ACUTE NON-ORGANIC PSYCHOSIS - OUTCOME AFTER 10 YEARS

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ABSTRACT

62 out of 68 acute psychosis patients who were initially recruited from the Bikaner Centre in 1982 for the Indian Council of Medical Research (ICMR) study on "phenomenology and natural history of acute psychosis" were assessed after completion of 10 years in 1992-93 on SCAAPS and PSE with the objective of studying the long term course and outcome of acute psychosis. The results show that 35 (56.45%) patients of acute brief episode of psychosis never had any psychotic illness during the course of follow-up. Remission was significantly better in the young, the unmarried, in those who belonged to the Hindu religion and in those who developed the full blown psychosis abruptly within 48 hours. Other sociodemographic, personal history variables, and symptomatology could not distinguish this remitted group from the rest of the patients.

Key words: Acute non-organic psychosis, phenomenology, outcome

Acute onset, short lasting, atypical psychosis which do not fit into either schizophrenia or affective psychosis categories have been reported to occur more frequently in developing countries than in industrialized countries. Some features like acuteness of onset, florid clinical picture, absence of autistic features, association with antecedent stress, and good prognosis appear common in the descriptions of these disorders (Faergman, 1963; McCabe, 1975). Descriptions of such conditions from India in the form of acute psychosis of uncertain origin (Wig & Singh, 1967), acute psychosis without precipitating stress (Kapur & Pandurangi, 1979) and acute schizophrenic episode (Singh & Sachdeva, 1981) highlighted the difficulties in putting these conditions in the existing International Classification of Diseases (ICD-9) (WHO, 1978) and indicated the need for a third category of psychosis in addition to schizophrenia and affective disorders.

Indian Council of Medical Research undertook a multi-centred one year follow-up study at four centres in the country with the objective of better understanding the phenomenology and predictors of the outcome of such acute onset psychotic disorders from 1981-84. The results indicated that about 40-50 percent cases who remitted in a short span of a few weeks and remained in remission for the one year follow-up period could not be categorised into either schizophrenia or manic depressive psychosis using ICD-9 (WHO, 1978) and the Catego system of classification (Singh, 1986). The demarcation of these conditions from schizophrenia and from one another remains a critical area of uncertainty in psychiatric diagnosis (Cooper et al., 1990). For instance, DSM-IV excludes from schizophrenia all remitting psychoses with less than 6 months of continuous illness (APA, 1994) and ICD-10 excludes only those with acute onset and less than 1 or 3 months of psychotic symptoms depending on subtype (WHO, 1992).

Long term studies on the outcome of these disorders are few. Patients originally diagnosed by Wimmer (1916) as suffering from psychogenic forms of mental disorders which resembles the description of acute non-organic psychosis were followed up by Faergman (1946)
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15 to 25 years after their index admission.

He reported a good outcome in 50% of patients and a long term course quite distinct from schizophrenia and affective psychoses. Welner & Stromgren (1958) followed up 106 patients diagnosed as schizophreniform psychosis and found 72 of these patients to have a benign course. Similarly Eiting et al. (1958) followed up 154 patients of schizophreniform psychosis and found a favourable outcome. Varma et al. (1996) studied the course and outcome after 12 months of acute non-organic psychosis and reported the highly favourable course and outcome of these cases. Susser and his co-workers (1988) carried out a 12 year follow-up study of the course of acute brief psychosis and reported that it had a distinctive and benign long term course when compared with other remitting psychoses thus supporting the ICD-10 concept of a separable group of acute and transient psychotic disorders. Thus there is a dearth of material on this subject and a long term study would throw more light on the outcome of these patients, the stability of diagnosis, and their unique illness characteristics. The present study has been carried out with the following aims:

1. To study the course, outcome after 10 years, and factors determining outcome of patients presenting with acute non-organic psychosis and
2. To study whether acute psychosis is a unitary, hitherto unrecognised disease entity or made up of a heterogeneous group of disorders, and if so whether it is possible to clearly define a separate category of acute psychosis as distinct from schizophrenia or affective illness.

MATERIAL AND METHOD

The methods of ICMR study of phenomenology and natural history of acute psychosis are described in detail elsewhere (ICMR, 1989). Briefly, it was a prospective clinical study of patients suffering from acute psychotic illness, who were brought to the psychiatry departments of medical colleges at four centres, Bikaner, Patiala, Goa and Vellore during January, 1982 to December, 1982. Patients were screened through a screening proforma. Those who were in age range of 15-60 years, developed full blown psychosis within 2 weeks, and contacted the department of psychiatry within 4 weeks of onset of symptoms and had at least two of eight symptoms like delusions, hallucinations, grossly inappropriate behaviour, excitement, withdrawal, elation or depression were included. Those with gross organic brain disorder, epilepsy, mental retardation, history of previous episode of psychotic illness or were on anti-psychotic medication for more than one week or were residing beyond the defined catchment area were excluded. Modified schedule for clinical assessment of acute psychotic states (SCAPS) which contains 14 items on psychiatric history and social description, a symptom checklist, ICD-9 diagnostic evaluation (WHO, 1978), ICMR descriptive categories based on predominant clinical presentation, and section to record treatment, course and outcome) and Present State Examination (PSE, 9th edition, Wing et al., 1974) were used for clinical evaluation at different stages during the course of one year follow-up study. The results of one year follow-up study have been reported (ICMR, 1989).

During January 1992 to December 1992, after completion of 10 years of initial assessment all the 68 patients from the Bikaner Centre of the ICMR 1 year follow-up study were contacted through repeated letters, relatives of patients coming to the centre from the same area as the study subjects, and key informants who were residing close to the study centre and whose addresses were available at the study centre. These key informants were personally summoned and requested to contact and encourage the patients and relatives to come to the study centre. With concerted efforts 62 out of the original 68 patients reported to the department. Of the remaining 6, two had died during the course of follow-up period and the other four had shifted from their old addresses and could not be traced. The complete record of
initial assessment and one year follow-up study was available in the department and the same assessment procedure was adopted for this follow-up from January 1992 to May 1993. They were administered SCAAPS which contains information about treatment, course and outcome and PSE for clinical assessment. Both the authors of the present study were well trained in the administration of SCAAPS and PSE and both of them were involved in ICMR study at Bikaner (ICMR, 1989). Reliability of ratings on PSE of the first author was tested in a formal meeting of ICMR investigators during the 1 year follow-up study and the reliability of the second author was checked by the first author during the course of the study. At 10 year assessment both the authors worked together in concert to evaluate the patients.

The course of illness was also studied by collecting information from the patients themselves and their accompanying relatives in 20 (32.3%) patients who were on regular follow-up, supplemented by hospital data. In the rest of the 42 (67.7%) patients who were not on regular follow-up information about the course of illness was gathered from close reliable family members who were living with the patients. Special emphasis was given to elicit even subtle signs of psychiatric morbidity, psychosocial performance in comparison with pre-morbid levels, personal care, and negative symptoms. To overcome the limitations of such retrospective data collection the patients and their reliable relatives were interviewed in detail by two examiners separately. In cases where there was the slightest of doubts, a second close relative was interviewed to confirm the authenticity of the facts. Thus the authors made all attempts to make sure that the course of illness could be ascertained with as much accuracy as possible.

RESULTS

62 patients could be assessed at 10 year follow-up out of the 68 initial intake patients. The follow-up rate was 91.17%. Only 16 (25.80%) patients were having frank psychotic symptoms on present state examination (PSE). Details of these 16 patients are as under:

- 10 patients had a continuous illness from the outset and never recovered completely.
- 6 patients initially remitted completely in one week (1), in two weeks (1), in four weeks (2), in five weeks (1), and in six weeks (1); and all remained asymptomatic for about 1-1½ years but subsequently psychotic behaviour developed and since. Then all 6 were continuously ill.

The distribution of 46 (74.2%) patients who were asymptomatic at the time of 10 year follow-up assessment is as under:

- 5 patients had multiple episodes in the interval period and were treated in the hospital. They were diagnosed to have bipolar affective disorder.
- 6 patients had prolonged initial illness lasting for one and half years to two years. During this period 4 patients were on regular treatment with antipsychotics while 2 patients took treatment only during exacerbation of symptoms. At the end of 2 years all recovered and remained asymptomatic without any antipsychotic medication for the next 8 years till follow-up at 10 years. These patients had been diagnosed to have schizophrenia at one year follow-up assessment.
- The remaining 35 patients had an initial brief psychotic illness. Thereafter all of them remitted after varying intervals. Remission occurred within one week in 3 patients, two weeks in 11 patients, three weeks in 4 patients, four weeks in 8 patients, five weeks in 1 patient, six weeks in 6 patients, eight weeks in one patient and twelve weeks in 1 patient. After recovery these patients were taken off all drugs after 2 weeks of remission. After remission all were asymptomatic till 10 years assessment without requirement of any intermittent antipsychotic medication.

Regarding socio-demographic variables. 50 (80.64%) patients were in the age range on 15-30 years. 47 (75.8%) were married, 49 (79.03%) were Hindus. Male/female ratio was 1.36:1.

With regard to important illness variables,
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35 (56.45%) patients contacted the hospital services within one week of onset of psychotic symptoms. The full blown psychotic picture developed within 48 hours in 31 (50%) patients. In 14 (22.58%) patients there was a definite history of antecedent stress and in another 15 (24.19%) patients there was a possibility of stress playing a causal role. 15 (24.19%) patients had a positive family history of mental illness. 11 (17.74%) patients had abnormal premorbid personality traits (predominantly schizoid), 4 (6.45%) patients had suffered from chronic difficulties in the preceding year and another 4 (6.45%) patients were occasionally abusing alcohol or some other drugs.

The factors which distinguished the completely remitted patients (N=35) from the rest of the patients were younger age, being single, Hindu religion, female gender, acuity of onset (i.e. onset within 48 hours) and presentation with predominantly "withdrawn" clinical picture according to ICMR descriptive diagnostic category (Table 1).

DISCUSSION

Acute short-lived psychosis was not recognised as a separate entity as per ICD-9 guidelines which were used to diagnose the subjects at intake. Out of the 35 patients who remitted, 33 (94.29%) did so by 6 weeks and the remaining two attained complete remission by 3 months. Hence, there was an observable tendency to put more of them in diagnostic categories of affective disorder or other non-organic psychosis. At the end of one year, of the 35 subjects who remitted completely 13 were diagnosed as schizophrenia, 4 as affective disorder and 18 in the category of 'other non-organic psychosis' for want of a better diagnostic label. Also at the end of the ICMR one year follow-up study, 32 (51.6%) of the total patients were still labelled as schizophrenia ignoring the fact that ten patients were asymptomatic for at least 9 months. This was because the guidelines for ICD-9 for 'other non-organic psychosis' (298.0-298.9) required that the diagnosis should be restricted to psychosis that is largely or entirely attributable to a recent life experience. The difficulties of diagnostic demarcation in this critical area have been already reported (Menuck et al., 1989; Malhotra et al., 1992; Wig & Singh, 1967; Wig & Parhee, 1988; ICMR, 1989).

From the present day viewpoint if one were to look retrospectively at the course and outcome of the single episode complete remission group one could categorise them under F.23 - Acute and transient psychotic disorder according to ICD-10 (WHO, 1992) guidelines. All 35 of these patients presented with features of psychosis and remitted within 6 weeks except for 2 patients. These 2 patients who recovered in 8 weeks and 12 weeks respectively also did not show typical schizophrenic symptom after initial 4 weeks of active symptoms. None of these 35 patients

### TABLE 1

| Variable                     | Complete remission (N=35) | Others (N=27) |
|------------------------------|----------------------------|---------------|
| **Acuity of onset**          |                            |               |
| (a) Acute, less than 48 hours| 23 (65.71)                 | 08 (29.63)    |
| (b) Acute, 48 hours to 1 week| 08 (22.86)                 | 13 (48.15)    |
| (c) Sub-acute 1 to 2 weeks   | 04 (11.43)                 | 06 (22.22)    |
| X² = 7.94, df = 1, p < 0.001 | (pooling b and c)         |               |
| **Age**                      |                            |               |
| 15-20 yrs                    | 15 (42.86)                 | 02 (7.4)      |
| 21-30 yrs                    | 16 (45.71)                 | 17 (52.96)    |
| Above 30 yrs                 | 04 (11.43)                 | 08 (29.63)    |
| X² = 10.45, df = 2, p < 0.01 |                            |               |
| **Marital status**           |                            |               |
| Unmarried                    | 12 (34.29)                 | 03 (11.1)     |
| Married                      | 23 (65.71)                 | 24 (88.9)     |
| X² = 4.56, df = 1, p < 0.05  |                            |               |
| **Religion**                 |                            |               |
| Hindu                        | 31 (88.57)                 | 18 (66.67)    |
| Sikh/Muslim/others           | 04 (11.43)                 | 09 (33.33)    |
| X² = 4.41, df = 1, p < 0.05  |                            |               |
| **ICMR descriptive categories** |                         |               |
| Predominantly withdrawn      | 9 (25.7)                   | 1 (3.7)       |
| Others (Elated, depressed, paranoid excited etc.) | 26 (74.3) | 26 (96.3) |
| X² = 5.44, df = 1, p < 0.05  |                            |               |
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TABLE 2

DIAGNOSTIC COMPARISON AT VARIOUS STAGES OF FOLLOW-UP ASSESSMENT

| Diagnosis                                | Under ICMR 1 year follow-up study | 10 year follow-up assessment (ICD-10) |
|------------------------------------------|-----------------------------------|-------------------------------------|
|                                          | Initial assessment (ICD-9)          | 1 year follow-up assessment (ICD-9)  |                                    |
| Schizophrenia                            | 36 (58.1%)                         | 32 (51.6%)                          | 22 (35.5%)                         |
| Affective disorder                       | 7 (11.3%)                          | 6 (9.7%)                            | 5 (8.1%)                           |
| Other non-organic psychosis (ICD-9)      | 19 (30.6%)                         | 24 (38.7%)                          | 0                                  |
| Acute transient psychotic disorder (F23, ICD-10) | 0                                   | 0                                   | 35 (56.5%)                         |

Includes 10 patients who had completely recovered within 6 weeks of onset of illness but could not be categorized in any other diagnostic category in ICD-9.

showed active symptoms of schizophrenia after initial 4 weeks of treatment. At 10 year follow-up, 10 of those patients who had been classified as schizophrenia, 1 as affective disorder, and 24 as other non-organic psychosis at the end of one year follow-up, could be re-grouped under the category of acute and transient psychotic disorder (F23, ICD-10) as they remained asymptomatic through-out the 10 year follow-up period (Table 2). In this regard the appearance of this diagnostic category in ICD-10 is a welcome development.

On examination of socio-demographic profile, acute remitting psychosis seems to occur more in the young age group and the prognosis is also significantly better in the younger group. This compares well with other reports from the country (Chaturvedi & Sahu, 1986; Dhavale & Kamath, 1993; Sivakumar & Chandrasekaran, 1993). Other socio-demographic variables like education, socio-economic status etc. could not differentiate these patients from the rest of the group. Varma et al (1996) also reported that patients from rural and urban clinics were similar in diagnosis and outcome in their 12 months follow-up study of acute psychosis.

Onset within 48 hours was a factor that clearly differentiated the single episode remitted group from the rest while other illness variables such as duration of illness prior to assessment, presence of stress, abnormal personality traits, family history of mental illness and living with other psychiatric patients did not make a difference. These findings are consistent with other reports from India (Kapur and Pandurangi, 1979; Sivakumar and Chandrasekaran, 1993; Varma et al., 1992). A look at the symptom profile at initial assessment of this group gives an impression that these cases are not distinguishable from manic or schizophrenic patients but a greater variability in clinical picture was observable in these patients.

Varma et al (1992) using Catego analysis of PSE symptoms pointed out that it is difficult to identify these psychotic states which may be different from schizophrenic or bipolar affective...
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Interestingly, 9 of the 10 patients who presented with predominant clinical picture of "withdrawal" according to ICMR descriptive categories, had a lasting remission within 4 weeks. Similar observations have been made in a recent 5 year follow-up study (Sivakumar & Chandrasekaran, 1993). However those patients who later in the course of illness developed withdrawal remained mostly symptomatic. Thus acute withdrawal presentation and development of withdrawal during the course of illness must be differentiated. Detailed interviews with informants of this group of patients during follow-up revealed that these patients were of a "reserved nature" and tended to show a pattern of withdrawn behaviour in the face of day to day stressful events.

In conclusion, a substantial number of patients presenting with first episode of psychosis are likely to remit quickly needing only a brief period of medication thereafter. Subsequently even without medication this group remains in remission for a prolonged period of time (10 years according to this study), and possibly lifelong, there by justifying the need to be classified as a separate group. This has significant implications in identifying these cases at the outset, planning the duration of treatment and offering prognosis. In the light of the present study, acuity of onset, younger age, being single and clinical presentation of withdrawal as opposed to excitement seem to be the favourable variables of this group. Much work needs to be done in future to identify other unique features of these cases at presentation which clearly delineate it from other non-organic psychoses, the role that psychic constitution and response pattern to stress plays in the genesis of this disorder, and its neurochemical basis.

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