CLASSIFICATION OF PSYCHOSIS

Thomas A. Ban and Ronaldo Ucha Udabe

1990

Structurally Determined Psychoses

Structurally determined psychoses, in variance with somatically determined psychoses, are characterized by distinctive psychopathologic syndromes in the absence of physical illness. Each disorder (psychosis) evolves, in a predictable-stereotypic manner, and becomes manifest in a structure, generated by the onset, course and outcome of the psychopathologic symptoms displayed in the cross-sectional clinical picture.

Etiology Based Diagnoses

In spite of the absence of etiologic knowledge, structurally determined psychoses are divided into reactive and endogenous. Within the frame of reference of this dichotomy, the diagnosis endogenous (also referred to as autochthonous) refers to psychoses which assumedly arise from inner causes.[1] The term implies an innate-genetic biologic defect (Morel 1857),[2] or, if one accepts the "endogeny theory" of Moebius (1893),[3] a "constitutionally determined predisposition." On the other hand, the concept

[1] GOODWIN (1989) in his Foreword to PSYCHIATRIC DIAGNOSIS (by GOODWIN and GUZE) pointed out that diagnostic terms, such as "functional" and "psychogenic" and "situational reaction" are sometimes involved by physicians to explain the unexplained." Regardless, "people continue to speculate about etiology, of course, and this is good if it produces testable hypotheses, and bad if the speculation is mistaken for truth."

[2] MOREL´s (1857) concept of an innate biologic defect was first presented in his TRAITE DES DEGENERESCENCES PHYSIQUES, INTELLECTUELLES ET MORALES DE LÉSPECE HUMAINE. In his monograph on A CENTURY OF PSYCHIATRY, published in 1983, PIERRE PICHOT summed up Morel´s concept of degeneration as follows: "From the two principles, namely, the production of pathological variations by pathogenic environmental conditions and the transmission of inherited characteristics, Morel logically deduced that these degenerative hereditary strains would become progressively worse in lineal descent since the continued existence of the causes could not fail to aggravate their severity in successive generations… For Morel, mental disorders were, in many cases, nothing but a pre-eminent expression of degeneration… the specific clinical manifestations corresponding to the level of degenerations affecting the individual presenting them."

[3] The endogeny theory was presented by MOEBIUS in 1893 in his BRISS DER LEHRE VON NERVENKRENKHEITEN; and subsequently in 1900 in his monograph on DEGENERATION. In their DIAGNOSTIC CRITERIA FOR SCHIZOPHRENIC AND AFFECTIVE PSYCHOSES, published in

of reactive (also referred to as psychogenic) refers to psychoses which arise assumedly from conflictual experiences and/or stressful life events.[4] However, in the absence of distinctive clinical features between the two categories of disorders, the concepts of endogenous and reactive psychoses have not yielded testable nosologic hypotheses.

Structurally Based Diagnoses.

Attempts to identify and classify disorders within the structurally determined psychoses began with a purely descriptive phase in which clinical research was restricted to "collecting, recording, and faithfully portraying phenomena as they were encountered." In the absence of an organizing principle the descriptive observations yielded "individual psychoses" in which, according to Birnbaum (1923), "each psychosis was unique and occurred only in the particular form displayed."

The initial approach "has been concerned first and foremost with describing and recording clinical phenomena from direct observation of patients, and with delineating individual symptoms and the course of the symptoms encountered." However, "by ordering and grouping its data in an exact, systematic and comprehensive manner, it had done more; it has amassed a firm body of clinical phenomena which recur in the regular, discrete form and sequence that is usually expected of specific disease categories" (Birnbaum 1923).[5]

Course and Outcome.

The first organizing principle for the detection and classification of nosologic categories within structurally determined psychoses was based on the course[6] and the

1983, BERNER ET AL. considered Moebius´endogeny hypothesis as one of the most important theoretical concepts relevant to the formulation of diagnostic criteria for endogenous psychoses.

[4] The concept of reactive psychosis is restricted to psychoses which are assumedly the result of psychogenic trauma because the term exogenous is reserved for psychoses which are the result of biologic trauma.

[5] The origin of the structural approach to psychiatric nosology is in Birnbaum´s (1923) monograph, DER AUFBAU DER PSYCHOSE. According to him "with the passage of time, descriptive research has not escaped the fate which finally befalls it in all scientific discipline: when too much material has been recorded and arranged further research tends to choke on the surfeit of data that have been amassed." To break the impasse created by the excess of data Birnbaum developed a new methodology he referred to as "structural analysis" which "by studying the tectonic relationships between symptoms allows one to arrange them according to their significance in regard to the category of illness involved." He believed that "in the sphere of nosology, or systematic psychiatry, structural analysis (by organizing the material around five factors, i.e., predisposing, preforming, path genetic, provoking and path plastic) paves the way for a schematic arrangement which is clinically beyond reproach and which distinguishes those features which are important, specific and caused by illness, from those which are incidental, non-specific accompaniments; and thereby establishes the decisive nosological factors in question". The first two chapters pf Birnbaum´s by H. MARSHALL under the title THE MAKING OF A PSYCHOSIS: THE PRINCIPLES OF STRUCTURAL ANALYSIS IN PSYCHIATRY, and are included in THEMES AND VARIATIONS IN EUROPEAN PSYCHIATRY, edited by HIRSCH and SHEPHERS (1974).

[6] It should be noted that already in 1838 "Esquirol emphasized age at onset and course of illness as valuable additions to cross-sectional descriptive definition" (Frances et al. 1990).

outcome of illness. By developing a clinical methodology for the assessment of variable relevant to course and outcome, and by employing the new methodology, KRAEPELIN (1896), in the fifth edition of his LEHRBUCH DER PSYCHIATRIE, identified and separated two major psychiatric disorders from the multitude of clinical syndromes.[7] One of these two syndromes, which in terms of course and outcome, was episodic and remitting, he referred to as manic depressive insanity,[8] and the other one, which in terms of course and outcome was continuous and progressing, he referred to as dementia praecox[9]. Kraepelin´s original nosologic concept of manic depressive insanity embraced "the whole domain of the so called periodic or circular insanities," including the "morbid states termed melancholia" and mania, and a considerable proportion of the amentias.[10] Similarly, Kraepelin´s (1899) original nosologic concept of dementia praecox embraced the whole domain of insanities which progressed towards "psychic enfeeblement".[11]

---

[7] Kahlbaum´s (1874) conceptual framework and especially his postulation of a close correspondence between etiology, brain pathology, symptom pattern and outcome picture, had a decisive influence on Kraepelin´s (1896) work, and especially his shift of emphasis from clinical syndromes to the progression of disease. To focus attention on his shift of emphasis, Kraepelin, in the Introduction to the fifth edition of his textbook, wrote: "In the development of the present work, the current edition represents the last decisive step which goes from the symptomatic conception to the clinical conception of insanity. This change in point of view, the necessity of which has been brought home to me more and more forcibly by practical needs, is mainly characterized by the delineation and grouping of pathologic pictures. Everywhere the importance of the external signs has had to yield place to the criteria which derive from the developmental conditions, the course and the issue of the individual disorders. All the syndromes have disappeared from the nosology" Pichot 1983).

[8] In the first edition of his textbook, Kraepelin (1883) described six different forms of melancholia, i.e., simple, gravis, stuporous, paranoid, fantastic and delirious, and four different forms of mixed states, i.e., depressed mania, agitated depression, depression with flight of ideas, and depression with partial inhibition. In his 1896 presentation he contended that all these different forms are manifestation of one and the same nosologic entity, i.e., manic depressive insanity. Subsequently, in the eighth edition, he characterized the disorder by "distinctive episodes (which are) more or less sharply delineated from each other or from health" and "may or may not resemble each other" to the extent that they "often represent antithetical pictures."

[9] Kraepelin (1893), in the fourth edition of his textbook, brought together the syndromes of hebephrenia, described by Hecker (1871) with consideration to Kahlbaum´s (1863) diagnostic concept of "paraphrenia hebetica," catatonia or tension insanity, described by Kahlbaum (1874), and dementia paranoids under the heading psychic degeneration processes. Subsequently in the fifth edition, he characterized this "group of clinical conditions" by its "peculiar destruction of internal connections of the personality and a marked damage of emotional and volitional life."

[10] Kraepelin´s (1896) already broad original definition of manic depressive insanity was later expanded to include "all cases of affective excess" and ultimately, on the basis of the contributions of Dreyfus (1905), also involutional melancholia, a disorder which at the beginning he regarded as a separate nosological entity because of its prolonged course.

[11] Kraepelin´s (1899) already broad original definition of dementia praecox was expanded in the seventh edition of his textbook to include Magnan´s (1891-1892, 1893) diagnostic concept of *delire chronique*. However, in the eighth edition he separated the paranoid forms of dementia praecox from the paranoid deteriorations (in which emotions and volition remained intact). In the eighth edition, Kraepelin (1909-1915) put forward a completely new classification in which he distinguished among 10 different forms of dementia praecox including Diem´s (1903) dementia simplex, silly deterioration (replacing the term hebephrenia), depressive deterioration, depressive deterioration with delusional formation, circular, agitated, periodic, catatonic, and paranoid forms, and schizophasia. Kraepelin´s (1904) textbook was abstracted and adapted from the seventh German edition into English by A. ROSS DIEFENDORF, under

Polarity and Phenomenology.

The second organizing principle for the detection and classification of valid nosologic categories within structurally determined psychoses was based on polarity and phenomenology. By developing a clinical methodology for the assessment of variables relevant to polarity[12] and phenomenology[13], LEONHARD (1957) undertook the task of re-evaluating Kraepelin´s (1899) classificatory scheme[14]. As a result, in his AUFTEILUNG DER ENDOGENEN PSYCHOSES[15], he identified and separated five

---

the title CLINICAL PSYCHIATRY: ATEXT-BOOK FOR STUDENTS AND PHYSICIANS. The English edition was published in 1907 by the Macmillan Company in New York and London.

[12] In defining polarity in his monograph, The Classification of Endogenous Psychoses, Leonhard (1979) wrote: "The bipolar form (of illness) displays a considerably more colorful appearance; it varies not only between the two poles, but in each phase offers different pictures. The unipolar forms of which there are several, return in a periodic course, with the same symptomatology. Every individual form is characterized by a syndrome associated with no other form and not even related transitions to any other forms. On the other hand, in bipolar cases, no clear syndromes can be described since there are many transitions between various formations and the picture may even be distorted during the first phase. In the same sense, one is also in the position to recognize as bipolar those forms which only accidentally swing toward one pole but which contain the potential toward the other pole. Consequently the differentiation is better made between polymorphic (bipolar) and pure (unipolar) forms." On the basis of this original definition, the concept of "bipolar" refers primarily to a multiform (polymorphic) – continuously changing clinical picture – and only secondarily to the potential to display both mood extremes, i.e., hyperthymia, i.e., elation or mania, and dysthymia, i.e., sadness or depression; and the concept of "monopolar" or "unipolar "refers primarily to a simple (monomorph) – consistently the same clinical picture – and only secondarily to the restricted potential to display only one or another mood, extreme, i.e., hyperthymia or dysthymia. Furthermore, within Leonhard´s frame of reference, polarity is not restricted to mood as in manic-depressive insanity, but extends to emotions in anxiety-happiness, one of the forms of cycloid psychosis, and to activity in periodic catatonia, one of the forms of unsystematic schizophrenia.

[13] Leonhard´s (1957) different subforms of disease were derived by a careful analysis of the phenomenology of the disorders, essentially on the basis of the principle set out by Jaspers (1913) in his General Psychopathology. As it will be discussed in Part Two in the Classification of Sui Generis Psychiatric Disorders, Leonhard combined Jaspers´ phenomenology with Wernicke´s (1900) conceptual framework relevant to the psychic reflex. It should be noted, however, that while Leonhard adopted Jaspers´ methodology, he did not share Jaspers´ theoretical frame of reference. Because of this, instead of employing Jaspers´ terminology – that could have been done without any difficulties – he introduced his descriptive, but somewhat idiosyncratic terms. Some believe that if this would not have happened Leonhard's work would not have been pushed aside from the main stream and would have gained much sooner, much wider acceptance.

[14] In the Introduction to his Classification of Endogenous Psychoses, Leonhard (1979) wrote: "Kraepelin´s teachings have been rejected, but whenever nosological questions are raised, his dichotomy of the endogenous psychoses reappears…. In this stance, which are at times great, and which hardly appear bridgeable. What could a melancholy have in common with a hebephrenia? Or solely within the context of the schizophrenias, how could one unite a fantastic paraphrenia with a negativistic catatonia. Kraepelin´s classification into only two forms has been damaging. He himself attempted many finer distinctions with great enthusiasm and continued open-mindedness, but his followers ignored this; they only saw the coarse division into schizophrenia, i.e., dementia praecox, and the manic-depressive disease."

[15] In his monograph, Aufteilung der Endogenen Psychosen, Leonhard (1957) used the conventional term, endogenous psychoses, for structurally determined psychoses. The monograph was translated from the fifth edition of the German original into English by RUSSELL BERMAN, under the title THE CLASSIFICATION OF ENDOGENOUS PSYCHOSES. The manuscript was edited by Eli Robins and

major groups of disorders[16] – consisting of 35 different clinical illnesses – within the psychoses included by Kraepelin under manic depressive insanity and dementia praecox.

It was on the basis of polarity, that Leonhard separated within manic-depressive insanity (or affective psychoses), the unipolar phasic psychoses, from bipolar manic-depressive disease; and within dementia praecox or schizophrenia, the unipolar systematic forms of illness, from the bipolar unsystematic forms. On the other hand, it was with consideration to outcome that he separated, within the bipolar disorders, the cycloid psychoses and manic-depressive disease (i.e., the disorders with full remission between episodes), from the unsystematic schizophrenias (i.e., the disorders with partial remission between episodes).

Similarly, it was on the basis of the primarily affected structures in Wernicke's (1900) psychic reflex arc[17], i.e., afferent structures (such as perception and thinking), central structures (such as emotions and mood) and efferent structures (such as drive and psychomotility), that Leonhard (1957) separated within the unipolar phasic psychoses, complete (pure mania and pure melancholia) , and incomplete forms (pure euphorias and pure depressions) [18]; and within each, the cycloid psychoses the unsystematic schizophrenias, and the systematic schizophrenias, three distinctive forms.[19] On the other

published in 1979 by Irvington Publishers (Halsted Press Division of John Wiley & Sons) in New York, London, Sydney and Toronto. The sixth and last edition of Leonhard´s monograph was published in 1986.

[16] The five groups of disorders in Leonhard´s (1957) classification are: unipolar phasic psychoses, manic-depressive and cycloid psychoses, unsystematic schizophrenias and systematic schizophrenias. In his monograph on the Classification of Endogenous Psychoses, Leonhard included both unipolar phasic psychoses and manic-depressive disease under the phasic psychoses.

[17] The term "reflex" was introduced by Descartes (1646) in his DES PASSIONS DE L'AME. It was adopted into physiology by WHYTT (1751) in his treatise ON THE VITAL AND OTHER INVOLUNTARY MOTIONS OF ANIMALS; and extended to embrace all activities, including the psychologic by SECHENOV (1866) in his REFLEXES OF THE BRAIN. "In accord with his attempt to grasp mental illness as cerebral illness… Wernicke´s ideas were dominated by the notion of the psychic reflex arc, and he only accepted objective symptoms as relevant, i.e., movement (motility) including its special mode language." However, Jaspers (1962) acknowledged that in spite of this seemingly simple model, Wernicke "subdivided movements into expressive, reactive and initiatory… Contents into awareness of the outside world, of one´s own body and of one´s personality… And distinguished delusion proper from explanatory delusion." By doing so, regardless of contemporary criticisms which perceived Wernicke´s work as brain mythology, he has created a series of concepts, such as for example "perplexity, overvalued ideas, registration of memory… and the differentiation of autopsychic orientation within the allopsychic disorientation of delirium tremens…" which are of sufficient importance that "no scientist can afford not to study him seriously."

[18] In his Introduction to the chapters on The Pure Depressions and on The Pure Euphorias (in The Classification of Endogenous Psychoses), Leonhard (1957) wrote: "Pure melancholy and pure mania do not represent purely affective diseases; thought and desire are also disturbed. There are, however also psychoses in which only the emotional side becomes diseased, although not in how I interpret the pure depressions and the pure euphorias." The term, complete in reference to pure depressions and pure euphorias, was first used by PETHÖ ET AL. (1984) in the KDK BUDAPEST, published in the Hungarian periodical, *Ideggyógyászati Szemle*.

[19] In Leonhard´s (1957) classification, disorders with primary afferent structure involvement are confusion psychosis, a form of cycloid psychoses, cataphasia, a form of unsystematic schizophrenia, and the paraphrenias, a category of the systematic schizophrenias. Disorders with primary central structure involvement are respectively anxiety-happiness psychosis, affect-laden paraphrenia and the hebephrenias;

hand, it was with consideration to Jaspers´ (1913) phenomenology, that Leonhard (1957) separated the cycloid psychoses from manic depressive disease[20], and distinguished among five sub-forms within each, the pure euphorias and the pure depressions; among three subforms within each, the cycloid psychoses and the unsystematic schizophrenias; and among 16 subforms (i.e., six paraphrenias, four hebephrenias and sic catatonias) within the systematic schizophrenias. .

and disorders with primarily efferent structure involvement are motility psychosis, periodic catatonia and the catatonias.

[20] In the DCR Budapest-Nashville cycloid psychoses are separated from affective psychoses in general, and manic-depressive psychoses in particular, by the presence of at least two symptoms from each of the following two sets of symptoms: I (1) polymorphous (fluctuating) clinical picture, (2) protopathic change of form, (3) confusion or perplexity, (4) change in the depth of emotions, (5) strong emotional involvement with content of psychopathologic symptoms, and (6) mood swings, and II (1) delusional perceptions including delusions of reference or sudden delusional ideas, (2) hallucinations, (3) thematic incoherence, (4) misidentifications, (5) quantitative changes in speech production, (6) quantitative changes in expressive movements and (7) quantitative changes in reactive movements and (7) quantitative changes in reactive movements (Pethö and Ban 1988).