Followup Studies of Schizophrenia:
A Comment

by Samuel B. Guze

Abstract

This set of articles provides a thoughtful and valuable review of the literature dealing with the findings and implications of long-term followup studies of patients receiving a diagnosis of schizophrenia. The results show clearly that if one starts with a psychotic disorder in a clear sensorium, the followup results may be quite variable. The articles provide, in addition, valuable discussions concerning methods, statistical analyses, and conceptual issues in followup studies.

Followup studies are carried out for a variety of reasons, but all of these may be subsumed under the concept of diagnosis. It is generally helpful in discussing diagnostic issues to review the basic purposes of diagnosis. First and last, diagnosis is necessary for communication. It provides the essential basis for comparison between or among studies. It permits us to compare our own clinical experiences to those of others. We need criteria that are as clear as possible and as explicit as possible, not only for comparison of clinical experiences, but for studies of epidemiology, etiology, response to treatment, long-term outcome, familial illness patterns, cost of long-term care, etc. The centrality of diagnosis within general medicine has led us to characterize a parallel emphasis in psychiatry as the “medical model.”

We have advocated this model for psychiatry because it requires only a few assumptions (though it carries many important implications) and does not need very elaborate inferences or abstractions to use it. The model is based largely on the distillation of general medical experience and practice. The current assumptions of the medical model are as follows: (1) While every individual is unique, whether sick or well, there are important common denominators to different illnesses, which need to be identified if medical progress is to take place. These common denominators are what we attempt to define by a diagnosis. (2) There are many different kinds of illnesses, each characterized by its own etiological, pathogenetic, epidemiological, and clinical features. However, different illnesses may share certain of these features. (3) Advances in medicine depend upon the development and progress of biological knowledge, including especially human biology.

The application of the model to psychiatric disorders is direct and unqualified. It assumes that what is true for general medical conditions is also true for psychiatric ones.

The principal problem with applying the medical model to psychiatric conditions is that, thus far, we know all too little concerning etiology and pathogenesis, and the neurobiological underpinnings of psychiatry are still rudimentary, even though recent developments offer promise and hope. The tremendous growth in the roles of the diagnostic laboratory and of radiology in the diagnostic process in general medicine have truly revolutionized the process. A parallel revolution has not yet taken place in psychiatry. Thus, the diagnostic process in this specialty must still depend primarily on the application of epidemiological principles to the study of course, response to treat-
ment, outcome, familial illness patterns, and other elements of what has been called clinical epidemiology.

It must be reemphasized that the most important reason for developing a reliable, consistent diagnostic system is its indispensable role in communication and teaching. We need a scheme for describing and comparing our experiences with those of others. We need a scheme for teaching our students. In each case, we are looking for ways to maximize the likelihood that we are all talking and thinking about similar clinical problems when we use certain diagnoses (or labels). If psychiatrists in St. Louis, Pittsburgh, Boston, Los Angeles, London, Stockholm, Paris, Moscow, and Delhi are all using the diagnosis of schizophrenia, we need to know what kinds of patients they are talking about and whether the patients so identified are similar to those we are seeing.

The Feighner criteria, the Research Diagnostic Criteria (RDC), and DSM-III, with all of their problems, were designed for just this purpose: to increase the likelihood that we are using diagnostic terms consistently. These criteria must and will evolve and change—one hopes, because of systematic studies rather than because of political debates. But the most useful and effective critiques of these criteria will require an understanding of the limitations of all medical classifications based as they typically are on incomplete and evolving knowledge concerning etiology and pathogenesis. Recognizing that even diagnoses based on gross and microscopic pathological studies may prove to be heterogeneous in etiology, as in the case of chronic renal failure or chronic hepatic inflammation, should prepare us to accept the possibility, if not the likelihood, that diagnoses based on a careful history and mental status examination will similarly prove to be heterogeneous.

Diagnosis is not a final goal; it is a process of systematic study of the patient integrated with the knowledge derived from systematic studies of other patients, designed to facilitate thinking and communication. The important question is always: "Given our state of knowledge, which is the best way to classify patients?" The answers to this question represent the various ways of validating classification. Those who challenge the underlying strategy of the criteria of Feighner et al., of the RDC, and of DSM-III have an obligation to propose alternate strategies and to show how the alternate strategies escape the criticisms expressed about these existing criteria.

We must always keep in mind that we are not primarily seeking a diagnostic classification that is aesthetically satisfying, though if we can achieve this at the same time that we improve our classification otherwise, all of us will be delighted. We want a scheme that makes a difference in the way we can communicate and that correlates with other important variables such as etiology, pathogenesis, treatment, outcome, and epidemiologic traits. As we learn more, our strategies will surely be modified, our diagnostic criteria and schemes will change, and our confidence will increase.

It may not be necessary to make the point for everyone, but it was not so very long ago that the entire enterprise of diagnosis and classification was viewed as marginally significant at best—if not downright retrogressive and anti-humanitarian. Many still resist the emphasis on diagnosis because they are not comfortable with the implications of such emphasis. If diagnosis is important and valid, it follows that we must take it into serious consideration when we focus on etiology, pathogenesis, treatment, and epidemiology. In other words, if we take diagnosis seriously, we find ourselves caught up in the central concerns of what we have called the "medical model"—even if some might prefer different terminology.

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