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The relation of "acute and transient psychotic disorder" (ICD-10 F23) to bipolar schizoaffective disorder

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Abstract

The aim of this work is to investigate differences between acute and transient psychotic disorders (ATPD; F23 of ICD-10) and bipolar schizoaffective disorders (BSAD). In a controlled prospective and longitudinal study, we compared all inpatients with ATPD treated at Halle university hospital during a 5-year period with matched controls with BSAD. Sociobiographical data were collected using a semi-structured interview. Follow-up investigations were performed at a mean of 2.2–3.3 years after the index episode or 8.2–16.1 years after the first episode by means of standardized instruments. ATPD differs significantly from BSAD on various relevant levels, such as gender (more female), age at onset (older), development of the full symptomatology (more rapid), duration of the symptomatology (shorter), acuteness of onset (more acute), preceding stressful life-events (more frequent) and long-term prognosis (better). It is concluded that ATPD and BSAD are different nosological entities.

Keywords: Bipolar schizoaffective disorders; Acute and transient psychotic disorders; Classification; Outcome

1. Introduction

Schizoaffective disorders and acute and transient psychotic disorders (ATPD) are both very special groups in psychiatric nosology. These diagnoses and their allocation within the classification systems are connected with some problems. The main question concerns their relation to the major group of psychotic disorders, namely schizophrenia and mood disorders: Are they subgroups of schizophrenia or affective disorders or are they separate entities? This question provokes an ongoing discussion, which is more than 100 years old (see Marneros and Angst, 2000; Marneros and Tsuang, 1986). The category ATPD (ICD-10 F23) is an attempt to integrate some national concepts such as 'cycloid psychosis' in Germany, 'bouffée délirante' in France, 'psychogenic psychosis' in Scandinavia, 'atypical psychosis' in Japan, and 'remitting schizophrenia' in the USA (Perris, 1986; Pichot, 1986; Marneros et al., 2000, 2002a,b; Pillmann et al., 2002). However, these so-called "national concepts" (and consequently, also ATPD) had a lot of difficulties when it came to distinguishing themselves from schizoaffective disorders (Marneros and Tsuang, 1986). The existing difficulties are understandable because the ATPD, as defined in ICD-10, show some symptoms which are also very common in schizoaffective disorders, especially the rapid changing mood status or even the bipolarity of affectivity in some patients with ATPD (Marneros et al., 2000, 2001a,b; Pillmann et al., 2002). This gives rise to the question whether there is any relation between them and the bipolar schizoaffective disorder. Finding the answer to this question is the intention of this study.

2. Methods

2.1. Recruitment

In the first phase of a prospective follow-up study, we identified all consecutive cases fulfilling ICD-10 criteria of ATPD (F23) treated as inpatients at the Department of Psychiatry and Psychotherapy at Martin Luther

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University Halle-Wittenberg, Germany, during a 5-year period. ICD-l0 research criteria were strictly applied. In total, we found 42 cases of ATPD (4.1%) among 1036 patients treated for non-organic psychotic or major affective disorders (F2 or F3 of ICD-10) during the study period. Patients with ATPD formed 8.5% of all patients with non-organic psychotic disorder (F2 of ICD-10).

2.2. Control groups

We also recruited a control group of patients with bipolar schizoaffective disorder. We only included bipolar forms of schizoaffective disorder (BSAD) for two reasons. Firstly, the restriction was necessary to obtain a more homogeneous sample because of the heterogeneity of schizoaffective disorder. Secondly, a bipolar characteristic of symptoms has been suggested to be an important feature in concepts of brief remitting psychoses related to ATPD (Pillmann et al., 2002). The control group was matched for gender and age with the index patients. All patients ($N=84$) were investigated and interviewed by the authors themselves (four psychiatrists and 1 clinical psychologist, R.B.).

We systematically recorded demographic, sociobiological and clinical features for both groups. All available information was used, including data from a semi-structured interview, hospital charts and—with the patient's consent—data from informants, such as family members. For the evaluation of psychopathological parameters during index episode, a symptom list that was derived from the AMDP system was used. All items were rated as "present" or "absent".

We did not require the index episode to be the first manifestation of the illness. 45.2% of the ATPD patients and 95.2% of the BSAD patients had earlier episodes (difference: $\chi^2 = 25.115$, df = 1, $P < 0.001$).

2.3. Follow-up

Follow-up examinations of all living and consenting patients were performed. For the ATPD patients, follow-up examinations took place 8.2±8.3 years (mean±S.D.) after the first episode (range 0.8–27.3 years) or 2.2±1.3 years (mean±S.D.) after the index episode (range 0.6–5.1 years). At the time of follow-up, one of the ATPD patients had died, three refused consent and the remaining 38 subjects were personally interviewed. In the control group of patients with BSAD, two subjects had committed suicide, two subjects were unable to communicate because of severe brain damage (one of these as a consequence of a suicide attempt) and one subject refused consent. The remaining 37 subjects were personally interviewed. For the BSAD patients, follow-up examinations took place 16.1±9.6 years (mean±S.D.) after the first episode (range 1.5–36.9 years) or 3.3±1.4 years (mean±S.D.) after the index episode (range 0.0–5.4 years). There were no significant differences in the parameters the groups were matched for (sex and age at index episode) or in the age at follow-up. In BSAD, the patients' ages at first episode were lower than that of ATPD patients. BSAD patients also had a significantly longer period of follow-up.

The instruments used were the WHO-SCAN (van Gülick-Bailer et al., 1995), WHO-PIRS (Biehl et al., 1989a) and WHO-DAS (Jung et al., 1989), all in their German translations, as well as a semi-structured interview for the evaluation of sociobiographic features already used in earlier studies. Present state ICD-10 diagnoses were assessed with the Schedules for Clinical Assessment in Neuropsychiatry (SCAN; van Gülick-Bailer et al., 1995). Past episodes of illness with in- or out-patient treatment were recorded. We considered the occurrence of a major affective syndrome or psychotic symptoms which lead to hospitalization or to outpatient treatment, including psychiatric medication and disruption of daily activities, as an episode. Episodes determined at follow-up by use of WHO-SCAN were also included. All interviewers were extensively trained in the use of this instrument. Training in the use of the WHO instrument SCAN was carried out by WHO-approved trainers, and the first 10 interviews were supervised.

Social disability was measured using the German version of the WHO Disability Assessment Schedule (WHO-DAS, Jung et al., 1989). The DAS evaluates functioning in a variety of social roles by means of a structured interview. Global functioning, functioning in general behavioral domains, and functioning in special roles (e.g. work, household and marriage) are measured on three separate scales ranging from 0 to 5, with a higher score designating a greater degree of handicap. Good inter-rater reliability has been demonstrated (Jung et al., 1989).

Deficits in psychological function perceived during the interview were evaluated by means of the Psychological Impairments Rating Schedule (WHO-PIRS), a rating instrument also developed by the WHO (Biehl et al., 1989a). The observer rates the patient's behavior during the interview. Seventy-five items from 10 domains are integrated into three scales including a general scale, a subscale to measure the level of activity and a further subscale measuring involvement in communication behavior. Scores on these scales range from 0 to 5, with a higher score indicating a greater degree of handicap. The reliability and validity of the instrument have been demonstrated (Biehl et al., 1989a,b).

The level of general functioning was assessed using the Global Assessment Scale (GAS; Endicott et al., 1976; Spitzer et al., 1976). The GAS is a widely used rating scale for the evaluation of the overall functioning of a subject during a specified period on a continuum