Reactive or Psychogenic Psychoses: The Scandinavian Concept[1]

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Abstract:

The concept of reactive or psychogenic psychosis through most of the 20th century has been widely used in the Scandinavian countries for a major group of the so-called functional psychoses, separate from manic-depressive psychosis and schizophrenia. Psychogenic psychoses are etiologically defined as psychoses apparently caused by a mental trauma in predisposed individuals. The traumatic stress determines the content and the course of the psychotic reaction, which tend to remit in days to weeks. Since the introduction of ICD-10, the reactive psychoses have been reallocated under various diagnostic categories, mainly as acute and transient psychotic disorders with associated acute stress F23.x1, which, however, seems to be sparsely used.

Keywords: Reactive Psychoses; Psychogenic Psychoses; Acute and Transient Psychotic Disorders.

In the Scandinavian countries (Iceland, Denmark, Norway, Sweden and Finland), no less than four concepts of reactive psychoses have been used[1]. Of these, only two cover what might be called psychogenic psychoses: the Danish concept of purely psychogenic psychoses, according to Wimmer[2] and Strömgren[4], and the Norwegian concept of constitutional and psychogenic psychoses according to Langfeldt and Retterstøl[5,6]. The other two concepts considered reactive psychoses, as functional psychoses with good outcome[7,8], or as a group of functional psychoses not clearly of schizophrenic, chronic paranoid or manic depressive type[9].

The concept of psychogenic psychoses was presented in a comprehensive monograph by the Danish Psychiatrist August Wimmer, written in 1913, but first published in 1916, unfortunately only in Danish and not translated until recently into English[2]. In his presentation, Wimmer stated that psychogenic psychoses were clinically independent psychoses caused by mental factors or traumas, generally on a predisposed terrain, in such a way that the trauma determines the time of onset, the course and the termination of the psychosis, and that the form and content of the psychosis reflects the trauma in a meaningful way. Finally, he added a predominant tendency to full recovery, never ending in deterioration. His monographic review and analysis were based on French and German authors, but not on Jaspers' concepts of genuine reactions, which also appeared the same year, 1913[10]. All the same, the Wimmer concept is in close accord with the concept of Karl Jaspers. For genuine reactive states, Jaspers required a causal traumatic experience, a close time relationship with the reactive state, a meaningful connection between the content of the experience and of the abnormal reaction, and a tendency to full recovery.

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The Danish concept was further elaborated by the Danish psychiatrist Erik Strömgren[3], who was professor of psychiatry at the University of Aarhus. For psychogenic psychoses he required an adequate mental trauma, a close temporal correlation between the trauma and the onset of the psychosis, the determination of the content of the psychosis by the trauma, directly with preoccupation with the traumatic experience or indirectly by repression or selective amnesia for the event, and that the course should have some relation to the traumatic situation with remission in the course of days or a few weeks with increasing distance and gradual adaptation to the event. The prognosis thus was good with complete recovery as the usual outcome.

The traumatic factors would be experiences of impersonal character like natural catastrophes or war-like situations; experiences of personal character, like economic loss, loss of job or imprisonment; conflicts within the family, marital or with the children; experiences of verbal isolation, like in refugees; and finally experiences of inner conflicts, such as disagreements between parts of personality, conflicts of consciousness or blows to self-esteem.

An individual predisposition or vulnerability might be present, but was not obligatory. Even the most robust individuals might succumb to catastrophic traumatic events. If a predisposition was present, it was supposed that the more vulnerable the individual was, the less traumatic experience was required to cause a psychogenic break-down. It was further supposed that the vulnerability might be specific to certain areas of personality, an idiosyncratic or catathymic vulnerability, which always had to be taken into consideration.

The clinical types of the reactive psychosis comprised emotional reactions, disorders of consciousness, and paranoid types. Emotional reactions included reactive depressions, also with melancholiform symptomatology or anxiety, excitations, and emotional paralysis. Disorders of consciousness included delirious reactions and states with clouded consciousness, like amnestic states, Ganser's Syndrome and pseudo-dementia. Further, they included depersonalization states and alternating personalities. The paranoid types included self-referring paranoid states like Sensitiver Beziehungswahn, litigious paranoia, paranoid psychoses associated with imprisonment, deafness, sensory deprivation or lack of verbal communication, and induced paranoid psychosis.

Determinants of the clinical forms of psychogenic psychoses have been proposed by Strömgren[4]. The emotional reactions, which account for the majority of the reactive psychoses, were assumed to be based on simple situational traumas. Disorders of consciousness were supposed to be caused

by a sudden disruption of the individual's "image of environment", "Gegenstandsbewusstsein", i.e. his ideas about other people, the surroundings, the structure of the world and what may happen in it. The paranoid reactions were supposed to be caused by a sudden blow to the self-esteem, the individual's "image of self", Persönlichkeitsbewusstsein, i.e. his ideas about own self, own value, his moral standing and his possibilities.

The diagnosis of reactive psychoses has been widely used in the Scandinavian countries. The prevalence of reactive psychosis, given in percentages of functional psychoses among all admissions in 1979, was in Denmark 21% and in Norway 30%. Iceland used the diagnosis as in Denmark to which it was closely connected. In Sweden it was used less, in 13% of functional psychoses, and in Finland even less. Among first admissions in 1979, the diagnosis was used in Denmark in 43% and in Norway in 52% of functional psychoses[1]. The reliability of the diagnosis in a Scandinavian multicenter study was reasonably high and at the same level as for schizophrenia and affective psychosis[11]. The reactivity concept has been operationalized in the Reactivity of Psychosis Rating Form, with good reliability and discriminant validity for the main factors[12].

The validity measured by the stability of the diagnosis of psychogenic psychoses has been investigated by the Danish psychiatrist Færgeman in a monograph from 1945[15,16] on 135 patients diagnosed according to the Wimmer concept, including some of Wimmer's own patients. Among 39 patients with emotional syndromes 9 were schizophrenic and 5 manic-depressive at the follow-up, Among 70 patients with reactive confusion 16 were schizophrenic, 3 manic-depressive, and 4 organic, and among 26 patients with paranoid syndromes 18 were schizophrenic at follow-up.

The genetics of reactive psychoses as validating factor was investigated by an American psychiatrist Michael McCape, who spent a year in Denmark at the Danish Psychiatric Institute in Aarhus. He learned to speak Danish, and performed personal interviews with a representative sample of probands, including a history of mental illness in first degree relatives[17]. In these he found morbid risks for reactive psychosis to be 5.5%, for manic-depressive psychosis 4.6%, which is more than in the general population, and for schizophrenia only 0.5%, which is of the same level as in the general population. If only hospitalized psychoses in first degree relatives are considered, the figures are lower, but still elevated for manic-depressive psychosis, which indicate that a number of the reactive psychoses may have been of manic-depressive nature.

In the WHO International Classification of Diseases ICD-8[18], reactive psychoses were included under the category of "other

psychoses" with five subcategories. In the WHO ICD-9, which was introduced in1978[19], reactive psychoses were included under the category of "other non-organic psychoses" with seven subcategories, but with a preliminary remark that they "should be restricted to the small group of psychotic conditions that are largely or entirely attributable to a recent life experience, but not for the wider range of psychoses in which environmental factors play some, but not the major part in etiology"[20]. This, all the same, allowed the wide use of the reactive psychoses in the Scandinavian countries.

At the ICD-10 revision[21], the non-etiological or purely descriptive approach did not allow nosological classification of the reactive psychoses as a separate category. The various reactive syndromes would have to be classified primarily according to their symptomatology and course. A new category of Acute and Transient Psychotic Disorders was meant to include reactive psychoses, with a subcategorization for Associated Acute Stress defined as events that would be stressful to most people in similar circumstances, occurring within the preceding two weeks.

Reactive Depressions were categorized by their symptoms as bipolar depressions F31.3, .4 and .5, single depressions F32, recurrent depressions F33, or as other depressions F38. The categories of stress-related disorders allowed stressful traumatic events to be taken into consideration. For catastrophic stress in Acute Stress Reaction F43.0 and in Posttraumatic Stress Disorder F43.1, and for identifiable psychosocial stressors, not of an unusual or catastrophic type in Adjustment Disorders, with depressive symptoms in F43.20, .21. and .22.

Reactive Excitations are categorized as manic episodes F30, or bipolar affective disorder, manic type F31.0, .1 and .2.

Reactive Confusions may appear among Acute and Transient Psychotic Disorders F23, with the exception that disorders of consciousness must not meet the criteria of organically caused clouding of consciousness as specified for Delirium F05. They may thus appear among Acute Polymorphic Psychotic Disorder without symptoms of schizophrenia, associated with acute stress in F23.01 or among Other Acute Transient Psychotic Disorders associated with acute stress in F23.81. Some of the clouded states or twilight states with amnestic syndromes now appear among dissociative disorders: Dissociative Amnesia, Fugue, and Stupor F44.0, .1, and .2. The Ganser Syndrome and Multiple Personality disorder in F44.80 and .81.

The Paranoid Reactions may appear among the Schizophrenias F20 or Persistent Delusional Disorder F22 if they meet the relevant criteria for these groups. They may also appear among the Acute and Transient Psychotic Disorders with associated

acute stress in Acute Polymorphic Psychotic disorder with symptoms of schizophrenia F23.11, or in Acute Schizophrenia-like Psychotic Disorder F23.21, if they have schizophrenia-like symptoms; in Other Predominantly Delusional Psychotic Disorders F23.31; and of course also in the Other and Unspecified categories F23.81 and F23.91.

The ICD-10 category of Acute and Transient Psychotic Disorders F23 was actually meant to include reactive or psychogenic psychoses. Comparison of the prevalence of Reactive Psychoses in the last two years of ICD-8 and of Acute and Transient Psychotic Disorders in the first two years of ICD-10 in Denmark[20], shows a substantial difference. In 1992 and 1993, Reactive Psychoses were diagnosed in 19.2% of non-organic psychoses. In 1994 and 1995, Acute and Transient Psychotic Disorders were diagnosed in 8.7% of non-organic psychoses. Furthermore, associated acute stress was recorded only in a minor fraction of 5.3% in the patients with F23-diagnosis, partially because the definition of associated acute stress was found too narrow.

The distribution of ICD-10 diagnoses at readmissions in 1994 and 1995 of patients admitted in 1992 and 1993 with Reactive Psychoses showed only 20.1% in the category of Acute and Transient Psychotic Disorders F23. A total of 24% went to affective disorders, 12% to schizophrenia, 11% to chronic delusional disorders, and only few to stress-related disorders F43.

The psychogenic or reactive psychoses thus seem to have disappeared almost completely. Nonetheless, the concept still survives with some patients in which the traumatic etiology of the concept seems to apply, and which do not change the diagnosis over time. Hopefully, the concept may have a future in the coming revision of ICD-11, which probably will have to include etiology in the categorization to a higher degree than the ICD-10.

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