Psychogenic Psychosis Revisited: A Follow up Study

Mohammed Omar Salem, Hamdy F. Moselhy, Hussain Attia, Saeed Yousef
Department of Psychiatry and Behaviour Sciences, Faculty of Medicine and Health Sciences
UAE University, AL Ain

Abstract:

Background: Although brief and acute psychoses are usually dramatic in presentation, they usually have benign course. Studies investigating clinical features and changes in diagnosis between psychotic episodes have differed in design. However, some consistent findings have emerged. This study seeks to clarify and extend these features by describing and comparing clinical diagnostic stability in a group of subjects with first episode psychosis diagnosed as acute psychotic disorder (psychogenic psychosis) followed up for 6 years.

Methods: The study comprises a retrospective evaluation of case records of 161 patients admitted for the first time with first episode psychosis. Among this group a subgroup of 69 psychogenic psychoses were followed up with special reference to stability of diagnosis within a period of 6 years.

Results: Forty-six patients (67.6%) were male, 22 (32.4%) were female and data were missing in one case-record. There was no significant statistical difference between gender and diagnosis. The mean age was 27.5 years (13-45 years).
There were criteria, which distinguish acute psychotic disorder (psychogenic psychosis). These criteria include acute onset with short duration of untreated psychosis, precipitating factors, adjusted pre-morbid personality, no family history of mental disorder, short duration of admission, full recovery in most of cases, with no further admission. Nearly 80% of the patients have never been admitted again in 6 years time.
Conclusions: *Our findings show a high level of agreement with the original concept of psychogenic psychosis; however, these bear little relationship to the DSM-IV (1994) and ICD-10 (WHO, 1993) criteria for brief or acute psychotic disorder.*

Correspondence:
Dr. H F Moselhy
Department of Psychiatry and Behaviour Sciences
Faculty of Medicine and Health Sciences
UAE University, AL Ain P O Box 17 666
Email: hamdy.fouad@fmhs.uaeu.ac.ae

Introduction

Atypical psychotic disorders designate psychotic conditions that cannot be easily classified as either schizophrenia or a mood disorder with psychotic features. They form a heterogeneous and poorly understood collection of disorders that are regarded as probably unrelated to schizophrenia and affective disorder, but on which surprisingly little empirical research has been carried out up to now. [1]

Although brief and acute psychoses are usually dramatic in presentation, they usually have benign course. Brief and acute psychoses have the air of a paradox. Thus, they have posed specific problems in regard to nosology, diagnosis and aetiology. Despite a strong convergence of the descriptive elements, the historical concepts of brief and acute psychoses have yielded different answers to the questions raised. Kahlbaum and Kraepelin set the stage on which brief and acute psychoses appeared `atypical'. The concept of `bouffée délirante` [2], used degeneration theory as a background for nosological and aetiological allocation. Similarly, the concepts of cycloid psychoses (Leonard, 1957), reactive (psychogenic) psychoses[3], and transient psychotic disorders[4] have provided diverging but interrelated ways to delineate brief and acute psychoses, to determine their nosological status and to explain the coexistence of severe disorder and favourable prognosis. Modern classifications, namely the acute and transient psychotic disorders of ICD-10 and the brief psychotic disorder of DSM-IV, reflect the varied history of the concept. [5] In Britain and the USA, psychoses that were not organic were classified, up to a recent past, either schizophrenia or affective disorders.[6] However, the French, Scandinavian and German schools of psychiatry on the contrary, excluded from schizophrenia different types of acute and transient psychoses.[1]

The aim of this study was to clarify the diagnostic stability in a group of patients diagnosed as acute psychotic disorder according to ICD-10 (WHO, 1992) (psychogenic psychosis) in their first episode of psychosis followed up for six years. [7]

Methods

Clinical setting

The psychiatry in-patient and outpatient facilities in Al Ain city-United Arab Emirates (UAE) exist on the District General Hospital site. It has an open referral policy and the members of the multi-disciplinary team offer a variety of treatment modalities. Al Ain city is the fourth largest city in the United Arab Emirates with a population of 348,000 (2003 estimate).

Subjects

Case notes of all inpatients admitted with the service for first episode psychosis were reviewed over 6 years period (1997-2003). Of 161 patients formally admitted, successful data extraction could be possible from 69 case records. Of a total 161, 92 were excluded as 35 were diagnosed as having manic episode, 31 had a diagnosis of schizophrenia, 16 had depression with psychotic symptoms, 3 had drug dependence, 1 had persistent delusional disorder, and 6 case records were missing.

Instrument and procedure

A data sheet was designed by the researchers to extract relevant information regarding signs and symptoms patterns and consequences. This data sheet was designed based on the initial assessment questionnaire used for each patient. Each patient when referred to the service is initially assessed using a semi-structured questionnaire, which focuses on the specific patterns of symptoms and its broad ranging bio-psychosocial consequences.

Statistical Analysis

Analyses were performed using the Statistical Package for Social Sciences (SPSS, version 14). Descriptive statistics were used to summarize socio-demographic and clinical characteristics of the sample. Chi square test was used to compare the frequencies of symptoms. All statistical tests were considered significant at p=0.05. Ethical approval was obtained from the Local Research Ethical Committee.

Results

Demography and characteristics of participants

Of 69 patients, 46 (67.6%) were male, 22 (32.4%) were female and data were missing in one case-record. There was no significant statistical difference between gender and

diagnosis. The mean age was 27.5 years (13-45 years) (SD=6.6). Nineteen patients (28.8%) were illiterate, 15 (22.7%) finished primary school, 13 (19.7%) finished intermediate school, 15 (22.7%) finished secondary school, 4 (6.1%) finished university and in three case-record data were missing. Thirty-one patients of the sample (47.7%) were single, 33 (50.8%) were married, one divorced (1.5%) and 4 missing data with no significant statistical differences. Ten patients (14.7%) were recognised in the notes as UAE nationality, 3 (4.4%) other gulf countries, 9 (13.2%) other Arabs, 10 (14.7%) Indians, 13 (19.1%) Pakistani, 10 (14.7%) Afghani, 6 (8.8%) Bangladeshi, 7 (10.3%) other nationality, and one missing data. There was no relationship between nationality and type of diagnosis of the patient ($\chi 2$=40.700, df=35, p=0.234).

Source of referral

Patients with acute psychotic disorder were more likely to be referred to treatment by their family (33.8%) or accident and emergency (23.1%). The rest were referred by various other agencies. There was no significant relationship between different sources of referral ($\chi 2$=26.553, df=25, p=0.379).

Family history of mental disorder and premorbid personality

The majority of the sample had no family history of psychiatric disorders (55 patients, 85.9%). Eight had family history of similar condition and one of other psychiatric conditions. There was no significant relationship between diagnoses and family history of psychiatric disorder ($\chi 2$=14.146, df=10, p=0.166).

The majority of the sample (49 patients-77.8%) had adjusted personality, 3 (4.8%) had mal-adjusted personality and the rest of case records had insufficient information recorded. There was a significant relationship between adjusted premorbid personality and psychogenic psychosis ($\chi 2$=22.408, df=10, p=0.013).

Exposure to stressful events before the onset of acute psychotic disorder

The majority of the sample (85.3%) had a stress prior to onset of the disease. Twenty-eight patients (41.2%) related to family problems, 17 (25.0%) related to work problems, and 13 (19.1%) related to physical problems. There was a significant relationship between stress related to work and the onset of the disease ($\chi 2$=13.008, df=5, p=0.023) and the stress related to physical problems ($\chi 2$=14.305, df=5, p=0.014), but not the family related problems ($\chi 2$=7.009, df=5, p=0.220).

Duration of untreated psychosis in acute psychotic disorder

Of the 69 patients, 49 patients (71%) suffered symptoms for less than one month before admission, (33 of them (49%) suffered less than 10 days and the rest suffered between 10-30 days. There was a significant relationship of acute psychotic disorder and the short duration of untreated psychosis ($\chi 2$=26.431, df=12, p=0.009).

Clinical features

There was no significant relationship between any of the symptoms either before admission or on mental state examination and type of the diagnoses (Table 1).

Table (1). Clinical features of acute psychotic disorder.

Clinical features	No.	% within indicated symptoms	$\chi 2$	Asymp-sig
Odd behaviour	64	95.5	18.352	0.003
Delusions	54	80.6	9.534	0.090
Aggression	49	72.1	18.921	0.002
Hallucinations	39	58.2	4.441	0.488
Lack of insight	56	83.6	5.247	0.387
Formal thought disorder	51	76.1	8.009	0.156
Self harm	11	16.2	5.193	0.393
Confusion	10	14.9	1.687	0.890

Duration of hospitalization

Although acute psychotic disorder group showed short duration of hospitalisation, there was no significant relationship ($\chi 2$=20.977, df=15, p=0.138). Twenty (29.0%) patients were admitted for 1-10 days, 39 (56.5%) between 10-30 days, 9 (13.0%) for 30-60 days, and only one patient for more than 60 days.

Follow up and Diagnostic stability

In follow up for acute psychotic disorder, 42 (60.9%) have never seen again, 12 (17.4%) attended the outpatient clinic 1-3 times then disappeared and 15 (21.7%) patients readmitted for the second time. There was a significant relationship between diagnoses and follow up ($\chi 2$=19.286, df=10, p=0.037), where patients who suffered acute psychotic episode were the highest frequent of not seen again.

Of the 69 patients suffered acute psychotic disorder, 15 (21.7%) readmitted again for the second time. Seven (46.7%) of them re-diagnosed as bipolar affective disorder manic type, another 7 (46.7%) re-diagnosed as schizophrenia, and only one (6.7%) patient diagnosed as acute psychotic disorder again.

On 3rd admission 3 patients who attracted a diagnosis of acute psychotic episode in first admission and bipolar manic in second admission, re-admitted for the third time with a diagnosis of bipolar affective disorder manic with 100% stability of their 2nd diagnosis.

Outcome of acute psychotic disorder

On discharge after the first admission, 39 patients (57.4%) of acute psychotic disorder showed full recovery. There was high significant relationship between outcome and diagnoses, where acute psychotic disorder was the most frequent diagnosis in full recovery compared with other diagnoses ($\chi 2$=31.452, df=5, p=0.005)

Discussion

The concept of psychogenic or reactive psychosis has been developed in Scandinavia. The first comprehensive survey of the concept of psychogenic psychosis is to be found in a monograph by the Danish psychiatrist.[3] According to Wimmer, psychogenic psychoses are clinically independent of schizophrenia and bipolar affective psychosis, usually develop in a predisposed individual, are caused by psychological factors, have a great tendency to recover and seem never to end in deterioration.[1]

Faergeman (1963) has investigated the prognostic validity of psychogenic psychosis, where he confirmed two thirds of the diagnosis and one third were re-diagnosed as suffering from schizophrenia.[8] In our study, nearly 80% of the patients have never been admitted again in 6 years time, which suggest either complete recovery or moving away from the area or the whole country where most of them were expatriates. In addition, there was a high level of significance in the measure of agreement between diagnoses in first and second admission.

Our findings show that stress related to work and physical problems are the significant stressor prior to the onset of acute psychotic disorder. Together with stress related to family problem, they account for nearly 85% of the first episode of acute psychotic disorder. According to Stromgren (1989), 65% of psychogenic psychoses are emotional reactions.[9] The high results in our study could be due to the adding on effect of being immigrants for most of the patients and other possibility is the retrospective nature of our data. However, there was no relationship between nationality and the diagnoses. This is inconsistent with El-Rufaie's study (1985) where he found that acute psychotic disorder is limited to particular nationalities, namely Indians, Pakistani, and Iranians in the same environment.[10] Possibly this is due to the limited number of his sample (25 patients) and the limitation to one sex (males).

Clinical picture and course

Our findings show that there are no specific significant symptoms in the presentation, however there were other criteria, which distinguish acute psychotic disorder (psychogenic psychosis). These criteria include acute onset with short duration of untreated psychosis, precipitating factors, adjusted pre-morbid personality, no family history of mental disorder, short duration of admission, full recovery in most of cases, with no further admission. The group of patient who has been re-admitted again (nearly 20%) were not consistent with this diagnosis but as the patient social function gradually diminished and the clinical picture became clear as episode recurred, a diagnosis of schizophrenia or affective disorder became possible.

Our findings show a high level of agreement with the original concept of

psychogenic psychosis; however, these bear little relationship to the DSM-IV (1994) and ICD-10 (WHO, 1993) criteria for brief or acute psychotic disorder.[11]

The concept of psychogenic psychosis will need to be investigated in long-term follow up study with reference to the level of agreement with current classification available.

Our study has some limitations. The first one comes from the inherent nature of retrospective studies with the occasional occurrence of missing data. The second limitation comes from the small number of patients represented that put some limitation in generalising these results. However, this study add on important clinical implications in our approach to diagnosis and put limitation into labelling our patients by diagnosing chronic psychiatric disorder with all the problem of stigma sticking to it.

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