The Fading of Psychosis

Werner Felber Thomas Reuster

Department of Psychiatry and Psychotherapy, Dresden Technical University, Dresden, Germany

A precise surveillance of the remission of schizophrenic psychoses has brought several aspects of this process to our attention: Concerning the dynamics of florid schizophrenia, it is mainly the development of acute symptoms which has been focussed upon until now. Conrad [1] developed the most comprehensive phenomenological systematic description for the onset of schizophrenia, but barely touched upon any possible rules followed during symptom remission. Regarding schizophrenic remission, Jaspers [2, 3] considered the reestablishment of awareness amongst the symptoms experienced; he distinguished disease awareness (partial distancing) from disease insight (an unclouded distancing), which represents the highest grade of remission.

We cannot cite any systematic investigations regarding the remission of positive schizophrenic symptoms in the literature, having only found sparse references to psychopathological states during the fading of schizophrenia [2, 4–11]. A more or less simple reversal of the onset of psychosis was always assumed in such cases.

Based on our own clinical experience and analysis of single case studies reported elsewhere [12], a provisional classification of six stages of remission is proposed here which can be operationalized according to specific criteria:

(1) *Psychotic catastrophe*: A state of total cognitive and affective overpowering by the psychotic symptoms (paranoid-hallucinatory, catatonic). The patient does not allow for

any doubts or communicate with others and often shows hostility towards anyone who tries to speak about the disease. The afflicted patient is usually totally ruled by the condition, and less often the psychopathology (in this case mostly delusions) is encapsulated. In the latter case, a sector of the real world might be preserved, but when critically discussing the delusions, the patient gets worked up immediately to a state of great infuriation or uncompromising rejection.

(2) *Physically accessible psychosis*: A state of being controlled by the psychosis which, however, does allow discussion of the physical-vegetative complaints that the patient admits to. Beginning a limited (medication) therapy is possible. In the vast majority of cases, this relates to sleep problems which the patient objectively suffers from and which can be alleviated with a 'sedative' (a tranquilizer can indeed be given initially, preferably a neuroleptic). The aspects of the psychosis, however, remain beyond the bounds of discussion.

(3) *Discussible psychosis*: A status of relinquishing the affective part of the psychosis, with a partial approval of cognitive alternatives. The patient can talk objectively about the actually unchanged contents of his delusions and hallucinations. He or she can sustain objections from others (therapists) who explain that they have another insight and/or perception. He or she can also call on several mental registers, and is capable of 'double-entry bookkeeping' (Bleuler [4]), allowing antipsychotic therapy to proceed ('if

you force me to stay on further in the clinic, I will stay here voluntarily').

(4) *Blurring psychosis*: A state of a relaxing psychosis, whereby hallucinations become indistinct and/or unsure and delusions become nebulous and/or are questioned. Hallucinated voices become (1) more removed and softer, (2) internalized and perceived as thoughts or conscience or (3) increasingly indistinct and change to acousmas. Delusions (1) change and become closer to reality, (2) become less convincing or (3) become less and less relevant to the current situation so that the patient does not want to be reminded of them anymore.

(5) *Psychotic remnants*: A status of a lack of a current psychosis psychopathology, but a still persisting subjective certainty of the reality of psychoses experienced in the past. The patient does not produce any psychotic (paranoid-hallucinatory) symptoms, but does not feel distanced from the past psychotic events which he retains as subjective 'remnants' experienced.

(6) *Disease insight*: A state of conviction of having been ill with regard to the psychosis endured. At this stage, the patient feels completely distanced from the psychosis. This represents the most extensive possible remission of the psychosis, and is recognized as disease insight, whereby the largest possible agreement between subjective and objective observations exists.

Apart from other interesting aspects such as quality of life, compliance, therapeutic indication, negative symptomatology, un-

derlying disorders, diagnostic (non)specificity, cognitive and affect research and the concept of 'locus of control', which shall not be delved into any further, we shall only mention here possible differences between the development and remission of psychosis. We certainly do not feel that one merely represents the mirror image of the other process. In fact, differences do exist regarding the following factors: the experience of the patient, which in many ways is not comparable; the reciprocity between losses and benefits with regard to restrictive delusory states on the one hand, and elated delusory states on the other; the specific course between the beginning and end of the process dynamics; the form and speed of the process, due to the therapy employed to bring about remission; the side effects appearing with the treatment modalities (medicines, ECT and other therapies); the experiences of the relatives, and the presence and influence of the therapists.

From these initial considerations the following statements can be made: the remission of a psychosis (1) is clinically a kind of *mirror image of the onsetting psychosis*, but pathodynamically and phenomenologically (following Jaspers' [2, 3] reasoning) it is not comparable; (2) can, unlike the onset of a psychosis, be *observed and experienced di-*

rectly close to the patient; (3) in many cases is traversed *more rapidly than the onsetting psychosis*; (4) has attracted interest only recently from *observations made on successfully applied antipsychotic therapy*; (5) is a *dynamic continuum* that can, however, be described *in comprehensible phases*; (6) frequently does not *achieve the final stage* of disease insight; (7) in the form of these phases represents a *yardstick for the stage of the healing process*, and (8) allows statements to be made (depending on the phase traversed) regarding *compliance and a differentially indicated therapy*.

References

- 1 Conrad K: Die beginnende Schizophrenie. Versuch einer Gestaltanalyse des Wahns. Stuttgart, Thieme, 1987.
- 2 Jaspers K: Allgemeine Psychopathologie. Berlin, Springer, 1948.
- 3 Jaspers K: Kausale und 'verständliche' Zusammenhänge zwischen Schicksal und Psychose bei der Dementia praecox (Schizophrenie); in Jaspers K: Gesammelte Schriften zur Psychopathologie. Berlin, Springer, Nachdruck der 1. Auflage 1963 (orig. 1913).
- 4 Bleuler E: Dementia praecox oder Gruppe der Schizophrenien. Leipzig, Deuticke, 1911.
- 5 Bodenheimer AR: The 3 phases of schizophrenic psychosis and their phase-specific psychotherapy (in German). Schweiz Arch Neurol Neurochir Psychiatr 1978;122:213-235
- 6 Janzarik W: Schizophrene Verläufe. Eine strukturdynamische Interpretation. Monographien aus dem Gesamtgebiet der Neurologie und Psychiatrie. Berlin, Springer, Bd 126, 1968.
- 7 Klosterkötter J: Basissymptome und Endphänomene der Schizophrenie. Eine empirische Untersuchung der psychopathologischen Übergangsreihen zwischen defizitären und produktiven Schizophreniesymptomen. Berlin, Springer, 1988.
- 8 Petrilowitsch N: Psychiatrische Krankheitslehre und psychiatrische Pharmakotherapie. Basel, Karger, 1966.
- 9 Searles HF: Der Übergang vom konkretistischen zum metaphorischen Denken im Gesundheitsprozess des Schizophrenen. Psyche 1965; 19:495-515.
- 10 Spitzer M: Was ist Wahn?; in Kaschka WP, Lüngershausen E (eds): Paranoide Störungen. Berlin, Springer, 1992.
- 11 van Os J, Gilvarry C, Bale R, van Horn E, Tattam T, White I, Murray R: To what extent does symptomatic improvement result in better outcome in psychotic illness? Psychol Med 1999; 29:1183-1195.
- 12 Felber W, Reuster T: Psychose in Rückbildung – Psychopathologie der Heilung; in Hippus H (ed): Auf den Spuren der Schizophrenie, in press.