

14 - Various atypical psychotic disorders

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© SPMM Course does not negate diagnosis. It is also called symbiotic psychosis or folie à deux. It is more common in couples and often involves nonbizarre delusions. Schizoaffective disorder is placed with F20 (psychoses) not F30 (affective disorders). In schizoaffective illness, both schizophrenic and mood symptoms are seen simultaneously in approximately equal proportion. The presence of mood-incongruent delusions is suggestive but not in itself sufficient to diagnose schizoaffective disorder; at least one typical schizophrenic symptom must be present. (Note - Affect neutral delusions are also included as incongruent delusions). The aetiology is assumed to be intermediate to that of schizophrenia and affective disorder. There are 2 subtypes: schizoaffective manic or depressive subtypes. Schizodepressive episodes are associated with a family history of schizophrenia and are usually less florid. The response to treatment is variable and may develop chronic negative symptoms. The depressive symptoms are more likely to signal a chronic course compared to manic presentations. In manic variant symptoms are florid but recovery is within weeks. Schizomanic episodes are associated with a family history of affective disorders. These patients respond well to mood stabilisers and recover rapidly. Various atypical psychotic disorders These disorders are recognized but not categorised separately in ICD-10.

Bouffée délirante: The classical description of bouffée délirante was given by Legrain. Psychosis of sudden onset, 'like a bolt from the blue'; Polymorphous delusions and hallucinations of any kind; Clouded consciousness associated with emotional instability; Absence of physical signs, i.e. the disorder is not caused by any organic mental disorder; Rapid return to the premorbid level of functioning; and Relapses may occur, but individual episodes are separated by symptom-free intervals. The episodes develop in a predisposed individual and are caused by psychosocial factors (which also determine the content and form of the disorder), have a greater tendency to recover and seem never to end in deterioration.

Process schizophrenia: The concept of process schizophrenia was first described by Langfeldt (1939). Langfeldt differentiated between two groups of psychoses usually diagnosed as schizophrenia: a group with poor prognosis, labelled 'genuine' or 'process' schizophrenia, and a group with good prognosis, labelled 'schizophreniform' psychosis. (But later studies that reclassified Langfeldt's 100 cases concluded that most of the 'schizophreniform psychoses' turned out to be affective disorders with psychotic

features). The term 'cycloid psychoses' was coined by Leonhard (1957) to describe endogenous psychotic syndromes characterized by a sudden onset, an admixture of symptoms belonging to the affective DSM-5 AND SCHIZOAFFECTIVE DISORDER A major mood episode (not merely mood symptoms) must be present for a majority (not merely 'substantial duration') of the disorder's total duration after Criterion A has been met. Diagnosis takes a more longitudinal perspective compared to DSM-IV

© SPMM Course disorders and of symptoms belonging to schizophrenia and phasic course. Leonhard subdivided the cycloid psychoses into three forms: motility psychoses, confusional psychoses and anxiety-blissfulness psychoses. Cycloid psychoses predominate in severe postpartum psychiatric disorders and are more common among women. Perris described the diagnosis as follows; psychotic episodes of sudden onset, mostly unrelated to stress, with good immediate outcome but with a high risk of recurrence, characterized by mood swings (from depression to elation) and at least two of the following: various degrees of perplexity or confusion; delusions (of reference, influence or persecution) and/or hallucinations not congruent with mood; motility disturbances (hypo or hyperkinesia); occasional episodes of elation and states of overwhelming anxiety (pananxiety).

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