CLASSIFICATION OF PSYCHOSIS

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Unitary Psychosis

Development of the Concept

In its original formulation, the concept of psychosis implied that all the different mental syndromes are based on detectable morphologic changes and identifiable diseases of the "nerves". Recognition, however, that this is not the case, led WILHELM GRIESINGER (1861) to postulate, that different mental syndromes represent different developmental stages of one and the same pathologic process.[1] In his classic text, DIE PATHOLOGIE UND THERAPIE DES PSYCHISCHEN KRANKHEITEN[2], he adopted the notion, that in the mental syndromes in which neuropathologic changes are absent, they will become detectable at a later stage of disease development.[3]

The origin of Griesinger's (1861) unitary concept of Psychosis was in the work of Bayle (1822); who was the first to report that in chronic arachnoiditis, the dementia syndrome displayed in "etat de demence", was preceded by other mental syndromes

[1] OTTO M. MARX (1972) in his paper on WILHELM GRIESINGER AND THE HISTORY OF PSYCHIATRY: A REASSESSMENT, summed up Griesinger´s concept of unitary psychosis as follows: "Viewing all mental illness as a part of one process, Griesinger proposed that in its initial phase, characterized by the dominance of certain pathological efforts, mental illness was unaccompanied by structural changes in the brain, and hence reversible. Brain structure was affected in the second phase in which mental image formation, or will was affected. Irreversible structural changes, and symptomatology typical of the second phase or of the third phase (characterized by deterioration), implied incurability."

[2] GRIESINGER´S monograph was first published in 1845. However, the concept of unitary psychosis was first presented in the second edition, published in 1861. The monograph was translated from the second edition of the German original into English by C. LOCKHART ROBERTSON and JAMES RUTHERFORD, under the title MENTAL PATHOLOGY AND THERAPEUTICS. The English edition was published in 1867 by The New Sydenham Society in London. The third and last edition of the monograph was published in 1871.

[3] Prior to the publication of the second edition of Griesinger´s monograph in 1861, in which the crystallized concept of unitary psychosis first appeared, a similar concept was presented by GUISLAIN in 1833, in his TRAITE DES PHRENOPATHIES, and by NEUMANN in 1859, in his LEHRBUCH DER PSYCHIATRIE (Crow, 1986).

during the first and second stages of disease development.[4] Considering that these syndromes corresponded with the second ("delire monomaniaque") and the third ("delire maniaque") syndromes in Esquirol´s (1838) classification, and the dementia syndrome corresponded with the fourth syndrome, i.e., with the syndrome associated with structural changes in the brain,[5] Griesinger (1861) felt justified in adopting Bayle´s findings, derived from the analysis of a neuropsychiatric condition, as a model of mental disease, i.e., unitary psychosis.

Place in Nosologic Develooment

There are several divergent views regarding the place and role of unitary psychosis in the conceptual development of diagnosis and classification of psychiatric disorders. In Lehmann's (1971) view, by the mid-19th century a widespread interest in the nosology of mental disease had crystallized and with it "an open controversy had developed between those who wanted a classification according to causes and those who wanted a classification according to symptoms." [6] Simultaneously, there was also a "violent controversy" between psychiatrists who, like Griesinger (1845), saw mental disease as a "disorder caused by physical brain disease[7], and psychiatrists who, like Heinroth (1818),

[4] In his RECHERCHES SUR LES MALADIES MENTALES, originally published as a thesis, BAYLE (1822) put forward the notion that "the symptoms of chronic arachnoiditis (arachnitis) can all be reduced to a general and incomplete paralysis and to the derangment of the intellectual faculties. These two orders of phenomena proceed at an equal and proportional pace and allow the disease to be divided into three periods, i.e., delire monomaniaque, with exaltation in the first, delire maniaque, accompanied by dominant ideas in the second, and etat de demence, in the third" (Pichot, 1983).

[5] Esquirol (1838) distinguished among five "general forms of insanity": (1) lypemania or melancholy of the ancient, (2) monomania, (3) mania, (4) dementia and (5) imbecility or idiocy.

[6] According to Lehmann (1971) "The old controversies of the 'symptomatologists' versus the 'etiologists', and of the 'organicists' versus the 'dynamicists' have survived a century and are still very much part of our ongoing discussions in modern psychiatry which has added one other fundamental controversy. Stengel calls it a controversy between the 'separatists' and the 'gradualists'. The separatists conceive of the psychoses as autonomous disease entities which are qualitatively different from the neuroses and character disorders. The gradualists, led by Menninger and Ey, advocate a unitary concept of mental diseases, and see mental pathology distributed on a continuum from the normal to the psychotic, which is, according to this school, only quantitatively different from the neurotic, i.e., sicker."

[7] The first (two) paragraph(s) of GRIESINGER´s (1867) MENTAL PATHOLOGY AND THERAPEUTICS read: "The following treatise has for its object the study of mental disease or insanity, its diagnosis and treatment. Insanity itself, an anomalous condition of the faculties of knowledge and of will, is only a symptom; our classifications of the group of mental diseases proceeds upon the symptomatological method, and by such a method alone can any classification be effected. The first step towards a knowledge of the symptoms is their locality -- to which organ do the indications of the disease belong? What areas must necessarily and invariably be diseased when there is madness? The answer to these questions is preliminary to all advancement in the study of mental disease. Physiological and

looked at mental disorders as "the result of dynamic, psychologic and spiritual struggles".[8] According to Lehmann (1971), it was "reacting to this confusion" that Neumann (1859) declared, that psychiatry would only be able to progress if it decided to "throw overboard the whole business of classification," and adopted the unitary concept of psychosis.

A completely different view regarding the place and role of unitary psychosis on the conceptual development of psychiatric diagnosis and classification was presented by Pichot (1986). In variance with Lehmann (1971), he suggested that the increase of interest in nosology during the last quarter of the 19th century, was triggered by Griesinger´s (1867) formulation of the concept of unitary psychosis.

Psvchopharmacologic Considerations

The initial clinical studies with chlorpromazine,[9] the first clinically employed neuroleptic[10], were carried out approximately 100 years after the introduction of the concept of unitary psychosis. They were conducted at a time, when the nosologic concept

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pathological facts show us that this area can only be the brain; we therefore primarily, and in every case of mental disease, recognize a morbid action of that organ."

[8] HEINROTH´s monograph, LENRHUCH DES STORUNGEN DES SEELENLEHENS, was published in 1818. It represents an "ethico-religious line of mentalism" in which "mental disease is by nature a loss of liberty and the result of sin and misdeeds" (Pichot, 1983).

[9] The basic constituent of chlorpromazine is the phenothiazine nucleus which consists of two benzol rings attached to each other by a sulfur and a nitrogen atom. It was synthesized on December 11, 1950 by Charpentier and his collaborators (1952); released for clinical studies by May 2, 1951, upon completion of the intitial pharmacological investigations by Courvoisier and her team (1953), and had been tried as an autonomic stabilizer (Laborit, Huguenard and Alluaume, 1952) to bring about a condition that Laborit (1952) described as 'artificial hibernation' within the same year (Ban, 1972).

[10] The term neuroleptic, was first used by Delay and Deniker in 1955 to replace the term "neuroplegic", the term used by Laborit in 1952 to characterize the action of chlorpromazine (Caldwell, 1970). In 1967 the World Health Organization adopted the term neuroleptic for drugs, which similar to chlorpromazine, have "therapeutic effects in psychoses and other types of psychiatric disorders and are accompanied in their action by certain neurological effects such as extrapyramidal signs" (Ban, 1969). However, SHEPHERD (1990) in his recent paper THE NEUROLEPTICS AND THE OEDIPUS EFFECT published in the Journal of Psychopharmacology, pointed out "that the widespread use of the term 'neuroleptic' in preference to the many alternatives that were originally suggested -- for example 'ataractics', 'tranquilizers', 'deturmoilizers', 'antipsychotics', 'anti-schizophrenics', etc. -- has no more than what even one of its advocates has admitted to be 'frail' scientific value (Collard, 1974). For this reason the committee responsible for the WHO Lexicon on Psychiatric and Mental Health Terms has recently proposed that 'neuroleptic' be defined as follows: A term applied by Jean Delay and Pierre Deniker to drugs, phenothiazines, reserpine, alkaloids, butyrophenones, whose supposedly specifically antipsychotic action is associated with the induction of a neurological syndrome of the extrapyramidal type. The value of the term is dubious and its use is to be deprecated. The comments received so far from an international panel of experts indicate that the definition commands general assent."

of unitary psychosis had long been replaced by a number of different diagnostic concepts of functional and organic psychoses. Because of this, it could readily be seen, that the therapeutic effects of chlorpromazine, did not distinguish among, and cut across the diagnostic boundaries of different psychoses. Considering that chlorpromazine (and other subsequently developed neuroleptics) were able to control psychopathologic symptoms, which could lead to construction of false environment out of subjective experiences, Lehmann (1961) referred to neuroleptics as antipsychotic drugs. He did not imply, however, that the different antipsychotic (i.e., neuroleptic) – responsive syndromic diagnoses, were an integral part of one and the same disease process.[11]

If therapeutic responsiveness to chlorpromazine during the acute phase of treatment alone would suffice as an acceptable validation criterion for a diagnosis, the results of the initial clinical studies with chlorpromazine[12] were in support of unitary psychosis.[13]

Considering, however, that this is not the case, and that therapeutic effects with neuroleptics show great variations with continuation of treatment, the similar therapeutic response during the acute phase[14], cannot be interpreted as supportive of a unitary concept of mental illness. On the other hand, it indicates, that chlorpromazine can control certain

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[11] Lehmann (1971), in his presentation at the International Collegium on Psychosis, held in 1969 in Montreal, made his position regarding unitary psychosis clear by the following statement: "One effect the advent of pharmacotherapy has had on clinical psychiatry may be considered detrimental to nosology, i.e., the immediate use of neuroleptic drugs in acute psychotic conditions before an adequate diagnosis has been established... The situation is not unlike that encountered in internal medicine, where the premature application of antibiotics in bacteremia, or of morphine in acute abdominal pathology, might obscure the precise diagnosis. At our hospital, we have a standing rule prohibiting the continued use of neuroleptic drugs in newly admitted patients until a definite diagnosis has been made."

[12] The first clinical study using chlorpromazine with psychiatric patients was conducted by Hamon, Paraire and Velluz (1952) at Val de Grace, the famous military hospital in Paris. It was followed by the initial clinical studies of Delay and Deniker (1952) in France, Staehelin and Kielholz in Switzerland (1953), and Lehmann and Hanrahan (1954) in Canada (Caldwell, 1970; Ban, 1972).

[13] Similar therapeutic effects on psychotic manifestations in different disorders suggest a common biologic anomaly of psychotic manifestations which is affected by the drug, and not of a common biologic basis of the different disorders. Because of this, only by stretching the concept of unitary psychosis into the concept of psychotic spectrum disorders could one consider that the findings of similar therapeutic effects with chlorpromazine in different disorders is supportive of unitary psychosis. In no way could one consider it supportive of the contention that different clinical syndromes are different stages of one and the same pathologic (disease) process.

[14] Therapeutic response to a particular drug during one developmental stage of an illness alone does not suffice as a validation criterion for a nosologic (diagnostic) concept. On the other hand, similar therapeutic response in all the different developmental stages of an illness, qualifies for a validation criterion.

target symptoms[15], commonly seen in the acute phase of different psychoses, regardless of the diagnosis.

[15] The term, target symptoms was first used by Freyhan (1955) for the specific symptoms which are selectively affected by chlorpromazine. Since the late 1950s the term has been in use in a broader sense for the different symptoms that are selectively affected by psychotropic drugs. Similar to the antipsychotic concept of Lehmann (1961), the essence of Freyhan´s target symptom concept is, that the effect of drugs, such as the antipsychotics (neuroleptics) is not on nosologic (i.e., etiologic) entities, but on the manifestations (i.e., the biologic substrate of the final common path) of psychosis.