

CLINICAL AND FOLLOW-UP STUDY OF UNSPECIFIED NON-ORGANIC PSYCHOSIS

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SUMMARY

The knowledge about unspecified psychosis is far from adequate currently. During a period of more than 3 years, 58 cases of Psychosis NOS or unspecified psychosis had been diagnosed and during a follow-up of more than 3 years, 21% cases developed Affective disorders, 16% cases developed reactive psychosis and 9% were diagnosed Schizophrenia during subsequent course of illness. 55% cases maintained the diagnosis of psychosis NOS. Unspecified psychosis seems to be a heterogenous group with diagnostic change occurring in 45% of cases. Unspecified Psychosis was noticed to be more in the younger people. No demographic variable had any significant association with the clinical variables.

The accurate classification of the psychiatric disorders has assumed greater importance with the availability of newer and more specific treatments for the psychosis. It has been suggested that the term undiagnosed psychiatric disorders or illness should be used when there is a lack of sufficient information or because the examination is incomplete (Hudgens 1971) or because it has been impossible to obtain the necessary history (Feighner et al 1972). The term Unspecified Psychosis or Psychosis NOS is to be used only as a last resort, when no other term can be used according to the International Classification of Diseases 9th Revision (W. H. O. 1978). But more than occasionally, one resorts to use this category of diagnosis.

Faergerman (1963) in the follow-up of 160 patients of Psychogenic psychosis cases for more than 15 years, duration found that 79 cases maintained the original diagnosis, 43 were diagnosed Schizophrenia and 25 cases were unspecified. Anstee (1977) in a 10 year follow-up of diagnosis uncertain cases noted the prevalence of Psychosis in the differential and follow up diagnosis and reported them to be high (43%). Chaturvedi and Sahu (1984) reported diagnostic change in 45% cases of unspecified psychosis

during follow up. On the contrary, Ray and Roy Choudhary (1984) reported that none of the unspecified psychosis case maintained the original diagnosis over a period of time. Out of 6 of their cases, two turned out to be Schizophrenia, two Mania and two had reactive psychosis. Khanna and Channabasavanna (1984) found highest change (13.46%) in the diagnosis of unspecified psychosis over a period of 5 years. Sethi et al (1985) in a 2 year follow-up of acute psychosis cases found that two-third of the cases developed Schizophrenia and rest of them were reactive psychosis. Varma (1985) reported 10% cases of unspecified psychosis including reactive psychosis in 232 cases of severe Mental Disorder. In an I. C. M. R. Multicentered Study Gurmeet Singh et al (1985) reported 40% cases of acute psychosis did not fit in the I. C. D. Diagnosis of Schizophrenia, Affective Psychosis and reactive Psychosis group.

Kala (1985) reported the utility of I. C. D - 9 three digit category in Indian patients and found that category 298 in I. C. D - 9 is used in only 4.98% of cases in General Hospital and only 0.9% in Mental Hospitals. Wig and Singh (1967) and Teja (1971) had proposed different classifications for Psychosis of uncertain origin but these never

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gained much popularity. Literature has very scant information on such psychosis. The exact phenomenology, clinical picture, course, outcome, prognosis and management of unspecified psychosis is unclear. It could be one of the specific types of psychosis observed in our culture (Sethi 1978, Sethi, et al 1982) or just a heterogenous group of psychotics who do not meet the criteria for other psychosis (McNeil 1983).

This study examines the follow-up, socio demographic, clinical and diagnostic characteristics of patients diagnosed as psychosis NOS, and to study the relationship between these variables.

Material and Methods

The sample included all new patients, who were evaluated and interviewed in detail and discussed with a senior consultant in the Psychiatric Out-Patient and were conferred a diagnosis of psychosis NOS (I. C. D. 9, Code 298.9) over a period of three consecutive years. For the purpose of inclusion into the study, patients should have completed atleast 3 years period following the detailed assessment at the time of inclusion into the study and should have had at least more than three follow-up visits. Contact was attempted with the cases by letters in those cases who did have adequate follow-up. Eighteen such cases responded and have been included after examination. In rest 40 cases adequate and regular follow-up was being maintained. An data collecting proforma was designed to incorporate details as socio-demographic, clinical diagnosis, treatment and outcome aspects. Patients about whom information was inadequate were excluded from the study. The statistical relationship between socio-demographic and clinical variables were than analysed.

Results

There were 58 patients diagnosed as

Psychosis NOS during the period of 3 years, had more than 3 follow-up visits and had adequate information and hence were included. Most patients were found to be of younger age group, married and with lesser education. There is not much difference in sex and habitat distribution (Table 1). 69%

Table 1
Socio demographic distribution

Variable	Number	Percentage
Age :		
16-29 years	33	56.9
30-44 years	16	27.6
45-60 years	9	15.5
Sex :		
Male	24	41.4
Female	34	58.6
Education :		
Primary	37	63.8
Matric	16	27.6
Above Matric	5	8.6
Background :		
Rural	31	53.5
Urban	27	46.5
Marital Status :		
Unmarried	9	15.5
Married	49	84.5

had acute onset, 52% remitted within one month and 33% remitted within another 6 months. Only 15% had a long duration of more than 6 months. Precipitating factors could be identified in 43% cases (Table 2). In 44.8% cases there was a diagnostic change, mainly to Manic-Depressive Illness (20.7%), Reactive Psychosis (15.5%) and Schizophrenia (8.6%). None developed organic psychosis. In 32.8% cases treatment was continued for more than 6 months. Neuroleptics constituted the main treatment of choice, 4 cases received ECT along with neuroleptics, 3 cases received anti-depressants.

Table 4 shows the relationship between the clinical and sociodemographic characteristics of the psychosis NOS patients.

Table 2
Clinical Aspects

	Number of Patients	Percentage
Onset :		
Acute	40	69
Sub-Acute	7	12
Gradual	11	19
Precipitating Factor :		
Present	25	43.1
Absent	33	56.9
Duration of Illness :		
1 week or less	9	15.5
1 week to 1 month	21	36.2
1 month to 6 months	19	32.8
More than 6 months	9	15.5
Condition when last seen :		
Recovered	22	37.9
Moderate Improvement	31	53.4
Slight Improvement	11	1.7
Condition same	4	7.0

Patients with low educational level have significantly low rate of precipitating

Table 3
Final Diagnosis

Diagnosis	Number of Patients	Percentage
Schizophrenia	5	8.6
M.D.P.	12	20.7
Organic Psychosis	0	0.0
Reactive & Others	9	15.5
Psychosis NOS.	32	55.2
	58	100.0

factors ($P < 0.01$). No other demographic variable significantly influenced any of the clinical aspects. Only 3 patients had a positive family history, 2 had a family history of Schizophrenia and one had history of paranoid illness.

Discussion

The study is quite revealing in the sense that it helps in the understanding about

Table 4
Relationship between Clinical & Socio-demographic Variables

	(N)	Onset		Precipitating Factor		Duration of illness		
		Acute	Insidious	No	Yes	1 Mth	1-6 Mth	> 6 Mth
Age :								
16-29 years	33	24	9	17	16	19	10	4
30-44 years	16	11	5	10	6	8	6	2
40-60 years	9	5	4	6	3	3	3	3
Sex :								
Male	24	18	6	14	10	13	6	5
Female	34	22	12	19	15	17	13	4
Education :								
Primary	37	25	12	26	11**	19	13	5
Matric	16	13	3	5	11	7	6	3
Above Matric	5	2	3	2	3	4	0	1
Background :								
Rural	31	23	8	17	14	16	12	3
Urban	23	17	10	16	11	14	7	6
Marital Status :								
Unmarried	9	6	3	7	2	5	3	1
Married	49	34	15	26	23	25	6	8

(** $P < .01$)

unspecified psychosis. In order to increase the validity of the case record information patients seen less than three times during follow-up and cases with inadequate information were excluded. All case records were gone into by the authors independently and the diagnosis of unspecified psychosis seemed to have been rightly applied in the sense that though all cases had certain psychotic features or behaviour, non had adequate reasons to be labelled Schizophrenia, Affective Psychosis, Reactive Psychosis or Paranoid Psychosis. Hence the first detailed work-up diagnosis seemed quite reliable, though it cannot be ruled out convincingly that certain features could have been missed at the time of first interview.

It is difficult to comment on the proportion of unspecified psychosis as there is hardly any comparable data. Kapur and Pandurangi (1979) found 11% of the patients with acute non-reactive psychosis to have a psychosis other than Schizophrenia or Affective disorder. Arce et al (1983) found 2 out of 179 of emergency cases to have unspecified psychosis.

Astrup (1966) in 5-15 year follow-up of 169, cases the diagnosis being Schizophrenia in 78 and Reactive Psychosis in 91 cases, found that 56 cases were re-diagnosed as unspecified cases of psychosis.

Other studies on inter-centre research projects (Cooper et al 1972), In-Patient settings (Chaturvedi et al 1983) and acute Schizophrenic episode (Singh 1981) to mention a few have found no cases of unspecified psychosis.

On studying the distribution of the clinical characteristics, it seems unspecified psychosis occurs more in younger age group, married and those with lesser education. They may have elicitable precipitating factors. But the group seems to be diagnostically heterogenous as about in half the

cases, the diagnosis was changed subsequently.

Correlation had been examined between the demographic and clinical variables and the change in diagnosis. Significant relationship was absent except regarding age. Age more than 30 years was associated significantly ($P < .03$) with change in diagnosis. Sethi (1985) reported duration and presence of reactive factor as indicators of the prognosis of acute psychosis cases, in our study we did not find any such relationship. There are no definite variables which could delineate those unspecified psychosis cases which would remain relatively stable. In certain aspects of presentation it resembles schizophrenia for example, younger age group and low education level but the prognosis is on the contrary, found to be better in younger patients. To establish a different nosological status for unspecified psychosis seems difficult from these findings. There is a likelihood that if the patients are regularly followed-up over a long period, many more cases might crystallize into known diagnostic entities as reported by Vivek (1975).

Family history was present in 2 of the cases who had diagnostic change. Family history was positive in one Schizophrenic and in one case of manic-depressive illness. Precipitating factor was observed in 12 cases who had diagnostic change. Of those 6 cases had Manic-Depressive illness, 4 cases had Reactive Psychosis, and in 2 cases the final diagnosis was Schizophrenia.

In conclusion, patients with atypical illness, including atypical psychosis or behaviour disturbances are difficult to diagnose and understand (Lion 1982). This study indicates indirectly that unspecified psychosis could just be a temporary diagnosis. However, further investigations of phenomenology, role of cultural factors, recurrences, and long term out-come of such a

psychosis are necessary for a more complete understanding of such cases.

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