Evaluation of Four-Year Stability of Unspecified Psychosis

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ABSTRACT

Introduction: Unspecified psychosis, defined with the F29 code in the International Classification of Diseases (ICD) 10th version is commonly used if there is inadequate information to make the diagnosis of a specific psychotic disorder. There is a lack of data about the prevalence, incidence, diagnostic validity and stability of this diagnosis. Therefore, we aimed to evaluate the prevalence and diagnostic consistency of unspecified psychosis in the outpatient unit.

Methods: Patients diagnosed with the ICD-10 F29 code at the first visit and interviewed at least three times between January 2012-2016 in the Psychiatry Outpatient Clinic were included (n=138). Hospital records were reviewed retrospectively and data were analyzed with SPSS 19th version.

Results: Mean duration of follow-up was 22.8±14.7 months. The diagnoses at the final follow-up were unspecified psychosis (43%), bipolar disorders (18%), schizophrenia (11%), major depression (7%), and anxiety disorders (4%). No significant difference was found between the follow-up diagnoses in terms of age, duration of follow-up, gender, educational status and marital status.

Conclusion: The diagnostic stability of unspecified psychosis is low compared to other psychotic disorders. Follow-up studies with larger sample sizes are required to elucidate the low diagnostic stability of unspecified psychosis.

Keywords: Unspecified psychosis, diagnostic stability, diagnosis, psychosis-not-otherwise-specified, psychosis-NOS

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INTRODUCTION

Many studies have been done investigating the insufficiency in the stability and continuity of the diagnoses using the American Psychiatric Association's Diagnostic and Statistical Manual for Mental Disorders (DSM) and the International Classification of Diseases (ICD) of the World Health Organization, the two most commonly used diagnostic systems, categorically and statistically determining diagnostic clusters (1-9). Reasons such as lack of a dimensional evaluation, omission of subthreshold symptoms, gender, the age of onset, substance abuse, and similar characteristics of different disorders may be causes of this deficiency (8,10). Moreover, transient or intermediate diagnoses such as the short psychotic disorder and schizophreniform disorder lead to deterioration in the stability of the diagnoses. Besides, a longitudinal evaluation is needed for the diagnosis of the schizoaffective disorder, and thus, it is challenging to establish this diagnosis at the first interview, which decreases the consistency of the earlier diagnosis (11). "Psychotic Disorder: Not Otherwise Specified" (PD-NOS) according to the DSM IV was included under "Unspecified Schizophrenia Spectrum and Other

Psychotic Disorder" in the DSM V, and "F29-Unspecified nonorganic psychosis" (UNP) according to the ICD10. However, this diagnosis is frequently used in cases of contradictory or inadequate information, when the process of the general medical condition is not clear enough, where symptoms change over time, emergency conditions, and in cases where psychotic disorders triggered by substance use cannot be differentiated (13,14). The stability of the diagnosis in patients with schizophrenia and bipolar disorder in ICD-10 and DSM-IV for up to four years follow-up was reported to vary between 80% and 100% (15,19). The findings of other psychotic disorder categories are more variable (17,20-22).

The diagnostic stability of patients applying to the clinics with the first psychotic attack was reported as approximately 70% in long-term follow-up studies. In this regard, schizophrenia had the highest diagnostic stability with 90%, while the diagnostic consistency of other psychotic disorders was around 30% (15). In another study (23), the stability of a

UNP diagnosis was evaluated as 44% according to ICD-10. In a follow-up study conducted with 500 patients diagnosed with first-episode psychotic disorder, it was observed that the diagnosis of 112 (22.4%) patients had changed two years later. Among the diagnoses with the highest change was the schizophreniform disorder, followed by UNP (17). Diagnostic stability is an important criterion determining the reliability and validity of psychiatric diagnoses and has implications to the clinical practice, where pharmacological as well as psychosocial interventions may vary depending on the diagnosis (3,16).

Validation of the diagnosis over time is particularly crucial for psychotic disorders because they typically have a more chronic course than other psychiatric conditions and require long-term treatment. It is imperial to ensure the diagnostic validity of PD-NOS according to the DSM, or UNP according to ICD and to measure the diagnostic inconsistencies, to optimize the long-term treatments. In light of this information, we aimed to evaluate the relationship between the diagnostic stability and related factors during the follow-up of the patients first-time diagnosed in our clinic.

METHODS

Sample Selection

This study included cases admitted to the Psychiatry clinics of the Çanakkale Onsekiz Mart University Medical Faculty Hospital between January 2012 and January 2016 with a first-time diagnosis of UNP. The study was conducted per the Declaration of Helsinki and has a retrospective and descriptive design. Therefore, ethical committee approval was not found necessary. The inclusion criteria were as follows: at least three visits since the first follow-up date, no relationship of the diagnosis with drug use, and having no psychiatric application before the diagnosis of UNP. At least three previous psychiatric outpatient clinics were considered as the minimum number of interviews in the evaluation of the stability of the diagnosis. Files of a total of 156 cases with a first diagnosis of UNP were retrospectively reviewed. Eighteen patients with less than three psychiatric outpatient visits were excluded from the study.

Statistical Analysis

Data analysis was performed using the IBM SPSS Statistics for Windows Version 19.0 (NY, USA) software. Conformity of the variables to the normal distribution was investigated by the Kolmogorov-Smirnov test. Mean, standard deviation, minimum, maximum, frequency, and percentage values were used in the presentation of descriptive data. Due to skewed data, the relationship between the total number of applicants and the number of people diagnosed with UNP was investigated by the Spearman correlation test. The diagnosis of UNP during the follow-up period was evaluated by the Kaplan Meier analysis. The mean age and follow-up month of the groups were examined by the Kruskal-Wallis Variance Analysis Test. A p-value below 0.05 was considered statistically significant.

RESULTS

Socio-demographical Clinical Features of the Sample

The mean age of the 13 patients was 44.6 ± 15.8 years (min: 19, max: 85). Of the participants, 79 (57.2%) were female, 59 (43.1%) were male, 53 (42.4%) were married, 54 (43.2%) were single, 44 (44.0%) had primary education, 28 (28.0%) were university graduates, and 21 (21.0%) were high school graduates. The mean follow-up period of the patients included was 22.8 ± 14.7 months. Approximately 8% of the patients included in the study applied to the polyclinics thrice. The proportion who applied 3-10 times was 38%, and the percentage of those with ten or more examinations was 44% (Table 1).

Table 1. Socio-demographic characteristics of the participants

Variables	Mean $\pm$ Standard deviation (min-max)
Age (n=138)	44,6 $\pm$ 15,8 (19–85)
Sex (n=138)	n (%)
Female	79 (57.2)
Male	59 (43.1)
Marital status (n=125)	
Single	54 (43.2)
Married	53 (42.4)
Widow/divorced	18 (14.4)
Educational status (n=100)	
Illiterate	6 (6.0)
Literate	1 (1.0)
Primary school	44 (44.0)
High school	21 (21.0)
University	28 (28.0)
Number of visits (n=138)	
3 times	11 (8.0)
4–5 times	24 (17.4)
6–9 times	43 (31.1)
10 and above	60 (43.5)

min: minimum; max: maximum; n: frequency; %, column percentage.

Table 2. Psychiatric diagnoses of patients at their last applications

Diagnosis	n(%)
Unspecified psychosis (UNP)	59 (43)
Bipolar disorders	25 (18)
Schizophrenia	15 (11)
Depressive disorders	11 (8)
Anxiety disorders	6 (4)
Other	22 (16)

n: frequency; %, column percentage.

Assessment of Diagnostic Stability

When the diagnosis of the patients in the last application is examined; 59 (42%) were diagnosed with PD-NOS, 25 (18%) had bipolar disorders, 15 (11%) had schizophrenia, 11 (7%) had depressive disorders, and 6 (4%) had anxiety disorders (Table 2). When the demographic data were compared according to the definitive diagnosis, no significant difference was found regarding age, duration of follow-up, sex, educational status, and marital status ($p=0.929$, $p=0.126$, $p=0.840$, $p=0.117$, $p=0.895$, respectively) (Table 3).

DISCUSSION

Studies examining the variability of the diagnoses at the first-episodes of UNP are limited. The diagnostic stability was 95% in patients with first-episode psychosis, while the consistency of the diagnosis in patients with a preliminary diagnosis of UNP was reported as 39–44%. 37% of the patients were diagnosed with schizophrenia at the end of the follow-up (23–25). The high stability in schizophrenia-spectrum disorders may reflect the confidence of clinicians in the diagnosis of schizophrenia. In general, the diagnosis of UNP may appear clinically more complicated,

Table 3. Comparison of demographic data according to outcome diagnoses

	UNP (n=59)	Schizophrenia (n=15)	Mood disorder (n=36)	Other (n=28)	p
	Mean ± SD	Mean ± SD	Mean ± SD	Mean ± SD	
Age	47.3±16.0	46.3±14.6	41.1±13.3	42.5±18.5	0.929
Follow-up (month)	21.4±15.1	29.4±15.3	24.8±13.3	19.6±14.5	0.187
Sex					p*
Female	36 (61.0)	9 (60.0)	19 (52.8)	15 (53.6)	0.840
Male	23 (39.0)	6 (40.0)	17 (47.2)	13 (46.4)	
Educational status					
Primary school and less	26 (61.9)	5 (45.5)	14 (50.0)	6 (31.6)	0.171
High school and above	16 (38.1)	6 (54.5)	14 (50.0)	13 (68.4)	
Marital status					
Married	22 (43.1)	4 (30.8)	14 (38.9)	13 (52.0)	
Single	22 (43.1)	6 (46.2)	17 (47.2)	9 (36.0)	0.895
Divorced, widowed	7 (13.8)	3 (23.1)	5 (13.9)	3 (12.0)	

UNP: Unspecified psychosis; SD: Standard deviation; p: Kruskal-Wallis variance analysis; p*: Chi-Square Test.

especially in cases of insufficient patient information. Hence, the attitudes of physicians can be variable in this clinical complexity. As to our setting, treating physicians could change during the follow-up period. Additionally, factors affecting the diagnostic process such as family attitude could have interfered with the diagnostic continuity.

The mean age of the patients included in our study was 44.6 ± 15.8 . As the studies usually focus on the first episode of psychotic disorders, the probability of observing an early onset age is very high due to the nature of the disease. Therefore, the average age reported in the studies varies between 20 and 30 years. In a study evaluating diagnostic stability, it was reported that the age of onset under 20 years and female gender caused a delay in the diagnosis of the bipolar disorder (7). In a study performed with five hundred patients, it was said that diagnostic consistency decreased significantly with the decreasing age at first diagnosis (17). In our study, the reason for the high mean age can be explained by the fact that unclassified psychotic disorder occurs at any age (3,5,23). One of the essential diagnoses to remember in late-onset psychotic disorders is psychotic disorder associated with the general medical condition (11). Psychotic disorder due to a general medical condition, which may start at later age and can be skipped due to the lack of adequate medical evaluation, was not considered as a final diagnosis in any of our patients.

On the other hand, in the literature on diagnostic consistency, Addington et al. followed 228 cases with a first-episode psychotic disorder for one year and reported the stability of diagnosis as 95% in schizophrenia-spectrum disorders and 62% in other psychotic disorders. In 68% of the patients included in the study, the diagnosis did not change, 26% converted to schizophrenia, 4% were associated with affective disorders, and 2% were labeled as another group of psychotic disorders. It was reported that the diagnosis did not change at one-year follow-up in 12 of the 27 patients (44%) who were initially diagnosed with UNP, 10 turned into schizophrenia (37%), and two cases (7%) had developed into mood disorder (23). Schwartz et al. reported that the stability of schizophrenia, bipolar disorder, and major depression was high in 44% of the patients with schizophrenia, 36% of the patients with schizoaffective disorder, and 27% of the patients with a short psychotic disorder (15).

Nicolson et al. in a study of 26 children, diagnosed with UNP and followed-up from 2 to 8 years, reported a change in the diagnosis in half of the patients and observed schizoaffective disorder in 12%, bipolar disorder in 15%, and major depressive disorder in 23% of the cases. Most of the children diagnosed with UNP had lost their psychotic symptoms at the end of the follow-up period. High levels of psychopathology, low cognitive capacity and movement disorders at the baseline were associated with poor outcome (26).

In a meta-analysis conducted in 2016, it was reported that the stability of the first-episode UNP diagnosis was 36%, and the final diagnosis was schizophrenia in 31% of the cases (25). In a study, conducted by Heslin et al., referencing ICD and DSM and evaluating diagnostic stability for eight years, the consistency of the diagnosis of schizophrenia according to DSM was 72.9%, while its stability according to ICD was 75.1%. In the same study, the stability of UNP was 26.7% according to DSM and 25% according to ICD (21). In a study performed with 500 patients, the diagnostic consistency of 66 patients diagnosed as UNP was 51.5%, and among the UNP diagnoses, the highest change was with 28.8% for schizoaffective disorder, followed by 10.6% who changed to mood disorders and 7.6% who were reported as schizophrenia (17). In studies investigating the diagnostic stability of acute and transient psychotic disorders, it is stated that the diagnostic stability is better in developing countries than in the industrialized countries, and the most common change is towards bipolar disorder and schizophrenia (27).

Since most studies focus in general on the stability of first-episode psychotic disorders, previous studies are highly limited concerning patients diagnosed with UNP. Therefore, evaluating the stability of the diagnosis of UNP in a larger sample, our study is the first study in this area. Similar to the available literature, in our study, diagnostic stability was achieved in 43% of patients with UNP, and the final diagnoses were bipolar disorder in 18% and schizophrenia in 11% of the patients. In our research, the stability of the UNP diagnosis was consistent with the literature. Contrary to the previous work, the final diagnosis included less schizophrenia and higher bipolar disorder cases. About one-fourth of the cases in our study had mood disorders as the definitive diagnosis. Because of the abundance and details of the phenomena that may occur in the early stages of most psychiatric disorders, the initial diagnosis

can be judged as UNP in cases accompanied by a psychotic disorder. The fact that first attacks of mood disorders under age 20 usually have mixed features and a history of impairment of school success and substance abuse precedes the attack, make the differential diagnosis of schizophrenia and mood disorder difficult in young patients. Although the diagnostic process is based on a detailed examination, the definitive diagnosis in these patients is usually the result of follow-up (28). In a study conducted with first-episode psychotic disorder patients, it was reported that diagnostic instability was associated with early onset age, auditory hallucinations, male gender, homicidal behavior, and non-affective psychotic disorder. However, in this study, all first-episode psychotic disorders, including UNP, were included as initial diagnosis, and thus, the relationship of UNP with these factors could not be evaluated (17). Whitty et al. have reported a decline in the diagnostic stability of the first-episode psychotic disorders with a low level of education, the presence of initially medium-severity psychopathology, and the presence of comorbidity with substance and alcohol use (16). On the other hand, in another study that focused on diagnostic stability and change, Haahr et al. assessed patients with the first-episode psychotic disorder, and re-evaluated the diagnoses at the end of one and two years. They reported diagnostic stability as 53% at the end of the first year and 38% at the end of the second year. The same study indicated the stability of schizophrenia diagnosis as 99% at the end of both the first and second year (3). Especially in cases where dimensional assessment is important, more stable diagnoses can be made as a result of reaching new information with frequent assessments and time.

Our study demonstrated that UNP diagnostic stability was not related to age, gender, follow-up period, educational status, and marital status. In this respect, it can be explained by the fact that our sample was only from one university clinic, and perhaps most importantly, such limitations as the retrospective pattern of our study.

Limitations

The retrospective pattern of our study is the most significant limitation. Although it may appear to be a limitation that we did not use a measurement tool, all cases were evaluated by a clinician. The fact that the patients were not seen by the same physicians during the four-year follow-up and that the conditions of application (time, the inadequacy of information) were different can be mentioned other limitations of our study. Due to these limitations, follow-up studies with larger sample sizes will be useful to evaluate the stability and validity of the UNP diagnosis.

CONCLUSION

In our study, it was observed that the diagnoses of 43% of the individuals with first-line psychotic disorder did not change during the follow-up period. Of those with a change in the diagnosis during the follow-up period, 18% were diagnosed with bipolar disorder and 11% with schizophrenia. We determined that the stability of UNP diagnosis was not related to age, gender, follow-up period, educational status, and marital status. Since the diagnosis of UNP is a preferred diagnostic category under emergency conditions, inadequate information about the person, and unsuitable general medical conditions, its stability is lower than other psychotic disorders. Therefore, it is absolutely necessary to reconsider the diagnosis during follow-up. This study has the largest sample size in Turkey and around the world in this diagnostic category. Nevertheless, there is a need for further studies with even larger sample sizes and long-term follow-up, controlling for the variables implicated in this diagnosis.

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Ethics Committee Approval: Ethical committee approval was not obtained since retrospective data was screened and evaluated. Our study was conducted in accordance with the Declaration of Helsinki and the permission was obtained from the institution for the use of the data

Informed Consent: Hospital records were screened retrospectively. Thus, informed consent was not taken.

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