

## ACUTE NON-ORGANIC PSYCHOTIC STATE IN INDIA: SYMPTOMATOLOGY

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*Patients with acute onset, non-organic psychotic states are frequently reported from India and certain other developing countries. This paper relates to an investigation of such cases in terms of their clinical history and their symptomatology examining the extent to which these are similar/dissimilar to schizophrenia and affective psychosis. 109 cases of acute psychosis fulfilling specified screening criteria were assessed on the Schedule for Clinical Assessment Acute Psychotic States (SCAAPS) and Present State Examination (PSE). The findings revealed that about 34% of all patients experienced significant stress before the onset of psychosis. About 40% of all cases presented with Catego subtype which was not indicative clearly of a specific diagnostic category. This subgroup of patients differed from the remaining 60% of patient in having greater frequency of stress before the onset of psychosis. On the whole the delusions were more commonly seen in patients from upper socioeconomic status & urban background. Limitations of classificatory provisions in the ICD-9 and catego in dealing with acute psychotic state are highlighted.*

Since Kraepelin, research in the nosology of the functional psychoses has mainly concerned itself with schizophrenia and affective disorders, especially on defining the boundaries between the two. However, there has been growing dissatisfaction among psychiatrists from different parts of the world with the present system of classification of functional psychotic disorders, primarily concerning its dichotomous approach into viewing functional psychoses as either schizophrenia or affective disorders. Certain schools of psychiatry in Euro-American countries have proposed alternative classificatory categories, for example, cycloid psychoses (Leonhardt, 1969); schizo-affective schizophrenia (Kasanin, 1933); schizophreniform psychosis (Lengfeldt, 1937); and reactive or psychogenic psychosis (Welner & Stromgren 1958; Faergeman, 1963), based on common features, such as acuteness of onset, florid clinical picture, greater affective colouring, association with antecedent stress and good outcome.

In recent years, there has been a resurgence of interest in some "acute" psychotic states occurring in non-European, non-North American cultures stimulated by the expansion

of mental health services in developing countries and by the recognition of the need for generation of statistical data base on mental disorders in these parts of the world.

Various workers in India have described, from time to time, certain conditions like acute psychosis of uncertain origin (Wig and Singh, 1967); acute psychosis without antecedent stress (Kapur and Pandurangi, 1979); and acute schizophrenic episode (Singh and Sachdeva, 1981) indicating that these are different from schizophrenia as well as affective psychoses and may represent a 'third' type of psychosis. These psychotic states occur in a variety of socio-cultural settings and have several important features in common, viz., acute onset usually precipitated by stressful events, a florid and rather variable clinical picture, short duration and marked tendency to recover with or without treatment. It appears that such psychotic states occurring in geographically & culturally different parts of the world like Africa (Lambo, 1955; Jilek and Jilek Aall, 1970) Japan (Mitsuda, 1965). West Indies (Littlewood & Lipsedge, 1977) have certain basic features common to those described as alternatives to schizophrenia & MDP in the

developed world. In a multicentered collaborative study of ICMR (Singh, 1986) it was found that about 40-50% cases of acute onset psychosis could not be categorised into either schizophrenia or MDP using ICD-9 and category systems of classification.

It is evident from review of literature that schizophrenia and MDP do not cover the entire range of non-organic psychotic conditions encountered in clinical practice. There is a need to achieve greater clarity in this entire area of acute non-organic psychotic states in terms of describing the characteristics symptomatology, antecedent factors, socio-demographic & clinical correlates, course & outcome. This would help in understanding the phenomenology & natural history of these illnesses vis a vis schizophrenia & MDP, and facilitate efforts in further refining the criteria for schizophrenia & MDP. In addition, this would throw light on the role of socio-cultural factors in causation, manifestations & outcome of psychotic disorders.

WHO launched a collaborative study "Cross-cultural study of acute psychosis" as part of the larger study "Determinants of outcome of severe mental disorder" with the following aims and objectives. Six centres from across the world (two in USA & one each in Nigeria, Czechoslovakia, Denmark & India) agreed to participate in the study. The present paper reports on the study carried out at the Chandigarh centre in North India.

## AIM

The aim was to study acute psychotic illnesses in a systematic manner in order to develop adequate treatment methods and classificatory provisions. It was envisaged that important clues would emerge about the relationships between such states and specific socio-cultural factors and the nature of

psychotic disorders in general. Specific, over-all objectives of the whole study were:

1. In what sense can it be said that there are in India functional psychoses which are different from schizophrenia and affective psychoses what is the natural history of such states?

2. Are such psychotic states in India similar to those in certain other cultures with regard to their symptomatology, course, outcome and response to treatment?

3. How are these psychotic states currently being classified? Are special classificatory provisions necessary with regard to ICD?

4. What treatment facilities and modalities are required for these patients? What are the problems encountered in the management of these patients?

The result of this entire study will be presented in series of papers. This is the first paper highlighting the methodology of the study and deals with the following objectives:

1. To study the clinical history and symptomatology of acute non-organic psychotic states in India.

2. To study whether there are, among them functional psychoses other than schizophrenia and affective psychoses.

3. How are these cases classified under ICD-9 system?

## MATERIAL AND METHOD

The study design involved the identification, clinical assessment and short-term follow up of patients with non-organic psychotic illness. The population under study included patients coming either to psychiatry outpatients

department of Nehru Hospital, Postgraduate Institute of Medical Education & Research, Chandigarh from the union territory and within 20 km radius of Chandigarh, or to the rural psychiatric clinic run by the department at a primary health centre 40 km away from Chandigarh. Only those patients were included who were likely to stay in the catchment area for at least one year after initial contact. All patients coming to these facilities were screened and those who fulfilled the selection criteria as described below were included in the study.

### INCLUSION CRITERIA

Patients of acute psychotic states, in the age range of 15-60 years, of either sex, who had sudden onset of psychotic symptoms developing within one week were selected. These patients should have presented at the initial screening, with any of the following symptoms: hallucinations (any modality), delusions (any content), confusion and disorientation, stupor or mutism, severe psychomotor excitement, marked hypomanic affect or marked depression. The patients should have had onset of psychiatric/symptoms within three months prior to initial assessment preceded by a state of apparent mental health for at least three months.

### EXCLUSION CRITERIA

Gross organic disorder of any etiology excluding alcohol and drug intake, epilepsy, neuroleptic or anti-depressant medication for a total period longer than one week at any time during the three months prior to initial assessment; having received ECT during the present episode prior to initial assessment; and maintenance lithium therapy, were the exclusion criteria.

### INSTRUMENTS

All selected patients were administered the Schedule for Clinical Assessment of Acute Psychotic States (SCAAPS), an instrument designed by Mental Health Division of WHO; and the Present State Examination (PSE) by Wing *et al.* (1974) 9th edition within two days of inclusion. SCAAPS is a structured interview schedule that consists of:

#### A: Screening criteria

**B: Psychiatric history and social description** (rapidity of onset past history of episode, presence of stressful events, use of intoxicating drugs, abnormal premorbid personality, history of mental disorder in the family, member of cultural minority group etc.)

#### C: Symptom checklist

**D: Initial assessment diagnosis and one year follow-up diagnosis**

**E: Treatment, course and outcome.** In addition, Socio-demographic characteristics were also recorded.

All the patients were diagnosed clinically according to ICD-9 at initial evaluation and treated accordingly.

### GENERAL PROCEDURE FOR DATA COLLECTION

All patients fulfilling the specified criteria who contacted the psychiatric services as first contact for the episode or relapse were assessed according to the following schedule:

**Initial assessment:** Included administration of (1) SCAAPS part A (Screening criteria): part B (Psychiatric history and Social description) & part C (Syndrome checklist) (2)

PSE (9th Ed. Hindi translation developed at the WHO collaborating Centre Chandigarh) for the period of time from onset of psychotic symptoms until one week prior to the first assessment and for one week period of time preceding the first contact with the psychiatric facility for the inclusion episodes of illness.

Syndrome checklist was repeated thrice at 2-3 weeks, at the end of three months & at one year after initial assessment.

PSE was repeated at the end of one year after initial assessment.

Diagnosis (i.e. Part D of SCAAPS) was filled at two points (i) on completion of initial evaluation and (ii) at the end of one year follow-up where the clinician ranked the probability (in his clinical judgement) for each of the five possible diagnostic categories (schizophrenia, affective psychosis, reactive/psychogenic

psychosis, alcohol drug induced psychosis, & other psychosis), as applied to the diagnosis of the patient at the time.

Treatment, course and outcome included in part E SCAAPS, were rated at three months & one year follow-up examinations.

The present paper deals mainly with the data on sociodemographic characteristics, screening criteria, psychiatric history & Social description Symptom checklist & intake diagnosis.

## RESULT

**D**istribution of the total sample according to diagnosis, age, sex, socio-economic status (SES) & urbanicity is given in table 1.

**Table-1 : Diagnostic breakdown and sociodemographic characteristics of the sample**

Sociodemographic factor	Diagnosis (ICD-9)				$\chi^2$
	Schizophrenia (N = 54)	MDP (N = 43)	Reactive Psychosis (N = 10)	Organic Psychosis (N = 2*)	
<b>Age (in years)</b>					
15-20	17	7	3	1	
21-30	25	13	3	1	
31-40	10	15	1	-	11.8
41-50	2	8	1	-	NS
<b>Sex</b>					
M	21	22	3	2	2.25
F	33	21	7	-	NS
<b>SES</b>					
Above average	1	2	-	-	
Average	35	27	8	-	0.73
Below Average	18	14	2	2	NS
<b>Urbanicity</b>					
Rural	30	23	8	0	2.24
Urban	24	20	2	2	NS

\* Excluded from  $\chi^2$

Majority of patients (about 66%) were below 30 years of age & represented average socio-economic status class. Almost equal number came from the urban and the rural background. The diagnostic group did not differ on various socio- demographic factors studied.

The diagnostic distribution of the total sample according to ICD-9 shows that about

half of the cases were diagnosed as schizophrenia & about 40% as MDP. There were two cases of organic psychosis, both of acute drug induced psychosis related to cannabis intake.

This table gives the distribution of prominent symptoms at screening in various SES categories. Delusions were found in

**Table-2 : Prominent symptoms at screening in different diagnostic categories**

Symptoms	Diagnosis (ICD-9)					$\chi^2$
	Total (N=109)	Schizophrenia (N=54)	MDP (N=43)	Reactive Psychosis (N=10)	Organic Psychosis (N=2)	
Hallucination any modality	28(25.7)	19(35.2)*	3(6.9)*	3	2	* 10.85, d.f. = 1, p < .001
Delusions any content	39(35.8)	21(38.9)	13(30.2)	4	1	NS
Confusion Disorientation	4(3.7)	2(3.7)	0	1	1	NS
Psychomotor excitement	60(55.0)	33(61.1)	15(34.9)	9	2	NS
Marked Hypomanic affect	26(23.8)	4(7.4)**	21(48.8)	2	1	** 21.47, d.f. = 1, p < .001
Marked Depression	22(20.2)	3(5.5)***	19(44.2)***	1	0	***20.37, d.f. = 1, p < .001

*Percentage of column total in parenthesis. Many patients had more than one syndrome.*

This table shows the frequency with which various symptoms were seen prominently at screening in different diagnostic categories. The commonest presenting symptoms was psychomotor excitement (55.04%) followed by affective symptoms (44.03%) in the form of hypomania or depression. Among those diagnosed as schizophrenia, the most common symptom at screening was psychomotor excitement (61.1%) followed by delusions (38.9%) & hallucinations (35.2%). Patients diagnosed as MPD when compared to schizophrenics

presented with hallucinations in significantly fewer number and with affective symptoms in significantly larger number.

This table gives the distribution of prominent symptoms at screening in various SES categories. Delusion were found in significantly larger number of patients from average and above average SES & urban background. Depression was significantly commoner in rural than urban patients.

**Table-3 : Prominent symptoms at screening vs. Socioeconomic Status & Urbanicity**

Symptoms	Total (N = 109)	Socioeconomic status			Urbanicity		
		Average (N = 54)	Below (N = 43)	$\chi^2$	Rural (N = 57)	Urban (N = 52)	$\chi^2$
Hallucination (any Modality)	28(25.7)	20(27.4)	8(22.2)	NS	12(21.0)	16(30.8)	NS
Delusions (any content)	39(35.8)	35(47.9)	4(11.1)	13 d.f. = 1, p < .01	12(21.0)	27(51.9)	11.26 d.f. = 1, p < .01
Psychomotor excitement	60(55.0)	38(52.0)	22(61.1)	NS	35(61.4)	25(48.1)	NS
Confusion Disorientation	4(3.7)	3(4.1)	1(2.8)	NS	4(7.0)	0	NS
Marked Hypomanic affect	26(23.8)	17(23.3)	9(25.0)	NS	11(19.3)	15(28.8)	NS
Marked depression	22(20.2)	15(20.5)	7(9.4)	NS	17(29.8)	5(9.6)	6.92 d.f. = 1, p < .01

Percentage of column total in parenthesis.

Table 4 shows the duration of illness (in weeks) before first assessment in patients of different diagnoses.

57% of patients were brought to hospital within one week of illness and this time duration did not differ across various diagnostic categories.

**Table-4 : Duration of illness (in weeks) before first assessment vs. diagnosis**

Duration of illness	Diagnosis				Total (N = 109)
	Schiz. (N = 54)	MDP (N = 43)	Reactive (N = 10)	Others(N = 2)	
1 Wk	31(57.4)	20(46.5)	8	2	63(57.8)
2-4 Wks	12(22.2)	12(29.9)	0	-	23(21.1)
4-12 Wks	11(20.4)	11(25.6)	2	-	23(21.1)

Out of the total sample, 37 patients (33.9%) experienced significant stress preceding the onset of psychosis (Table. 5) 22 of these

patients (59.5%) were diagnosed as schizophrenia. None of the patients diagnosed as MDP reported as having encountered sig-

**Table-5 : Diagnostic breakdown and stress factors preceding the onset of psychosis**

Diagnosis	No. (%)	Psychological stress in preceding 3 months	Physiological stress in preceding 3 months	Ch. stress in the last 1 year	Total
Schizophrenia	54(49.5)	17	1	4	22
MDP-mania	23(21.1)	0	0	0	0
MDP-depression	20(18.3)	0	0	0	0
Reactive psychosis	10(9.2)	9	1	3	13
Organic Psychosis (Cannabis induced)	2(1.8)	1	0	1	2
Total	109	27(24.8)	2(1.8)	8(7.3)	37(33.9)

*Percentages in parenthesis*

nificant stress and all the patients of reactive psychosis experienced stress preceding the onset of psychosis in them. In 27 (24.8%) patients there was psychological stress and in 2 (1.83%) there was physiological stress in the

preceding 3 months, whereas in 8 (7.34%) it was chronic stress in the last one year.

Table 6 shows the frequency with which certain history variables were found positive in different diagnostic categories.

**Table-6 : Certain history variables vs. diagnosis**

History variables	Diagnosis					$\chi^2$
	Total (N = 109)	Schizophrenia (N = 54)	MDP (N = 43)	Reactive Psychosis (N = 10)	Organic Psychosis (N = 2)	
Index episode was the first episode of mental illness	72(66.0)	43(79.6)	21(48.8)	6	2	*10.13, d.f. = 1, p < .01
Abnormal traits in premorbid personality present	6(5.5)	1(1.8)	3(7.0)	1	1	NS
Family history of mental illness present	13(11.9)	7(13.0)	4(9.3)	1	1	NS
Living with a mentally ill person	3(2.7)	3(5.5)	-	-	-	NS
Belongs to identified minority group	18(16.5)	7(13.4)	8(18.6)	2	1	NS

Table-7 : Certain history variables vs. diagnosis

Catego classes	Catego subclasses	No.	Total No. = 104
S+	NS+ (Nuclear schizophrenia)*	15	22
	NS? (Nuclear schizophrenia)	1	
S?	DS+ (Schizophrenic without first rank symptom)	5	11
	DS? (Schizophrenic without first rank symptom)	1	
P+	DP+ (Paranoid psychosis)	2	25
P?	DP? (Paranoid psychosis)	2	
	DP?/AP? (Paranoid psychosis/Affective psychosis)	7	
O+	CS+ (Catatonic schizophrenia)*	11	25
O?	CSMN (Catatonic schiz/ manic)	1	
	UP+ (Borderline psychosis)	5	
	UP? (Borderline psychosis)	4	
	XP (Borderline psychosis)	2	
	SS (Simple schizophrenia)	1	
RS+ (Residual schizophrenia)	1		
D+	PD+ (Psychotic depression)*	1	24
D?	AP? (Affective psychosis)	6	
R+	RD+ (Residual depression)	17	
M+	MN+ (Mania)*	14	19
M?	HM+ (Hypomania)*	4	
	MN? (Mania)	1	
M+	SD+ (Simple depression)	1	3
H	HT (Hysteria)	1	
X	XN (Residual neurosis)	1	

\* Subclasses indicative of specific diagnostic category

In about 79% of patients of schizophrenia, the index episode was the first episode of mental illness whereas about 57% of MDP patients have had earlier episode(s). This difference was statistically significant. Family history of mental illness was present in 11.91% of total sample almost equally distributed across various diagnostic categories. In a very small proportion of patients (2.7%) there was history of drug & alcohol use.

All the patients were administered PSE at intake. Complete PSE data was available for

104 cases, which was subjected to catego analysis. Table 7 shows the Catego class 0+ and 0? (other psychosis) out of which only 11 cases were assigned to subclass CS+ which is clearly indicative of a diagnostic category. 24 cases were categorised into D+, D? & R+ (depression), of which, 18 presented with catego subclasses PD+ (1) and RD+ (17) categories that are clearly indicative of a diagnostic category. Almost all (18 out of 19) patients of M+ & M? presented with subclasses MN+ and HM+. However, among 32 patients relegated to S+ & S? classes, only 15 presented with subclass NS+



as clearly indicative of a diagnostic category. In total, 62 (60%) patients exhibited symptoms and catego sub-classes clearly indicative of a diagnostic category like NS + CS +, MN +, HM +, RD + & PD +, whereas 40 (40%) patients presented with nonspecific symptoms not clearly indicative of a diagnostic category.

These two groups of patients were further compared on various antecedent history variables as shown in table 8.

It was found that a significantly larger proportion of patients who did not present with specific symptoms clearly indicative of a diagnostic category experienced psychological and physiological stress in the preceding 3 months.

**Table-8 : Certain history variables vs. catego subclass**

History variables	Catego subclasses * (N = 104)			
	Total (N = 104)	Indicative of a diagnostic category (NS +, CS +, MN +, HM +, RD +, PD +) (N = 62)	Not indicative of a diagnostic category (all others) (N = 42)	$\chi^2$ at d.f. = 1
Psychological or physiological stress present in preceding 3 months	37(33.9)	9	28	29.71, p < .001
Past episode of mental illness present	37(33.9)	26	11	2.7, NS
Family history of mental illness present in a first degree relative	13(11.9)	7	6	0.20, NS
Abnormal traits in premorbid personality present	(5.5)	3	3	0.24, NS
Belongs to identified minority groups	18(16.1)	11	7	0.32, NS

Percentage in parenthesis

\* Catego analysis was not available for 5 cases

## DISCUSSION

The term acute psychosis in its broadest sense can be construed as an acute onset psychosis without any specific features of its own representing a particular kind of onset in well known psychotic categories like schizophrenia & MDP which have their characteristic symptomatology course and outcome.

However, this term also refers to a heterogenous group of disorders characterised by an acute onset (i.e. time duration between first symptom and fullblown picture is less than 2 weeks), presence of clearcut psychotic symptoms such as delusions, hallucinations and gross disruption of normal behaviour and a complete recovery within a maximum of 3 months labelled as acute

the study revealed that using conventional criteria of ICD-9, most patients (about 89%) were diagnosed as either schizophrenia or MDP and only about 11% were labelled as reactive or organic psychosis. This shows that there is a general tendency to diagnose patients in accordance with the classificatory provisions & those conditions which do not appear in a nosological system are often not identified.

About 34% of all patients experienced significant stress before the onset of psychosis out of which about 60% were given a diagnostic level of schizophrenia. This finding again reflects a sort of diagnostic bias inherent in the classification criteria because, if more liberal scandinavian approach to stress and psychosis were to be applied to these patients, many more of them would have been diagnosed as reactive psychosis. It is noteworthy that none of patients diagnosed as MDP, either mania or depression, reported stress preceding the onset of psychosis, whereas, all the patients of reactive and organic psychosis reported having experienced stress of some kind. Data from three other collaborating centres in this study revealed that the highest proportion of sample (55.4%) was diagnosed as other non-organic psychosis (ICD 298) in Aarhus, Denmark, which was only 4% in Ibadan Nigeria (Cooper *et al.*, 1990). The concept of reactive psychosis in ICD -9 follows stringent Jaspersian criteria, thus possibly forcing the inclusion of some such cases in the schizophrenia rubric, and diluting the concept by making it overinclusive. However in Scandinavia, the concept of reactive psychosis is more liberal.

In recent years there has been increasing reliance on phenomenological approach to classification of psychiatric disorders including psychosis. In accordance with this approach to classification of acute psychosis states in the present study, it was found that at screening maximum number (about 55%) of patients presented with psychomotor excitement irrespective of the diagnosis, socioeconomic and

urbanicity status. This was followed by marked affective symptoms in the form of hypomania or depression seen in about 44% which was significantly more common (as expected) in MDP as compared to schizophrenia (table 2). Depression is more common in rural patients than urban (table 3). Delusions were present only in about 35% of all patients, being as common in schizophrenia as in MDP. However, a clear relationship of delusion appeared with SES and urbanicity; it being significantly more common in patients from average and above -average SES and urban background. Presence of delusions being related to socio-cultural factors rather than the diagnosis is a very significant finding in this study: Certain other studies have also corroborated the finding that delusions are seen with relatively lesser frequency in patients of schizophrenia in developing countries in contrast to those from developed countries (Hoch, 1961; Wittkower and Dubreuil, 1971; WHO, 1979; Verma, 1986). Various reasons like poor linguistic competence (Verma, 1986) or tendency for somatization of symptoms through the use of body language in India (Hoch, 1963) have been attributed to explain this finding. Nevertheless, it is apparent from the foregoing that including delusion as essential criteria for sub categorizing acute psychotic states will be less desirable. Hallucination were seen in about 25% of cases at initial screening which were more frequent in schizophrenia than in MDP. SES and rural-urban status did not make significant difference to the distribution of hallucinations.

About one third of all patients had history of past episode(s) of mental illness, larger majority of whom were diagnosed as MDP. About 16.5% belonged to identified minority group who mostly came from below average socio-economic status and represented ethnic and religious minority. Family history of mental illness was present in about 12% of patients which represents the general figure for positive family history in schizophrenia and MDP. There was no differences between the diagnos-

tics group on various other antecedent history variables like presence of abnormal traits in premorbid personality family history of mental illness, living with a mentally sick person, belonging to identified minority group, use of drug or alcohol, or the duration of illness before first assessment.

PSE is a highly reliable and objective instrument of symptom rating. Catego reduces the PSE data to six descriptive categories through nine stages. At stage 2, 140 symptom of PSE ninth edition are converted into 35 syndrome of which, certain syndrome, if present, by themselves immediately suggest a particular diagnosis. Each such syndrome is converted into a 'potential category'. There are other syndromes that are although diagnostically relevant but they do not, in themselves, suggest one particular diagnosis. Such syndromes may occur in several different psychotic condition and their diagnostic significance depends upon the context of other syndromes (Wing, *et al.*, 1974). In the present study analysis of syndrome was carried out in order to know how many patients in this cohort presented with such syndromes as would directly suggest a particular diagnosis whether this group of patients differed in any way from those who presented with syndromes not directly suggestive of a diagnosis. Distinction at this stage is important because after this stage in catego analysis the syndromes are combined in accordance with certain logical commands creating hierarchies for diagnostic significance of syndromes.

It was found that largest majority of patients were categorized as 0+ or 0? (other psychosis) which is generally included in the schizophrenia rubric along with classes S & P. 43 patients were relegated to Catego classes D, R & M representing affective psychosis rubric. There were only 3 cases which were not assigned to any class within schizophrenia and affective psychosis range. On the contrary these were categorized into nonpsychotic classes. This highlights the limitation of Catego clas-

sification when applied to acute psychoses, that it is unable to adequately recognize those psychotic states which may be different from schizophrenia or MDP. Catego sub-class analysis of PSE at intake revealed that in about 60% (N=62) of patients the Catego subclass was indicative of clearcut diagnostic category (e.g. NS+, CS+, MH+, HMN+, RD+, PD+), whereas in the rest (N=42) it was not indicative of a specific diagnostic category (e.g. UP?, AP?, DP?, DS?). Overall concordance of Catego cases S P & D with ICD-9 schizophrenia and of Catego D R & N with depressive psychosis of ICD-9 was significantly high (Malhotra, *et al.*, unpublished paper). It is possible that these 50%-60% of patients in whom the symptomatology is more differentiated to suggest a diagnostic category (i.e. schizophrenia & MDP) may perhaps be different from the remaining subgroup comprising 40% of the total sample, who are more likely to be labelled as "acute psychosis". The later subgroup of patients with undifferentiated symptomatology differed from those with more differentiated symptom presentation is having greater frequency of stress preceding the onset of psychosis in them.

Thus, it is apparent that there is a subgroup of patients of acute psychosis who are different from other conventional diagnostic entities like schizophrenia and MDP, in terms of their antecedent history and symptom profile. The question arises as to what are those patients and how do these compare with other entities described in literature. This subgroup of patients is different from "reactive and psychogenic psychosis" of Jaspers (1918), McCabe and Stromgren (1975) because all of these did not fulfil some of the Jaspersian criteria like psychosis serving some psychological purpose, symptoms reflecting stress in a meaningful manner, and they did not show constitutional abnormal character traits. In term of symptoms profile these patients could be similar to those labelled as schizophreniform psychosis (Langfeldt, 1937), remitting schizophrenia

(Kant, 1941) or Fowler's (1972) good prognosis schizophrenia, (notwithstanding the outcome data which is not included in this paper), which have all been subsumed under the larger rubric of 'schizophrenias'. However, the empirical data suggests that this may not be a valid assumption. Descriptively, these non-schizophrenic, non-affective psychotic states which are reported as common clinical presentations in India (Venkoba Rao, 1986; Wig, 1990) and other developing societies as in Taiwan (Rin & Lin, 1962); Africa (Jilek & Jilek-Aall, 1970); & West-Indies (Littlewood & Lipsedge, 1977) may at best be regarded as "acute polymorphic psychosis" described in ICD-10 draft amongst other categories of acute psychoses. Recognition of this condition in ICD-10 is a significant step forwards towards bringing in greater acceptance of these acute polymorphic psychosis and focusing attention of professionals onto these disorders which are so vastly reported from the developing parts of the world. An investigation into their course & outcome is likely to be helpful in understanding the extent to which these maintain a distinctive profile.

It is noteworthy that "acute and transient psychotic disorder", have been included in the ICD-10 draft (May, 1990) as a major three character category (F 23) with four, four character categories each with or without stress subsumed under it.

## CONCLUSION

Acute non-organic psychotic states in India can be divided into two types of presentation one in which symptoms are largely indicative of a conventional diagnosis like MDP or schizophrenia seen in about 60% of patients, which are less often associated with stress and often have past history of mental illness. Second group comprises of about 40% of subjects who

show more undifferentiated symptomatology and are related to antecedent stress. This subgroup of "acute unspecified psychosis" may represent a third psychosis validity of which needs to be further established through follow-up and outcome studies. This study highlights the limitation of ICD-9 and Catego classificatory systems in dealing with these cases of acute unspecified psychosis. The other significant finding of this study is that delusion are commoner in patients from higher socio-economic status and urban areas irrespective of the diagnosis.

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