Brit. J. Psychiat. (1984), **144**, 209–210

Affective Illness Changing to Paranoid State
Report on Three Elderly Patients

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The problem of a change of diagnosis is of particular concern to psychiatrists. It suggests inadequate assessment and wrong treatment. The association between manic depressive psychosis and schizophrenia has been debated for many years, and it is acknowledged that a change of clinical picture can occur. Sheldrick *et al* (1977) reported 29 cases out of 171 in which a schizophrenic illness remitted, but was then followed by an unequivocal affective episode within two years. Shulman and Post (1980) observed that some patients with repeated depressive illnesses in earlier years have their first manic episode in later life. Post (1971) reported a series of 29 elderly patients with a schizoaffective psychosis, of whom six were earlier undoubted depressives. Later in the paper he refers to one patient who had a hypomanic presentation, but with a delusion about a phantom lover. The delusion persisted throughout his illness, which soon developed into a schizophrenic end state. Three cases are reported here in which previous hypomanic and depressive episodes were followed in later life, and in the setting of a stable mood, by the development of a paranoid illness. A change of clinical picture of this kind has not yet been reported before. The illnesses were diagnosed according to ICD 9 criteria.

Case reports

Case 1

The patient was a woman who came from a family of four children. There was no medical or psychiatric history in the family. As a child she did well at school, but was considered nervous. She worked as a secretary and was happily married until the time of her husband's death. She was diagnosed as having a tuberculous kidney at the birth of her only child, and consequently underwent nephrectomy. At the age of 65 years, she developed a prolonged grief reaction after the death of her husband. The family persuaded her to take a holiday because of this, and she went on a cruise. When she returned she was overactive and excessively talkative.

Later that year she arranged to go on a ship to the Argentine for a second holiday. On board she suffered a hypomanic episode. She drank to excess and became involved with a member of the crew. A few days later, when feeling guilty, she experienced the voice of one of the ship's officers whispering at her through the lamp fitting, making persecutory and sexual remarks. She became convinced that she was being filmed through a two-way mirror and requested she be moved to another room, explaining her reasons. This led to her being admitted to hospital at the next port, where she received an unknown treatment until her son collected her and brought her back to England. When she arrived home, her auditory hallucinations continued, and she feared that her son had been killed as part of a plot, and consequently telephoned the police. This led to her admission to hospital. Physical examination and investigations including an EMI scan, were normal. She made friends with all the patients, was overactive, had pressure of speech, and was elated. It was thought that this was basically an affective illness, and that because of guilt, she had developed persecutory ideas. She was treated with thioridazine, and soon became depressed, saying that the medication would damage her heart.

After four weeks her mood lifted. The delusions about her son, and her auditory hallucinations disappeared. She was discharged on dothiepin 150 mg and thioridazine 200 mg daily. In outpatients she said she could hear her husband's voice inside her head. The antidepressant and phenothiazine were withdrawn, and all was well until the age of 72 years, when she needed to be readmitted, as she had developed threatening auditory hallucinations, and believed a neighbour was preparing to kill her with an electronic ray device. Treatment with thioridazine was successful, but she stopped taking her medication after six months. Her previous delusional fears about the neighbours wanting to kill her never fully resolved, now returned in full force. She was admitted to hospital and started on pimozide 4 mg daily, and there was rapid resolution of her symptoms, and after discharge the development of a degree of insight.

Psychological testing confirmed the clinical impression of cognitive impairment. When aged 65, her full scale IQ was 131 (verbal 136, performance 119); her Wechsler Memory Scale IQ was 112; and she scored 101 on the Kendrick Battery Object Learning Test. When aged 72, her full scale IQ was 114 (verbal 128, performance 94); her Wechsler Memory IQ was 49; her Kendrick Object Learning score was 79.

Case 2

This patient had become depressed aged 64, hypomanic aged 68, and then developed a paranoid illness aged 72. There was a past personal history of hypertension and a family history of bipolar affective illness (in son). At the age of 78, the patient's IQ fell from 88 to 78, and this was accompanied by marked short-term memory loss.

https://doi.org/10.1192/bjp.144.2.209 Published online by Cambridge University Press

Case 3

At the age of 67, this patient developed depression, and in the same year hypomania. A paranoid illness then supervened at the age of 75 without cognitive impairment.

Discussion

It has been pointed out by Cooper *et al* (1967) that a change in diagnosis is significantly associated with a change in doctor, and thus a change in diagnostic criteria. The cases reported here were all seen by the same consultant psychiatrist, and closely studied throughout their illness, so a diagnostic artefact is unlikely. Paranoid symptoms occurred in two patients while they were taking lithium (cases 2 and 3), and in both, the drug was withdrawn without effect on mood, delusions or hallucinations. This is in contrast with the series reported by Brockington *et al* (1980), who demonstrated the usefulness of lithium in schizoaffectives, although their paranoid symptoms were present at the time of the affective disturbance, unlike the cases reported here.

It is not unusual for a mood change to occur prior to a schizophrenic illness (Lewis and Poitrowski, 1954), although the quoted incidence of a change in clinical state from manic-depressive psychosis to schizophrenia varies. Winokur (1974) using strict research criteria found six out of 66 patients underwent such a change during a follow-up period of between one and 20 years.

The fact that these three patients were seen within a short period of time on the same unit suggests that diagnostic change in the elderly may be more common than previously acknowledged. Post (1971) showed a high frequency of cerebral organic deficits in elderly schizoaffective patients. The significance of the cognitive deficits in the two patients in this paper is uncertain, but the possibility that factors associated with aging may contribute to a change in clinical picture in the elderly warrants further investigation.

Acknowledgement

I wish to thank Dr Raymond Levy for his kind permission to report these cases, and for the help he has given me in preparing this manuscript.

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(Received 25 July 1983)

https://doi.org/10.1192/bjp.144.2.209 Published online by Cambridge University Press