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Letter to Editor. In search of definition of the term "psychotic process" – thoughts and doubts

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The term "psychotic process" is used by psychiatrists and clinical psychologists. This is puzzling – it is difficult to determine the actual meaning of the term. The only definition the authors could find is not informative: illness which "is characterized by a course. The course of illness may be specific or unspecified, but can usually be divided into the initial period (buildup of disorders), the period of full-blown illness and the period of improvement of symptoms. The course can obviously have different forms for many reasons, e.g., a lack or prolonged duration of prodromal symptoms, acute exacerbation of symptoms, periods of remission, or a phasic course of illness. In this place it was emphasized to underlie dynamic properties of illness, that it is a process. [...] and thus we sometimes use the term psychotic process" [1]. Despite the fact that defining simple terms in psychiatry can be difficult (the best example of such difficulties are attempts to define the term "mental illness" [2]), the definition quoted above states that the psychotic process is a sequence of specific or non-specific psychotic symptoms. However, "non-specific" symptoms should not be taken as a basis for the occurrence of a "psychotic process". Using this term is not problematic when understood as synonymous with the presence of psychotic disorders, but this is not always so. The "process" is something more than a collection of separate symptoms; it means the continuous existence of psychotic symptoms, their sequence and mutual interactions, which may be more important for this term adherents than presence of symptoms alone. It should be noted that "psychotic process" does not appear as a criterion in disorder classifications (e.g., ICD-10 or DSM), therefore contemplation of the essence of this term is of secondary importance. So why does this term exist in clinical practice? There exists another possible interpretation of the "psychotic process" as a type of psychotic disorder with a specific, unfavorable, course. Recall, also, attempts to identify a distinct "procesual schizophrenia", an illness with a severe course and low susceptibility to treatment; some argued that it should be named "kraepelin-

ian", as Kraepelin himself used the term *dementia praecox* to suggest a chronic and irreparable illness process [2].

An understanding of schizophrenia as a progressive brain illness is not reflected in clinical observations or brain and cognitive functioning research [3]. MRI studies show small deviations from the norm after a person's first psychotic episode. Later depletion of brain tissue volume in patients is attributed to chronic medication and psychoactive substance abuse [4]. As much as 25% of patients have poor treatment outcomes, but few of them exhibit progressive worsening of cognitive functions, characteristic of neurodegenerative diseases. The deterioration of a patient's functioning is mostly explained by lack of access to treatment, insufficient compliance or substance abuse, comorbid mental disorders, poverty, and the loss of social connections. Early psychosocial, cognitive-behavioral, and pharmacological interventions for people with at-risk mental states may delay the occurrence of illness and reduce symptom severity [5], more so, given that the duration of untreated psychosis is correlated with greater symptom severity and number of relapses [6]. If there is a process in schizophrenia it is probably more psychosocial – associated with patients' needs, marginalization, and lack of care, rather than purely biological.

Use of this term may also be iatrogenic – the results of an Internet search of the term "psychotic process" show that patients also have difficulties understanding this concept and that they search for answers in topics like "my psychiatrist stated that I have severe psychotic process" [7, 8]. Doubts arise when there are visible differences in different clinicians' understanding of this term. To verify these differences the authors, using social media, posted a survey directed at psychiatrists, psychologists and psychotherapists. 105 professionals, of whom 36.2% treat patients with schizophrenia, took part in the survey. Participants who used the term "psychotic process" to describe patients (16%) and used it while making a diagnosis (15%) were asked to provide a definition of the term "psychotic process".

This group of professionals consisted of 20% physicians or psychiatrists, 80% psychologists and 50% psychotherapists (percents do not add up to 100 because it was possible to choose more than one occupation). 35% of participants had less than 2 years of work experience, 15% of participants had between 2 and 5 years, 10% of participants had between 6 and 10 years, 25% of participants had between 11 and 15 years, and 15% of participants had over 15 years of experience. 8 participants had the title of specialist – psychiatrists or clinical psychologists. 4 participants had a psychotherapeutic certificate, 2 participants had a doctorate or higher scientific qualifications. The following theoretical approaches were selected by these participants (more than one could be chosen): biomedical – 25%, psychoanalytic – 10%, psychodynamic – 35%, cognitive-behavioral – 55%, systemic – 20%, humanistic – 20%, integrative – 20%.

The 15 obtained definitions were subsequently divided into four categories: psychosis (40%), schizophrenia as a process (26.5%), prodromal symptoms (26.5%) and cognitive impairment (7%). The first category, psychosis, refers to the presence of positive symptoms – delusions, hallucinations, disorganized thinking. Some definitions included specific features, such as a "lack of insight" or "use of primitive defense mechanisms", referring to psychoanalytic theory. The second category, schizophrenia

as a process, is a definition that contained two elements: a reference to the symptoms of schizophrenia (positive and negative) and a reference to the dynamics of these symptoms over time. This category included both general and very specific definitions relating to a particular course of the illness, the "psychotic process has its own specific dynamics, a sudden, acute onset, later alternating with exacerbations and remissions and moving to the residual phase which is dominated by deficit symptoms (the schizophrenic defect) [...]". The third category, prodrome, included definitions relating to the initial phase of psychotic disorders or schizophrenia. It included, for example, definition like "changes in behavior prior to the occurrence of acute psychotic symptoms, lasting for months or even years". The last category, cognitive disorders, refers to disorders of memory and disorders of thought content and form.

The above examples illustrate the inconsistency of the understanding of the term "psychotic process" among clinicians and show that it may serve as a less stigmatizing term for schizophrenia, which fits into the eastern trend. In Japan, the name for schizophrenia has been changed from "Seishin-Bunretsu-Byo" (split mind) to "Togo-Schitcho-Sho" (integration disorder), which was introduced because of difficulties in communication between doctors and patients.

Most doctors did not inform patients about the diagnosis because of the stigma and the poor prognosis associated with the original name of the disorder [9, 10]. This change was also intended to reduce patients' stigma [11].

Is it a success for a clinician to leave a patient entangled in concepts that are not well defined and, moreover, seem to be used to hide the actual diagnosis? Is it a success to protect patients from "the painful truth" about the diagnosis, even if we risk delaying the process of coming to terms with the diagnosis, even when preceeded by denial? In this context, it is interesting that as many as 35% of respondents who use the term "psychotic process" have less than 2 years of practice in the workplace. Are these people going to "grow out of" using the term "psychotic process", or on the contrary, will they continue to prefer using it? On the other hand, it may be a matter of sampling. Using an online survey mostly attracted participants at the start of their career (40% of all respondents). At the same time, the use of this term by those who are studying or just after having finished formal education remains a mystery.

The questionnaire distributed by the authors of this report had a limited range and should be generalized with great caution. The survey did not ask respondents whether they use the term "psychotic process" instead of "schizophrenia", which could be an interesting extension of the study. The authors conclude:

1. The use of the term "psychotic process" seems to be independent of years of experience, level of education and theoretical approach of the responder.
2. The definition of the term "psychotic process" differs radically among mental health professionals, which can hinder communication both between specialists and between specialists and patients.
3. In this regard, efforts should be made to remove this term from scientific and teaching work, as well as clinical practice.

References

1. Jaroszyński M. ed. *Podstawy psychiatrii. Podręcznik dla studentów*. Warsaw: PZWL; 1988, p. 19.
2. Jarema M. *Leksykon schizofrenii*. Poznan: Termedia Medical Publishing House; 2010.
3. Zipursky RB, Reilly TJ, Murray RM. *The myth of schizophrenia as a progressive brain disease*. Schizophrenia Bull. 2013; 39(6): 1363–1372.
4. Zipursky RB. *Why are the outcomes in patients with schizophrenia so poor?* J. Clin. Psychiat. 2014; 75(Suppl. 2): 20–24.
5. Millan MJ, Andrieux A, Bartzokis G, Cadenhead K, Dazzan P et al. *Altering the course of schizophrenia: progress and perspectives*. Nat. Rev. Drug Discov. 2016; 15(7): 485–515.
6. Cechnicki A, Hanuszkiewicz I, Polczyk R, Bielańska A et al. *The prospective assessment of the influence of duration of untreated psychosis (DUP) on the course of schizophrenia*. Psychiatr. Pol. 2010; 44(3): 381–394.
7. https://portal.abczdrowie.pl/pytania/nasilony-proces-psychotyczny-a-schizofrenia (retrieved: 23.08.2016).
8. http://www.schizofrenia.pl/forum/vt,51,25,44554,0 (retrieved: 23.08.2016).
9. Boonstra N, Wunderink L, Sytema S, Wiersma D. *Detection of psychosis by mental health care services; a naturalistic cohort study*. Clin. Pract. Epidemiol. Ment. Health. 2008; 4: 29.
10. Sato M. *Renaming schizophrenia: a Japanese perspective*. World Psychiatry 2006; 5(1): 53–55.
11. Omori A, Tateno A, Ideno T, Takahashi H, Kawashima Y, Takemura K et al. *Influence of contact with schizophrenia on implicit attitudes towards schizophrenia patients held by clinical residents*. BMC Psychiatry 2012; 12: 205.