Section XII

ONSET AND COURSE

INTRODUCTION
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The literature on onset and course of schizophrenia is one of the most extensive in psychopathology, but it is poor on fact and rich in theory. The main thrust of this section of the volume is to winnow the fancy from the facts.

Onset: A widely held clinical impression has been that sudden onset leads to a poor outcome while gradual, insidious onset leads to a poor outcome. To test this impression, a survey of the world literature was conducted in 1961 by Zubin et al (1), and 177 studies were found that assessed type of onset clinically as either sudden or gradual. In each study, those with sudden onset had a superior outcome.

Indirect measures of type of onset based on premorbid personality assessment were obtained in 563 other studies in which the premorbid personality of the patients was assessed with regard to cyclothymic versus schizoid characteristics, psychosexual development, social and work history, interest in the environment, duration of illness prior to hospitalization, and presence of precipitating factors. The patients who had a good premorbid personality adjustment fared much better than those who had a poor premorbid adjustment in 531 out of the 563 studies. Only 21 studies showed a contrary trend, and 11 showed no decisive advantage in outcome for either the good or the poor premorbid patients.

The seeming advantage of sudden onset, predicting favorable outcome, has held true over the years despite the introduction of new therapies and changes in patient management. A recent study in the drug era by Gittelman-Klein and Klein (2) confirmed this finding for the premorbid schizoid (asocial) group, who fared poorly, but not for the nonschizoid (nonasocial) group whose outcome varied from very poor to very good. Why the good premorbid patients often improve while the poor premorbid patients do not, raises a fundamental question regarding the efficacy of therapy. By choosing good
premorbid patients for any new therapy, its efficacy can be made to appear quite high. Many therapies may have achieved early prominence by such a selection. If it is also true that good premorbid patients more often experience spontaneous improvement, this too may produce the impression of a higher efficacy than the treatment warrants.

If we were to choose candidates for canonization into laws among the generalizations in psychopathology, the law that sudden onset leads to good outcome while gradual onset leads to poor outcome, and the law that good premorbid patients improve while poor premorbid patients do not, would rank high. However, determining the type of onset retrospectively is very difficult; identification of valid prospective clues appears to be even more elusive. It requires detailed knowledge of early school adjustment, family relationships, type and quality of adolescent friendship patterns, work history, including first jobs during vacation periods, and social and psychosexual adjustment. Sudden versus insidious changes in these variables ought to be apparent before the illness is diagnosed. One example of an attempt at finding indications of insidious onset was the study of friendship patterns in early adolescence (13-14 year olds) by Kreisman (3). She found, in a retrospective study, that there was little behavioral difference between the preschizophrenics and their normal controls in sociability as measured by overt participation in friendship relationships. However, they differed significantly in their feelings about friendship, e.g., feelings of loneliness and satisfaction with regard to friendship and intimacy. Apparently, before overt signs of schizophrenia appeared, some of the preschizophrenics evinced experiential precursors of the later clinical episode.

Outcome: One of the results of a survey of follow-up studies by Staudt and Zubin (4) concluded that up to the drug era, when mere release from the hospital was a significant outcome, the results indicated that about one-third of the patients seemed to improve, one-third remained unchanged, and one-third deteriorated. This generalization is another candidate for canonization as a law. The only change that has occurred since the drug era is that the middle third can now be released; it is this group that turned our formerly custodial institutions into “revolving-door hospitals.”

We were puzzled by the ubiquity of the \( \frac{1}{3} - \frac{1}{3} - \frac{1}{3} \) law and tried to find some explanation for it. One explanation leans on the possibility that the law does not reflect outcome as much as it reflects human judgment when faced with the uncertainty engendered by a classification task without specified objective criteria. Two extreme groups can always be selected, leaving a residual group in the middle. Windle (5) has pointed out that if the initial and final assessment of the patient has a reliability of 0.57, it follows, through statistical regression, that about one-third would shift from a lower to a higher level (improve). Following this reasoning, it may be possible to demonstrate that one-third would shift downward (deteriorate), and one-third would remain in the middle (unchanged).

The need for developing objective criteria for measuring improvement is paramount. The evaluation of outcome in the past has been made largely by the judgment of the clinician, by the patient, by the family, by important others, by society, especially with regard to employability and social acceptance, and by the after-care provided by the delivery system of health services. These judgments are not the most unbiased, do not always coincide, and may not be linearly related. The development of an integrated approach across these factors for assessing outcome is a dire necessity. Instead of appealing to multiple regression methods which depend upon such assumptions as linear rela-
tionships, we may find that it is more useful to apply typological analyses in which the patterning across these factors is sought.

These are some of the challenges we face, and at least some of these problems are clarified in this volume.

REFERENCES
