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Paranoid Psychoses

The Stability of Nosological Categories Illustrated by a Personal Follow-up Investigation

By N. RETTERSTÖL

In the present paper the author will try to elucidate the stability of nosological categories as revealed by a personal follow-up investigation of 301 previously hospitalized patients with paranoid psychoses. Since the terminology used will be the Scandinavian one, a short review of the diagnostic concepts will be given. The Scandinavian concept of *schizophrenia* is rather narrower than that employed in the rest of Europe, and especially narrower than that prevailing in the Anglo-American literature. Many American authors include in their concept of schizophrenia what may be called "the schizophrenic reaction types". In the present paper, the concept of schizophrenia used by Langfeldt (1937, 1939), sometimes, referred to as "process schizophrenia" or "nuclear schizophrenia" is used. "Primary symptoms" occur in clear consciousness; these include disturbances of thinking, disintegration of emotions, autism, marked feeling of influence and passivity, massive depersonalization and derealization. As a rule the illness has an insidious development and a chronic course ending up with a greater or lesser degree of mental deterioration.

Among a series of cases which had been labelled "unmistakeable schizophrenias", Langfeldt (1939) was able to single out a group which he labelled "*schizophreniform*" or "atypical", having in common a good prognosis. He also stated that the symptomatology in these cases had been especially rich, mixed with pathoplastic features and often mixed with trends from other forms of psychosis. The onset of the illness has in these cases most often been acute, with a clear-cut precipitating factor, and the premorbid personality is usually better integrated. The symptoms may be very similar to those of a typical schizophrenia. Clouding of consciousness and depression or exaltation are, however, common. In Anglo-American countries this group will most often be classified among the schizophrenias. The group corresponds to the so-called "reactive schizophrenia" (Rodnick and Garmezy, 1957). It will also correspond to Kasanin's (1933) "schizo-affective psychosis" and to Labhardt's (1963) "schizophrenieähnliche Emotionspsychosen". Follow-up studies, especially from Scandinavian quarters, have shown that there are great differences in outcome between the more typical schizophrenias and the schizophreniform psychoses (Langfeldt, 1937; Eitinger *et al.*, 1958; Achté, 1961; Astrup *et al.*, 1962, 1966; Retterstöl, 1966). For a more detailed description and discussion of this concept the reader is especially referred to Langfeldt (1937, 1939, 1965), Vaillant (1964) and Strømgren (1965).

A great many of these schizophreniform psychoses will now not be classified under the "schizophrenias" but under the "reactive psychoses".

The concept of "*reactive psychosis*" is more commonly used in the Scandinavian countries than elsewhere. As reactive psychoses are considered those whose development seems understandable in terms of constitutional background, personality development and a life situation which made an outbreak of the mental disturbance possible in that specific person in that specific situation and at that specific time. Emphasis is put on eliciting the personality development and life pattern of the patient and on considering the psychosis in connection with these and the traumatizing factors. To gauge psychic traumas quantitatively is hardly possible; they have to be evaluated on the background of

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the individual's life development. What may be a great trauma to one person may not be to another, and may even be of no importance to the former at another stage of the life. The mental trauma must be evaluated as being of such importance that the psychosis would not have come to an outbreak in its absence. There must also be a temporal connection between the trauma and the outbreak of the psychosis. Accordingly these psychoses are "psychogenic" although not in the strictest sense of this word. They are psychoses to be distinguished from neuroses in that the patient has no insight into his disease and no understanding that the symptoms he presents (i.e. the paranoid ideas) are of a morbid nature.

Even though a psychogenesis seems probable, other "causal" factors are not ruled out. Somatic factors may play a role and the disease still be called a reactive psychosis. Physical affections may be present which reduce the patient's general psychic resistance, or moderate organic brain disorders (for instance cerebral atrophy of milder degree) which reduce the patient's capability of solving problems in his life situation or which provoke a state of insufficiency and thus contribute to a psychotic development. The latter conditions are ordinarily classified as organic brain disorders, but where the reactive factors are considered essential for the outbreak the case may be labelled as a reactive psychosis (and the organic changes, in such cases of long standing, are regarded as constitutional features (Langfeldt, 1965)).

The reactive psychoses, outlined above, have in Norwegian terminology been called "psychogenic" or "constitutional" psychoses, the term "constitutional" stressing the fact that in these cases there is a special vulnerability making the threshold lower for psychotic reactions to environmental stress. From 1963, however, the diagnostic classification in Norway has been "reactive psychosis (psychogenic and constitutional)". In Danish terminology the term "psychogenic psychosis" has been used. The term "reactive psychosis" covers both the Norwegian and the Danish concept.

Interest in these psychoses was in Scandinavia originally aroused by the late Danish Professor August Wimmer (1916), who wrote an outstanding book about psychogenic psychoses, with a careful analysis of these cases. Unfortunately this brilliant book was published only in Danish. His ideas were followed by Færgeman, who has given the most extensive review of these psychoses, with a careful follow-up (1945), later revised and translated into English (1963). For further studies of the Scandinavian concept of reactive psychoses, the reader is referred to Strømgren (1940, 1961), Lunn (1953), Eitinger (1958, 1964), Langfeldt (1965) and Retterstöl (1966).

It is usual to divide the reactive psychoses into subgroups on the basis of symptomatology. The official Danish sub-division is (Strömgren, 1961): emotional syndromes, disorders of consciousness, paranoid syndromes; the official Norwegian sub-division: paranoiac and paranoid forms, depressive forms, excitations, confusions. It ought to be added that the term "reactive psychoses" is not exclusively a Scandinavian one. In France Widlocher (1958) has given a most penetrating analysis of these "psychoses réactionelles", defining them in a way very similar to that of the Scandinavian psychiatrists: "mental disorder of psychotic structure, provoked by a given situation, i.e. occurring in relation to that situation. They are *psychoses*, to be distinguished from adequate emotional reactions and from conflict neuroses. The term *reactional* indicates that it is not necessarily a relation of causality, nor merely an accidental coincidence."

It may be added that the term "reactive psychoses" is also used in the U.S.S.R. classification according to Giljarovskij (Stengel, 1960), where under "psychogenic disorders" are classified "reactive psychoses" (traumatic mental reactions including psychogenic stupor; fugues, including psychogenic twilight states; reactive depression; psychogenic paranoid state; iatrogenic reactions; paranoia).

The patients in the material to be presented here belong mainly to the diagnostic groups "schizophrenia" and "reactive psychoses". As will be seen, the reactive psychoses constitute the bulk of the material.

It may be of interest for an international reader to see how the stability of the nosological categories according to the Scandinavian con-

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cept comes out under the acid test of a long and nearly complete personal follow-up. The problem will be elucidated for psychoses of paranoid symptomatology.

Definition

As "paranoid psychoses" were counted any psychoses accompanied by delusions. Cases that during hospitalization were diagnosed as pure and indubitable manic-depressive psychoses and whose whole pathological picture was characterized by the depressive or manic state have, however, been omitted from the material, as also pure confusional states where the delusions faded as soon as the patients' confusion cleared up.

Incorrect or unreasonable ideas, arising on a pathological basis and given the value of absolute truths by the patient, were counted as delusions (Lunn, 1953).

Case Material and Method

The material of this study consisted of first admissions to the Psychiatric Department, University of Oslo, suffering from paranoid psychoses, according to the above definition. The material consisted of consecutively admitted patients during two time intervals, 1 January 1946 to 20 March 1948 (the long-term group) and 1 May 1958 to 23 March 1961 (the short-term group). Paranoid psychoses were found to constitute about the same percentage of the consecutively admitted patients in the two periods, 12·5 and 11·8 per cent. respectively. In both periods about 30 per cent. of the patients in the clinic had a diagnosis of psychosis.

The hospital has 100 beds, half for each sex, and receives patients from the whole of Norway, but particularly from the southern and eastern part of the country and the districts around Oslo. The hospital only takes patients in for a relatively short stay, up to 3 to 4 months. Patients who cannot be discharged home after that time will as a rule be transferred to a mental hospital. As Norway is a country with a rather scattered population and the travelling difficulties in the western and northern parts of the country are exceptionally great because of the many fjords and long distances (the distance from Oslo to Kirkenes equals that of Oslo to Rome), it was decided to restrict the investigations to patients who at the time of follow-up (1963, 1964) were living (or had died) in Eastern and Southern Norway up to the Trondheim district.

Out of a total of 334 such patients, 5 refused contact with the hospital and 28 had died during the observation period. Thus the sample under discussion consists of 301 living, personally contacted patients, i.e. 98 per cent. of the living patients selected for follow-up. Of these 132 were in the long-term group (15–18 years of observation) and 169 were in the short-term group (2–6 years of observation).

Sex and age distribution in the material will be apparent from Table I expressed in percentage.

The diagnoses given on discharge will be apparent from Table II. The diagnosis psych. e gen. incert. (psychosis e genere incerto) had been given in cases where there was doubt about the diagnosis, usually a question of a case belonging to the group of schizophrenias or reactive psychoses. The group of other psychoses consisted of nine patients with organic brain disorders, and one with an alcoholic psychosis.

All the patients' case histories were first studied and the most important points drawn up in a new record. All patients in the short-term group were personally seen and investigated by the author during their hospitalization. Patients in the long-term group had not been seen by the author during their stay in hospital. Symptoms at time of admission were in most cases fairly well described. However, information on other points, such as childhood condition, was in many cases insufficient. These gaps had to be filled in during the personal re-examination of the patient, as far as possible.

The follow-up was done during the period March 1963 to June 1964. The patients were notified of the examination in 1962 and were asked to send word should they be unwilling to co-operate. Only 5 patients did not want to receive the investigator, a surprisingly low number considering that previously paranoid patients were concerned.

Of the patients, 54 per cent. were visited in their homes, 26 per cent. in institutions (mental hospitals, nursing homes), while the remaining 20 per cent. came to the authors' office for interviews. In 90 per cent. of the cases an interview was also held with one or more relatives.

As can be seen, most of the patients were visited in their homes. This was the most satisfying type of follow-up, giving an impression of the atmosphere in the family and easy access of relatives.

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TABLE I

Sex and Age Distribution in the Long-term and Short-term Groups on Admission

		0-29 years percentage	30-49 years percentage	50 years and over percentage	Basis
Long-term observations	Male	36	53	11	75
	Female	23	70	7	57
	Both sexes	30	61	9	132
Short-term observations	Male	26	57	17	93
	Female	22	65	13	76
	Both sexes	24	60	16	169
	Total male	30	56	14	168
	Total female	23	67	10	133
	Total both sexes	27	60	13	301

TABLE II

Hospital Diagnosis (on Discharge) for the Long-term and Short-term Group

	Reactive psychoses	Schizo-phrenia	Psych. e gen. incert.	Other psychoses	Total
Long-term observations	54	33	42	3	132
Short-term observations	109	19	34	7	169
Total	167	52	76	10	301

The interview usually lasted for about two to four hours. Usually the author spoke first with the patient alone, then with the spouse or other members of the family. Finally the interview was rounded off by talking to both of them together. In the interviews in the office the same routine was followed.

In the institutions doctors and nurses in charge of the patients were also interviewed and the case histories studied. In 70 per cent. of the total material the treating physician was contacted. The visiting of the patients in their homes or institutions included travelling by car of a distance covering 16,000 kilometres (about 10,000 miles) over a time interval of two years (1963 and 1964).

The entire material has been checked against the Central Register for Psychoses in Norway. This centre records all patients with psychoses admitted to psychiatric hospitals or clinics in Norway. Thus all readmissions for psychoses in the observation time should be registered.

With regard to all patients known to have been readmitted to psychiatric clinics or mental hospitals, complete case records were obtained and included in the present study. All available information on possibly afflicted relatives was also collected from psychiatric hospitals and departments.

The investigator was acquainted with the hospital diagnoses at the time of follow-up and had in fact taken part in the diagnosing of the short-term group at the team meeting presided over by Professor Langfeldt. However, conscious effort has been made not to be unduly influenced by the discharge diagnosis, but to consider the overall course in order to arrive at a just diagnosis on follow-up. It has been regarded as of primary importance to uncover any new factors that would be conducive to better understanding of the individual cases.

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On the basis of the course of the illness and all the data verified and brought to light on follow-up, a final diagnosis was made. The diagnosis is likely to be more certain with reference to the long-term observations. Further observation of the pathological development may to some extent change the diagnostic conception as regards the short-term patients. In the final diagnosis, the group "psychosis e genere incerto" has been avoided, and the patient been placed in another diagnostic group.

The *reactive psychoses* were divided into: *cured reactive psychoses without relapse*, *cured reactive psychoses with subsequent relapse* (recovered again or assumed to recover from an acute relapse), and *chronic reactive psychoses*.

A relapse was considered to be the recurrence of psychosis, regardless of whether or not paranoid symptoms were present, but not the occurrence of a nervous disorder of non-psychotic type (for instance neurosis) even if this had led to hospitalization. As chronic reactive psychoses were counted psychoses of reactive pathogenesis that did not subsequently take a schizophrenic turn but which presented psychotic symptoms during the entire or main part of the observation period. These psychoses were mainly of paranoiac type.

The schizophrenias were divided into "cured" and "non-cured" according to outcome. The "cured" group includes those in whom the illness left no definite trace of deterioration and where the patient's future life had not been noticeably affected by the past illness. The "non-cured" group is made up of patients whose schizophrenic development continued throughout the observation period, with personality disturbances or defects, persistent schizophrenic symptoms, or further progression to a state of dementia or complete deterioration.

Other psychoses were also divided into "cured" and "non-cured" groups. The group of other psychoses consisted of 7 patients with organic brain disorder, 2 patients with a manic-melancholic psychosis and 2 with an alcoholic psychosis, The 4 patients in the two last-mentioned groups were classed as "cured" as were two patients with organic brain disorder, where no psychotic signs were demonstrable on follow-up, nor signs of defect.

TABLE III

Course of the Psychosis for the Long-term and Short-term Groups, Separately Evaluated for the Two Sexes

Final Diagnosis (after follow-up)		Long-term M.	Long-term F.	Short-term M.	Short-term F.	Total M.	Total F.	Total Both
Reactive psychoses	Cured without relapse	19	27	36	36	55	63	118
	Cured with subsequent relapse	15	6	24	19	39	25	64
	Chronic	4	2	11	7	15	9	24
	Total reactive psychoses	38	35	71	62	109	97	206
Schizophrenia	Cured	4	1	1	1	5	2	7
	Not cured	29	19	16	13	45	32	77
Other diagnoses	Cured	3	2	1	—	4	2	6
	Not cured	1	—	4	—	5	—	5
	Total other diagnoses	4	2	5	—	9	2	11
Total Favourable course	N.	41	36	62	56	103	92	195
	Percentage	55	63	67	74	61	69	65
	Total all diagnoses	75	57	93	76	168	133	301

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The material was also divided into psychoses with a *favourable clinical course*, including cured reactive psychoses with and without relapse, "cured" schizophrenias and "cured" other psychoses and a group with an *unfavourable clinical course*, including chronic reactive psychoses, "non-cured" schizophrenias and "non-cured" other disorders.

For detailed information about prognosis and prognostic factors, the reader is referred to Retterstöl (1966).

Results

The final diagnoses arrived at on follow-up will be apparent from Table III, where the diagnoses are separately evaluated for male and female and for the short-term and long-term material. The percentage of "favourable" course, according to the above criteria, is also given.

The relationship between discharge diagnosis and final diagnosis is given in Table IV.

Diagnostic Changes

1. The diagnosis of schizophrenia changed to reactive psychosis

This was the case for 7 patients (14 per cent. of the patients discharged from the clinic under the diagnosis of schizophrenia), 2 long-term and 5 short-term observations, 4 men and 3 women. Thus, with regard to the long-term patients, the diagnosis of schizophrenia has only been changed in 2 out of 31 cases, or 7 per cent.

Closer study of these cases reveals a certain pattern. Psychogenic factors that seem to make the outbreak of the psychosis understandable on a reactive basis are present in all cases. In one of the cases a severe situational conflict preceding the illness was not brought to light until the follow-up. In 5 of the 7 patients, the mood on the admission to the clinic had been depressive. Duration of illness prior to admission was under six months in 5 cases. In 2 cases, closer scrutiny of the case records shows that the symptoms suggestive of schizophrenia have been vague or doubtful. However, 5 of these patients belong to the short-term group, 4 of whom have an observation time of less than 5 years, and the possibility of development in a schizophrenic direction in the course of a longer observation period cannot be ruled out.

2. The diagnosis of reactive psychosis changed to schizophrenia

This was the case for 16 patients (10 per cent.), 7 (13 per cent.) long-term and 9 (8 per cent.) short-term observations, 9 men and 7 women.

On closer scrutiny, certain features common to these cases appear to be traceable. In 4 cases scrutiny of the case history revealed no distinct precipitating factor, and the case should hardly have been diagnosed as reactive psychosis in the first place. In 2 cases the disorder seems to have broken out following somatic illness or overexertion, and in the remaining it seems to have been provoked by psychic conflict situations (5 of marital or sexual nature). Mood on admission was registered as neutral in 8 cases (half). Duration of illness prior to admission was less than six months for 7 patients and more than six months for 9 patients. The pathological

Table IV

Relationship between Discharge Diagnosis and Final Diagnosis

	Final Diagnosis									
	Reactive psychosis			Schizophrenia		Other diagnoses		Total cured		
Discharge diagnosis	Without relapse	With relapse	Chronic	Cured	Not cured	Cured	Not cured	Number pat.	%	% Basis
Reactive psychoses	81	50	16	1	15	0	0	132	81	163
Schizophrenia	6	1	0	5	40	0	0	12	23	52
Psych. e gen. incert.	27	13	8	1	22	3	0	46	61	76
Other diagnoses	2	0	0	0	0	3	5	5	50	10
Total	118	64	24	7	77	6	5	195	65	301

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TABLE V

*Some factors pertaining to change of diagnosis from psych. e gen. incert. to reactive or schizophrenic psychoses. *marks that the difference is significant at the 5 per cent. level between patients in and patients outside the category in question*

Category	Total number	Number of patients who became: Reactive (total=50)	Schizophrenic (total=23)	Percentage who became schizophrenic
Male	34	22	12	35
Unmarried	48	30	18	38
Low education	34	27	7	21
Social decline	5	5	0	0
Early loss of father	10	4	6	60
Extreme insecurity in childhood	7	4	3	43
Sensitive premorbid personality	32	26	6	19
Not sthenic-asthenic personality	19	9	10	53*
Athletic body build	21	10	11	52*
Leptosomatic build	36	29	7	19
Age at outbreak less than 30 years	36	22	14	39
Duration of psychoses less than 6 months	39	26	13	33
No precipitating factor	12	0	12	100*
Type of onset insidious	11	7	4	36
Initial symptoms:				
Self-reference	14	13	1	7
Personality changes	7	—	7	100*
Syndrome schizophreniform	55	34	21	38
Hallucination	32	17	15	47*
Ideas of reference	52	41	11	21*
Influence	39	22	17	44*
Derealization	20	15	5	25
Depressive mood level	11	9	2	18
Psychomotor state inhibited	9	4	5	56
Poor emotional contact	27	14	13	48*
Discharge category: unchanged	31	17	14	45
Good insight on discharge	15	13	2	13

picture during hospitalization was regarded as of schizophreniform type in 7 patients. Auditory hallucinations were recorded for 9 patients.

3. *The diagnosis of organic brain disorder changed to reactive psychoses*

This was the case for two patients, where the organic background seemed less important (moderate cerebral atrophy) and where new material was brought to light on follow-up, explaining a definite psychogenic factor precipitating the illness.

4. *The group "psychosis e genere incerto"*

Eight (24 per cent.) of the 34 short-term and 15 (36 per cent.) of the 42 long-term patients were classified as schizophrenias on follow-up. The majority were classified as reactive psychoses, 26 (76 per cent.) of the short-term and 24 (57 per cent.) of the long-term patients. Three (6 per cent.) of the long-term patients were classed under "other psychoses", 1 alcoholic and 2 manic-depressive psychoses.

Statistical comparison of the group classed as reactive psychoses and the group classed as schizophrenias on follow-up was carried out with reference to the principal variables from the life history and clinical data, inclusive of the symptoms described above (the 3 cases diagnosed as "other psychoses" are omitted from the comparison). The results are presented in Table V.

The tests revealed that the incidence of schizophrenic development was significantly higher among patients *with* than those *without* the following factors:

a. Not sthenic-asthenic personality against sthenic-asthenic personality,

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b. athletic body build against other body types,
c. no precipitating factor against precipitating factor,
d. initial stage characterized by personality changes against initial stage not characterized by personality changes,
e. presence of hallucinations against no hallucinations,
f. presence of ideas of influence against no ideas of influence,
g. poor emotional contact against good emotional contact.

The reverse applies to presence of ideas of reference. The incidence of schizophrenic development was significantly lower for patients presenting reference phenomena than for those not presenting such phenomena.

Discussion

In the author's opinion the study demonstrates a relatively great stability of the nosological categories used according to the current Scandinavian tradition. As to the differentiation between process schizophrenia and schizophreniform psychoses, Langfeldt (1965) has indicated that by exact diagnosing it should be possible to differentiate between these psychoses with a safety margin of 90–95 per cent., as suggested by Eitinger, Laane and Langfeldt (1958). In the present work, with regard to the long-term patients, the diagnosis of schizophrenia has been confirmed in 93 per cent. Inclusion of the short-term group brings the figure down to 86 per cent., but with reference to these patients one has to reckon with the possibility of later schizophrenic development. If two of the short-term observations take a schizophrenic turn in the course of the next 10 years, the safety margin for the total material will be 90 per cent.

Like the work of Langfeldt (1937, 1939), Eitinger *et al.* (1958), Johanson (1958) and Achté (1961) the present study seems to demonstrate that it is possible to make a rough distinction between two main groups, namely a nuclear group of schizophrenias and a different group, which has a much better prognosis, the schizophreniform psychoses. One objection may appear against Langfeldt's diagnostic system from the present work, namely that he is left with about 25 per cent. of paranoid psychoses which eventually prove to be either "reactive" or "schizophrenic" and which cannot be so diagnosed at the time of discharge. As can be seen, however, there are obvious possibilities in better differentiation in this group already at the time of discharge.

The schizophreniform psychoses certainly are more a symptomatological than a nosological concept, as has been clearly pointed out by Vaillant (1964) in his excellent survey of the most important studies on "remitting schizophrenias", and not least by Strømgren (1965) in his thought-provoking discussion on "schizophreniform psychoses".

However, as pointed out by the last author, and as also clearly emerges from the present study, a majority of the "schizophreniform psychoses" belong to the nosological concept "reactive psychoses". This nosological concept, according to the present experiences, seems to be a relatively reliable one, which can be kept in about 90 per cent. on follow-up.

However, for this group also, one has to keep in mind the relatively large group of psychosis *e genere incerto*. It has also to be kept in mind that of the reactive psychoses the paranoid type has the greatest tendency to schizophrenic development. In his 34 cases of paranoid "psychogenic" psychoses, Færgeman (1945, 1963) was able to confirm the diagnosis on follow-up in only 16 (47 per cent.) Astrup *et al.* (1962) found that of the 131 patients originally classified as paranoid reactive psychoses, as many as 66 per cent. subsequently took a schizophrenic course, as revealed by follow-up. Therefore they advise caution in diagnosing paranoid reactive psychosis. In the study of Astrup and Noreik (1966) the diagnosis of reactive paranoid psychoses was confirmed on follow-up in 53 per cent. of the 113 patients who had been discharged from the hospital under this diagnosis. Ødegård (1966) also, from the Norwegian national registration system, has demonstrated a tendency for the diagnosis of reactive paranoid psychoses to be changed. However, in the majority of cases, the diagnosis was kept.

That the stability of the diagnosis of reactive

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psychosis is greater in the present material may be due to several factors. First, the stability will be considerably less when our group of psychosis *e genere incerto* is included. This group has been used mainly for cases where there have been special difficulties in differentiating between reactive psychoses and schizophrenia. The cited authors have no such group. Secondly, our hospital is a clinical department, where more acute cases supposedly of slighter symptomatology are admitted, while Astrup *et al.* are concerned with patients in a mental hospital and thus presumably with more severe symptoms. Thirdly, our hospital has a long tradition in using the terminology of reactive psychoses. Professor Langfeldt (the Head of the hospital for 26 years up to 1966) strongly emphasized this diagnosis and the differential diagnosis between schizophrenia and reactive psychoses.

It may be said in criticism that the patients in the short-term group have only been observed over a period varying from two to six years. However, the difference was not very great between the groups, 13 per cent. of the reactive psychoses in the long-term group and 8 per cent. in the short-term group being changed to schizophrenia on follow-up. In addition it may be mentioned that a personal reinvestigation by the author of all the patients in the short-term group is now being completed, giving a period of observation for this group varying from five to nine years. The diagnosis of reactive psychoses seems to be slightly changed. The results of this reinvestigation will be published later.

It emerges from the present study that the prognosis is far better in the group of reactive psychoses than in that of schizophrenia (favourable course in 81 per cent. against 23 per cent.).

A differentiation between schizophrenia and reactive psychosis thus seems fruitful even if only prognosis is concerned. For a Scandinavian psychiatrist it is striking how little attention has been paid to this group, especially in the English-speaking countries, where the term is hardly used. The explanation is not that these psychoses do not exist in these countries. It is a question of terminology. The terms of affective psychosis or schizophrenia may be preferred. For the group of paranoid psychoses here discussed, the term paranoid reactions or paranoid conditions certainly would be used in many of the cases. Criticism may certainly be raised against the concept of "reactive psychoses", especially if a psychogenesis in the strictest sense is claimed. As will be apparent from the present paper, some of the psychoses originally labelled as reactive turn out on follow-up to be schizophrenia.

The borders between a reactive psychosis and schizophrenia may not seem sharp enough. Nevertheless, at the moment there seems to be an increasing interest in the concept of reactive psychosis. In the eighth edition of the International Classification of Diseases of the World Health Organization there exist five subgroups under a main group (298) labelled "other psychoses". These sub-groups are named: reactive depressive psychosis; reactive excitation; reactive confusion; acute paranoid reaction; reactive psychosis unspecified.

In a seminar on Psychiatric Diagnosis, Classification and Statistics, held by the World Health Organization in Oslo, 17–21 October 1966, the concept of reactive psychosis was the main topic. As an indicator of the Scandinavian interest in these psychoses it may be mentioned also that "the reactive psychosis" was the main topic at the Fifteenth Congress of Scandinavian psychiatrists held in Norway in June 1967.*

Summary

A short survey is given of the common Scandinavian concepts of schizophrenia, schizophreniform psychosis and reactive psychosis with special emphasis on the last-mentioned group. The aim of the paper is to see how the stability of the nosological categories according to the Scandinavian concepts comes out under the test of a nearly complete personal follow-up.

All first-admission patients suffering from paranoid psychosis, irrespective of diagnosis, consecutively admitted to the Psychiatric Department, University of Oslo, during two periods,

* From the W.H.O. Seminar it appeared that there is not yet a general agreement on the concept of reactive psychoses, while the Scandinavian Congress demonstrated a nearly common Scandinavian agreement upon the usefulness of this concept. Generally, the Swedes have a tendency to use the concept in a more restricted way than do the Danes and Norwegians.

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1946–48 and 1958–61, and domiciled in Southern and Eastern Norway were selected. Of these 334 patients, 301 were personally examined by the author. For 132 of these patients the observation period ranged from 15 to 18 years, and for 169 from 2 to 6 years.

The hospital diagnoses were: reactive psychoses 167, schizophrenia, 52, psychosis e genere incerto 76, other psychoses 10.

On follow-up, the hospital diagnosis of schizophrenia was changed to that of reactive psychosis in 7 cases (14 per cent.), the diagnosis of reactive psychosis to that of schizophrenia in 16 cases (10 per cent.). In 2 cases the diagnosis of organic brain disorder was changed to that of reactive psychosis. Thus a major change of the diagnosis was only necessary in 25 patients or 8 per cent. of the total material. Of the patients with the hospital diagnosis of psychosis e genere incerto, 66 per cent. were on follow-up classified as reactive psychosis, 30 per cent. as schizophrenias and the rest (3 patients) as other psychoses.

There was a considerable correlation between hospital diagnosis and clinical course. The percentage of "cured" on follow-up, based on hospital diagnosis, was: reactive psychosis 81 per cent., schizophrenia 23 per cent., psychosis e genere incerto 61 per cent. and other psychoses 50 per cent.

It is concluded that the concept of reactive psychosis is a fruitful one, which can be kept in about 90 per cent. on follow-up. A differentiation between schizophrenia and reactive psychosis seems fruitful even if only prognosis is concerned. The increasing international interest in the concept of reactive psychosis is emphasized.

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