. A significant finding is that except for three cases of atypical psychosis one of whom had a family history of schizophrenia and the other two had family history of both schizophrenia and affective psychosis, in no other case was there a history of schizophrenia occurring in any family member. On the other hand a family history of affective illness was present in eight cases and in the remaining eleven (i.e. half of all cases), there was no family history of any mental illness.

Table 4—Showing type of Illness in Families of Probands of Atypical Psychosis

| Initial picture | Number | Schizophrenic | Affective— | Schizoaffective— |
|-----------------|--------|---------------|------------|------------------|
|                 |        | Manic         | Depressive | Schizomanic      |
| Schizophrenic   | 6      | 3             |            |                  |
| Affective—      |        |               |            |                  |
| (a) Manic       | 1      |               |            |                  |
| (b) Depressive  | 2      | 2             |            |                  |
| Schizoaffective—|        |               |            |                  |
| (a) Schizomanic | 5      | 1             |            |                  |
| (b) Schizodepressive | 8 | 2           |            |                  |
|                 | Total  | 22            | 8          | 1                | 2                |

Table 5 shows development of subsequent symptomatology on follow up. Of the six schizophrenic patients two developed a definite affective episode on follow up while the other four patients developed a
schizoaffective or atypical psychosis. All the three patients of the affective group developed additional schizophrenic symptoms during the subsequent episodes, i.e. they became clinically schizoaffective. Out of the 13 patients in the schizoaffective group, there were five schizomanics—two of these developed a similar episode on follow up while one developed a pure affective illness, the remaining two had no subsequent illness during follow up period. Out of the eight schizodepressive patients, five patients developed a similar episode while three patients had developed clear cut affective episodes on follow up. Final outcome in terms of complete or partial recovery is shown in Table 6. Out of a total of 22 patients, 18 had completely recovered while four patients had shown partial recovery and were still under treatment at the time of last visit to the clinic. Groupwise all schizophrenics had recovered completely. Two of three patients of affective group had complete recovery and one was still under treatment. Out of schizoaffective group, all five schizomanics and 5 of the 8 schizodepressives recovered completely while three schizodepressives

| Index admission           | Number | Development of subsequent symptomatology |
|---------------------------|--------|----------------------------------------|
|                           |        | Schizophrenic | Affective | Schizo-affective |
|                           |        |               |           | Schizo-manic    |
| 1. Schizophrenic         | ..     | 6             | 0         | 2               |
| 2. Affective (N=3)       | ..     | 1             | 0         | 0               |
| (a) Manic                | ..     | 2             | 0         | 0               |
| (b) Depressive           | ..     | 5             | 0         | 1               |
| 3. Schizo-affective (N=13)| ..     | 8             | 0         | 3               |
| (a) Schizomanic         | ..     |               |           | 0               |
| (b) Schizo-depressive   | ..     |               |           | 2               |
| Total                    | ..     | 22            | 0         | 6               |

TABLE 6—Showing Outcome of Patients of Atypical Psychosis

| Presenting picture | Number | Complete recovery | Partial recovery (maintained on drugs) | No response or deterioration |
|--------------------|--------|-------------------|----------------------------------------|------------------------------|
| Schizophrenic      | 6      | 6                 | ..                                     | ..                           |
| Affective (N=3)    | 1      | ..                | 1                                      | ..                           |
| (a) Manic          | 2      | 2                 | ..                                     | ..                           |
| Schizo-affective (N=13)| 5  | 5                 | ..                                     | ..                           |
| (a) Schizomanic    | 8      | 5                 | 3                                      | ..                           |
| Total              | 22     | 18                | 4                                      | ..                           |
had not recovered completely and were continuing treatment at the time of last visit to the clinic. None of the patients had shown any deterioration.

DISCUSSION

On clinical grounds, we can divide our cases of schizoaffective or atypical psychosis into two groups. Group I consisting of thirteen patients (59.1%) who present with schizoaffective features (according to defined criteria) seven of these retained their atypical psychosis features, i.e. they were diagnosed as schizoaffective during a subsequent attack, another four patients had developed clear cut affective illness while two patients remained well and had no further illness during the three year follow up period.

Group II consisting of nine patients (40.9%) who presented with atypical manifestations: (a) consisted of six patients presenting with primary schizophrenic symptomatology along with affective features (27.3%) and (b) three patients who presented primarily with affective picture but who developed additional schizophrenic features on subsequent episodes (13.6%). If we review the family history of mental illness in these two groups, we find that in group I, three patients had family history of manic depressive psychosis, one had a history of schizophrenia and one had loading of both schizophrenia and affective illness. There was no family history of mental illness in eight cases. No definite conclusions can be drawn from the family history data of this group, the number of ill relations being very small. In the other group of nine patients, five had a family history of affective disorders, one had loading of both schizophrenia and affective illness and three had no family history of any psychiatric illness. There was no history of schizophrenia in the first degree relatives in any of the patients.

Another important observation which emerges from the study of these cases is that none of the patients developed a clear cut schizophrenic episode on follow up. Rather, two patients who were diagnosed as schizophrenia on initial presentation, became purely affective on follow up, and none of them had a family history of schizophrenia.

Our findings, therefore, do not support the generally held view of schizoaffective disorders being a subtype of schizophrenia (I.C.D., 8th ed.). On the contrary, it is suggested that they may consist of two subgroups—Type I being an independent atypical psychosis with a tendency to have a similar illness in the family. Our findings of such cases being an independent entity (third psychosis) have been supported by Leonhard (1961) who used the term cycloid psychosis for such cases and Mitsuda (1961) who used the label of atypical psychoses: Type II consisting of subjects of a primary affective disorder with atypical (schizophrenic) manifestation. Our results of such cases being a variant of affective psychoses are well supported by findings of Clayton et al. (1968) who in a study of thirty nine cases of Schizoaffective psychosis found that family history of such cases indicated a high prevalence of affective disorders and suggest that this group is a variant of primary affective disorders. Tsuang et al. (1977) also studied fifty-two cases of schizoaffective illness and found that on the basis of family history studies, schizoaffective patients bear a much closer resemblance to affective disorders than to schizophrenia. On the basis of recovery also they found that recovery rate of schizoaffective (46.2%) is significantly different from 7.7% for the schizophrenic group whereas not significantly different from the group of affective disorders (57.8%). In our study also, 18 cases (81.8%) fully recovered (Table 6) which is consistent with the better prognosis observed in affective disorders as compared to schizophrenia. The findings of the present series thus suggest that the group of schizoaffective or atypical psychosis is a heterogeneous group consisting of a few patients (a small minority)
suffering from a primary schizophrenic illness while in some cases there is evidence of a genetic loading of both schizophrenia and affective disorders and these patients have repeated attacks of identical nature. However, the majority are probably patients of primary affective disorders who also have atypical manifestations in the form of schizophrenic features consisting of paranoid ideas, primary delusions, formal thought disorders etc., at the start or during the course of illness. Ziskind et al. (1971) have described five such cases who had initially clear cut schizophrenic symptoms but later on developed manic depressive psychosis. Recently Freedman and Schwab (1978) in a study of paranoid features in 264 cases found that 25% of cases had various types of affective disorders.

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