CLASSIFICATION OF PSYCHOSIS

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Current Classifications Revisited

ICD-9

The structurally determined psychoses reviewed, are included under the categories of schizophrenic and affective psychoses, i.e., the two major group of other psychoses, in the ICD-9.

The ICD-9 concept of schizophrenic psychoses is based on Bleuler´s (1911) syndromic definition, with consideration to Schneider´s (1957) first rank symptoms.[1] As such, it is an all embracing diagnostic concept, which includes both, the systematic and the unsystematic forms of schizophrenia, as well as the cycloid psychoses[2] (Leonhard, 1957). Accordingly, it extends beyond the hebephrenic, catatonic and paranoid types, of Kraepelin´s dementia praecox (1899) to include simple schizophrenia, described by Diem

[1] In the ICD-9, schizophrenic psychoses are defined as "a group of psychoses in which there is a fundamental disturbance of personality, a characteristic distortion of thinking, often a sense of being controlled by alien forces, delusions which may be bizarre, disturbed perception, abnormal affect out of keeping with the real situation, and autism. Nevertheless, clear consciousness and intellectual capacity are usually maintained…. The diagnosis 'schizophrenia' should not be made unless there is, or has been present during the same illness, characteristic disturbance of thought, perception, mood, conduct, or personality-preferably at least in two of these areas. The diagnosis should not be restricted to conditions running a protracted, deteriorating, or chaotic course…."

[2] Cycloid psychoses (Leonhard, 1957) are included in the ICD-9, as schizoaffective type of schizophrenic psychoses (also referred to as cyclic schizophrenia, mixed schizophrenic and affective psychosis and schizophreniform psychosis, affective type). The disorder is defined as "a psychosis in which pronounced manic and depressive features are intermingled with schizophrenic features and which tends towards remission without permanent defect, but which is prone to recur".

(1903),[3] latent schizophrenia described by Bleuler (1911),[4] schizoaffective psychosis, described by Kasanin (1933),[5] acute schizophrenic episode,[6] and residual schizophrenia.[7]

In variance with the ICD-9 concept of schizophrenic psychoses, which is based on Bleuler´s (1911) definition, the ICD-9 concept of affective psychoses is based on Kraepelin´s (1896) original definition of manic-depressive insanity.[8] As such, it embraces both, the bipolar and the unipolar phasic psychoses, including the manic, the depressive and the circular forms[9].

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[3] DIEM in his paper, DIE EINFACHE DEMENTE FORM DER DEMENTIA PRAECOX described a "simple form" of "dementia praecox". The paper was published in 1903 in Arch. Psychiat. Nervenkr. Eight years later Bleuler (1911) used the term "simple schizophrenia" to designate the "form" of "schizophrenia" with "market formal thought disorder" and "flattening of affect" in the absence of "delusions", "hallucinations" and/or "catatonic symptoms". He adopted the term, "simple", from Pick, who, in 1891 "described a ´simple´ syndrome, which remained after the two groups described by Hecker (1871) and Kahlbaum (1874) had been separated from the broad category of Morel (1853)" (Fish, 1962). Recently BLACK and BOFFELI (1989), in their paper, SIMPLE SCHIZOPHRENIA: PAST, PRESENT AND FUTURE, gave a historical overview of the concept.

[4] The term, latent schizophrenia, was first used by BLEULER (1911) in his monograph, DEMENTIA PRAECOX ODER GRUPPE DER SCHIZOPHRENIEN, to designate "a group of psychoses with odd, distorted personalities, which he believed, were due to a schizophrenic process which had not been acute and had ceased to be active". In his monograph on Schizophrenia, Fish (1962) noted, that the concept of latent schizophrenia is not very helpful and is "beyond proof or disproof" (Hamilton, 1976). The term is included in the ICD-9 but "it is not recommended for general use". Included under the heading of "latent schizophrenia" are also "some other poorly defined varieties of schizophrenia", such as "borderline", "prepsychoptic" or "prodromal schizophrenia", and "pseudoneurotic" or "pseudopsychopathic schizophrenia".

[5] KASANIN, in his paper THE ACUTE SCHIZOAFFECTIVE PSYCHOSES, published in 1933, described a group of patients with concurrency schizophrenic and affective symptoms, In spite of the fact that these patients recovered from their symptoms, Kasanin diagnosed them as having s subtype of schizophrenia (Kaplan and Sadock, 1988). Prior to Kasanin, similar cases were described by Kirby (1913) and Hoch (1921), but classified as manic-depressive psychosis.

[6] The ICD-9 concept of acute schizophrenic episode corresponds with the diagnostic concept of oneirophrenia described by MEDUNA and McCULLOCH (1945) in their paper THE MODERN CONCEPT OF SCHIZOPHRENIA. Prior to them, MAYER-GROSS (1024) in his monograph, SELBSTSCHILDERUNG DER VERWIRRTHEIT: Das Oneroide Erlebnis, described the "oneroid experience". In the ICD-9, acute schizophrenic episode is characterized by a dream-like state with sligh clouding of consciousness and perplexity. It is based on MEDUNA´S (1950) described in his monograph, ONEIROPHRENIA, published by Illinois University Press.

[7] In the ICD-9 residual schizophrenia is defined as "a chronic form of schizophrenia in which the symptoms that persist from the acute phase have mostly lost their sharpness. Emotional response is blunted and thought disorder, even when gross, does not prevent the accomplishment of routine work." Chronic undifferentiated schizophrenia is synonymous for residual schizophrenia in the ICD-9.

[8] The ICD-9 definition of manic-depressive psychosis corresponds with Kraepelin´s original definition of manic-depressive insanity. It differs from his last (1921) definition which also includes the "slightest colorings of mood…. Which on the one hand are to be regarded as the rudiment of more severe disorders, on the other hand, pass without sharp boundary into the domain of personal predisposition" (Akiskal, 1983).

[9] In the ICD-9 affective psychoses are defined as "mental disorders usually recurrent, in which there is a severe disturbance of mood (mostly compounded of depression and anxiety, but also manifested as elation and excitement) which is accompanied by one or more of the following: delusions, perplexity, disturbed

DSM-III

The structurally determined psychoses reviewed, are included under schizophrenic and affective disorders in the DSM-III. They represent two of the 15 categories of Axis I diagnoses.

Similar to the ICD-9 diagnostic concept of schizophrenic psychosis, the DSM-III diagnostic concept of schizophrenic disorders is based on the presence of characteristic symptoms (Schneider, 1957), involving multiple psychological processes (Bleuler, 1911) and deterioration from a previous level of functioning (Kraepelin, 1899). However, unlike in the ICD-9, in the DSM-III, the diagnosis if schizophrenia cannot be made without the presence of psychotic symptoms[10] during the active phase of the illness, in case of onset of symptoms after 45, and before the duration of symptoms of at least six months.[11] As a result, diagnoses, such as simple, latent and schizoaffective types[12] of schizophrenia, as well as acute schizophrenic episode, are dismissed; and the different types of the disorder

attitude of self, disorders of perception and behavior; these are all in keeping with the patient´s prevailing mood (as are hallucinations when they occur".)

[10] In contradistinction to the ICD-9, in the DSM-III, schizophrenic psychoses are referred to as schizophrenic disorders. Nevertheless, it is in the DSM-III, that psychotic symptoms are one of the essential prerequisites for the diagnosis of schizophrenia.

Because of the absence of psychotic symptoms both simple and latent schizophrenia are omitted from the DSM-III. They are perceived as personality disorders and included among the Axis II diagnoses of schizoid, schizotypal and borderline. This might need to be reconsidered in view of TORGERSEN´S (1984, 1985) findings of a "familial and even genetic relationship between schizophrenia and schizotypal personality", reported in his papers, GENETIC AND NOSOLOGICAL ASPECTS OF SCHIZOTYPAL AND BORDERLINE PERSONALITY DISORDERS and RELATIONSHIP OF SCHIZOTYPAL PERSONALITY DISORDER TO SCHIZOPHRENIA: GENETICS, published in Arch. Gen. Psychiat. And Schizophr. Bull., respectively. Similar findings were reported by Kendler, Gruenberg and Tsuag (1985) and Kendler, Masterson and Davis (1985). According to Goodwin and Guze (1989), the finding that there is a "familial and even genetic relationship between schizophrenia and schizotypal personality" is in support of "the validity of the schizophrenia-spectrum concept".

[11] Because the diagnosis of schizophrenic disorder cannot be used prior to the duration of at least six month of the manifestations, patients who otherwise fulfill criteria for schizophrenic disorders are diagnosed in the DSM-III as schizophreniform from Langfeldt (1939). However, the DSM-II concept of schizophreniform disorder does not correspond with the ICD-9 concept of acute schizophrenic episode, because it is not based on the presence of oneroid features.

[12] In the DSM-III, the diagnosis of schizoaffective disorder is included under the Axis I category of psychotic disorders not elsewhere classified. It does not correspond with the ICD-9 concept of schizoaffective type of schizophrenic psychosis. In the DSM-III, the category of schizoaffective disorder is retained "without diagnostic criteria for those instances in which the clinical is unable to make a differential diagnosis with any degree of certainty between 'affective disorder' and either 'schizophreniform disorder' or 'schizophreniform disorder', 'manic depression' or 'bipolar disorder' with 'mood congruent' or 'mood incongruent' features, or 'schizophrenia' with a superimposed 'atypical affective disorder'."

are restricted to the disorganized,[13] catatonic, paranoid, undifferentiated and the residual.[14]

The DSM-III diagnostic concept of affective disorders was formulated with consideration of Leonhard´s (1957) contributions relevant to the dichotomy of bipolar and unipolar phasic (affective) psychoses. However, by shifting emphasis from the formal characteristics of polarity, expressed in the distinction between multiform-polymorph and simple-monomorph disease pictures, to the content of the manifest syndrome, expressed in the distinction between elation and separated into bipolar disorders and depressions.[15] Furthermore, by replacing phenomenology with severity and duration as the primary organizing principle, affective disorders in the DSM-III, are subdivided into major (severe with short duration),[16] other specific (mild with prolonged duration),[17] and atypical[18].

DSM-III-R

There is little difference between the DSM-III-R and the DSM-III in terms of the disorders discussed. However, the DSM-III term, schizophrenic disorder was replaced in the DSM-III-R, by the term, schizophrenia,[19] the term, affective disorder by the tem,

[13] The term hebephrenia (Hecker, 1871), was replaced in the DSM-III by the term, disorganized, and the disorder, which had been referred to in the ICD-9 as schizophrenic psychosis, hebephrenic type, is referred to in the DSM-III as schizophrenic disorder, disorganized type. The new name reflects a shift in emphasis in the diagnostic criteria. It should be noted that Bleuler (1911) considered hebephrenia as a " big kettle into which all forms that cannot be grpuped into the other three headings" are thrown (Leonhard, 1978).

[14] While in the ICD-9, the diagnosis chronic undifferentiated schizophrenia is used as a synonym for the diagnosis of residual schizophrenia, in the DSM-III, the undifferentiated type differs from the residual type by the presence of prominent delusions, hallucinations, incoherence, or grossly disorganized thinking.

[15] The DSM-III restricts unipolar disorders to depressions. Because it does not recognize unipolar mania or unipolar euphorias, disorders, which are displayed by recurrent episodes of mania and/or hypomania, are included in the DSM-III under bipolar disorder, manic.

[16] The DSM-III diagnostic concepts included under major affective disorders correspond to Leonhard´s (1957) diagnostic concepts of manic-depressive disease, pure mania and pure melancholy, i.e., disorders with acute or subacute onset and relatively short duration.

[17] Of the two diagnoses included under other specific affective disorders in the DSM-III, one, i.e., dysthymic disorders, corresponds with the traditional diagnostic concept of depressive neurosis, whereas the other, i.e., cyclothymic disorder, does not correspond with traditional diagnostic concepts. The term was adopted from Schneider (1959)who used it as a synonym for manic-depressive disorder. The use of the term, however is more in keeping with Kretschmer´s (1921) concept of cyclothymic temperament.

[18] The term atypical affective disorders refers to a residual category of affective disorders in the DSM-III. The same term was used by Nan (1989) to designate affective disorder with an insidious onset. The term atypical depression refers to a residual category of depression in the DSM-III. The same term was used by Sargant (1961) to designate depression with hypersomnia and weight gain.

[19] Estimated prevalence rate for schizophrenia is from 0.2 percent to almost 1 percent.

mood disorder, and the trichotomy within the affective disorders, by the discho0tomy of bipolar disorders[20] and depressive disorders[21].

ICD-10

Disorders relevant to the structurally determined psychoses reviewed, are included under two disease categories in the ICD-10, I.E., (1) schizophrenia, schizotypal[22] and delusional disorders and (2) mood (affective) disorders. The ICD-9 concept of schizophrenia includes the controversial diagnostic concept of post-schizophrenic depression,[23] among the seven subforms of schizophrenia; and recognizes sex different patterns of course.[24] The ICD-10 is the first of the consensus based classifrications in which acute and transient psychotic disorders displaying polymorphic clinical pictures, and resembling both, Leonhard´s (1957) non-affective, bipolar diagnostic concepts, i.e., unsystematic schizophrenias[25] and cycloid psychoses, and Magnan´s (1893) diagnostic concept of transitory delusional psychosis, are separated from the schizophrenias; and, in

[20] Estimated prevalence rate for bipolar disorder is from 0.4 percent to 1.2 percent.

[21] Estimated prevalence rate for major depression is from 9 percent to 26 percent in females and from 5 percent to 12 percent in males.

[22] Schizotypal disorder is perceived in the DSM-III-R as a personality disorder, and as such, it is an Axis II diagnosis. In the ICD-10, it is perceived as a disease, similar to schizophrenia, but without psychotic manifestations, and as such, it is included under the diagnostic category of schizophrenia, schizotypal, and delusional disorders.

[23] The diagnostic concept of post-schizophrenic depression was discussed by McGLASHAN and CARPENTER (1976) in their paper, AN INVESTIGATION OF THE POST-PSYCHOTIC DEPRESSIVE SYNDROME, published in the Am. J. Psychiztry. Post-schizophrenic depression is a purely defined diagnostic concept which needs to be distinguished from the REVEALED DEPRESSION (AND DRUG TREATMENT FOR SCHIZOPHRENIA), described by KNIGHTS and HIRSCH (1981), and from AKINETIC DEPRESSION (IN SCHIZOPHRENIA) described by VAN PUTTEN and MAY (1978).

[24] Course of illness in schizophrenic disorders is separated in the DSM-III-R into subchronic, chronic, subchronic with acute exacerbation, chronic with acute exacerbation and in remission; whereas in the ICD-10, patterm of course is separated into continuous, episodic with grogressive deficit, episodic with stable deficit, episodic remittent, incomplete remission, complete remission and other. In the formulation of the patterns of course, consideration was given to the patterns described by MANFRED BLEULER (1941) in his monograph, KRANKHEITSVERLAUF, PERSöNLICHKEIT, UND VERWANDTSCHAFT SCHIZOPHRENER UND IHRE GEGENSETZIGE BEZIEHUNGEN, and to the patterns described by ARNOLD (1955) in his monograph SCHIZOPHRENER PROZESS UND SCHIZOPHRENE SYMPTOMGESETZE. It should be noted that Bleuler distinguished among seven patterns, i.e., acute onset with a steady course leading to permanent deterioration, chronic simple course leading to a permanent defect, acute onset with a steady course leading to a permanent defect, chronic simple course leading to a lasting defect, acute periodic course resulting in permanent defect and acute periodic course resulting in complete or social cure; whereas Arnold distinguished among 11 patterns, i.e., phasic course of illness with complete cure, phasic course passing over into a shift like course, phasic course passing over into a process, shift like course passing over into process with exacerbation, primary process course of illness, primary process with exacerbations, mixed psychoses and mixed psychoses passing over into process (Hamilton, 1976).

[25] Both of the diagnostic concepts of Leonhard (1957), i.e., cycloid psychoses and unsystematic schizophrenias, are disorders with a polymorphic disease picture. As such, they correspond to some extent with the ICD-10 diagnostic concepts of acute polymorphic psychotic disorder without symptoms of schizophrenia and acute polymorphic psychotic disorder with symptoms of schizophrenia.

which schizoaffective disorder[26] is perceived as a distinctive bipolar disorder, that differs from both, the monomorphic schizophrenic and the monomorphic delusional disorders, and the polymorphic acute and transient psychotic disorders.

In terms of mood (affective) disorders, the other ICD-10 category of disorders, relevant to the structurally determined psychoses reviewed, the distinction between bipolar and unipolar affective disorders, including manic,[27] depressive and recurrent depressive disorders, and the separation of the persistent from the other affective disorders are retained.[28] In this respect, the ICD-10 is similar to the DSM-III.R.

[26] There are four distinctive types separated within the schizoaffective disorders in the ICD-10. These are: unipolar manic, unipolar depressive, bipolar mixed and other. The criteria of the unipolar typos were adopted from the description of BROCKINGTON, WAINWRIGHT and KENDELL (1980), presented in their paper MANIC PATIENTS WITH SCHIZOPHRENIC OR PARANOID SYMPTOMS, and from the description of BROCKNGTON, KENDELL and WAINWRIGHT (1980), presented in their paper DEPRESSED PATIENTS WITH SCHIZOPHRENIC OR PARANOID SYMPTOMS; and the criteria of the bipolar mixed type were adopted from the description of ABRAMS and TAYLOR (1980) , presented in their paper, IMPORTANCE OF SCHIZOPHRENIC SYMPTOMS IN THE DIAGNOSIS OF MANIA, and from the description of MAJ (1985), in his paper, CLINICAL COURSE AND OUTCOME OF SCHIZOAFFECTIVE DISORDERS. The validity of the diagnostic concepts of unipolar and bipolar affective disorders have received substantial support by the results of the family genetic study of Grchon et al. (1982). (Information relevant to the classification of schizoaffective disorders is reviewed and discussed in several papers by MAJ, published in 1984, 1985 and 1986.)

[27] Similar to Leonhard (1957), but in variance with the DSM-III-R, the ICD-10 recognizes unipolar manic disorders as an independent group of illnesses. The same disorders in the DSM-III-R are included under bipolar disorders.

[28] The DSM-III-R diagnostic concept of persistent affective disorders was adopted in the ICD-10. Because of this, affective disorders in the ICD-10 are restricted to cyclothymic and dysthymic disorders and do not include hyperthymic disorders.