Review

[J Tokyo Wom Med Univ
86 (Extra 1) E10～E14 (2016)]

# How Does Chronification Occur?
# The Psychopathology of Classic Defect Schizophrenic Syndromes

**Keiko KOJO**[1] and **Kazumasa IWAI**[2]

[1]Department of Psychiatry, School of Medicine, Tokyo Women's Medical University
[2]Kanagawa Psychiatric Center

(Accepted July 28, 2015)

On the basis of their previous long-term investigations, the authors have observed defect psychoses according to the "typical schizophrenic" Kraepelin model. Their origin cannot be adequately analyzed by the juxtaposition of positive and negative symptoms and their structure. Whether negative or positive symptoms are primary in long-term progressions is still controversial. Ciompi considers chronic psychoses as a result of psychosocial stress after acute episodes. However, in addition to considering chronicity according to vulnerability and stress models or to the model of basic disorder, one should once again return to the symptomatological view as well. Six (6) characteristics should be considered here: 1) resolution of acute psychotic unity of affective, delusional-hallucinatory and minus symptoms, 2) juxtaposition of the delusional world and the real world, 3) qualitative change of delusion to imaginative-confabulation delusion, 4) coexistence of different layers of ego disorder, 5) manifestation or re-manifestation of reactive and neurotic symptoms, 6) episodic exposure of affective, predominantly manic components with otherwise permanent states. On the psychopathological level, the authors have observed the six (6) characteristics determined as signs of chronification in endogenous psychoses which are closely related to each other.

**Key Words**: chronification in endogenous psychoses, symptomatology of classic defect schizophrenic syndromes, double orientation in chronic schizophrenia, outcome, psychopathological issues

## Introduction

Based on their long-term investigations[1)~5)] and their observations[6)~8)] of individual patients with so-called defect psychosis, the authors would like to return to the foundations. Although this area appears to be sufficiently clarified with classic chronic schizophrenic symptomatology, they hypothesize that precise symptomatology is only provided on rare occasions. Since they have to deal with these questions in practice, they want to analyze typical schizophrenic defect psychoses on the symptomatological level and on the level of psychopathology here.

## Definition of the terms "chronification" and "chronifying clinical features"

When the authors speak of chronification, they are referring to the change of state that is characteristic of the long-term progression of endogenous psychoses. When speaking about "chronifying clinical features" they are referring to endoform conditions that show a continuously persistent, and chronic progression, but not if the clinical feature remains the same from the start, as is the case for example in hebephrenic features or chronic paranoid features such as those in chronic paranoia and chronic interpretative delusion.

✉ : Keiko KOJO Department of Psychiatry, School of Medicine, Tokyo Women's Medical University, 8-1 Kawada-cho, Shinjuku-ku, Tokyo, 162-8666 Japan
E-mail: kojo.keiko@twmu.ac.jp

**Why do the authors propose speaking of "current chronifying clinical features"?**

This is about how the state traditionally labeled as "typical schizophrenic defect psychosis" develops, which the authors would like to designate as a "chronifying clinical feature", because only when the term is understood as "clinical feature" does the term not imply irreversible defects or residuals. On the other hand, real residuals are considered a type of state of decreased psychomotor drive without schizophrenic traits. Discussed are pure deficiency syndromes (Huber G, 1966[9], 1994[10]) or uncharacteristic dynamic insufficiency (Janzarik W, 1959[11]). There are different approaches regarding the genesis of pure defect syndromes, but one may well say that a favorable progression is more common with pure defect syndromes in terms of good social adjustment, vs. with chronifying clinical features.

On the other hand, schizophrenic defect psychoses (chronifying clinical features) require long-term clinical treatment because it is difficult to have an abrupt therapeutic impact on such patients. Despite the great contribution of Huber's analysis of chronic clinical features, the fact that the chronifying clinical feature remains resistant to therapy is a focus in the treatment of schizophrenic patients.

**Has everything already been said regarding "chronifying clinical features"?**

Currently there are very few studies in this area on the symptomatological level or on the psychopathological level, because it is an established fact that the symptomatology of these clinical features can already be adequately represented with the symptomatology of "classic chronic schizophrenia", as in the case for old catatonics, permanent hallucinations, and paraphrenics. As a result, the interest in pathogenetic approaches lacks a precise symptomatology to a large extent.

The symptomatological characterization of these clinical features seems to have little prospect for being further pursued, since the tendency in the nosological approach is to see the entire progression in schizophrenia with process modeling as a permanent progression and to describe the various clinical features occurring throughout the progression on one single level, as if all the presentations were a direct result of the disease. It is difficult for them to accept this traditional organogenetic finding, if the authors, on the basis of the relevant literature (Janzarik W, 1968[12], Harding CM, 1987[13], Yuzawa Ch, 1998[14]) and their own long-term follow-up studies (Iwai K, 1996[3], Kojo K et al, 1998a[4], Kojo K, 1998b[5]) consider that these clinical features do not result in a final state, but result in a milder, improved state through a "second positive kink".

On the other hand, a sociological point of view has to be taken into account, namely, the circumstances in which the patients live. It is possible that milder presentations are due to factors affecting the living conditions in psychiatric hospitals (Ciompi L, 1980[15], 1995[16]). One could think of the changes achieved in the hospitals by improving quality assurance through which the clinical features of classic defect psychoses might have changed. One might perhaps say that some of the changes in the presentation are associated with these factors. The easing of and the ability to influence the chronifying clinical features caused them to once again return to the symptomatological view.

**How does chronification occur?**

**1. The foundation of the authors' method**

In order to investigate how one arrives at chronification, especially in the psychopathology of long-term progression in endogenous psychoses, one must not only consider the symptomatological meaning of the presentations and what category to symptomatically classify them in, but also on which psychopathological basis these clinical features can be categorized in terms of dimension. Hence the authors need symptomatology and psychopathology as a method for observing the long-term progression. For the time being, the authors want to discuss here how, based on the following three symptomatological dimensions, one arrives at chronifying clinical features and how these clinical features may or may not change: firstly, on the side of emotions and psychomotor drive, dynamics within the meaning of Janzarik W (1988[17]), secondly, for disorders of ego consciousness including negative and positive symptoms or "structural invento-

**Table 1** 6 Characteristics as Signs of Chronification in Endogenous Psychoses

1) Resolution of acute psychotic unity of affective, delusional-hallucinatory and minus symptoms.
2) Juxtaposition of the delusional world and the real world.
3) Qualitative change of delusion to imaginative-confabulatory delusion.
4) Coexistence of different layers of ego disorder.
5) Manifestation or re-manifestation of reactive and neurotic symptoms.
6) Episodic exposure of affective, predominantly manic components with otherwise permanent states.

ries" according to Janzarik, and thirdly, for ego reactions to the environment or the shared world.

## 2. Characteristics on the symptomatological level

In the authors' recent long-term follow-up studies and also in their observations in individual patients, there are six (6) symptomatic characteristics that have been considered as seen in Table 1.

The first characteristic is the resolution of the acute psychotic unity consisted of 3 symptoms category, such as affective, delusional-hallucinatory, and minus symptoms. This means delusional-hallucinatory and minus symptoms develop and continue independent of affective symptoms. On the other hand, in the context of acute psychotic symptoms, these 3 symptoms category develop in connection with each others.

The second characteristic is the juxtaposition of the delusional world and the real world, namely, i. e. double bookkeeping (Bleuler E, 1985[18]) and sudden switching (Rümke HC, 1963[19]) between the psychotic world and the real world, and thus the restoration of reality in the form of "double orientation" (Jaspers K, 1973[20]).

The third characteristic is a formal and qualitative change of the delusion and hallucination to sudden delusional ideas, imaginative-confabulatory delusion, to voices from speechless objects or dolls as if one were in the world of animism, to functional hallucinations and acousma, predominantly with good content.

The fourth characteristic is the coexistence of different layers of ego disorder, such as the coexistence of delusion of reference, i. e. reference to oneself and auditory hallucinations.

The fifth characteristic is the manifestation or re-manifestation of reactive and neurotic symptoms, whereby hysterical reactions or reactions to conflict up to the level of borderline disorders occur as psycho-reactive, conflicting responses.

The sixth characteristic is the episodic exposure of affective, predominantly manic components with an otherwise permanent state.

## 3. Psychopathological reflections on relationships between the six (6) symptomatological characteristics

The six observed characteristics are closely related to one another. The authors would like to consider this on the psychopathological level.

First, the continuance of disorders of ego consciousness is considered to be chronifying, mostly in the form of hearing voices after acute stages, and also in that the autonomous emergence of disorders of ego consciousness stems from a changed psychomotor drive (characteristic 1). Such findings show that disorders of ego consciousness of a deeper level may also be based on transient psychomotor drive changes. Therefore, the authors assume that the tendency toward disorders of ego consciousness is structurally prepared. As a result, these clinical features are considered an unfavorable progression.

Secondly, the second characteristic is closely related to the 4th, 5th and 6th. In the type of double bookkeeping that the authors have shown as characteristic number 2, there appears to be a realistic adjustment to the environment and communication with the shared world is also possible, although this is entirely caused by an ego consciousness disorder. One may view that as a partial improvement of the ego function. As a result, the tendency towards self-involvement according to characteristic number four (4), manic traits according to characteristic number six (6), and reactive or neurotic symptoms according to characteristic number five (5) may occur on the basis of such an improved ego function.

In the sudden switching between the real world and the delusional world, tuning out of the real world promotes the disintegration of the inner world. Accordingly, usually a hearing of voices not

related to the environment or an imaginative-confabulatory delusion occurs (characteristic 3). The patient reacts realistically insofar as s/he is oriented towards the real world. But if s/he is directed to the inner world, s/he is increasingly hallucinatory or delusional with negative symptoms. However, this should not be taken as an unfavorable progression, because the patient connects with the real world when s/he finds this stance of dual orientation when switching. A structurally prepared autonomous emergence of disorders of ego consciousness may be considered essential for chronifying clinical features. The resulting limitation, but also the recovery of reference to reality causes the authors to consider the switching between the real world and the inner world as the pivotal point of the symptomatology of chronifying clinical features.

## Conclusion

The authors may summarize their findings concerning so-called defect psychoses as follows:

On the symptomatological level, the authors have found six (6) characteristics as signs of chronification that are closely related to each other.

On the psychopathological level, this results for example in a connection regarding the autonomous emergence on the side of disorders of ego consciousness because of psychomotor drive changes, usually in the form of continuous auditory hallucinations after acute stages. On the one hand, one can assume that temporary psychomotor drive changes also lead to disorders of ego consciousness at the deeper level such that the tendency towards disorders of ego consciousness is structurally prepared. This will determine whether these clinical features must be regarded as unfavorable progression or as a sign of chronification.

On the other hand, one may consider it a partial improvement of the ego function if, through a double orientation, a realistic adjustment to the environment, the tendency to self-involvement, manic traits and reactive or neurotic symptoms become manifest, even if it is often the case that the disintegration in the inner world is encouraged by tuning out of the real world. This tuning out occurs mostly in form of auditory hallucinations which are not related to the environment or through imaginative-confabulatory delusion. The authors believe that these clinical features should not be designated as unfavorable progression, but as a restoration of reality, because patients are able to connect with the real world by finding this stance of dual orientation. In any case, these clinical features do not represent any irreversible defects or residuals.

The summary[8] of this article is published in DGPPN (German Association for Psychiatry, Psychotherapy and Neurology) Congress 2000 (Aachen, 20–23. 09, 2000).

## Acknowledgments

The authors thank Katsumi Yoshimasu, M.D., Ph.D. and Shinichi Hirasawa M.D., Ph.D. for their valuable advice regarding the methodology of long-term follow up studies during this study.

The authors have no conflicts of interests to disclose.

## References

1) **Kojo K, Yamazaki T, Kamo T et al**: Consideration on depressive syndromes in the longitudinal courses of schizophrenia. Seishin-Igaku-Kenkyu (Psychiatr Res) **6**: 106–117, 1986
2) **Ishihara S**: The long-term course of endogenous psychoses: A study on dual axial evaluation based on affective and schizophrenic syndroms. Tokyo-Joshi-Ikadaigaku-Zasshi (J Tokyo Wom Med Coll) **63**: 726–742, 1993
3) **Iwai K**: Die Verlaufsdynamik endogener Psychosen-Ergebnisse von Verlaufsuntersuchungen aus einheitspsychotischer Sicht. *In* 150 Jahre Psychiatrie: Das Jubiläumswerk der DGPN in zwei Bänden und einem Ergänzungband (Peters UH, Schifferdecker M, Krahl A eds), pp101–105, Martini, Köln (1996)
4) **Kojo K, Hirasawa S, Kamo T et al**: Cognitive disoders (BSABS) studied by the longitudinal aspects of schizophrenia. Seishin-Igaku-Kenkyu (Psychiatr Res) **11**: 172–185, 1998a [Abstract: Jpn J Psychiat Neurol **41**: 160–161, 1987]
5) **Kojo K**: Structural analysis of erotomania in the stage of chronic schizophrenic couse: The relation between negative structures and ideo-affective delusional work. Rinsho-Seishin-Byouri (Jpn J Psychopathol) **19**: 157–162, 1998b
6) **Kojo K**: Endogenetics in German-speaking countries' psychopathology. Rinshou-Seishin-Igaku (Jpn J Clin Psychiat) **40**: 1013–1020, 2011
7) **Kojo K**: Unitary psychosis. Schizophrenia Frontier **12**: 215–221, 2012
8) **Kojo K, Iwai K**: Wie geschieht Chronifizierung?

Nervenarzt **71** (Suppl 1): 169, 2000
9) **Huber G**: Reine Defektsyndrome und Basisstadien endogener Psychosen. Fortschr Neurol Psychiatr **34**: 409–426, 1966
10) **Huber G**: Psychiatrie: Systematischer Lehrtext für Studenten und Ärzte. 5 Aufl, Schattauer, Stuttgart-New York (1994)
11) **Janzarik W**: Dynamische Grundkonstellation in endogenen Psychosen, Springer, Berlin-Göttingen-Heidelberg (1959)
12) **Janzarik W**: Schizophrene Verläufe, Springer, Berlin-Heidelberg-New York (1968)
13) **Harding CM**: Chronicity in schizophrenia: Fact, partial fact, or Artifact? Hospital and Community Psychiatry **38**: 477–486, 1987
14) **Yuzawa Ch**: On the concept of double orientation in chronic schizophrenia—In relation to neagtive symptoms—. Rinsho-Seishin-Byouri (Jpn J Psychopathol) **19**: 149–156, 1998
15) **Ciompi L**: Ist die chronische Schizophrenie ein Artefakt? Fortschr Neurol Psychiat **48**: 237–248, 1980
16) **Ciompi L**: Die Einfluß psychosozialer Faktoren in der Schizophrenie. Theoretische und praktisch-therapeutische Konsequenzen. Schweiz Arch Neurol Psychiatr **146**: 207–214, 1995
17) **Janzarik W**: Strukturdynamische Grundlagen der Psychiatrie. Enke, Stuttgart (1988)
18) **Bleuler E**: Lehrbuch der Psychiatrie. 15 Aufl, Springer, Berlin-Heidelberg-New York (1985)
19) **Rümke HC**: Über alte Schizophrene. Arch f Neurol Neurochirg u Psychiat **91**: 202–210, 1963
20) **Jaspers K**: Allgemeine Psychopathologie. 9 Aufl, Springer, Berlin-Heidelberg-New York (1973)

## どのようにして慢性化は生じるか—古典的欠陥統合失調症症候群の精神病理学のために—

[1]東京女子医科大学医学部精神医学講座
[2]神奈川県立精神医療センター
古城（コジョウ） 慶子（ケイコ）[1]・岩井（イワイ） 一正（カズマサ）[2]

本稿では筆者らのこれまで行ってきた長期経過研究を基礎にして，Kraepelin モデルによる「典型的欠陥統合失調症」を検討した．その成立については陽性と陰性症状との区別によっては十分には構造分析することはできない．長期経過においては陰性あるいは陽性症状のいずれが一次的であるか，そのことについてはいまだなお議論の余地がある．Ciompi は慢性精神病を急性エピソード後の精神社会的ストレスの結果とみなした．しかし易損性モデルやストレスモデル，あるいは基底障害モデルによる慢性性の考察のほかに，今一度症状学的観点に戻って，この問題を取り上げる必要があるであろう．その際，症状学的水準では以下の６つの指標が顧慮された．①感情性，妄想幻覚性そして欠損性の諸症状の急性精神病性統一性が弛緩すること，②妄想世界と現実世界との二重見当識的態度，③空想作話性妄想への妄想の質的変化，④段階の異なる自我意識障害の複層化，⑤反応性ないしは神経症性症状の顕現あるいは再顕現，そして⑥それ以外は持続状態にありながらも感情病性，特に躁病性要素の出現である．内因性精神病における慢性化の徴候として取り上げられたこの６つの諸特徴相互の意味連関を精神病理学的水準で考察した．