De klassifikatie en het beloop van schizofrenie en reactieve psychosen
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SUMMARY

Chapter J first introduces the problem of the differences between two groups of non-affective psychoses, viz. schizophrenic and reactive psychoses. In the 'International Classification of Diseases' (ICD) the two are treated as different groups, although this by no means represents internationally accepted practice. An appraisal of the history of their classification in the 19th and 20th centuries has shown that the controversy about whether the distinction is valid is anything but new. The borderline between non-affective and affective functional psychoses and personality disorders has always been ill-defined and became even more vague when etiological considerations were adopted as criteria for classification. Before that time, categorization has been based on syndromes and their course. Until the 1920s the idea was held that psychiatric disorders were nosological entities, but this view was later abandoned. For functional psychoses the syndromal principle of classification and the disease model were maintained. This classificatory principle was supported by heredity, psychopharmacology and the course of the disorders. The disease model offered a theoretical and practical starting-point which moreover appeared to be suitable for empirical testing. As understanding grew of the contributions made to the etiology by personality, post-natal development of personality, and social circumstances, the frequency with which articles were published about 'reactions' increased. These 'reactions' were given various names, for example Haftpsychoses, Ganser's syndrome, hysterical psychoses, etc. These brief and vehement psychoses with many affective symptoms originated acutely after some severely emotional or threatening event. Kraepelin included them in his pathology. In spite of the impressive efforts of phenomenologists, psychoanalysts and clinical psychiatrists the fundamental differences between diseases and reactions were not adequately established. Their inheritance is characterized as much by a wealth of descriptions as by a lack of useful criteria for classification. That is why so much of this material passed into oblivion.

According to Kraepelin's early notions the diagnosis of schizophrenia is confirmed by an unfavourable progress of the disease, while E. Bleuler claimed that this class of diseases is characterized by a common symptomatology. The latter held that the course of the disorder tended to vary but that there was never any complete recovery.
These opposed views led researchers of mainly Scandinavian origin to study the relation of symptoms, syndromes and course in greater detail. According to them, syndromes which ran a favourable course corresponded to 'reactions' and those with an unfavourable progress corresponded to 'diseases' or processes. Various new names were given to non-affective psychotic reactions, such as schizophreniform, reactive, psychogenic and schizoaffective psychoses. Contrary to E. Bleuler's findings, with these psychoses complete remissions were found, which led present-day researchers like Fowler, Winokur, Ollereishaw, Pope and Lipinski to classify them with affective psychoses. This view is supported by the frequent occurrence of affective psychoses among relatives of the patients, and by the clinical pictures. According to K. Schneider, the clinical picture of reactive psychoses differs from schizophrenias by the presence of affective symptoms and the absence of first-rank symptoms. 

It is described in this chapter that the study of the relation between the symptomatology of the psychoses, their etiology and course has so far produced only little result, rendering the outcome in individual patients hard to predict. Furthermore, the supposed connection has so far not been empirically supported.

Follow-up studies of reactive psychoses indicated that after some time had passed schizophrenia was usually a more appropriate diagnosis. More often than not the diagnosis of paranoid disorders also underwent such a modification. In a small number of cases the diagnoses of reactive psychoses and paranoid disorders were changed to affective psychosis. It goes without saying that it is quite possible that different methods of study and differing criteria employed for symptoms, syndromes, life events and personality features are to be blamed for the continuing lack of any clear insight into these disorders. The World Health Organisation has tried to straighten out the chaos by introducing an explanation of the classes specified in the ICD and by adopting a semi-standardized diagnostic tool, the Present State Examination (PSE). In the ICD three categories are set aside for non-affective psychoses, viz. schizophrenic psychoses, paranoid disorders, and reactive psychoses. Participation by the Social Psychiatry Department of Groningen State University in the 'WHO Collaborative Study on the Assessment and Reduction of Psychiatric Disability', in which these tools were used, presented us with an opportunity to consider the differences between schizophrenic and reactive psychosis in more detail.
In Chapter II the objective, selection and methodology of the follow-up study are described and a number of methodological problems discussed. The WHO study keeps track of the course of symptomatology, psychological dysfunctions and social functioning by means of three interviews at yearly intervals. Following every interview the psychosis in question was classified using the ICD guidelines in a panel discussion of the investigating team; all available data were used for this. This allowed the process of classification and the influence of characteristics of disease such as symptomatology, precipitating and predisposing factors and course to be scrutinized.

Further, classification was set up in a multi-axial fashion. Beside the main diagnosis each patient's present mental state, premorbid personality, level of intelligence, and somatic condition during the onset of psychosis were all separately classified. In this way the classification was roughly identical with the diagnostic process. It was therefore decided to further ignore the distinction between both concepts. During the selection of the cohort a quarter of the patients had been ill for over a year, which meant that a comparison of symptomatology and life events prior to psychoses and the study of the diagnostic process would become difficult unless compensations for the length of the disorder were built in.

In Chapter III the method adopted for the present study is dealt with in more detail. To be able to analyse deviating experiences a division into sections of PSE symptoms was developed, and a rating system for each section to be employed together with the results produced by the CATEGO computer program to represent symptomatology. The PSE-CATEGO classification is eminently suitable for simple representation of symptomatology in classes, and also as a tool for studying the diagnostic process.

Moreover, in this chapter the compensation for disease length is discussed. This adjustment to some extent neutralizes the objections raised in chapter II.

In Chapter IV the classification of psychoses in the course of the study comes up for discussion. It appeared that compared to foreign studies the investigating team diagnosed reactive psychosis very frequently. After three years almost half the cohort of 81 patients had been diagnosed as reactive psychotics. At first the number was even higher, because the diagnosis of reactive psychosis was changed to schizophrenia in 15 patients. The reverse
happened in only one instance. Further, in one female patient the diagnosis of reactive psychosis was changed to affective psychosis. These findings reflect the team's uncertainty about diagnosis at an early state of disease. In this chapter it is also illustrated that sociodemographic features did not play any significant role in the classification.

In Chapter V the symptomatology of schizophrenic and reactive psychoses is specified. It is remarkable that after the first six months since onset the symptomatology tended to decrease and after that remained virtually constant. There is no fundamental distinction between the symptomatology of schizophrenic and reactive psychoses, although unlike the reactive psychoses the schizophrenias were characterized by psychotic symptoms much more frequently in the second and third years of the study. The symptomatology of schizophrenia was somewhat more severe and covered a broader range of aspects. Personality changes were observed as part of the course of schizophrenic psychoses, while these were hardly ever perceived after a reactive psychosis. Apart from that, as to the existence of pathological experiences, the personality changes did not differ from the neuroses. Probably our criteria for diagnosing a personality change included the deviating behaviour, affects and communicative skills of the patient, though this did not show in the CATEGO findings. Further, there was little relation between the diagnostics using ICD and CATEGO, respectively. What the comparison does show, however, is the need for a multi-axial classification, in which diagnostics of personality are kept completely separate from those of current mental state.

For the interpretation of the CATEGO findings one should employ the Index of Definition. This index shows to what extent one is faced with a 'psychiatric case'. It should be noted, however, that the threshold value of the Index for a 'case' is too high for the majority of personality changes and many neuroses diagnosed according to the ICD. Initially, the influence of symptomatology on the classification of schizophrenic and reactive psychoses appeared to be limited, and decreased further over time. The state of being psychotic for a long time or having a relapse and a complete recovery after a psychosis contributed to the diagnosis of schizophrenia and reactive psychosis, respectively.

Chapter VI describes the course of schizophrenic and reactive psychoses. The course of schizophrenic psychoses was specified in Chapter V.
course of schizophrenic psychoses turned out to be less favourable than that of reactive ones. Schizophrenic psychoses had insidious beginnings more often (41%), they were of longer average duration, showed more recurrences (59%), and were often characterized by a (virtually) chronic psychotic course (47%). Their incomplete remissions were often accompanied by personality changes (29%), and after three years full remission was observed in only 17% of the 41 cases examined. Reactive psychoses often had an acute onset (58%), they were of shorter average duration, recurrence was observed in 35% of the cases, and they never took on a chronic character. Remissions were often complete (53%) or were characterized by a neurosis (35%), while after three years a personality change was found in only one of the 40 patients. The differences in course of the two groups of psychoses were partly due to the alterations in diagnoses. The influence of course features on classification increased over time. If the beginnings of a psychosis had been of an insidious nature and the disease ran an unfavourable course, this caused the diagnosis to be changed to schizophrenia. However, knowledge of the development of the disease proved not to be a prerequisite for the diagnosis of schizophrenia. A favourable development of a schizophrenic psychosis did not cause the team to alter the diagnosis. This chapter also contains a discussion of the predictive value of some characteristics of the illness which occurred in the first six months after the onset of psychosis, including the onset, the symptomatology, the duration of the episode in the first year, and the diagnosis in the first year. With patients interviewed during the first year the application of the classification according to DSM III had a somewhat greater predictive value for the diagnosis of schizophrenia than when the ICD was employed.

In Chapter VII the precipitating and predisposing factors preceding the onset of schizophrenic and reactive psychosis is described. Among precipitating occurrences we reckoned life events in the year preceding the onset of psychosis, while predisposing factors included stressful conditions of living that had existed for a long time, premorbid personality disorders or mental subnormality, a somatic disease or handicap, or a pregnancy before the onset of psychosis, as well as possible heredity. The occurrence of stressful events in life prior to the psychosis made only a minor contribution to the distinction between schizophrenia and reactive psychosis. The same holds true for the other characteristics.
With reactive psychoses it was remarkable that a premorbid personality disorder or mental subnormality and long-term stressful living was accompanied by a slightly higher average number of burdensome events prior to psychosis. This finding is indicative of the fact that the etiological process follows various routes.

In Chapter VIII the findings are discussed. Although it is concluded that the validity of the category reactive psychosis was not confirmed, the evidence is not conclusive. The diagnostic and classification processes did not turn out to be completely identical. Some flaws and shortcomings in the methodology and the instruments are discussed. Some directions for further investigation are suggested.

APPENDIX

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