

# Reactive psychoses revisited

Gabor Sandor Ungvari, Paul Edward Mullen

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**Objective and Method:** This paper describes the overlap between reactive (psychogenic) psychosis and other brief psychotic episodes, and explores the gradual disappearance of reactive psychoses as a distinct nosological entity from international classifications. Clinical and conceptual issues concerning reactive psychosis are examined on the basis of a critical review of major classical and modern papers. A brief illustrative case history is also provided.

**Results:** Reactive psychoses are conceptualised as severe disturbances of mental state, on occasion chameleon-like in their shifting form and content, arising in response to a stressful event or life situation. Reactive psychoses have an abrupt onset and usually run their course to complete resolution in a matter of days or weeks. Precipitants include overwhelming fear, threat of imminent destruction, social isolation (as can occur with imprisonment, immigration or deafness), bereavement and intense sexual or interpersonal conflicts. The emergence of a reactive psychosis usually occurs against the background of a predisposing vulnerability in terms of personality disorder, organic impairment, or a history of sensitising experiences, occasionally operating in combination.

**Conclusions:** The increasing failure to recognise reactive psychoses diminishes clinical psychiatry because it removes an important opportunity for understanding mental disorder in terms of an integration, and totalisation, of developmental history, psychological makeup, social context and current realities, and in so doing lessens our awareness of the links between psychosis and our common humanity.

**Key words:** acute and transient psychotic disorders, hysterical psychosis, psychogenic psychoses, reactive psychoses.

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The notion that a serious mental disorder characterised by gross disturbances, such as hallucinations and delusions, can be primarily a reaction to overwhelming stress, or distress, is increasingly foreign to

contemporary Western psychiatry. The current conceptualisation of psychoses and their aetiologies tends to emphasise notions of illness determined by as yet unknown brain dysfunction whose content are only secondarily influenced by the psychological and social worlds of the patient. In contrast, classical psychopathology divided mental disorders into processes, developments and reactions, and, though psychoses were usually processes, the reactions and the developments could on occasion constitute the primary form of a psychosis [1,2]. Equally important was the recognition of the overlaps and interactions between the categories of development, reaction and process in the individual case [2]. Classical psychiatry attempted to

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establish clinical groupings on the basis of process, development and reaction, incorporating implications for the aetiology, presentation, course, management and outcome. This paper will explore one group of the reactions where brief, but often intense, psychotic symptoms arise in the context of psychological and social stress.

The following case vignette illustrates the core features of reactive (psychogenic) psychoses.

### **Case description**

A 22-year-old man serving a 12-month sentence for car theft was examined following a siege in which he had assaulted two prison officers and then barricaded himself in his cell. He was in a highly aroused state claiming he was about to be killed. He claimed he was the victim of a plot by a secret organisation made up of prison officers. He reported attempts to poison his food and that prison officers had been waiting outside of his cell for the last 3 days until he fell asleep with the intention of spearing him like a pig as he slept. He had heard them planning this and talking about him outside of his cell. In the interview at one point he reported hearing the voices of his persecutors talking about him in the next room. He was transferred out of the prison to a forensic hospital. His agitation rapidly decreased, though he remained suspicious and still attempted to remain wakeful refusing to go to bed for the first 3 days. He received only minor tranquillisers, but within a week had returned to his boastful, truculent self with no continuing fears or arousal. He was reluctant to speak of his recent experiences but remained convinced 'they' had planned to kill him. A full drug screen was negative as were neurological and general medical work-up.

He came from a disturbed and disrupted home and had spent extended periods during childhood in institutional and foster care. He had had a variety of unskilled occupations and supplemented his income with petty crime and occasional car theft. He was an intermittent heavy drinker, but had had minimal involvement with drugs. He was a large, powerfully built man with an air of self-confidence and a facility with language, and had established himself as a figure of some influence among the more marginalised and socially deviant young people in the country town in which he lived. Despite his reputation for toughness and villainy, of which he was the major publicist, he had committed only relatively minor property and nuisance offences. He surrounded

himself with a wide circle of acquaintances though he had no close friends and only the briefest of sexual relationships.

This was his first period of imprisonment, but despite this, he had been placed in a unit with predominantly violent and recidivist offenders, in no small part because of his intimidating appearance and demeanor. He was treated with contempt by these fellow inmates and to establish himself he became increasingly confrontational in his interactions with prison officers. This eventually led to a series of incidents for which he was punished by being placed for 2 weeks in what is euphemistically termed a 'management unit', but which is in effect solitary confinement. Initially, he shared the unit with several other equally obstreperous young men with whom he had shouted conversation and in concert with whom he provoked and irritated the guards. After a few days the other prisoners, having completed their period of punishment, returned to the mainstream prison and by chance he was left alone with officers from whom he had thoroughly alienated himself and who responded by keeping their contact with him to a minimum. For the first time in his adult life he was thrown back on his own resources with no audience with whom to establish his identity. Initial attempts to provoke the guards into responding resulted only in his loss of his one privilege, the radio. Now with little external stimulation and effectively no human interaction he began to become increasingly distressed with escalating fears that the guards would take this opportunity to revenge themselves on him. These fears merged into the deluded and hallucinated state in which he was first seen. There was no recurrence of symptoms during the rest of his sentence nor during the subsequent years when followed up in the community.

### **Clinical picture**

Reactive psychoses or, as they are occasionally termed, psychogenic psychosis, have an abrupt onset, usually lasting from a few days to a few weeks and are followed by a complete resolution of the symptoms. They cannot be fully characterised by their symptoms since virtually the whole range of psychiatric symptomatology may appear, even if transiently [3–5]. Individual symptoms are changeable, they emerge, fade and fuse. Following Schneider's division of 'abnormal psychic reactions', three forms of reactive psychoses are customarily distinguished, namely affective psychosis, paranoid psychosis and psychoses

presenting with disorders of consciousness [6,7]. The latter includes stuporous and confusional states. The clinical picture may vary between cultures. Pandurangi and Kapur [8] found that their Indian patients presented with more histrionic behaviour, excitement and sleep disturbances and less confusion, irritability and depression than their Scandinavian counterparts.

A precipitating event in the form of a stressful event or life situation is the *sine qua non* for reactive psychoses. Most authors also regard a predisposing vulnerability as essential to the pathogenesis of reactive psychoses, questioning the possibility of a psychosis ever occurring in a psychologically normal and balanced individual [1,5,9]. The diagnosis therefore depends less on certain well-circumscribed symptom clusters, than the totality of the clinical picture. Recent multicentre reliability studies [10,11] and persuasively written case reports [12–14] attest to the presence, and ease of recognition, of reactive psychoses.

Reactive psychoses usually emerge against the background of a vulnerable personality [3,7,15–17]. There have been a wide variety of personality traits observed, for example ‘sensitive’ [18], ‘suspicious’ [19], ‘timid’, ‘excitable’ and ‘asocial’ [20]. McCabe [4] systematically assessed personality traits in his cases and noted shyness, oversensitivity, lability of affect, lack of self-confidence and hypochondriacal and anxious traits. According to DSM-III-R [21], borderline personality disorder is frequently associated with brief reactive psychosis and DSM-IV [22] acknowledges further personality disorders (paranoid, histrionic, narcissistic, schizotypal and borderline) as predisposing to brief psychotic disorder.

European diagnostic traditions regard pre-existing organic impairment as a potential predisposing factor including infection, sleep deprivation, physical exhaustion, and surgery [2,3,5,7]. Often, the boundaries between ‘organic’ and ‘reactive (psychogen)’ causation are blurred [23]. Recently proposed operationalised criteria for the paranoid (delusional) type of reactive psychosis, however, regard organic pathology, irrespective of its relation to the psychosis, as exclusion criterion [24,25].

The core concept of reactive psychoses is the presence of a precipitating event or situation preceding the outbreak of psychosis, without which the psychosis would not have occurred [1,7]. The precipitating event is either so powerful that it would shake the foundation of existence of virtually any human being, or a specific one which strikes an individual who is,

for a number of psychological and somatic reasons, vulnerable at the time to that particular event. Sensitising previous experiences, though dormant for decades in some cases, are postulated as contributing to the underlying vulnerability and they may surface in the content of the psychosis.

Precipitating situations can be divided into acute and chronic groups. Acute situations involving intense interpersonal conflicts, loss of loved ones, social prestige, power or wealth, loss of freedom (e.g. prison) and natural disasters (e.g. forest fires). Among the chronic traumatising situations, the classical examples are the isolation due to deafness [26], language [27] and immigration [28].

Judging the immediacy of the precipitating and/or causative event(s) in relation to the psychosis is always problematic and somewhat arbitrary. Some modern authors [29] accept only a very brief period of up to 1 week between trauma and psychosis, others [25] are more generous, allowing as long as 3 months. Classical writers focused on the context in which the precipitating events unfolded and were less concerned with the exact time frame [1,3].

### Differential diagnostic considerations

Reactive psychoses are not defined by their symptom profile, but by the relationship of a wide variety of syndromes, with the stressful event against the background of the patient’s biography and particular life situation. Hence, delimitation of reactive psychoses from other psychoses should be made on the basis of characteristics other than individual symptoms or syndromes. (For instance, the clinical presentation of a reactive stupor followed by a period of confused agitation may be cross-sectionally indistinguishable from a severe depression or an acute episode of schizophrenia.) As our case vignette shows, the diagnosis required the careful consideration of the patient’s personality and coping style, the details of the situation in which the psychosis emerged, the content of psychotic experiences and the temporal relationship between events and the onset, course and an outcome which was recovery without residual symptoms or functional impairment.

Drug-induced psychosis poses an important differential diagnosis. The clinical features can overlap with an acute or abrupt onset, fragmentary psychotic symptoms and fluctuating clouded consciousness. The correct diagnosis is based on a proper history, longer clinical observation and a drug screen.

## Epidemiological data

Owing to varying diagnostic practices and research methods, there are no hard data on the incidence and prevalence of reactive psychoses. On the basis of Scandinavian national statistics a life-time risk of 0.3–1% was estimated for reactive psychoses [3,7]. National registries in Scandinavia suggest reactive psychoses are diagnosed in 13–30% of all psychiatric admissions [30]. In Denmark, between 1970 and 1988 there were 21 615 first admissions with reactive psychoses to psychiatric institutions while the corresponding figures for affective psychoses and schizophrenia were 18 293 and 3825, respectively [31]. Outside the Nordic countries this diagnosis is rarely, if ever, used. Acute non-organic psychoses with good prognosis are common in developing countries although the percentage of reactive psychoses within this broad category is unknown [32].

## Clinical–genetic studies

No major study has been published in this area since the mid-1970s, so recent major methodological advances in psychiatric genetics have not been utilised. On the whole, clinical–genetic investigations have contributed modestly to the validation of reactive psychoses as a distinct entity. Most studies found higher rates of reactive psychoses, schizophrenia and bipolar illness in relatives of subjects with reactive psychoses than in the general population. However, with the exception of McCabe's study [4], reactive psychoses were not found to breed true.

Apart from earlier clinical–genetic studies, there has been a conspicuous absence of biological studies concerning reactive psychosis. This is understandable in the context of recent trends in psychiatry. Biological psychiatry needs simple, operationalised diagnostic categories and the classical concept of reactive psychoses does not meet this expectation. In addition, in the USA and other developed English-speaking countries where biological psychiatry has dominated psychiatric research, reactive psychoses have never been fully accepted as distinct clinical categories [33].

## The development of the reactive psychosis concept: a brief overview

The establishment of the category of reactive psychoses is usually jointly credited to Jaspers [1,2] and Wimmer [34], though psychogenesis itself has a far

longer history [3,35,36]. Independently, a number of specific psychoreactive psychoses were described and named after the situation in which they occurred. An example was *Situationspsychosen* [37] which included prison psychosis [38], war (battle) psychosis [39], fear psychosis [40] and, at a later date, immigrant psychoses [28,41].

## Jaspers and the tradition of German psychopathology

In his quest to develop a scientific psychopathology, Jaspers [1,2], though never enumerating clinical criteria for reactive psychoses, did formulate a theoretical structure for reactive states. These are that the psychosis (i) follows soon after a precipitating event of a nature which could reasonably be expected to produce significant psychological disruption; (ii) have a content which reflects at some level the nature of the precipitating event; and (iii) resolve when the precipitating event is either removed or otherwise ameliorated. Jaspers [2] held that 'in all psychogenic reactions (*Erlebnisreaktionen*) it is the meaning of the experience [to the patient] which is the decisive factor' (p.365). Reactive psychosis 'springs from a conflict with reality which has become intolerable. The psychosis often manifests all the individual's fears and needs as well as their hopes and wishes in a motley procession of delusion-like ideas and hallucinations. It serves as a defence, a refuge, an escape, as well as a wish fulfilment' (p.389). When a reactive psychosis resolves there should be eventually full insight into the illness though elements 'may continue to exert an influence' (p.385), as with the paranoid reaction which on recovery still leaves a degree of suspiciousness and apprehension directed at the object of their previous delusions. Jaspers [2] emphasised that 'however, well we understand the experience, its shattering significance and the content of the reactive state, the actual translation into what is pathological remains nevertheless incomprehensible' (p.384).

Attempts to validate Jasper's concept of reaction in clinical practice have produced conflicting results with some groups failing to find all the psychopathological criteria for reactive psychosis in patients given that diagnosis [3,15,24], and others finding the majority with reactive paranoid psychoses met Jaspers criteria [42]. In McCabe's prospective study [4] of reactive psychoses, 82% of psychotic episodes had a temporal relationship to the precipitating

trauma, 85% had a trauma regarded as adequate to precipitate the psychosis and in 82% the content of the psychosis reflected the stressful event. The meaning of the psychosis (e.g. escape, wish) was apparent to the clinicians in every case. However, only 60% of the subjects fulfilled all Jaspers' criteria. The question immediately arises why those who did not meet the Jaspers' basic psychopathological principles of reaction were given the diagnosis of reactive psychosis in the first place. Clinical practice here, as elsewhere, dilutes psychopathological principles. Frey [23, p.1] suggested: 'what really matters, when it comes to diagnosing reactive psychosis, is if the disease in question cannot be labelled schizophrenia, manic-depressive or an organic psychosis'. This is not an observation with which we have any sympathy, but we accept that diagnosis by exclusion is not infrequent in clinical practice.

From the 1920s onwards, apart from Schneider [6], no other major figure in German psychiatry paid particular attention to reactive psychoses. During the Nazi era the emphasis shifted unilaterally to the genetic determination of mental disorders with well-known tragic consequences [43]. Following World War II, only one major study [44] dealt with the problem of reactive psychiatric disorders although not specifically with psychoses. Over the past 20 years, mainstream German psychiatry has gradually moved towards criterion-based descriptions embodied in successive editions of DSM and ICD.

### **The Scandinavian view on reactive psychoses**

It has been primarily the Scandinavian psychiatric schools which have kept the clinical concept of reactive psychoses alive. The first monograph on the topic was written by a Danish psychiatrist, August Wimmer [34] and the most influential recent proponent of the concept has been another Scandinavian, Erik Stromgren [7] whose views on reactive psychoses can be summarised as follows:

(1) The mental trauma must be of such a nature that the psychosis would not have arisen in its absence.

(2) A close temporal correlation exists between the trauma and the start of the psychosis.

(3) The mental trauma plays an important role in determining the content of the psychosis.

(4) A predisposing vulnerability is usually obvious in the individual's personality.

(5) If the precipitating situation resolves, the psychosis will usually also resolve; though even if

the situation persists the psychosis will not go on forever.

(6) It is not the objective force of the trauma which determines the reaction of the patient; it is the subjective experience determined by the special sensitivity of the patient to the meaning of the trauma.

(7) If the mental trauma cannot be ascertained, this is not a sufficient cause for discarding the diagnosis of psychogenic psychosis.

With the exception of the last, theoretically untenable criterion, Stromgren remains close to Jaspers' original formulation. Stromgren believed reactive psychoses could last from a few days, as with funeral mania, to months or years, as with litigious paranoia or psychoses of immigrants. Most authors would not, however, classify paranoia (delusional disorder) under the heading of reactive psychoses in any circumstances because the connection between mental trauma and ensuing psychosis is rarely unequivocal (for a contrary view see [45,46]).

Stromgren [7] also proposed that specific types of trauma would lead to characteristic clinical pictures. Thus, a serious blow to the individual's self-image, or social isolation arising from, for example, deafness or immigration, would generate reactive paranoid psychosis. Sudden disasters overturning the individual's sense of the world as a safe place, such as earthquakes, would tend to produce disorders of consciousness and confusional states. Finally, unforeseen situational conflicts could generate emotional reactions, that is, reactive affective psychoses. Doubts have been expressed on whether specific types of trauma lead to specific types of psychoses [3,15]. On the other hand, McCabe [4] found that a statistically significant number of patients presented the syndrome predicted by the type of trauma, a finding which still needs replication.

Faergeman's eloquently written monograph [3] on reactive (psychogenic) psychoses made the concept accessible to English-language psychiatry. In an attempt to integrate psychoanalytic theory into Jaspers' concept of reaction, Faergeman extended the boundaries of interpretation, asserting that not only the content but the form of the psychosis was also understandable from the patient's personality and the situation. Although Faergeman was a brilliant clinician, not even his own personally conducted follow-up study could support his views. Of 98 patients diagnosed with reactive psychosis 14-19 years earlier by Wimmer, Faergeman [3] could confirm the diagnosis only in 48 cases as the majority of patients was reclassified as suffering from schizophrenia.

Faergeman's book [3] appeared in the advent of the era of operationalised criteria-based, 'objective' diagnostic practice in psychiatry. No wonder, therefore, that his inconclusive results and the inclusion of psychoanalytic theory elicited scathing criticism of the usefulness of reactive psychoses and discredited the whole concept for Anglo-American psychiatry [33].

Recently, an attempt has been made to improve the reliability of the diagnosis of reactive psychoses across the Nordic countries [11]. Operationalised criteria for reactive psychoses have been published [24,47], but they consider only the paranoid (delusional) subtype and gloss over emotional (affective) syndromes and disorders of consciousness. Guldberg *et al.* [47] operationalised reactivity by devising the Reactivity of Psychosis Rating Form, which has 10 variables encompassing all the relevant features of reactive psychoses with good interrater reliability and construct validity.

### Reactive psychoses in French psychiatry

French psychopathology and nosology developed in a cultural–philosophical context distinctly different from that of German and Anglo-American psychiatry [48]. Reactive psychoses did not occupy a separate category in traditional French classification but later they were grafted upon the classical French concept of *bouffée délirante*. *Bouffée délirante* has shown remarkable stability over more than a hundred years [49], denoting an acute, brief, non-organic psychosis with sudden onset, ever-changing (polymorphous) delusions and hallucinations, clouded consciousness and rapidly fluctuating affective states. *Bouffée délirante* remits spontaneously, but tends to recur [50]. In Magnan's classical interpretation [50] a fragile premorbid personality (degeneracy) confers the vulnerability while traumatising events play minimal, if any, part in its pathogenesis. In the recent official French classification [51], a reactive variant of *bouffée délirante* is entertained which is clinically the same as the classical type, but occurs in response to a stressful situation. The reactive type is said to take up approximately 15% of all *bouffée délirante* cases, and corresponds to reactive paranoid psychosis [50]. Outside the recent French *bouffée délirante* category, the classification also has a separate rubric for reactive confusional states [51]. Both reactive *bouffée délirante* and reactive confusional states are widely used diagnoses in the French-speaking developing countries of Africa [32].

### Reactive psychoses in current international classifications

Reactive psychoses first appeared in ICD-8 [52] under the heading of 'Other psychoses' (298) as reactive depression (298.0), reactive excitation (298.1), reactive confusion (298.2), acute paranoid reaction (298.3) and unspecified reactive psychosis (298.9), although users were cautioned to apply these categories sparingly. Unlike its predecessors, ICD-10 [53] does not recognise reactive psychoses as an independent category. The ICD-10 classification created a new composite diagnostic class, acute and transient psychotic disorders (ATPD) in response to the twin goals of rationalisation: avoiding any aetiological assumptions [54], and world-wide consensus, that is, to incorporate benign, acute psychoses frequently encountered in developing countries [55,56]. Any of the six subtypes of ATPD may occur with or without the modifier, associated acute stress, but there is no requirement to link any features of the psychosis to the stressful life situation which has been a principal component of the definition of reactive psychoses.

The division of acute psychoses in ICD-10 is deliberately simplistic [54] and seductively logical. Because of its simplicity, ATPD will predictably have a satisfactory reliability, while its diagnostic stability is doubtful [57]. However, the inherent danger of the simplicity of the classification is that it may induce mental health professionals, not trained in classical descriptive psychiatry, to count individual symptoms and catalogue stressful events separately from each other. There is, in fact, encouragement to pursue a multiaxial classification, which fails to recognise the interaction of theoretically distinct axes in giving rise to both the form and the content of these psychoses.

Until DSM-III [58] introduced the category of brief reactive psychosis, most reactive psychoses were diagnosed as acute schizophrenia in North America [59]. In DSM-III-R [21], the diagnostic criteria for brief reactive psychosis were based on some, albeit not all, of Jaspers' criteria of abnormal reaction. In an attempt to bring DSM-III-R closer to the Scandinavian concept of reactive psychoses [60], the restrictive DSM-III criteria were modified significantly; DSM-III-R states that the psychosis occurs not simply after, but in response to, the stressful life event(s), that is, the interaction between the event(s) and the psychosis is emphasised, thus giving Jaspers' notion more prominence. The balance is further shifted in the Jaspersian direction by permitting a chain of events, instead of one, to contribute to the pathogenesis of

reactive psychosis. The importance of confusion and perplexity in the clinical picture are underscored, basically acknowledging the existence of the disorders of consciousness, a classical category of reactive psychoses. The relationship between reactive and organic conditions is more sensibly worded by not ruling out chronic organic conditions as a predisposing factor, provided they do not initiate or maintain the reactive disturbance.

Nevertheless the North American concept of reactive psychosis was still more restrictive than the classical one for four main reasons [61]. First, it excluded patients with premorbid schizotypal personality disorder or prodromal symptoms of schizophrenia, which is an arbitrary decision not supported by empirical evidence. In the European tradition, reactive psychoses may occur independently or may be superimposed on any chronic organic, or even non-organic, psychiatric conditions [1,62]. Second, like ICD-10, DSM-III-R ignores reactive affective psychoses (emotional reactions), which constitute a substantial part of reactive psychoses in classical series [3,4,63]. It seems to be an illogical decision to differentiate between reactive and non-reactive paranoid disorders, but to insist on the unitary nature of mood disorders. Third, the maximum duration of brief reactive psychosis is limited to 1 month, an extension of the 2-week criterion in DSM-III, which was still far too short in light of several classical and recent studies [3,4,8,24,29,63]. Fourth, emphasising the severity of stressor(s), DSM-III-R paid no heed to individual vulnerability, another salient constituent of the original concept [2,3,5,7,64].

Although DSM-III-R represented an improvement over its predecessor, it still fell short of reflecting the fertile clinical traditions of the European, particularly German and Scandinavian, schools of psychiatry [30,61]. For this reason, Jauch and Carpenter [61] suggested a return to the traditional concept of reactive psychoses. Instead, and similar to ICD-10, DSM-IV [22] did not even retain reactive psychosis as a separate entity. In DSM-IV the acute stressor serves only as a specifier to a new, composite category, brief psychotic disorder (298.8), which collapsed good-prognosis, reactive and non-reactive brief psychoses into one category.

### **Reactive psychoses and the so-called ‘third psychosis’**

The deficiencies of Kraepelin’s dichotomisation of endogenous psychoses have led to the search for a

‘third psychosis’ [65], some of which have similarities to reactive psychoses. It is important, however, to emphasise that reactive psychoses are fundamentally different from psychoses which represent a transition between schizophrenia and manic–depressive illness.

A careful reading of Kasanin’s [66] original paper on acute schizoaffective psychosis reveals many features in common with reactive psychoses including a stressful life event prior to the onset of the psychosis, an oversensitive premorbid personality and the conceptualisation of the psychosis as a meaningful reaction offering a type of solution to the patient’s current dilemma. The psychosis ends in complete recovery with full insight. In fact, Kasanin incorporated most of the clinical characteristics of reactive psychoses into his schizoaffective psychosis without acknowledging their psychopathological foundations. Since Kasanin’s original description, the concept of schizoaffective psychoses has undergone several transformations and in its current usage bears no resemblance to reactive psychoses, though whether these developments have enhanced its clinical relevance is open to question.

Leonhard’s cycloid psychosis [67], was an attempt to establish a ‘third psychosis’, following the classical German psychiatric traditions of Wernicke and Kleist. Cycloid psychosis, despite similarities in clinical presentation (acute onset, confusion, emotionally charged psychotic symptoms and excellent short-term prognosis) are not related to reactive psychoses [67]. According to Leonhard, stressful life events may precipitate the onset of cycloid psychoses, but the content does not reflect the traumatic situation, if there was any, and their course and outcome are unrelated to environmental changes.

Langfeldt [68] also attempted to bridge the gap between typical schizophrenia and manic–depressive psychosis by creating the category of schizophreniform psychoses. Schizophreniform psychoses are characterised by typical schizophrenic symptoms, but with a relatively short duration and a good long-term prognosis [68]. Two of the five subtypes of schizophreniform psychoses described by Langfeldt [68] were considered psychologically comprehensible, which, in effect, makes them indistinguishable from reactive psychoses. Over the past 60 years this term has been widely used in various contexts with different meanings. Langfeldt’s original five-tiered category has by now dissolved. In ICD-10 ‘Acute schizophrenia-like psychotic disorder with associated acute stress’ (F.23.21) harks back to Langfeldt’s reactive schizophreniform psychosis while his

non-reactive subtypes have found their way into both ICD-10 and DSM-IV.

Owing to conceptual and terminological confusion, reactive psychoses sometimes appear in the literature in the disguise of other terms. Hysterical psychosis, which has never formed part of official classifications, has haunted psychiatric nosology over the past hundred years [20,69]. The diagnostic criteria proposed by Hollender and Hirsch [70] are similar to those of the classical reactive psychosis, with the restriction that the premorbid personality is hysterical and the acute episode seldom lasts longer than 1 to 3 weeks. Evaluating blindly the case notes of patients with hysterical psychosis, non-hysterical reactive psychosis, and schizophrenia for a number of demographic and clinical variables, Modestin and Bachmann [71] found no difference between hysterical and reactive psychoses, while patients with schizophrenia differed significantly from both groups. Their conclusion, shared by many authors [72,73], was that hysterical psychosis is essentially a reactive psychosis occurring against the background of hysterical character traits. Hence the term 'hysterical psychosis' is redundant and should not be used.

It is worthy of note that many descriptions of dramatic reactions to situational stress have been annexed to what we now term posttraumatic stress disorder (PTSD). At first glance, PTSD appears, other than in terms of its precipitation, to occupy an entirely separate realm from reactive psychosis, it being an extended, non-psychotic disturbance with marked affective and dissociative symptoms. In clinical practice, however, some of those quite properly described as having PTSD have an initial reaction to the trauma which could be regarded as amounting to a reactive psychosis. If one accepts the notion of reactive psychoses which extend beyond clinical pictures dominated by delusions and/or hallucinations to incorporate disturbances of consciousness (e.g. fugues), disturbances of volition (e.g. stupor) and disturbances of affect (e.g. 'emotional paralysis') then the potential overlap with cases currently classified as PTSD becomes clear.

## Conclusion

The diagnosis of reactive psychosis in most cases is not possible without the empathic and accurate engagement with the patient and the patients' past history and current predicament. The simple cataloguing of life events, by employing questionnaires

for instance, does not give sufficient information without the background of a detailed biography [4,74]. Jaspers' two masterly written case histories, 30 densely printed pages each, exemplify this empathic understanding [1]. Boundless curiosity, empathic immersion in the patients' lives and their current experiences and diligent investigative inquiry form the cornerstone of the diagnosis of reactive psychosis. Modern clinicians can rarely afford the luxury of the time to pursue such inquiries. The fundamental changes in clinical practice since Jaspers' time including, for example, the introduction of multidisciplinary team work and the widespread use of questionnaires and rating scales employed by mental health professionals other than psychiatrists, would partly explain why reactive psychosis is seldom considered in clinical practice. In addition, the layout of modern multiaxial diagnostic schemes listing clinical picture, personality characteristics and stressful life events separately fragments assessment and creates an environment in which dynamics and interactions are reduced to the impoverished notion of comorbidity. Finally, there is a neglect of environmental factors in the aetiology of mental disorders in general, which is particularly erosive of notions of reactive mechanisms.

As for the nosological status of reactive psychoses, they appear in truncated form, in both DSM-IV and ICD-10 hidden behind the composite categories of brief psychotic disorder and acute and transient psychotic disorders respectively. In our view, this is an entirely illogical arrangement as the presence of a major stressful event, its temporal relationship with, and impact on, the content and emergence of the ensuing psychosis set reactive psychoses sharply apart from other forms of psychotic disturbances and warrant a separate diagnostic category for them.

The failure to consider and recognise reactive psychoses diminishes clinical psychiatry. The understanding of the meaningful connections between both the individuals' personality and life history and the content of their reactive psychoses not only enriches the clinicians capacity for empathic management, it also lays a basis for similar, even though more limited, understanding of other psychotic disorders. The dehumanising potential of multi-axial approaches which all too easily degenerate into a technology which reifies and fragments the disordered individual can, in part, be ameliorated by re-establishing a tradition which understands mental disorder as reflecting the interaction and totalisation of those elements of vulnerability, developmental history,

psychological makeup, social context and current realities which go to make up the existence of us all.

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