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# A Shakespeare's tragedy: the unclear border between affective and psychotic disorders

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The original radical separation between early dementia and manic-depressive illness, even considered incompatible, has its correlate in the present nosological systems that difficultly include clinical pictures in which the affective coexists with the psychotic. The schizoaffective disorder is the only category that specifically includes this combination in the ICD-10 and DSM-IV international classifications. However, this is a very restrictive category. The concept of marginal psychosis, which has disappeared as a specific category, constituted an approach to those borderline cases, which in view of the diagnostic difficulties posed by pictures like the case presented, could be interesting to recover.

**Key words:**

Psychoses. Atypical. Marginal. Cycloid. Nosology. Schizoaffective

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### Una tragedia de Shakespeare: la difusa frontera entre lo afectivo y lo psicótico

La radical separación original entre demencia precoz y locura manícodepresiva, consideradas incluso incompatibles, tiene su correlato en los sistemas nosológicos actuales que acogen con dificultad cuadros clínicos en los que lo afectivo conviva con lo psicótico. El trastorno esquizoafectivo es la única categoría que incluye específicamente esta combinación en las clasificaciones internacionales CIE-10 y DSM-IV; sin embargo, se trata de una entidad bastante restrictiva. El concepto de psicosis marginales, desaparecido como categoría específica, constituyó un acercamiento a estas entidades «fronterizas» que, a la vista de las dificultades diagnósticas que plantean cuadros como el que ilustra este caso, podría resultar interesante recuperar.

**Palabras clave:**

Psicosis. Atípicas. Marginales. Cicloides. Nosología. Esquizoafectivo.

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### REASON FOR CONSULTATION

7:30 a.m. on January 15th: SAMUR (Municipal Health Care Emergency and Rescue Service) picked up a 30 year old, nude, disoriented and incoherent woman in a doorway. One day later and after several hospital transfers, evaluations and sedation regimes were made. As a negative measurement of toxic agents was obtained, there was a doubt in the diagnosis between an affective picture and psychotic disorder. The patient, whose initials are C. R., has provoked psychopathological descriptions as: agitated, euphoric and incoherent, with inadequate contact, disinhibited, suspicious and sometimes incoherent speech; megalomaniac ideation and other delusional contents not congruent with the mood status together with delusional perceptions.

On January 16th, the patient was admitted to our Short Psychiatric Observation Unit. In the first interview, she maintained an inappropriate, playful, expansive attitude with exaggerated affective resonance. This state was maintained during the days in observation. However, she has offered truthful and specific information about her life (she is single, shares an apartment, she was fired from her job in the spring and she became depressed, she attempted suicide, etc.). She has respected the hospital functioning rules and establishes affective bonds with the rest of the patients, who she organizes.

Although C. R. denies auditory hallucinations or other sensoriperceptive alterations, the incorrectness of her interpretation of reality is of interest. This has false continuous recognitions; the search for the symbolic and magic; identifications of real situations with other especially manifest literary ones when she is questioned on the reason for her admission (it is difficult for her to distinguish if it really occurred or she dreamed it and she wants to find a «revelation» in it) or on her family situation. During the first week, it was impossible to reconstruct the study of what happened on the day of admission, after which C. R. became aware of her disease. It was decided to transfer her to the ward.

## Evolution

In the second week of the patient's admission, she was totally asymptomatic and the time course of the disease was ascertained through her own story and the information obtained from those in her setting. Interviews with her father and brothers revealed an old family conflict with rupture of contact in the last 8 years and made it possible to reconstruct the biographic history and ascertain the family background:

- First cousin (on father's side) recently admitted to psychiatry (possible psychosis).
- Two uncles on her father's side who receive antidepressive treatment.

## BIBLIOGRAPHIC HISTORY

There was no early development, schooling or early relational setting abnormalities during her childhood. However, there were family problems in her background: a father who drank alcohol and hit her brothers and rivalry with her brother Alberto (4 years older) who required psychological treatment due to pyromaniac tendencies.

Her best memories occur with her maternal grandparents, her grandfather died in a residence and only said that he wanted to return to his town, a fact that the patient remembers with a guilty feeling.

During her adolescence, well integrated in the institute, she performed leisure time, theater, and natural life activities. She decided to study to be a music teacher. At 20 years, her mother died (her main support in the family). Then she decided to distance herself from the family nucleus, causing serious conflicts among her brothers. She left her career (which she later would complete) and took a course in environmental education, beginning an independent life.

At that time, she met the man with whom she lived for 4 years, when she broke up the relationship and decided to share an apartment with friends and work as a music and physical education teacher. In that period, the patient was very active, with many projects in mind, to which she dedicated much energy and which finally were not fruitful.

It is at that point in which the onset of the present disease is found. The patient had anhedonia, and was seen to be very isolated, with low mood and hopelessness state, a situation that alarmed her friends who insisted that she contact her family and a specialist. However, she refused and it was then that the suicide attempt occurred, which was planned and before which she said goodbye to her friends in a letter.

When she left the hospital, they recommended that she go to a psychologist. She was in Logroño for two weeks in follow-up and then returned to Madrid. During this week, C. R. was very nervous, with feelings of emptiness and some-

times euphoric, she hardly ate, smoked a lot, hardly slept; it was during these days that she sent telephone messages to her friends telling them that her time had arrived. The patient attributed this state to the fact that the psychologist was removing many things, reminding her of scenes of fire, shouting, etc. These days, she heard voices in the house, felt how the nightstand burnt, but when she turned on the light, it was not burnt.

C. R. experienced the day when she was hospitalized as a dream; a trip to the past that ended in the doorway where the police found her nude. «All began because one morning I got up and went to find my grandfather because he died tragically. He escaped from the residence to go to his town and died on the way». Searching the house of her grandparents, she saw two elderly persons in the street that she thought she recognized and followed them to a residence where she asked if her grandfather was there. They threw her out of the center as she stirred up the elderly shouting: «Does anyone want to return to their town?» When she left, she saw a child with his nanny, it was her friend Jose who had gone to Tibet! She hugged him and with her eyes closed, she noticed that he became very big. She thought that Jose was in danger, so she went to Barajas. It was like a revelation «I knew that he was being Shakespeare and that he was testing me, I had to save someone and I did not know whom». When she returned home «there were many ghosts, they were like shadows and hidden noises. I arrived, but I did not have the door keys. I went to the park from my home, singing and playing the piano in English. I met a colored person who told me that we were angels and that I should follow the moon.... and I followed it». It was two a.m. and she decided to look for her friend Alberto in the doorways. «I called on the intercom, I said it was Carla Bruni and they opened the door, so that I realized that it was the theater, it was as if Shakespeare had betrayed his family, they were going to try to kill me and, surprise, they had sent the police to kill me...». Thus, she decided «to pretend she was crazy» and got undressed, resisting with violence.

## DISCUSSION

This is a woman in her thirties with personal background of depressive and family episodes of psychosis and affective pictures. Previous personality includes extroversion and histrionic traits, high vital tone, mood instability, with magic thinking and tendency to imaginative evasion.

After occupational failure, the patient had a depressive type reactive picture without psychotic symptoms that ended in a suicide attempt. In the later period, support networks were activated and the patient initiated psychotherapy, partially recovering in one month. In the week prior to admission, there was a state of excitement, irritability, problems falling asleep, and withdrawal that is attributed to the emotional mobilization provoked by the psychotherapeutic approach. After this prodromic phase, wandering behaviors appeared, provoked by the appearance of perceptions and

delusional interpretations, experiences of derealization, false recognitions and ideas of significance in a general context of confusion (with specific disorientation of time and place), very fluctuating exaltation and perplexity. The picture ended in psychomotor agitation prior to transfer. During admission, the following also stood out: baseline state of hyperalertness and expansiveness, incoherent verbosity and emotional hyperthesia (with irritation, disinhibition or crying). The picture had a short-lived end with restitutio ad integrum after two weeks of evolution (from the onset of the symptoms).

### Differential diagnosis

The coexistence of frank psychotic symptoms with other affective ones suggests the old question of the borderlines between both syndromic fields. According to the present nosological systems, we should consider several alternatives:

1. The possibility of there being a type I bipolar disorder, present manic episode with psychotic symptoms. Against this hypothesis: the frank destructure of awareness and language; absence of a congruent delusional theme, together with rapid resolution of the picture.
2. The option of psychosis is conditioned by two characteristics: coexistence of affective symptoms and course. Two possibilities are opened here:
  - *Acute polymorphic psychotic disorder (without schizophrenia symptoms)*. Described as a picture characterized by sudden onset and complete re-

solution, polymorphic and with fluctuation of symptoms that include several types of hallucinations or delusional ideas, a changing emotional state and pseudoconfusional state.

- *Schizoaffective disorder*. The diagnostic criteria establish the coexistence of characteristic symptoms of an affective disorder with others that are typically schizophrenic (specifically those of Schneider first rank) that should appear more or less simultaneously and which, with an acute onset, resolve in a few weeks.

They are categories that are not strictly excluding and the demonstration of this is that, as has been described in the literature (Colodrón, 2002; Brockington, 1982), the choice between both depends on such deceptive factors as the country in which the patient goes to the psychiatrist (many patients listed as schizoaffective by the North American Psychiatry would be diagnosed of acute polymorphic psychotic disorder in Europe). This problem of interobserver diagnostic validity is verified on confirming the very limited temporal stability of both diagnoses and refers us to that which could be one of the historical enigmas in the history of psychiatry: is the nature of psychosis somehow inconsistent with the essence of the affective? How can the border between both be characterized?

The schizophrenia manic-depressive psychosis dichotomic conception developed by Kraepelin has received many criticisms during its history. Some attempt to explain the existence of pictures in which psychotic and affective

Table 1		Coincidences in diagnostic criteria of different pictures belonging to the so-called autonomous or atypic psychoses	
	Schizoaffective D. (Kasanin <sup>9</sup> )	Cycloid P. (Pull and Pichot <sup>11</sup> )	Bouffées delirantes (Magan <sup>7</sup> and R. M. Dárdennes with B. Samuel-Lejaunesse)
Normal premorbid personality and good sociolaboral adjustment		Absence of psychiatric PB except 1-2 similar previous episodes	
Sudden onset, associated to environmental stress factor		Sudden appearance of delusion, in less than 48 h	Sudden onset, without precipitating factor or based on a minor incident
Symptoms characterized by		At least 3 of the following	
Mixture of schizophrenic and affective symptoms		Polymorphic delusion without prevalent subject	Polymorphic and unstable delusional semiology, variable and multiple subjects. All the mechanisms (interpretations, intuitions, etc.)
Large emotional component		Sudden mood and emotional reaction changes	Possible cerebral exaltations or manic excitement. Important variation of emotions and mood
Alteration in perception of surroundings		Hallucinations or unusual perceptions of any type	Hallucinations of all the systems
Absence of passiveness and withdrawal			Important variation of awareness (from normality to intense confusion)
Complete recovery in a period of weeks or months		Disappearance of symptoms with complete recovery in less than 2 months	Rapid remission with restitutio ad integrum (maximum of some weeks)

symptoms co-exist. Colodron<sup>1</sup> divides these attempts into two groups:

- Those that suppose the existence of mixed psychosis or transit forms: for Kretschmer the schizoidism and cycloidism traits are not mutually excluding and thus describe the existence of «associated» or «mixed psychosis»<sup>3</sup>, a theory that was later developed by other authors<sup>4-6</sup>. At present, it corresponds with the hypothesis of a «psychosis continuum», from schizophrenia to manic-depressive with a large number of intermediate forms defended by other groups<sup>2,7</sup>.
- Those that have bet on raising those difficultly classifiable forms, «autonomic» or «atypic psychoses» to independent categories. With Kleist as maximum representatives with the concept of «marginal psychoses», this alternative has known multiple expression: «bouffées delirantes» of Magnan<sup>7</sup>; psychogene psychosis of Wimmer<sup>8</sup>; schizo-affectives of Kasanin<sup>9</sup> or cycloids of Leonhard<sup>10</sup>, etc.

These different atypical psychoses have common traits as reflected in table 1.

Many authors<sup>11-15</sup> have defended the importance of preserving the recognition of these psychoses as independent entities and specifically of the cycloid psychoses. With this case, we verify once more that the Leonhart's classification gives us a better quality description with more prognostic value. This fact has a repercussion both on the symptoms as well as in the possibilities of extending our scientific knowledge on this type of diseases.

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