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Conceptual Development of Current Psychiatric Nosology

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Nosology in Development

A Re-evaluation of Diagnostic Concepts

Introduction

Modern psychopharmacology was triggered by the demonstration of the therapeutic effects of lithium urea in mania by Cade (1949), chlorpromazine in schizophrenia by Delay, Deniker and Hare (1952), imipramine by Kuhn (1957) and chlordiazepoxide by Hines (1960). With progress of psychopharmacology, a rapidly growing number of psychoactive drugs have been synthesized. In spite of their increasingly better defined pharmacodynamic actions, however, none of the new drugs offer major advantages in treatment over the old ones, and all of the new drugs display similar pharmacological profiles to the "parent substances" developed between 1949 and 1960. Accordingly, all of the new drugs belong to one of four major pharmacologic class, i.e., mood stabilizers, neuroleptics (or antipsychotics), antidepressants and anxiolytics.

Clinical psychopharmacologic research, directed to identify treatment responsive populations to the new psychotropic drugs, focused attention on the biologic heterogeneity of patients -- in terms of responsiveness to pharmacologic agents -- within the traditional diagnostic categories. For a long period, however, this was overshadowed by the recognition that the therapeutic action of psychotropic drugs is intrinsically linked to their effect on "neuronal transmission," i.e., "conduction of impulses" at the "synaptic cleft" (Brodie, 1959, 1960). Because of this it was not before the late 1960s that it was acknowledged (Ban, 1969) that psychopharmacology, by the development of psychotropic drugs with differential action on the "processing of experience," has provided a suitable means, and a heuristically important new frame of reference, for the re-evaluation of traditional diagnostic concepts and classification of psychiatric disorders.

Since the early 1970s clinical psychopharmacology has played an important role in the re-examination of "nosologic systems" (Cole, Freedman and Friedhoff, 1973). In the course of this re-evaluation, the boundaries of three distinctive classes of psychiatric populations have emerged. Of them, one, "neuropsychiatric disorders," is characterized, by "pathology in the reception of experience," another, "sui generis psychiatric disorders," by "pathology in the processing experience," and the third, "personality disorders," by "abnormal responses to experience." Psychotropic drugs, in spite of their extensive use, only in one of the three classes of diagnoses i.e., "sui generis psychiatric disorders," have shown verified therapeutic effects. In the other two "classes," i.e., "neuropsychiatric disorders" and "personality disorders," psychotropic drugs have no demonstrable clinical-therapeutic action, although in one, i.e., "neuropsychiatric disorders," they may produce favorable changes during episodes, in which syndromes of "sui generis psychiatric disorders, "characterized by "pathology of processing experience," are displayed and superimposed on the "neuropathologic process."

In the following the "ontology" of "psychiatric disorders" will be outlined; characteristic features of the three major classes of "psychiatric disorders" and their respective diagnostic categories will be described; and the basic principles of a proposed new classification will be discussed.

Ontology of Psychiatric Disorders

Recognition of the three major distinct classes of "psychiatric disorders" followed a historical sequence; "neuropsychiatric disorders" based on an identifiable "neuropathological process" were recognized first, and "sui generis psychiatric disorders" based on an identifiable psychopathologic process, " and "personality disorders," based on "anomalies of development," were recognized only (in this order), considerably later.

Neuropsychiatric Disorders

The origin of our present diagnostic concept of "neuropsychiatric disorders" is in Bayle's inaugural thesis, “Recherche sur les Maladies Mentales,” he defended in 1822. Stimulated by Morgagni's (1761) attempt to correlate postmortem findings in the brains with clinical manifestations in former mental patients, Bayle (1822) described his observation that chronic arachnoiditis, seen in general paralysis may lead to "dementia," a general decline of mental -- primarily intellectual -- faculties, in the terminal (third) stage of its development. The initial observation was further substantiated by Bayle himself in the case histories of this classic text, entitled *Traite des Maladies du Cerveau et de ses Membrane*, published in 1826, and confirmed by Calmeil in his monograph DE *La Paralysie Consideree chez les Alienes*, in the same year.

Dementia Syndrome

Bayle's (1822, 1826) work opened the path for the recognition that any disease, regardless of etiology, which is based on a chronic, identifiable morbid "neuropathologic process," such as "Huntington's chorea" (Huntington, 1872), Pick's disease (Pick, 1892), "Alzheimer's disease" (Alzheimer, 1907), "Kraepelin's disease" (Kraepelin, 1912) and "Jakob-Creutzfeldt's disease" (Creutzfeldt, 1920; Jacob, 1920), by producing "pathology in the reception of experience," may lead to gradually increasing "dedifferentiation," reduction of mentation, that becomes manifest in "dementia," a non-specific "personality (intellectual) deterioration." Although clinical manifestations in the early stages of "neuropsychiatric disorders" depend on the sites of, and structures affected by the "neuropathologic process," in the later stages, with the progress of the disease, the clinical picture becomes "non-specific," leading to "performance changes" (decreases) with "secondary effects" in "adaptive behavior."

In support of the "non-specific "nature of the "personality (intellectual) deterioration" in "neuropsychiatric (or "secondary psychiatric) disorders" are the findings that the "dementia syndrome" is encountered in more than 150 different disorders (Koranyi, 1988) and in at least 10 different classes of disorders, such as "degenerative," "vascular," "ayelinoclastic," "traumatic, hydrocephalic," "inflammatory," "infectious," "neoplastic," "toxic" and "metabolic" (Cummings, 1987). Among the different etiologies the most frequent is Alzheimer's disease, representing 50-60% of the total population. It is followed by multi-infarct dementia, representing 10-20% and drug-induced dementia representing approximately 10% (Thal, 1988). By the introduction of "causal treatment" for "pellagra" and "cerebral syphilis," the "dementia syndrome" induced by these disorders is virtually eliminated in all civilized countries. On the other hand, the dementia induced by "renal dialysis," first described by Alfrey, LeGendre and Kachny (1976), and especially the dementia-induced by AIDS, described independently by Ho et al. (1985) in the *New England Journal of Medicine* and by Shaw et al. (1985) in *Science*, are in the ascent.

The contention that "neuropsychiatric disorders" in general and the "dementia syndrome" in particular is the result of "pathology in the reception of experience" corresponds with the traditional view that "acquired, organic dementia" which differs from "congenital feeble-mindedness" and "schizophrenic defect" is the outcome of an "organic (neuropathological) process" which "destroys, in a far-reaching manner, the preconditions of intelligence." In the course of this "process," patients display a great variety

of "psychopathological symptoms." However, they are displayed in a "haphazard sequence in the different stages of "disease development," in the absence of a "psychopathologic process." Furthermore, they do not crystallize into increasingly differentiated, distinct psychiatric syndromes or follow any predetermined "pattern" in sequence. Because of this, in "dementia" it is not the pathology of the "subjective phenomena of psychic life" (subsumed under "phenomenology"), but the pathology of the "objective performances of psychic life" (subsumed under "performance psychology") which plays the primary role in the diagnostic process (Jaspers, 1913).

Amnestic Syndrome and Presbyophrenia

In addition to "dementia," there are two other non-specific syndromes, the "amnestic syndrome" and subsumed under "neuropsychiatric disorders": presbyophrenia. "Similar to "dementia," both the "amnestic syndrome" and "presbyophrenia" are the result of an "organic (neuropathologic) process" which, by the "pathology in the reception of experience" becomes manifest in "performance changes" (decreases) with "secondary effects" in "adaptive behavior." In contradistinction to "dementia," however, in both the "amnestic syndrome" and "presbyophrenia," the "organic process" destroys in a selective manner the preconditions of "memory," while leaving the preconditions of "intelligence" virtually unimpaired.

The origin of the diagnostic concept of the "amnestic syndrome" is in Korsakoff's description of a "polyneurotic psychosis" in alcoholics in 1887; whereas the origin of the diagnostic concept of "presbyophrenia" is in Wernicke's description of a selective memory disturbance in elderly patients in 1990. Of the two, Korsakoff's (1887) "amnestic syndrome" is characterized by impairment of "registration" and/or "consolidation of memory" with "allopsychic (i.e., space and time) "disorientation" and "confabulations," which is possibly the result of "tramline thinking" according to Fish (1967); whereas Wernicke's (1900) "presbyophrenia" is characterized by a selective impairment of "recent memory," due to an impairment of "registration" using Wernicke's (1900) own terminology. Both Korsakoff's (1887) "amnestic syndrome" and Wernicke's (1900) "presbyophrenia" were conceptualized at the time of their inception in terms of Sechenov's (1863) reflexology, but only in case of the "amnestic syndrome," usually associated with "loss of spontaneity" and "lack of insight" (Nyiro, 1962), did anatomical studies (at a much later date) show that lesions of the mammillary bodies and the dorsomedial thalamic nuclei (Victor, Talland and Adams, 1959; Victor, Adams and Collins, 1971), due to thiamine deficiency, interrupt a neuronal circuit (a "reflex arc"), involved in the "consolidation of memory" (Pichot, 1983). Probably even more important is, that only in case of the "amnestic syndrome" and not in case of "presbyophrenia" is there evidence for an "abnormality of transketalose," a thiamine regulating enzyme (Blass and Gibson, 1977). Would the findings of an inborn abnormality of the "transketolase" enzyme in patients with the "amnestic syndrome" be supported by further evidence, it would explain why only some patients display the "amnestic syndrome," in case of absolute or relative thiamine deficiency, regardless whether it induced by dietary changes or toxic agents, including alcoholism (Ban, 1980).

Sui Generis Psychiatric Disorders

While the origin of our present diagnostic concept of "neuropsychiatric disorders" is in the work of Bayle (1922), the origin of the conceptual development which led to our current diagnostic classification of "sui generis psychiatric disorders" (or simply "psychiatric disorders") is in Griesinger's classic text, *Die Pathologie und Therapie der Psychischen Krankheiten*, published in 1845; and in Griesinger's (1845) original formulation of the concept of "Einheitpsychose" or "unitary psychosis."

Stimulated by Feuchtersleben (1845) who firmly believed that "every mental disorder implies the existence of a disease of the nervous system," Griesinger (1845) maintained that "psychoses," using Feuchtersleben's (1845) term for "mental disorders," are "diseases of the brain" (Ban, 1964). Accordingly,

while adopting with some modifications Esquirol's (1838) "syndromic classification," he put forward the notion that the "different kinds of emotional states" (syndromes) are "different stages of an (undetectable) pathologic process," and as such share common properties with "neuropsychiatric disorders" in which the "neuropathologic process" can be identified (Table I).

While Griesinger's (1845) contention that all mental disorders are based on a "neuropathologic process," which in the terminal stage of its development lead to "dementia," a state of "dedifferentiation, " was not borne out by evidence, his diagnostic concept of "unitary psychosis," based on Bayle's (1822) concept of "neuropsychiatric disorders," provided the necessary frame of reference to trigger the separation of a class of "psychiatric disorders," referred to as "sul generis psychiatric disorders," and for the identification of five distinct disease categories within "sui generis psychiatric disorders."

Common Characteristics

Sui generis (or primary) psychiatric disorders, in contradistinction to "neuropsychiatric disorders," are based on a "morbid psychopathologic process" which becomes manifest in the "patterns generated" by "pathology of processing experience." Considering that the generation of "pathologic forms of experience" continues throughout the different "developmental stages" of the "disease," the specific differences in the "pathology of processing experience" in the different disorders, are expressed by increasingly differentiated "clinical syndromes" ("end-states") based on the "determining structure" of each "sui generis psychiatric disease." Or in other words, in "sui generis psychiatric disorders" specific differences in the "pathology of experience" yield to gradually increasing differentiation that becomes manifest in distinct "forms" and "subforms" of "mental disease"; whereas in "neuropsychiatric disorders," the "pathology in the reception of experience," regardless of the etiology of the disease, yields to increasing "dedifferentiation," reduction of mentation, which becomes manifest in "dementia," a non-specific "personality (intellectual) deterioration. "Accordingly, while in the diagnosis of "dementia" it is the pathology in the "objective performances of psychic life which plays the decisive role, in the diagnosis of "sui generis psychiatric disorders," it is the pathology of the "subjective phenomena of psychic life," i.e., phenomenology (Jaspers, 1913). Because of this, the diagnosis of "sui generis psychiatric disorders" is based on the formal characteristics" of the "psychopathologic process" and not on the "contents" expressed in "social behavior" and "life events."

Specific Characteristics

Separation of "sui generis psychiatric disorders" from the "neuropsychiatric disorders" began with the description of "demence precoce" by Morel (1852) which was followed by the description of "delire de persecution" by Lasegue (1852), "folie circulaire" by Falret (1854), "1'hysterie" by Briquet (1859), and "bouffee delirante" by Magnan (1893). Each of these five disorders is characterized by a distinct "determining structure" and represent a distinct "pathology of processing experience.

Table I

Esquirol 1838		Griesinger 1845
General Forms of Insanity		States
1st	Lypemania or Melancholia of the Ancient	States of Mental Depression - Melancholia A. Hypochondriasis B. Melancholia C. Melancholia with Stupor D. Melancholia with Destructive Tendencies a. Melancholia with Suicidal Tendencies b. Melancholia with Destructive Murderous Tendencies E. Melancholia with Persistent Excitement of the Will
2nd	Monomania	States of Mental Exaltation A. Mania B. Monomania
3rd	Mania	
4th	Dementia	States of Mental Weakness A. Chronic Mania B. Dementia C. Apathetic Dementia D. Idiocy and Cretinism a. Idiocy b. Endemic cretinism
5th	Imbecility or Idiocy	

Esquirol's (1838) five "general forms of insanity" and the corresponding "states of mental depression," "mental exaltation" and "mental weakness" in Griesinger's (1845) classification in which the different "states" are considered to be as different developmental stages of the pathologic process.

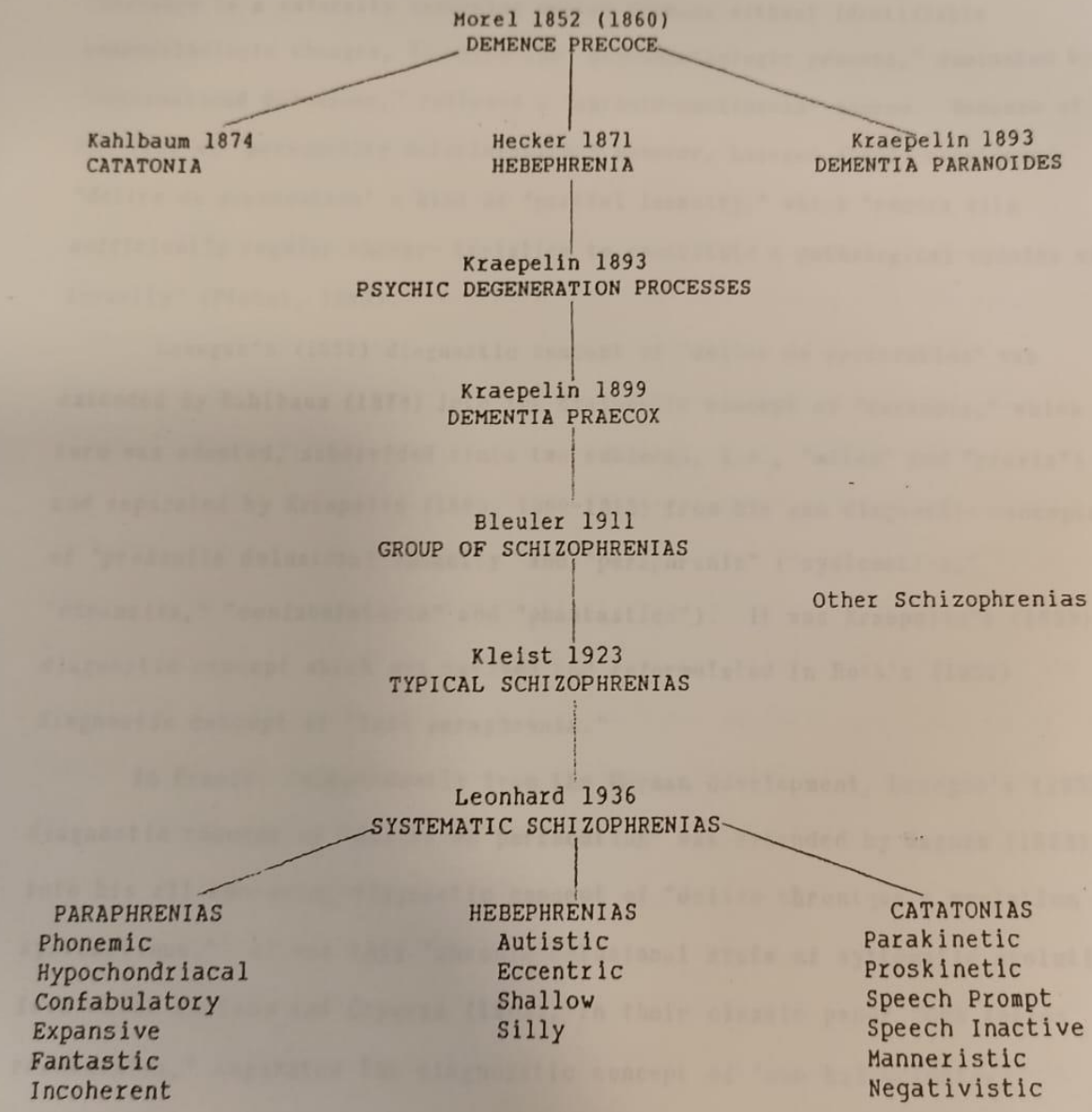
From Morel's Demence Precoce

The origin of the first diagnostic category within the "sui generis psychiatric disorders" was in Morel's diagnostic concept of "demence precoce" he first recognized and described in his *Etude Clininques* in 1852 (although the term "demence precoce" was first used in his *Traite des Maladies Mentales* published in 1960). He used the term in reference to a naturally occurring mental illness in which the psychopathologic process without identifiable neuropathologic changes resulted in a syndrome that resembled the "dementia syndrome" of "neuropsychiatric disorders."

In subsequent years several other somewhat similar illnesses were described, such as for example, "hebephrenia" by Hecker in 1871, "catatonia" by Kahlbaum in 1874 and "dementia paranoides" by Kraepelin in 1893, in which a psychopathologic process, without identifiable neuropathologic changes, resulted in a syndrome that resembled the "organic dementias," in terms of "personality deterioration," i.e., deterioration of "thinking," "feelings" and "behavior," but differed from the "organic dementias," by the virtual lack of impairment of "memory" and "intellect." The three syndromes were pooled together by Kraepelin first under the diagnostic concept of "psychic degeneration processes" in 1893; a term, he replaced by the term "dementia praecox" in 1899. The diagnostic concept of "dementia praecox" was expanded and the term "dementia praecox" replaced by the term "schizophrenia," or the "group of schizophrenias" by Bleuler in 1911; and it was from this heterogeneous population that Kleist, in 1923, separated a group of illnesses, he referred to as "typical schizophrenias." Kleist's (1923) diagnostic concept was further elaborated by Leonhard, who, in 1936, replaced the term "typical schizophrenias by the term "systematic schizophrenias."

On the basis of their "determining structure," Leonhard (1936) characterized "systematic schizophrenias" as "simple" (monomorphous) diseases with an "insidious onset" and "chronic-continuous course" that leads to highly differentiated "end-states" ("clinical defect"); and on the basis of the "pathology of processing experience" he distinguished within the "systematic schizophrenias" three major forms of disorders, i.e., "paraphrenias," "hebephrenias" and "catatonias," with 16 "subforms," i.e., six paraphrenic" ("phonemic," "hypochondriacal," "confabulatory," "expansive," "fantastic" and "incoherent"), four "hebephrenic" ("autistic," "eccentric," "shallow" and "silly") and six "catatonic" ("parakinetic," "proskinetic," "speech prompt," "speech inactive," "manneristic" and "negativistic") (Table II). Considering that each of these "end-states" is distinct and can be differentiated from the others, one has to accept the fact that "personality deterioration" is associated with increasing "differentiation" in the "systematic schizophrenias." In this respect, "systematic schizophrenias" differ from the "organic dementias."

Table II



From Morel's (1852, 1860) "dementia precoce" to Leonhard's (1936, 1957) "systematic schizophrenias."

From Lasegue's Delire de Persecution

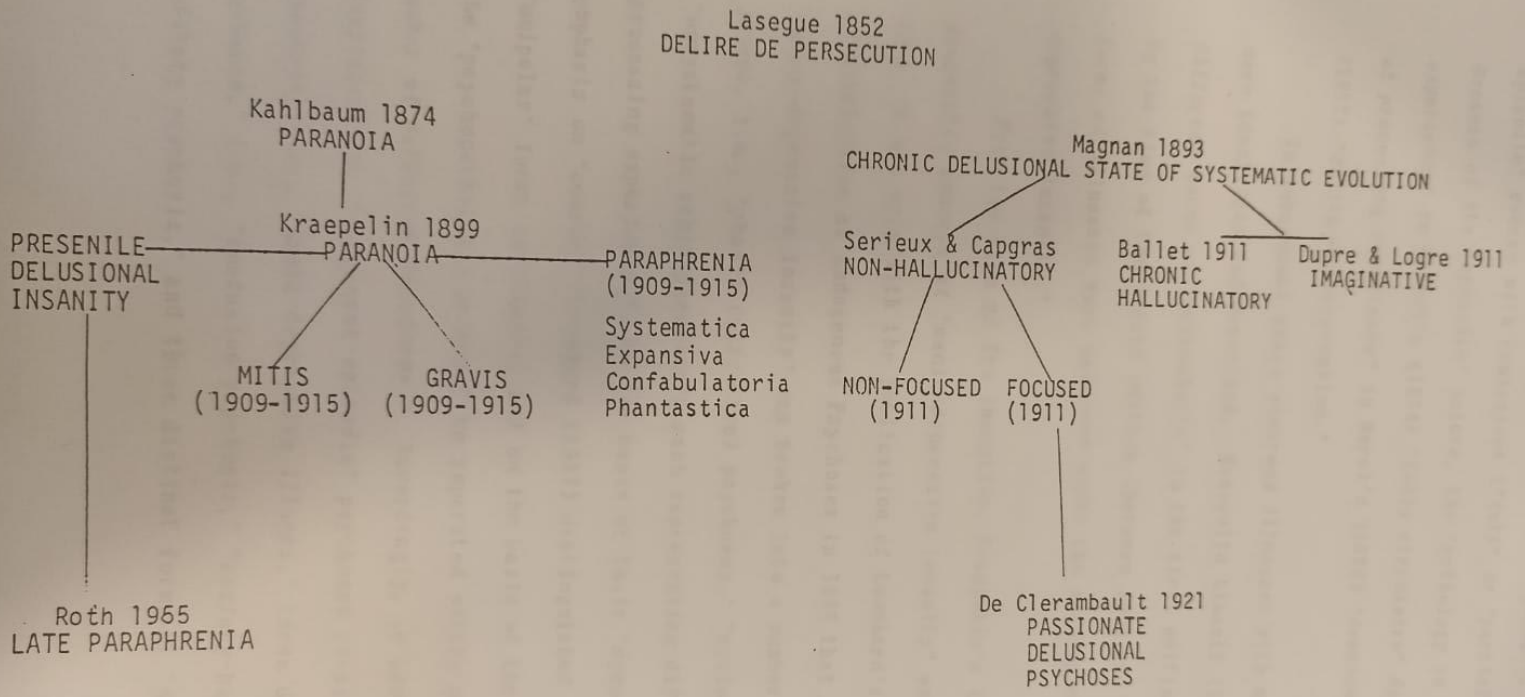
The origin of the second diagnostic category within the "sui generis psychiatric disorders" was in Lasegue's diagnostic concept, he first described in his paper *Du Delire de Persecution*, published in 1852. He used the term in reference to a naturally occurring mental illness without identifiable neuropathologic changes, in which the "psychopathologic process," dominated by "systematized delusions," followed a "chronic-continuous" course. Because of the lack of "personality deterioration," however, Lasegue (1852) considered "delire de persecution" a kind of "partial insanity" which "recurs with sufficiently regular characteristics to constitute a pathological species of insanity" (Pichot, 1983).

Lasegue's (1852) diagnostic concept of "delire de persecution" was extended by Kahlbaum (1874) into the diagnostic concept of "paranoia," which in turn was adopted, subdivided (into two subforms, i.e., "mitis" and "gravis") and separated by Kraepelin (1899, 1909-1915) from his own diagnostic concepts of "presenile delusional insanity" and "paraphrenia" ("systematica," "expansiva," "confabulatoria" and "phantastica"). It was Kraepelin's (1899) diagnostic concept which was revived and reformulated in Roth's (1955) diagnostic concept of "late paraphrenia."

In France, independently from the German development, Lasegue's (1852) diagnostic concept of "delire de persecution" was extended by Magnan (1893) into his all-embracing diagnostic concept of "delire chronique an evolution systematique." It was this "chronic delusional state of systematic evolution" from which Serieux and Capgras (1909), in their classic paper *Les Folies Resonnantes* separated the diagnostic concept of "non-hallucinatory interpretative delusional psychoses," corresponding extent with Kahlbaum's (1874) diagnostic concept of "paranoia"; Ballet (1911) separated the diagnostic concept of "la psychose hallucinatoire chronique," or "chronic hallucinatory psychosis," corresponding with Kraepelin's (1909-1915) diagnostic concept of "paraphrenia"; and Dupre and Logre (1911) separated the diagnostic concept, "les delires d'imagination," i.e., "chronic imaginative psychosis." Finally, in their follow-up publication, entitled *Le Delire Interpretation et la Folie Systematisee*, Serleux and Capgras (1911) distinguished within "non-hallucinatory interpretative delusional psychoses" two subforms, i.e., "non-focused" and "focused" (Pichot, 1983), of which the latter was subsumed by de Clerambault under the diagnostic concept of "psychoses passionnelles" or "passionate delusional psychoses in 1921 (Table III).

In the ultimate analysis, "chronic delusional disorders," regardless whether derived by the German ("paranoia" and "paraphrenia") or the French ("non-hallucinatory interpretative delusional psychoses," "passionate delusional psychoses," "chronic hallucinatory delusional psychoses" and "imaginative delusional psychoses") psychiatric schools, differ from the "systematic schizophrenias," by their "determining structure," and "disease patterns" generated by the "psychopathologic process." In the majority of these disorders, "logical" ("non-bizarre") and "organized" ("systematized") "delusions" are the prevalent features, while pathologies of "emotions" and "volition" are mild, if present at all. Because of this, and the lack of "personality deterioration," the "pathology in the processing experience" is less pervasive (i.e., more restricted) in the "chronic delusional psychoses," than in the "systematic schizophrenias."

Table III



From Lasegue's "delire de persecution" to the diagnostic concepts of "chronic delusional psychoses" in the German (and English) and French psychiatric schools.

From Falret's Folie Circulaire

The origin of the third diagnostic category within the "sui generis psychiatric disorders" was in Falret's diagnostic concept, he first described in his thesis *De la Folie Circulaire* in 1854; and in Baillarger's presentation "de la folie a double forme" in the same year. Folle circulaire refers to a same naturally occurring mental illness in which the "psychopathologic" process, without identifiable morphologic changes, follows a "discontinuous-episodic course with remissions ("full" or "partial") between episodes. Because of its "episodic" nature, the "pathology in the processing of experience" in Falret's (1854) "folie circulaire" differs from the "pathology of processing experience" in Morel's (1852) "demence precoce" and Lasegue's (1852) "delire de persecution."

In subsequent years numerous illnesses with a recurrent episodic course were identified and described. Kraepelin himself (1883) described six different forms of "melancholia" in the first edition of his text book. However, by the time of the eighth edition (between 1909 and 1915), all these different forms of illnesses were subsumed under the nosological category of "manic-depressive insanity."

From the time of its inception, Kraepelin's (1909-1915) unitary diagnostic concept of "manic-depressive insanity" was questioned. In spite of this, it was only with the publication of Leonhard's monograph on *The Classification of Endogenous Psychoses* in 1957 that the diagnostic concept of "manic-depressive insanity" was broken into a number of different diagnostic groups, i.e., "phasic (affective) psychoses," "cycloid (mixed) psychoses" and "unsystematic schizophrenias"; each representing different "pathologies in the processing experience." On the basis of their "dynamic totality," with special emphasis on "course," Leonhard (1957) distinguished between "bipolar" and "unipolar" forms of illness; and on the basis of the "patterns" generated by the "psychopathologic process" he separated within each "form" of illness a number of different "subforms." Accordingly, in Leonhard's (1957) classification, "recurrent-episodic" psychoses consists of seven bipolar disorders, i.e., "manic-depressive illness," three distinct forms of "cycloid psychoses," i.e., "confusion psychosis," "anxiety-happiness psychosis" and "motility psychosis," and three distinct forms of "unsystematic schizophrenias, i.e., "cataphasia," "affect-laden paraphrenia" and "periodic catatonia"; and 12 unipolar disorders," i.e., "pure melancholia," "pure mania," five subforms of "pure depression" ("harried," "hypochondriacal," "self-torturing," "suspicious" and "non-participatory") and five subforms of "pure euphoria" ("unproductive," "hypochondriacal," "enthusiastic," "confabulatory" and "non-participatory") (Table IV).

Table IV

Phasic Psychoses			Cycloid Psychoses	Unsystematic Schizophrenias
Unipolar		Bipolar	Bipolar	Bipolar
Pure Mania	Pure Melancholia	Manic-depressive Illness	Confusion Psychosis	Cataphasia
Pure Euphorias	Pure Depressions		Anxiety-happiness Psychosis	Affect-laden Paraphrenia
Unproductive	Harried		Motility Psychosis	Periodic Catatonia
Hypochondriacal	Hypochondriacal			
Enthusiastic	Self-torturing			
Confabulatory	Suspicious			
Non-participatory	Non-participatory			

Leonhard's (1957) classification of "recurrent-episodic" psychoses.

From Briquet's L'Hysterie

The origin of the fourth diagnostic category within the "sui generis psychiatric disorders" was in Briquet's diagnostic concept, first described in his monograph, *Traite Clinique et Therapeutique a L'hysterie*, published in 1859. Derived by a meticulous analysis of 430 cases, "l'hysterie" refers to a naturally occurring "mental illness" in which the "psychopathologic process," without identifiable "neuropathologic changes," produces "selective pathology in the processing of experience."

In subsequent years, at least three groups of illnesses with a "selective pathology in the processing of experience" were identified. Instrumental in their conceptual development were classic papers such as Benedict's *Uber Platzschwindel*, published in 1870; Westphal's *Uber Zwangsvorstellungen*, published in 1878; and Purtell, Robins and Cohen's *Observation on Clinical Aspects of Hysteria*, published in 1951. It was Benedict's (1870) description of "agoraphobia" which opened the path for the separation of "phobic disorders," characterized by "anxiety attacks," which are triggered and "circumscribed" in both, "time" and "content," from "panic disorders" (including the "depersonalization-derealization syndrome"), characterized by "anxiety attacks," which are "spontaneous" and "circumscribed" only in "time"; and the separation of "monophobic" and "polyphobic" disorders from "agoraphobia." Similarly, it was Westphal's (1878) description of "obsessional states," which led to our current diagnostic concept of "obsessive-compulsive disorder"; and it was Guze's (1967) redefinition of "hysteria," triggered by Purtell, Robins and Cohen's (1951) publication, which led to our current diagnostic concept of "somatization disorder" which includes "conversion disorder" (conventionally referred to as "hysteria").

While the three groups of "disorders," i.e., "anxiety" ("panic" and "phobic") disorders," "obsessive-compulsive disorder" and "somatization disorder" differ in the "patterns generated" by the "psychopathologic process, they share a common basis in the "selectiveness" of the "pathology in the processing experience." Because of this, they are distinct from the "first," "second" and "third" categories of "sui generis psychiatric disorders" which are characterized respectively by "continuous," "restricted" and "episodic" pathology in the processing of experience" (Table V).

Table V

Briquet 1859
L'HYSTERIE

Benedict 1870
AGORAPHOBIA
(ANXIETY DISORDERS)

Westphal 1878
OBSESSIVE-COMPULSIVE
DISORDER

Purtell, Robins & Cohen 1951
Guze 1967
HYSTERIA
(SOMATIZATON DISORDER)

PHOBIC DISORDER
Monophobic
Polyphobic
Agoraphobia

PANIC DISORDER
Depersonalization-
Derealization
Syndrome

From Briquet's (1859) "l'hysterie" to current diagnostic concepts of "anxiety disorders," "obsessive-compulsive disorder" and "somatization disorder."

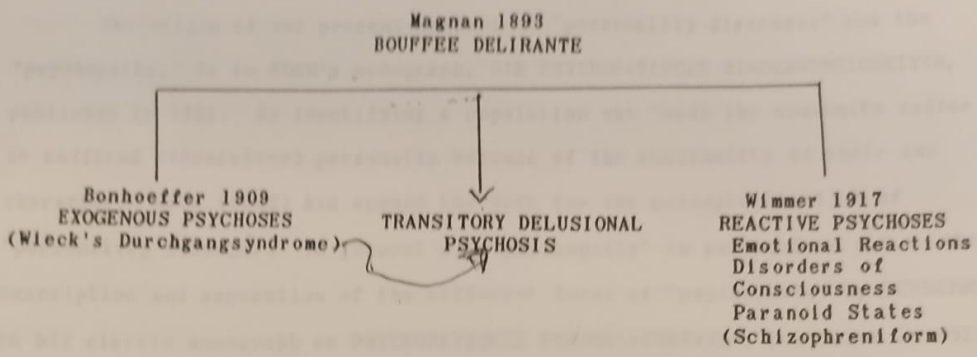
From Magnan's Bouffee Delirante

Finally, the origin of the fifth and last well-defined diagnostic category within the "sui generis psychiatric disorders" was in Magnan's diagnostic concept of "bouffee delirante," or "transitory delusional psychosis," presented in his *Leconc Cliniques sur les Maladies Mentales*, published in 1893. It refers to a naturally occurring "mental illness" in which the "psychopathologic process, " without identifiable "neuropathologic changes," yields to "multiform" disease pictures with "clouded state of consciousness" and "primary delusions." Considering that the "psychosis" has a "sudden onset" with a "rapid remission," "bouffee delirante" represents a "transient pathology in the processing of experience."

In subsequent years several groups of "psychoses" with a "transient pathology in the processing of experience" were identified. Among them, from a nosologic point of view, the two most important are Bonhoeffer's "acute exogenous predilectional types" or "symptomatic psychoses," first presented in his classic paper *Zur Frage der exogenen Psychosen*, published in 1909; and Wimmer's "reactive (or psychogenic) psychoses," first presented in his monograph *Psykogene Sindssygdomsformer,* published in 1916. In typical cases, the characteristic feature of "exogenous psychoses," which are triggered by "toxic agents" and/or "systemic disease," is "disorder of consciousness," i.e., a "lowered" and/or "clouded" state. Because of this, "exogenous psychoses" may resemble "transitory delusional psychoses." On the other hand, in atypical cases, "exogenous psychoses" may display the cross-sectional features of the disorders described in the first four categories of "sui generis psychiatric disorders." Subsumed under "exogenous psychoses" is the "Durchgangsyndrome," a diagnostic concept put forward by Wieck in 1956.

In contradistinction to "exogenous psychoses," "reactive psychoses" are triggered by "psychic trauma" and/or "life events." They are displayed in one of three clinical "forms," i.e., "emotional reactions," "disturbance of consciousness" and "paranoid states," which may closely resemble "affective" or "phasic" psychoses, "symptomatic psychoses" and "delusional psychoses," respectively. Subsumed under "reactive psychoses" are "schizophreniform states," a diagnostic concept, put forward by Langfeldt in 1939 (Table VI). While the three groups of "disorders," i.e., "transitory delusional psychosis," "symptomatic psychoses" and "reactive psychoses," differ in the "patterns generated" by the psychopathologic process," they share a common basis in the "transient" nature of the "pathology in the processing of experience." Because of this, one may consider at least two of these three groups of these disorders, i.e., "symptomatic psychoses" and "reactive psychoses," as "forme frustres" of "sui generis psychiatric disorders with ("continuous," "restricted," episodic" or "selective") "pathology in the processing of experience."

Table VI



From Magnan's (1893) "bouffee delirante" to current diagnostic concepts of "exogenous psychoses" and "reactive psychoses."

Personality Disorders

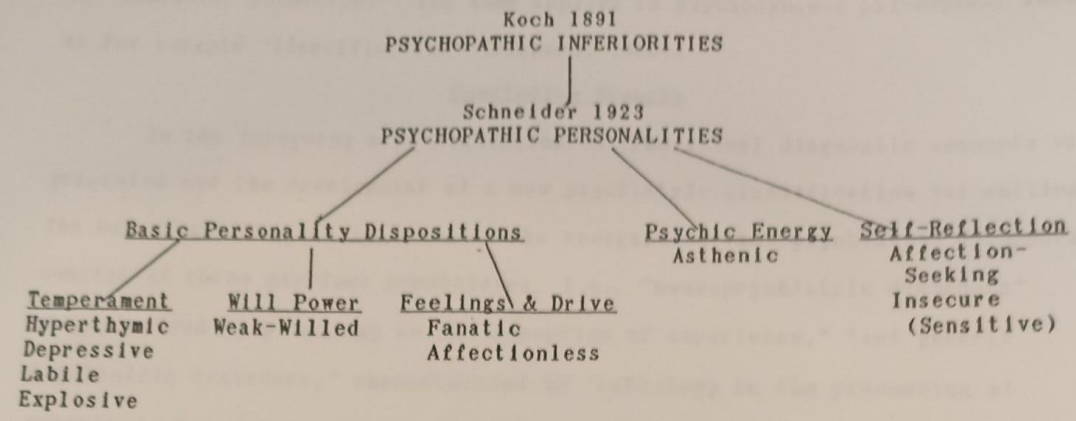
The origin of our present concept of "personality disorders" and the "psychopathy," " is in Koch's monograph, *Die Psychopatische Minderwertigkeiten*, published in 1891. By identifying a population who "made the community suffer or suffered (themselves) personally because of the abnormality of their own character," Koch (1888) had opened the path for the conceptualization of "personality disorders" in general and "psychopathy" in particular; and to the description and separation of the different forms of "psychopathy" by Schneider in his classic monograph on *Psychopatische Personlichkeiten*, published in 1923.

Instrumental in the conceptual development of "personality disorders" was Jaspers' (1909) separation of "personality development" and "disease process"; and the recognition that "personality disorders," in contradistinction to "neuropsychiatric disorders" and "sui generis psychiatric disorders," are not based on a "morbid -- neuropathologic or psychopathologic -- process." Because of this, the "abnormal responses to experience," which are the common characteristics of these disorders, are not the result of "pathology in the reception of experience," or "pathology in the processing of experience," but the outcome of "anomalies in personality development."

In Schneider's (1923) original formulation, adopting Jaspers (1909) distinction between "personality development" and "disease process," anomalies of "personality development" yield to "abnormal personalities," i.e., "variations upon the accepted, yet broadly concerned range of average personality," which are based on "personality traits" outside the "normal range." While "abnormal personalities" differ from "normal personalities" in terms of the accepted norms of a given society, "abnormal personalities" are not considered to be "psychopathic" unless their "abnormal personality traits" become manifest by "suffering," or "making the community suffer," and thereby fulfill Koch's (1891) criteria of "psychopathic inferiority." However, in variance with Koch's (1891) original usage of the term "psychopathy" that referred to a "social interaction," Schneider (1949) maintained that the diagnosis of "psychopathic personality" must be based on the "affliction of the individual" with the "abnormal personality" and not on the "amount of social friction which might be engendered around him."

By shifting emphasis to the "affliction of the individual" from the "affliction of the society," and restricting "personality disorders" to "psychopathy" i.e., to a subpopulation of "abnormal personalities," Schneider (1949) classified "psychopathic personality" primarily on the basis of "personality structure," i.e., "dispositions" which are "purely formal characteristics of the personality" (Klages, 1910), with consideration to "psychic energy" and "self-reflection" (Jaspers, 1959). Accordingly, he distinguished among 10 different types of "psychopathies," of which seven, "hyperthyumic, depressive," "labile," "explosive," "weak willed," "affectionless" and "fanatic" were "abnormal variations" of "basic personality disposition," one, i.e., "asthenic," was an "abnormal variation" of "psychic energy"; and two, i.e., "attention-seeking" and "insecure" (including the "sensitive") were "abnormal variations" of "self-reflection" (Table VII). While the 10 different "types of "psychopathy" vary greatly in "social behavior," they share the common characteristic of "abnormal response to experience," the nature of which is determined by the "abnormality" of "basic personality disposition," "psychic energy" and/or "self-reflection." Although it is a commonly held belief that "character" or "personality" is acquired by a "process of learning," none of the 10 "types" of "psychopathy" in Schneider's (1949) classification is based on the principles of "psychodynamics" and/or "learning." One possible reason for this is the lack of evidence in support of the role of the learning process, including "initiation" and "copying," in "character formation." The same applies to psychodynamic principles, such as for example "identification" (Jaspers, 1959).

Table VII



From Koch's (1891) "psychopathic inferiorities" to Schneider's (1923) classification of "psychopathic personalities."

Concluding Remarks

In the foregoing, a re-evaluation of traditional diagnostic concepts was presented and the development of a new psychiatric classification was outlined. The new classification is based on the recognition that psychiatric disorders consist of three distinct populations, i.e., "neuropsychiatric disorders" characterized by "pathology in the reception of experience," "sui generis psychiatric disorders," characterized by "pathology in the processing of experience," and "personality disorders," characterized by "pathology in the responding to experience."

Of the three psychiatric populations only two, i.e., "neuropsychiatric disorders" and "sui generis psychiatric disorders" are based on a "morbid process," whereas "personality disorders" are primarily based on "dispositions"; and only one of the three, i.e., "sui generis psychiatric disorders" respond favorably with a significantly greater probability to "psychotropic drugs" than to an "inactive placebo."

In "neuropsychiatric disorders," the "neuropathologic process" leads to "dedifferentiation," i.e., "dementia," whereas in "sui generis psychiatric disorders," the "psychopathologic process" leads to increasing "differentiation." As a result, "sui generis psychiatric disorders" consist of five distinct populations, characterized by "continuous," "restricted," "episodic-remitting," "selective" and/or "transient" pathology in the processing of experience.

Differential responsiveness to psychotropic drugs has focused attention on the diagnostic heterogeneity of patient populations within the traditional diagnostic categories of "sui generis psychiatric disorders." Linear regression equations and biologic measures have failed to identify the treatment responsive subpopulations and thereby increase "homogeneity" in terms of therapeutic responsiveness. It remains to be seen whether the new classification could provide greater "homogeneity" in terms of "responsiveness to treatment" and new "end-points" for research in the development of new "psychotropic drugs."