

Political Change and Course of Affective Psychoses: Berlin 1989-90

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Abstract. In this study, the political change associated with the fall of the Berlin Wall in November 1989 was examined as a shared life event for the population of West Berlin. Its influence on the course of affective psychoses was studied in 67 patients in long-term treatment. Recurrences from November 1989 to March 1990 were compared with the same period 1 year before. While patients with bipolar affective psychosis did not show a difference in recurrences between the two periods, patients with unipolar depression had a significantly better and those with schizoaffective psychosis a significantly worse course of illness after November 1989 than in the year before.

Key Words. Affective disorders, political change, life event, morbidity index.

Although the effect of life events on the course of affective psychoses is believed to be limited (Paykel, 1978, 1983; Katschnig, 1986; Wittchen, 1987; Sclare and Creed, 1990), it has repeatedly been shown that stress factors in general and life events in particular may influence the onset (Patrick et al., 1978; Glassner and Haldipur, 1983; Bidzinska, 1984; Ambelas, 1987) and the course (Paykel and Tanner, 1976; Murphy, 1983; Billings and Moos, 1985; Monroe et al., 1983; Ghaziuddin et al., 1990) of affective psychoses. In this study, the political change in 1989 and its social consequences were regarded as a shared life event for the population of West Berlin. On November 9, 1989, the Berlin Wall was opened. That change came unpredictably, or was at least surprisingly sudden, for most people in West Berlin. People were affected by favorable as well as unfavorable consequences in different ways and viewed them differently.

From the opening of the Berlin Wall, West Berlin was far more crowded than before, with—on some days—hundreds of thousands of visitors from East Germany. Many West Berliners went to the Wall and to East Berlin to get an impression, and take advantage, of the ongoing changes. Potentials and dangers of the new situation were the subject of most public and private discussions. We investigated the way in which that change affected the course of illness in patients who were in long-term treatment for an affective psychosis.

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Methods

The study was carried out in the lithium clinic of the Freie Universität Berlin (Müller-Oerlinghausen et al., 1990). We studied a sample of 67 patients who had a diagnosis of schizoaffective, bipolar affective, or unipolar depressive disorder according to *ICD-9* (World Health Organization, 1978), had a routine appointment in the lithium clinic between the middle of March and beginning of April 1990, and had continuously been in treatment at the lithium clinic since October 1988. There were no other selection criteria.

The course of illness was assessed by a modification of the "morbidity index," originally proposed by Coppen et al. (1973; Priebe et al., 1989). The index reflects the severity and length of recurrences (number of days spent in the hospital multiplied by 3, plus all days on which a temporary antidepressant or neuroleptic medication in addition to lithium or carbamazepine was given multiplied by 2, and then divided by the number of days of the observation period). The morbidity index was calculated for 4 months after November 9, 1989, and for the same time period 1 year before. Morbidity indices for the two time periods were compared for each diagnostic subgroup.

In addition, patients were asked on a 10-item questionnaire about their views of the change and of its effect on their personal lives.

Results

ICD-9 psychiatric diagnoses were as follows: 22 patients had a schizoaffective psychosis (11 females, 11 males), 25 patients a bipolar affective psychosis (14 females, 11 males), and 20 patients a unipolar depressive disorder (15 females, 5 males). Table 1 summarizes age, duration of illness, and number of previous hospitalizations in each group.

Patients with a unipolar depressive disorder were significantly older than patients with bipolar affective ($t = 3.83$, $df = 41$, $p < 0.001$) or schizoaffective psychoses ($t = 6.07$, $df = 38$, $p < 0.001$). Other differences between the three groups were not statistically significant.

Table 1. Age, duration of illness, and number of hospitalizations in diagnostic subgroups

	Unipolar depressive psychosis ($n = 20$)		Schizoaffective psychosis ($n = 22$)		Bipolar affective psychosis ($n = 25$)	
	Mean	SD	Mean	SD	Mean	SD
Age (yr)	63.7	9.3	42.3	13.3	49.8	14.9
Duration of illness (yr)	20.3	13.5	13.9	8.2	17.1	11.7
Hospitalizations	4.8	3.6	6.3	3.8	4.8	3.4

Table 2 shows morbidity indices for the 4 months after November 9, 1989, and the same period in 1988-89.

Morbidity indices for the two time periods do not differ significantly in the whole sample or in patients with bipolar affective psychosis. However, in 1989-90, patients with a schizoaffective psychosis had a morbidity index five times higher than a year before. The opposite tendency was seen in patients with unipolar depressive disorder: the morbidity index in 1989-90 was just a third of what it had been 1 year before. The

differences in patients with schizoaffective psychosis and in those with unipolar depressive psychosis were statistically significant.

In the group of patients with a schizoaffective psychosis, frequency of relapses leading to a hospital admission changed from three in 1988-89 to seven in 1989-90, and in patients with unipolar depressive disorders from five in 1988-89 to only one in 1989-90. In patients with a bipolar affective psychosis, there were four hospital admissions in each period. In those patients who received prophylactic lithium or carbamazepine, serum levels did not differ significantly between the two periods. Most patients expressed positive subjective views of the political change on the questionnaire, and there were no significant differences between the diagnostic subgroups. Regardless of diagnosis, those patients who had a higher morbidity index in 1989-90 than in 1988-89 more often stated that their lives were still affected by the political change ($\chi^2 = 8.33$, $df = 1$, $p < 0.01$).

Table 2. Morbidity indices for the 2 time periods (November 1989-March 1990 and November 1988-March 1989) in diagnostic subgroups

	1989-90		1988-89		<i>p</i>
	Mean	SD	Mean	SD	
Schizoaffective psychosis (<i>n</i> = 22)	0.55	0.74	0.10	0.22	< 0.05 (<i>t</i> = 2.65, <i>df</i> = 21) ¹
Bipolar affective psychosis (<i>n</i> = 25)	0.48	0.75	0.39	0.66	NS
Unipolar depressive psychosis (<i>n</i> = 20)	0.16	0.48	0.55	0.81	< 0.05 (<i>t</i> = 2.11, <i>df</i> = 19)

1. All *t* tests were 2-tailed.

Discussion

To study the possible influence of political change on the course of affective psychoses, we compared the morbidity index after the change with the index for the same period the year before. This method has some methodological problems. In particular, the effect of spontaneous changes in the course of illness cannot be controlled. However, since treatment variables were consistent during the two periods of time and differences in morbidity indices were statistically significant, the findings suggest some influence of political change on the course of illness in the sample examined here. It remains open whether even clearer differences would have been found had shorter or longer observation periods after November 9, 1989, been analyzed. Yet, it should be taken into account that the sample is highly selective, that the diagnostic subgroups are small, and that prophylactic lithium or carbamazepine could have affected liability to relapse. On average, patients with bipolar affective psychosis did not show a different course of illness than in the year before. However, the events in Berlin 1989-90 seem to have had opposite effects on patients with schizoaffective psychosis vs. those with unipolar depressive disorder. Although the two groups did not differ in their subjective views of the events as assessed retrospectively on a brief questionnaire, one may speculate as to whether the depressive patients were affected by an—at that time—elated and partly euphoric

mood in West Berlin and by a generally rather stimulating atmosphere. In contrast to unipolar depressive patients, patients with schizoaffective psychosis may have experienced feelings of insecurity and irritation as a result of the changed and uncertain situation associated with many negative prospects for living conditions in West Berlin as well as with positive ones.

The opening of the Berlin Wall was an event that was entirely outside the patients' control and independent of their illnesses. Obviously, the possible association of political change and course of affective psychoses suggested in this study arose under special historical circumstances and cannot be generalized to other situations of political change.

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