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HOMMAGE TO REACTIVE PSYCHOSIS

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SUMMARY

When looking back in the history of psychiatry, the concept of reactivity had very variable impact on ethiological considerations. If classification of mental disorders is taken as a proxy, it seems that this impact is presently at the lowest that it has been in the last hundred years. The author gives a short historical overview of concept of reactive psychosis, followed by a description of the current state of the art. He pleads for a rethinking of the current position as stated in ICD-10. Reintroduction of a certain degree of the reactivity concept into the classification seems to be required.

Key words: *schizophrenia – psychosis – reaction - reactivity*

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The Past

The idea of reactivity had various meanings and values in different time frames and in different psychiatric traditions. An illustrative example is the use of the word "reaction" in successive revisions of the Diagnostic and statistical manual of mental disorders. In its first revision (DSM I), all neuroses and functional psychoses were labeled as reactions (e.g. today's schizophrenia was schizophrenic reaction, bipolar disorder was manic – depressive reaction). To a large extent, this was a consequence of Adolf Meyer's environmentalistic orientation; he was convinced that we could understand the psychopathology of every single patient if we had a good enough knowledge of his life history (McCabe 1975). However, as early as in DSM III "reaction" was mentioned twice only – of this once in adult psychiatry: in the diagnosis of Brief reactive psychosis (APA1980).

K. Jaspers defined genuine reactive psychosis (as opposed to triggered, "ausgeloesste" endogene psychosis) as follows: 'Content of psychosis is understandably connected to a recent traumatic event; psychosis would not have emerged without such an event; course of psychosis depends on the traumatic event' (Jaspers 1978). The Danish author Wimmer added two more criteria (Degkwitz1985): there is a certain predisposition, which can sometimes be inferred from former reactions, and psychosis never ends in dementia (as the article was written in 1916, it should be understood as "there is no progression to chronic end state"). As some of these criteria can be difficult to apply, (e.g. how could one tell whether psychosis would have emerged or not without a traumatic event), Retterstoel's definition (Retterstoel 1983) seems to be more useful: "...a psychosis, which occurrence seems understandable from the standpoint of the individual's constitutional background and personality development and in the frame of a life situation, which facilitates occurrence of psychosis in a specific individual and in a specific period of his life." Most authors used term "psychogenic psychosis" as a synonym to reactive psychosis; it implicated "pure psychic disorder" as opposed to presumed (but not necessarily demonstrable) organic basis of other (non-psychogenic) psychoses (Degkwitz 198).

The concept of reactive psychosis was widely accepted in scandinavian countries. Data from Denmark (1986) show that hospitalized psychotic patients were more often diagnosed with reactive psychosis than with schizophrenia (Stroemgren 1986). In France, psychosis with similar characteristics (acute beginning; absence of schizoid personality features, autism and flattened affect; frequent and pronounced mood changes; complete remission in some hours, days or weeks) was named boufée délirante. However, contrary to the scandinavian view it was not considered primarily reactive and the main etiological factor was presumed to be a specific personality structure. Its reactive subtype was boufée délirante réactionelle (Pichot 1986). In the United States, similar

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psychotic states were called hysteric psychoses; the term had psychoanalytical connotations and was used quite frequently (Hollender 1964).

However, when preparing the eight revision of the International classification of diseases (ICD), angloamerican experts did not agree to include a chapter on reactive psychoses; when outvoted, they insisted on a comment in the english version of the text which cautioned against the use of diagnoses from this group (Stroemgren 1986). In ICD-9 there was a chapter on reactive psychoses of various clinical presentation, but was accompanied with an explicit warning to use such diagnoses restrictively – a comment quite unusual for this classification (Stroemgren 1986).

Present

One has to admit that reactive psychosis is a problematic concept in the era of evidence – based medicine. Its diagnostic stability is rather low: in 18 to 50% of patients, diagnosed with reactive psychosis at first hospitalization, the diagnosis was changed at subsequent admissions – mostly to schizophrenia or bipolar disorder (Stroemgren 1986, Pichot 1986). The problem might however be a methodological one, in that psychiatrists often tend to avoid using diagnosis of schizophrenia at a first hospitalization so as not to stigmatize patients. Another problem is the "reactivity" itself: although such psychoses by definition emerge closely after a traumatic event, psychoses with the same clinical picture and outcome can also appear without such a connection (boufée délirante). An unresolved question is one of the severity of traumatic event: does it need to be such as to "cause important symptoms of distress in almost anyone" (APA 1980) or must it be viewed through the individual succeptibility, in which case a relatively modest event could lead to psychosis in a person with a specific personality structure (Weiss 1979)?

In the present international classification (ICD-10) there is no chapter on reactive psychoses. Disorders of the same clinical picture and course are included in the chapter of Acute and transient psychotic disorders. If an important traumatic event, which would be regarded as stressful to most people in similar circumstances, closely preceded the beginning of psychosis, one could use the fifth character to specify "associated acute stress" (WHO 1992). However, in some countries including Slovenia, technical limitations only allow the use of four characters. The same goes for DSM IV: in the chapter on Brief psychotic disorder there is a possibility to specify for the presence of marked stressor(s); reactive psychosis as such does not exist (APA 1994).

Future

In the present ICD, an obvious trend is to follow the rules of evidence – based medicine. This is of course necessary if psychiatry is to be a scientific discipline. The etiology of most mental disorders is at present poorly understood. That is why classification follows descriptive principles. Just as an example, depression is classified as mild, moderate and severe, which has far less therapeutic implications than a more etiological classification would have. The same goes for acute and transient psychotic disorders. Psychosis is as a rule treated with antipsychotics irrespective of its diagnosis and presumable etiology; however, other forms of treatment and management should not be the same. A patient with schizophrenia needs a different approach from a patient with reactive psychosis; in the latter, the main therapeutic emphasis (after remission of psychotic symptomshas been achieved) has to be in searching for disfunctional elements in his basic beliefs and his lifestyle, which made possible that the traumatic event caused such an intense state of stress. By abolishing the reactivity concept, this very important therapeutic accent might be lost and the patients'needs might not be optimally fulfilled. Although complete remission of the psychotic episode is a rule, omission of proper treatment may result in repeated psychotic episodes, anxiety and/or depressive disorders and suicidal behaviour.

Conclusion

There is far less research going on in acute and transient psychotic disorders when compared to schizophrenia. So, it might not be reasonable to hope for enough hard data to support the existence of reactive psychosis when final decisions on ICD-11 will be made. However, as the absence of proof does not mean the proof of absence, it would be wise to reintroduce a certain degree of the reactivity concept in the classification. This could probably mean a step back in scientific strength (there is no huge scientific interest in such psychoses anyway), but at the same time three steps forward in therapeutic correctness.

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