AN INTRODUCTION TO PSYCHIATRIC NOSOLOGY

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PREFACE

In the absence of clearly identifiable morphological substrate by histological and/or neurochemical methods, there is no consensus in regard to the meaning of "disease entity" in relationship to mental illness. In spite of this, "psychiatric nosology," the discipline concerned with the classification of "disease entities" in psychiatry is well over 200 years old. It began in the mid-18th century with the work of Boissier de Sauvages (1768); developed during the early 19th century through the classifications of Pinel (1798) and Esquirol (1838) in France; and reached maturity in the classifications of Kraepelin (1896) in Germany and Bleuler (1916) in Switzerland.

The basic principles of "psychiatric nosology" were set out in JASPERS' classic text on GENERAL PSYCHOPATHOLOGY, first published in 1913. In his monumental work, Jaspers (1913, 1919, 1922, 1942, 1959,1962) separated "nosography," the case history," from "biography," the "life history," and defined "nosology" as the discipline concerned with the "synthesis of disease entities" primarily from "psychopathological phenomena." For Jaspers (1962) "the idea of the disease entity" was "an idea in Kant's sense of the word; the concept of an objective which one cannot reach since it is unending," but which "indicates the path for fruitful research and supplies a valid point of orientation for particular empirical investigations." He maintained that "in nosology we do not secure a single, definite disease-entity, but guided by the idea of disease-entity, we give preference to certain, particular elements and isolate for our diagnostic purposes the relative disease entities as best we can."

The notion of "relative disease entities" and the "conceptual continuum of disease entities" led to empirical studies. These, in turn,

yielded to increasingly "more developed" disease pictures, such as the "psychopathological disease entity" of Pauleikhoff (1969), the "etiological-syndromatological disease entity" of Petho, Tolna and Tusnady (1979) and the "small disease entity" of Schneider (1925, 1932) (Petho et al., 1984). By rendering "relative disease entities" accessible for direct investigation, the detection of "natural disease-entitites" and the development of a "valid nosology" have become distinct possibilities in psychiatry.

In the following INTRODUCTION TO PSYCHIATRIC NOSOLOGY, the basic principles of psychiatric nosology will be discussed and the conceptual development of a new classification of mental disorders will be outlined.

BASIC PRINCIPLES OF PSYCHIATRIC NOSOLOGY

Introduction

The two major disciplines which serve as the foundation for modern psychiatry are psychopathology (general psychopathology) and nosology (clinical psychopathology). The two disciplines are intrinsically linked with each other; psychopathology deals with "subjective phenomena" ("phenomenology"), such as for example "hallucinatons," and "objective performances" ("performance psychology"), such as for example "amnesias," of "psychic life," whereas "nosology" deals with "disease entities," and the "classification" of "disease entities," which result from the "synthesis" (integration) of "subjective phenomena" and "objective performances" (Jaspers, 1962).

It is a common contention that a valid "psychiatric nosology" is an essential prerequisite for a meaningful interpretation of contributions from the neurosciences with possible relevance to mental illness. Such a "nosology" could play a significant role in bridging the increasingly widening gap between neuropharmacological research and its clinical psychopharmacological applications. In spite of the high expectations from a valid system of diagnostic classification, the essential prerequisites of a"psychiatric nosology" will still need to be verified by properly conducted research. Among these prerequisites the first and probably the most important is that naturally occurring categories of mental illness exist, regardless whether any of the natural psychiatric disorders have been identified (discovered). Another important prerequisite is that each naturally occurring category of mental illness represents a "dynamic totality" which cannot be restricted to, and should not be studied in a given static-state of "cross-sectional psychopathology" without considering the permanent changes in the disease from

"onset" to "outcome." The final and third prerequisite of a valid "psychiatric nosology" is, that each psychiatric disorder is defined by a characteristic "determining structure," which, as a rule, has the dominant effect on the integration of a variety of different elements into distinct categories of disease.

Prerequisites of Psychiatric Nosology

It was in the MEDICAL DICTIONARY of ROBERT JAMES, published in London in 1743, that the term "nosology" appeared for the first time. Twenty-five years later,in 1768, the term reappeared in the title of BOISSIER DE SAUVAGES treatise, NOSOLOGIA METHODICA, the first acknovledged classification of mental disorders. The influence of NOSOLOGIA has been so great and long-lasting, that even today we use the term "nosology" in a sense of a "methodology" in the "diagnosis" and "classification" of mental disorders (Lehmann, 1971).

Naturally Occurring Categories of Psychiatric Disorder

The origin of the first essential prerequisite of a "psychiatric nosology"--that naturally occurring categories of mental illness exist--was in the work of Boissier de Sauvages (1768). As a "botanist" and a recognized "specialist" in "mental illness" (Cullen, 1810), he was especially well prepared for adopting the two basic rules of Linne (1735)--for classifying flowering plants and ferns--to the classification of psychiatric disorders. Accordingly, he maintained that "psychiatric nosology" should consist of "categorical diagnoses" which are based on criteria,or special characteristics, which "allow the attribution of each patient to one and only one class," and should represent a "natural classification" of the disease categories thereby identified.

Boissier de Sauvages (1768) was "an outspoken advocate of symptomatological nosology." He firmly believed that "a disease should be defined by the

enumeration of the symptoms which suffice to recognize it and to distinguish it from others" (Rosenzweig, 1982). Because of his strong influence, the first important "nosologies"--Pinel's (1801) and Esquirol's (1838)--were "descriptive classifications which defined empiricaly isolated syndromic classes" (Pichot, 1986).

Dynamic Totality of Psychiatric Disease

The origin of the second "essential prerequisite" of a "psychiatric nosology"--that naturally occurring categories of mental illness represent a "dynamic totality"--was in Falret's (1864) notion that "a natural form of psychiatrric illness implies a well defined predictable course" and vice versa "a well defined predictable course presupposes the existence of a natural species of disease with a specific pattern of development." By focusing attention on the evolution of symptomatic expressions, i.e., on the natural history of psychiatric illness, Falret (1864) has opened the path for "nosologies" which are based on an increasing number of developmental stages of psychiatric disorders. An important role in this development was played by Kahlbaum (1874), who put forward the task "to use clinical methods in the study of the developmental picture of psychiatric illness." He maintained that for diagnostic purposes "the whole course of illness must be taken into account."

The new conceptual framework was applied by Kahlbaum (1874) to the description of "catatonia." Subsequently, it was adopted by Kraepelin (1896) for the description of the whole field of mental illness. Because of this, it was Kraepelin (1896) whose system of diagnostic classification combined for the first time "a careful description of symptoms and syndromes with their course and outcome" (Lehmann, 1971). Kraepelin (1896) believed that the "clinical pictures of disease with similar causes, a similar psychological form and similar cerebral pathology, are genuine-natural disease

entities." However, his major contribution to psychiatric research was in the shift of emphasis from the "course of illness"--which remained the focal point for Kahlbaum (1874)--to the "outcome picture." His rationale for the shift of emphasis was in the supposition "that knowledge of the psychological structure of the outcome" would allow the detection of "the basic psychological forms of the disease process even in the finest of indications at the very beginning" of the disorder (Jaspers, 1962).

Determining Structure of Psychiagtric Disease

The origin of the third "essential prerequisite" of a "psychiatric nosology"--that each psychiatric disorder is defined by a specific "determining structure"--is in the work of Jaspers (1962), who was the first to note that psychiatric "diagnosis can only be made from the total picture when one knows 'a priori' of a definite illness that can be diagnosed."

The term "determining structure" was put forward in the PROLEGOMENON TO THE CLINICAL PREREQUISITE by BAN (1987). It refers to the form of the mental illness, i.e., the "pattern" that is predetermined by the illness, which cannot be reduced to the sum of information from the subsequent developmental stages (dynamic totality) of the disorder.

Prerequisite of Psychiatric Diagnosis

If the prerequisites of "psychiatric nosology" are fulfilled, psychiatric illness, like any other medical illness is the result of a disease process that becomes manifest in the "case history" of patients.

In "sui generis" psychiatric disorders the "case history" is independent of, and superimposed on, "personality development," which is intrinsically linked with the "life history" of the patient. In contradistinction to the "life history," or "biography," which is expressed by a chain of events, or "contents," the "case history" is expressed in the different "forms" of

"pathological experiences" during the different developmental stages of the "dynamic totality" of psychiatric illness.

It is a commonly held view that psychiatric disorders are behavioral disorders. However, psychiatry differs from behavioral medicine, because psychiatric disorders are based on pathological (forms of) experiences--which are stronger than, and override physiological real experiences--and not on abnormal behavior. This is the case even if the abnormal behavior is the most prevalent feature of the clinical picture.

Life History vs Case History

Personality development or "life history" has its primary source in a specific "Anlage or disposition" which "grows, evolves and absorbs in a continuous sequence of the changes brought about by respective age epochs." This particular "disposition is in constant interaction with the milieu," it "gains its specific shape through its human destiny" and it "reacts to experiences in a constant way according to its own nature" (Jaspers, 1962).

In the "case history" a "disease process" intervenes and becomes superimposed on "life history" disrupting "personality development" (Petho, 1984). While in the original formulation a "process" implied only a "disease processs" with lasting changes, today the concept of "process" is extended to include "disease processes" which are "phasic," i.e., transient, and do not affect the "life history," i.e., "personality development" of the patient between episodes.

Neuropathological Process vs Psychopathological Process

Depending on the nature of the morphological substrate involved, the "case history" is based on a "psychopathological" or on a "neuropathological process." In case of the former, i.e., "sui generis" psychiatric disorders, the "case history" is characterized by increasing differentiation of psychopathological features, whereas in case of the latter, i.e., somatically

determined (organic) psychiatric disorders, the "case history" is characterized by gradual dedifferentiation--dementia--of the clinical picture.

It has been noted that in chronic brain disease, where the actual chain of events lies in the cerebral substrate, the psychopathological manifestations are largely a haphazard sequence of symptoms (Jaspers, 1962). One possible reason for this is that they are dependent on "neuropathological changes" in the absence of a "psychopathological process" (Hoenig, 1985).

Psychopathological Process and Psychopathological Symptoms

The morphological substrate of the "psychopathological process" is reflected in psychopathological symptoms. Each psychopathological symptom is a concept based on pathological mental (psychic) experiences (phenomena); and each psychopathological symptom has a content, which is derived from past experiences, and a form, which is characteristic of the illness.

The importance of psychopathological symptoms in psychiatric diagnosis cannot be overemphasized, because it is the relative frequency of "pathological forms of experience," with consideration to the "form of onset," "course" and "outcome" of these experiences, that provides (primarily) for the clinical diagnosis.

Psychopathology and Psychiatric Diagnosis

The term "psychopathology" was first employed by Emminghaus in 1878. However, the scientific discipline, "psychopathology," which deals with the identification, description and conceptualization of signs and symptoms which occur in patients with psychiatric disorders, was born only with the publication of Jaspers' Allgemeine Psychopathologie in 1913. One of the essential prerequisites for any scientific inquiry is the development of a set of concepts which can be communicated to others. Because of this, without the development of "psychopathology," psychiatry could not be regarded as a medical-scientific discipline. Today, "psychopathology," provides the

conceptual basis of verified psychiatric knowledge that is necessary for diagnostic practice and the conceptual framework of research relevant to psychiatric problems.

Boundaries of Psychopathology

Phenomenology, or "subjective psychopathology," deals with the subjective phenomena of mental life. It is one of the four component disciplines of "psychopathology" with the special task to provide "a concrete description of the psychic states" experienced by the patient. Because of its utmost importance in the diagnostic process and classification of mental illness, the term "phenomenology" is frequently used in an interchangeable manner with "psychopathology." However, while the task of "phenomenology" is to present the "psychic states" experienced by the patient "for observation" and to render these "psychic realities," "intelligible" by concepts and "a suitable terminology," which can be communicated to others, the task of "psychopathology" is to integrate the information contributed by "phenomenology" with the information contributed by the other component disciplines. These other disciplines are "objective psychopathology"[1] dealing with "observable performances" and "somatic (physical) accompaniments or consequences of psychic events"; "understanding psychopathology," dealing with "meaningful connections" and "comprehensible relations"; and "explanatory psychopathology," dealing with "causal connections" and "causal explanations," i.e.,with findings "by repeated experience that a number of phenomena are regularly linked together" in a particular manner with another "intrinsic" or "extrinsic" factor (Jaspers, 1962; Pichot, 1983).

A closely related discipline to "psychopathology" is "pathopsychology," or "abnormal psychology." The essential difference between the two

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[1]In Jaspers (1962) General Psychopathology both "Phenomenology" and "Performance Psychology" (or "Objective Performances of Psychic Life") are dealt within Part One under the heading "Individual Psychic Phenomena."

disciplines is that in "pathopsychology" abnormal "mental phenomena" are perceived and understood in terms of deviations from the statistical mean, accepted as normal for the subject's social background, whereas in "psychopathology," abnormal "mental phenomena" are perceived and understood within the frame of reference of mental illness (Juhasz and Petho, 1983; Schneider, 1958).

In spite of their close relationship to each other, "abnormal psychology" is not an adequate substitute for any of the component disciplines of psychopathology in the diagnostic process and classification of mental illness. Similarly, none of the four component disciplines alone is an adequate substitute for "psychopathology," the discipline responsible for the integration of phenomena into "forms" or "patterns," which are synthesized by "clinical psychopathology" into "disease entities," which in turn are grouped together on the basis of different principles and considerations in the different classifications of psychiatric disorders.

Exploration of Psychopathology

The diagnostic process in psychiatric disorders is based on the mental status examination. The purpose of this examination is the establishment of patient's "psychopathological symptom profile," primarily on the basis of "phenomenological exploration."

There are numerous difficulties encountered in the detection of psychopathological symptoms. One of the most important is that "conscious psychic life" presents itself in a "total relational context" instead of "distinct," "clearly separated" and "isolated phenomena" (Jaspers, 1962).

The difficulty is compounded by the "constant flux" of this complex clinical picture; and the simultaneous presence, and quick succession, of widely varied "phenomenological forms" of the same content. In acute

psychosis, for example, the same jealous content may appear in the form of an emotional state, a hallucination and/or a delusion.

For sometime it was believed that the "individual momentary experience," which is "woven from a number of phenomena," is so complex, that it cannot be "disentangled." It is, however, increasingly recognized that psychopathological symptoms can be "separated" and "artifically isolated" from each other even within the most "complex" and "entangled individual momentary experience Furthermore, it is also increasingly acknowledged that among the "artificially isolated phenomena," those which are relevant to patient's mental illness appear to be "clearer" and "sharper" than all other phenomena in patient's experience. Because of this, some consider "artificial isolation of phenomena" as one of the important methods in the exploration of psychopathological symptoms and in the diagnostic evaluation of psychiatric patients.

Ordering of Psychopathological Symptoms

The role of "psychopathology" in the diagnostic process is to render the "knowledge" obtained through the mental status examination accessible by "integration" and "systematization" for clinical-diagnostic decisions. "Ordering," or "integration" and "systematization," is an "arbitrary process," which depends on its ultimate purpose.

For diagnostic evaluation psychiatric patients are usually described in terms of "disorders of perception and thought," "disturbances of emotions and mood," and "disorders of drive and psychomotility" (Wernicke, 1981; Nyiro, 1962). To obtain a comprehensive picture, however, this information must be supplemented with other information e.g., on "disorders of consciousness," "disturbances of attention and memory," "disorders of the experiencing of the self (ego)" as "one" in a "moment of time" ("ego-integrity"), as the "same" in the "course of time" ("ego-identity") and as "distinct from the environment" ("ego-boundaries") (Guy and Ban, 1982).

Considering that psychiatric illness represents a "dynamic totality," information on "psychopathology" must include information on "onset," "course" and "outcome"; and considering that psychiatric illness is primarily based on "pathological experiences," information on "psychopathology" must qualify the "pathological forms" and "contents," i.e., whether the experiences are "allopsychic," reflecting the outside world, or "autopsychic," reflecting one's self, or "somatopsychic," reflecting one's body (Wernicke, 1899).

Integration of Psychopathological Symptoms

While the role of "general psychopathology" in the diagnostic process is the "ordering" of information relevant to diagnostic decisions, the role of "clinical psychopathology" is the "integration" of this pre-ordered information into "disease entities" of mental illness. Since psychiatric patients present their "problems" (symptoms) in terms of events, i.e., "contents," while clinical diagnosis is based on the integration of "pathological forms of experience," the crucial step in the diagnostic process is the separation "in the steady flow of contentual information the modes, or forms in which the different events are experienced."

Separation of Form from Content

In all "psychic experience" there is an "object," i.e., "an objective element in its widest sense" that is called "psychic content" and a "subject," i.e., "a mode" in which the "subject" is presented with the "object." "Perceptions," "ideas," "judgments," "feelings," "drives," "self-awareness" are all "forms" of "psychic phenomena," whereas "events" and "behaviors" are "contents." Accordingly, "hypochondriacal complaints," a "content," may appear in the "forms" of "hallucinatory voices," "compulsive ideas," "overvalued ideas" and/or "delusional ideas," and "grandiose delusions," a "content," may appear in the "forms" of "hyperthymic mood" and/or

"fabulations" i.e., "memory falsifications" (Jaspers, 1962). Furthermore, in case of "delusions of being controlled," the delusions are the "content" (or "object") of the "pathological experiences," which are presented in the form of "disturbance of self-integrity" to the "subject." Because of this, "delusions of being controlled," a "content disorder of thought," is a "disturbance of ego-integrity" in so far as psychopathology is concerned.

Formal Characteristics of the Psychopathological Process

In the ultimate analysis the "formal characteristics" of the "psychopathological process" must be separated from their "contents" in terms of "onset," "course," and "outcome." While the "form of onset" may be "acute," "subacute" or "insidious," the "form of the course" may be "episodic" or "continuous." Among the formal characteristics of the course "periodicity" ("irregular" or "rhythmic"), "polarity" ("unipolar" or "bipolar") and "progressiveness" ("remitting" or "deteriorating") must also be considered (Petho, 1984). "Form of outcome" ranges from "full recovery" to "clinical defect." In between are "maladjustment," "accentuated personality," "transformation of personality," "personality defect," "transient partial remission," "clinical recovery" and "residual psychopathology" (Petho et al., 1984).

Finally, in so far as cross-sectional "psychopathological symptoms" are concerned the total clinical picture may display one of three forms, i.e., "polymorphous," "monomorphous" or "amorphous" (Petho et al., 1984). In case of a "polymorphous," i.e., "multiform" or "variable" clinical picture, different symptoms and/or syndromes prevail at different times, whereas in case of a "monomorphous," i.e., "well defined," "pure," or "distinct" clinical picture, the prevalent manifestations remain unchanged during the illness, or at least within a single episode of the illness. In case of an "amorphous" clinical picture the different "psychopathological symptoms" and

tendencies do not combine into a uniform picture. They do not crystallize and define themselves, but remain transient and indefinite.

Theoretical Issues

There are two major theoretical controversies relevant to psychiatric classification.

Categorical Model

The controversy whether diagnostic classification in psychiatry should be based on a "dimensional model" or a "categorical model" began with the dialogue between the adherents to Griesinger's (1845) concept of "unitary psychosis," a "dimensional concept"--which implies that "psychiatric disorders" are based on a "large number of continuously distributed measures on one or more dimensions in a homogenous space"--and the followers of Kraepelin's (1896) "categorical nosology," which implies that "psychiatric disorders" are based on a "large number of discontinuously distributed elements of to or more categories in a heterogenous space" (Pichot, 1986). Essentially the same controversy was reflected in the dialogue between the "separatists" and the "gradualists" (Stengel, 1959). For the "separatists," "psychoses" were "autonomous" disease entities, i.e., categories, qualitatively different from the "neuroses" and "character disorders," whereas for the "gradualists" mental pathology was distributed on a "continuum," i.e., on a "dimension" from the "normal" to the "psychotic," that was considered to be only quantitively different from the "neurotic" (Lehmann, 1971).

One of the most powerful arguments against the "categorical" model and in favor of the "dimensional" model in psychiatric classification, was put forward by Eysenck (1960). His argument was based on the findings that factor analytic and related techniques have consistently failed to replicate the clustering of the features implicit in "categorical nosologies." After failing to demonstrate "bimodality" between "affective disorder" and

"schizophrenia" (by "discriminant function analysis"), a similar argument against the "categorical model" was raised by Kendell and Gourley (1970). Nevertheless Roth (1978) maintained that with consideration to the "clear, and in some instances qualitative differences (which) have been demonstrated between these two conditions in respect of heredity, fertility, measures of personality, course,, outcome, response to treatment" among many others, "it is the validity and relevance of the particular dimension (they have chosen) that fails to reveal discontinuity." Because of this, according to him, the only valid conclusion one can derive from such a study is that the dimensions chosen for differentiation have been wrong and "not the independence of schizophrenic and affective psychoses as nosological entities."

The dialogue was reopened by Kendell's (1982) suggestion that a "dimensional classification" of depression offers at least "theoretically" some advantages for biological research (Philipp and Maier, 1986). According to him, "transforming the graduation in symptomatology between two syndromes into a linear variable allows to select groups with high diagnostic homogeneity" (Philipp and Maier, 1986). But even such an "exercise would be (considered as) impractical" by Roth (1978), because "starting from a clinical tabula rasa, which ignores all existing categorical entities, the number of dimensions required for categorizing patients would be without limit." Consequently, "to reduce the task to managable proportions, a clinical diagnosis would have to be made first."

In recent years Loranger (1981) has presented findings on the "genetic independence of manic-depression and schizophrenia," in support of the "categorical model." In spite of this, on the basis of complex genetic considerations, Crow (1986) put forward a speculation on "the continuum of psychoses," in favor of the "dimensional model" of psychiatric disorders.

Hierarchical Order

In the late 1970's Pope and Lipinski (1978), Koehler (1979) and Berner (1982) challenged Jaspers (1962) contention that in case of the presence of both, "schizophrenic psychopathological symptoms" outweigh "affective psychopathological symptoms." According to these authors they are the "affective" and not the "schizophrenic psychopathological symptoms" which have differential diagnostic significance. This is to the extent that not only current, but also prior "affective psychopathology" and/or family history of "major affective disorder" may be of relevance in ruling out a diagnosis of "schizophrenia."

One of the arguments used in favor of the "reversed hierarchical principle" is that all original concepts relevant to "affective disorder" have remained by and large unchanged, whereas all the original concepts relevant to "schizophrenia" have "continually been the subject of scientific disagreements and new attempts at formulation" (Berner et al., 1983). Another argument in favor of the "reversed hierarchical principle" is based on Janzarik's (1949, 1959) contention that Schneider's (1957) "first rank symptom of schizophrenia" are the result of "dynamic--affective--instability," one of the three forms of "dynamic derailment" that may arise in a variety of disorders, e.g., "transitory psychosis," "mixed psychosis" and even "manic-depressive psychosis." Because of this, Berner et al. (1983) suggested that "schizophrenic symptoms in general are fully unspecific phenomena which may appear under various psychotic conditions." A third and possibly the most powerful argument used in favor of the "reversed hierarchical principle" is the significantly greater predictive validity of the "endogenomorphic cyclothymic (affective) axial syndrome" than of the "endogenomorphic schizophrenic axial syndrome" (Berner et al., 1986).

The controversy regarding the "hierarchy" of disorders in psychiatric classifications has not affected diagnostic practice. Although some of the recent diagnostic classifications allow for multiple diagnoses, in general the "traditional hierarchy"--"organic dementias," "functional psychoses," and "personality disorders"--still prevails. One of the main reasons for this is, that it is difficult to diagnose a "functional psychosis," i.e., a schizophrenic disorder or an affective disorder in case of the presence of an "organic disorder"; and impossible to diagnose a "personality disorder" in case of the presence of any of the other disorder (although the DSM-III-R requires an Axis II - personality disorder diagnosis regardless of the Axis I - clinical syndrome diagnosis.)

Methodology of Psychiatric Classification

Classification in general refers to the ordering of objects "into groups on the basis of their relationships" (Sokal, 1974). In the medical disciplines, similar to other disciplines, the "classificatory system" provides for "denomination," "qualification" and "prediction," i.e., "common names," "descriptive features" and "probabalistic statements" about expected "course" and "outcome" of the diagnostic groups (Feinstein, 1922). Since the validity and usefulness of classifications are largely dependent on the strength of their prognostic implications, Kendell (1975) maintains that in a meaningful classification the boundaries between diagnostic groups "should be placed in such a way that the (diagnostic) categories are as homogenous as possible with respect to prognosis, including therapeutic responsiveness."

Classification of Psychiatric Classifications

In his paper on METHODOLOGICAL ISSUES IN PSYCHIATRIC CLASSIFICATION, JABLENSKY (1988) proposed a "three-way classification of classifications which can be applied to the examination of psychiatric classifications." According to their "taxonomic strategy," classifications in psychiatry may be

"phyletic," i.e., based on a "primary essence," or "phenetic," i.e., based on a "meticulous description of the appearance of objects"; according to the "cognitive operation involved," classifications may be "empirical" i.e., based on "observable facts," or "inferential," i.e., based on inferences or "guesses" about "possible underlying causes and processes"; and according to their "end product," classifications may be "monothetic," i.e., based on "classes" which "differ by at least one property which is uniform among the members of each (one) class," or "polythetic," i.e., based on "classes" which "share a large proportion of their properties but do not necessarily agree in the presence of any one property" (Beckner, 1959; Guze, 1978; Sokal, 1974).

Currently used diagnostic classifications in psychiatry are "polythetic taxonomies" (Guze, 1978) which are to a great extent based on a "phenetic" "taxonomic strategy." However, in spite of its "atheoretical approach," not even the DSM-III-R is a truly "empirical" classification, because its diagnostic concepts are derived from a "meaning (consensus) analysis," and not from an "empirical analysis" exclusively (Schwartz and Wiggins, 1986).

Numerical Taxonomy

Phenetic classifications today may employ "numerical taxonomy," a statistical approach which has become practically feasible only with the advent of computers and multivariate statistical techniques. In a manner "reminiscent of the position of logical postivism," "numerical taxonomy" would like to be free of assumptions and therefore treats, at the start of analysis, "all characters and attributes of being of equal weight" (Jablensky, 1988). Such an approach of course is eminently suited in testing the validity of clinical hypotheses and impressions.

One of the heuristically important findings in a clinical diagnostic-study which employed "numerical taxonomy" was, that inclusion of, "social adjustment" variables with "psychopathological symptoms" and "personality

characteristics," lowered the "predictive validity" of diagnoses at the time of the "index psychoses." In the same study, the "clusters" based on "psychopathological symptoms" and "personality characteristics" had good correspondence with diagnoses at the time of the "index psychosis" whereas the variables of "social adjustment" had not (Petho, 1984).

Concluding Remarks

In the foregoing the essential prerequisites of a valid "psychiatric nosology" were described and the basic principles in the construction of such a "nosology" reviewed. It was emphasized that "psychiatric nosology" is based on the assumption (of philosophical materialism) that "naturally occurring mental illness" is an "objective reality"; and it was suggested that "mental disorders" must be studied in their "dynamic totality," i.e., in their (dialectic) "movements" and "changes" as they unfold within their specific "determining structure."

The role of "psychopathology" in general, and the importance of "phenomenology" in particular, in the diagnostic process was discussed. It was pointed out that "abnormal psychology" is not an adequate substitute for any of the "component disciplines" of "psychopathology"; and that none of the "component disciplines" of "general psychopathology" alone is an adequate substitute for "psychopathology," i.e., the integrating discipline, in the diagnostic process.

Attention was focused on the distinctiveness between "form" and "content" in terms of "psychopathological symptoms" and in terms of the "psychopathological process," i.e., "onset," "course" and "outcome"; and an attempt was made to demonstrate that it is the information on the "how," i.e., on the "form" and not the information on the "why," i.e., on the "content," which is of diagnostic significance.

Some of the "theoretical controversies," such as the controversy of "categorical" vs "dimensional" diagnoses, and the "hierarchy" of diagnoses, were reviewed; and some of the "methodological issues," such as "phyletic vs "phenetic" nosologies, "inferential" vs "empirical" classifications, and "monothetic" vs "polythetic" taxonomies, were examined.

Finally, the difficulties in constructing a "truly empirical" classification of psychiatric disorders were discussed, with special consideration to the possibility that confounding the exploration of "phenomenology" with the study of "meaningful connections" may impede the diagnostic process. The same applies to the broadening of the scope of information from "psychopathology" to "social adjustment" which instead of adding a new dimension may decrease the validity of diagnoses.

NOSOLOGY: REVIEW OF HISTORICAL DEVELOPMENT

Introduction

The history of nosology is intrinsically linked with the formulation of the three essential prerequisites of a valid classification of psychiatric disorders. Formulation of the first essential prerequisite, and the concentrated efforts which followed to recognize "naturally occurring categories of mental illness," led to the classifications of Philippe Pinel (1801) and Jean-Etienne-Dominique Esquirol (1838). Similarly, formulation of the second essential prerequisite, and the subsequent shift of emphasis from a given, static state of the cross-sectional clinical picture to the "dynamic totality," i.e., course and outcome of psychiatric disease, led to the classifications of Emil Kraepelin (1883-1927) and Eugen Bleuler (1916). Finally and most recently, the formulation of the third essential prerequisite, and the re-evaluation of traditional diagnostic categories in terms of their totality, i.e., "determining structure," which followed, led to the classifications of Kurt Schneider (1950) and Karl Leonhard (1957). An integration of Leonhard's (1957) classification, the first classification in which the diagnostic heterogeneity of populations within the major categories of endogenous psychoses was convincingly shown, with the classification of Kurt Schneider (1950), the first classification in which the distinctiveness between personality development and disease process was explicitly recognized, has been proposed by Frank Fish in his Clinical Psychopathology, published in 1967.

In the following, the three consecutive "epochs" in the development of psychiatric "nosology" will be reviewed with special reference to the classifications of Pinel (1801), Esquirol (1838) (1st epoch), Kraepelin (1883-1915), Bleuler (1916) (2nd epoch), Schneider (1950) and Leonhard (1957) (3rd epoch).

First Epoch

The "first epoch" in the history of psychiatric "nosology" was triggered by the work of Boissier de Sauvages (1768) who classified mental "diseases as if they were specimens of nature," and divided "them into ten classes with as many as 295 genera and 2400 species" (Garrison, 1960). Sauvages' (1768) contention that "naturally occurring categories of mental illness exist" and can be identified by the grouping of symptoms (manifestations) at a particular point--cross section--of time, opened the path for the development of "syndromic" classifications of psychiatric disorders.

In the first psychiatric nosologies, in keeping with their "syndromic" nature, the descriptive disease categories were based almost exclusively on the grouping of signs and symptoms of mental illness at a point (cross-section) of time. An exception to this, was the classification of Cullen (1769) which was based exclusively on the manifest clinical picture (Rosenzweig, 1982). Because of the tension between naturally occurring mental disease and the diagnostic categories created by the exclusion of "symptoms which tended to change over time," Cullen's (1769) classification remained outside the main stream in the classification of psychiatric disorders. The same applies to the classification of Boissier de Sauvages (1768), a frequently referred to classification, which has never been clinically employed.

Pinel's Classification

The first clinically employed psychiatric nosology was the diagnostic classification of PINEL, presented in his MEDICO-PHILOSOPHIQUE SUR L'ALIENATION MENTALE, published in 1801. Pinel's (1801) nosology was an "empirical" classification, based on "observable facts," without "mixing metaphysical discussions or certain disquisitions of the ideologists with a science."

In terms of "taxonomic strategy," Pinel's (1801) nosology, was a "phenetic" classification based on "meticulous description of the appearance of (its) objects," in which, "mental derangements" were "distributed" into five "different species," or "syndromes," i.e., "melancholia," "mania without delirium," "mania with delirium," "dementia" and "ideotism" (Table I). Since each syndrome differed from the others by at least one property--uniformly present in one "species" while absent in all the others--in Pinel's (1801) classification the criteria of a "monothetic taxonomy" were fulfilled.

Esquirol's Classification

It is a commonly held view that the roots of all psychiatric classifications are in the nosology of ESQUIROL, presented in his treatise DES MALADIES MENTALES CONSIDEREES SOUS LES RAPPORTS MEDICAL, HYGIENIQUE ET MEDICO-LEGAL, published in 1838. Similar to the classification of Pinel (1801), Esquirol's (1838) nosology was an "empirical" classification, based on "the results of forty years of study and observations" of "the symptoms of insanity" and "the manners, habits, and wants of the insane." As a "phenetic" classification it was confined "to facts," which were "arranged according to their relations" and "stated as they have been observed," without "any attempt to explain them." Esquirol (1838) "avoided systems, which always appeared to be more seductive by their splendor, than useful in their applications." Because of this, Esquirol's (1838) nosology was the first practical classification from a clinical point of view.

In Esquirol's (1838) nosology "insanity" was separated into five distinct "general forms" or "syndromes" i.e., "lypemania" (or "melancholy of the ancient"), "monomania," "mania," "dementia" and "imbecility" (or "idiocy") (Table II); and each "syndrome" differed from the other by at least one unique property. Because of this in Esquirol's (1838) classification, like in

Table I

Species	Mental Derangements	Characteristic Features
First	Melancholia or delirium upon one subject exclusively	"the powers of perception and imagination are frequently disturbed without any excitement of the passions"
Second	Mania without delirium	"the functions of the understanding are often perfectly sound, while the man is driven by his passions to acts of turbulence and outrage"
Third	Mania with delirium	"periodical delirium united with extravagance and fury"
Fourth	Dementia or the abolition of the thinking faculty	"dementia or mental disorganization, where the ideas and internal emotions appear to have no connection with the impressions of sense, and to succeed each other without order, and to vanish without leaving any traces of their existence"
Fifth	Ideotism or obliteration of the intellectual faculties	"total obliteration of the thinking faculties or a privation more or less absolute of all ideas and emotions"

Pinel's (1801) five "species" of "mental derangements" and their characteristic features.

Table II

General Forms	Insanity	Characteristic Features
First	Lypemania or Melancholy of the Ancient	"delirium with respect to one, or a small number of objects, with predominance of a sorrowful and depressing passion"
Second	Monomania	"delirium is limited to one or a small number of objects, with excitement, and predominance of a gay, and expansive passion"
Third	Mania	"delirium extends to all kinds of objects, and is accompanied by excitement"
Fourth	Dementia	"the insensate utter folly, because the organs of thought have lost their energy, and the strength requisite to fulfill their functions"
Fifth	Imbecility or Idiocy	"the conformation of the organs has never been such, that those who are thus afflicted could only reason justly"

Esquirol's (1838) five "general forms" of "insanity" and their characteristic features.

Pinel's (1801) "nosology," the criteria of a "monothetic taxonomy" were fulfilled.

Because of lack in empirical evidence, Esquirol (1838) rejected Griesinger's (1845) idea of "unitary psychosis," a dimensional concept, which later on had its champion in Neumann (1859). In variance with the notion that different "forms" of "insanity" are different manifestations of "one and the same malady," i.e., different developmental stages of the same disease, Esquirol (1838) regarded the five "forms" or "syndromes" of "insanity "as too distinct ever to be confounded." On the other hand, he recognized that his five "general forms of insanity" cannot "characterize (all) the species and varieties (of mental disease) which are reproduced with infinite shades of differences." By acknowledging that under his five "general forms" of "psychiatric syndromes" they are subsumed "many mental afflictions whose origin, nature, treatment and termination are widely different," Esquirol (1838) opened the path for the "second epoch" in the history of nosological development.

Second Epoch

The "second epoch" in the history of psychiatric "nosology" was triggered by the work of Jean-Pierre Falret (1864). His contention that "a natural form of psychiatric illness implies a well defined predictable course" and/or "a well defined predictable course presupposes the existence of a natural species of disease with a specific pattern of development," focused attention on the diagnostic importance of the "dynamic totality" of psychiatric disorders. Recognition that for the characterization of disease, information on symptoms at a particular point--cross-section--of time does not suffice, the syndrome-oriented approach was gradually replaced by a disease-oriented approach in the classification of mental illness.

Instrumental for the development of the second epoch in the classification of psychiatric disorders was the work of Kahlbaum (1874). By describing "catatonia" and distinguishing "between transitory mental states and the disease form itself," he set the stage for Kraepelin (1903-1904), who maintained that "the scientific conception of the disease demands knowledge not only of the present state, but also of the entire course of the disease." Since Kraepelin (1899) shifted emphasis from the "course of illness," the focal point for both Falret (1864) and Kahlbaum (1874), to the "outcome picture" (Pichot, 1983), it was his system of diagnostic classification which combined for the first time "a careful description of symptoms and syndromes with their course and outcome" (Lehmann, 1971).

Kraepelin's Classification

The most influential psychiatric nosology to-date is the diagnostic classification of Kraepelin (1899) presented in his textbook, PSYCHIATRIE EIN LEHRBUCH FUR STUDIERENDE UND AERZTE, first published under the title COMPENDIUM DER PSYCHIATRIE in 1883 (Hippius, Peters and Ploog, 1983).

Kraepelin's (1899) nosology evolved from a "syndromic" classification he described in the first (1883), second (1887) and third (1889) editions of his textbook. An important step in its development was the grouping of the three disorders, i.e., "dementia praecox" (a term adopted from Morel for Hecker's diagnostic concept of "hebephrenia"), "catatonia" (a diagnostic concept adopted from Kahlbaum) and "dementia paranoides," under the heading "psychic degeneration processes" (a concept adopted from Magnan), in the fourth (1893) edition.

The shift from a "syndromic" classification to a "clinical" (disease-oriented) classification took place in the fifth (1896) edition of Psychiatrie, by subsuming all "psychic disorders" under two "inferential" classes, i.e., "acquired" (including "metabolic diseases" and "involutional madness")

and "constitutional" (including "periodic insanity" and "paranoia") (Pichot, 1983). It was fully accomplished in the sixth (1899) edition, in which the unifying diagnostic concept of "dementia praecox" for "hebephrenia," "catatonia" and "dementia paranoides" first appeared. In the same edition, as well as in the seventh edition (1903-1904), the "inferential" classes of "acquired and "constitutional" "psychic disorders" were replaced by 15 disease categories of which, in terms of etiology, seven ("exhaustion psychoses," "involution psychoses," "paranoia," "psychogenic neuroses," "constitutional psychopathic states," "psychopathic personalities" and "defective mental "development") were based on inferences or "guesses" about "possible underlying causes and processes" whereas six ("infection psychoses," "intoxication psychoses," "thyrogenous psychoses," "dementia paralytica," "organic dementias" and "epileptic insanity") were attributed to organic (including toxic) etiologies (Table III). The remaining two diagnostic categories were "manic-depressive insanity" and "dementia praecox." By pooling patients primarily on the basis of the "course" and "outcome" of their illness into these two distinct disease categories, Kraepelin (1899, 1903-1904), in the sixth and seventh edition of his textbook, laid down the foundation for the "Krapelinian dichotomy" of "endogenous psychoses" (a term adopted from Mobius).

It is rather paradoxical, that the "Kraepelinian dichotomy" was abandoned by Kraepelin (1908-1915) himself in the eighth edition of his textbook. By separating "paranoid deterioration (paraphrenia)" from the "paranoid form of dementia praecox," and the "endogenous deteriorations," i.e., the "paranoid form of dementia praecox" and the "paraphrenias" from "manic-depressive insanity" (Pichot, 1983), he proposed a trichotomy, which is much closer to current trends in "nosology" than the "Kraepelinian dichotomy" which has served as the basis for most of the classifications of "endogenous psychoses" to-date (Jablensky, 1981). The same applies to the integration of

Table III

No.	Disease Forms and Subforms
I.	Infection Psychoses
	A. Fever Delirium
	B. Infection Deliria
	C. Post-infection Psychoses
II.	Exhaustion Psychoses
	A. Collapse Delirium
	B. Acute Confusional Insanity (Amentia)
	C. Acquired Neurasthenia (Chronic Nervous Exhaustion)
III.	Intoxication Psychoses
1.	Acute Intoxications
2.	Chronic Intoxications
	A. Alcoholism
	Acute Alcoholic Intoxication
	Delirium Tremens
	Korsakow's Psychosis
	Acute Alcoholic Hallucinosis
	Alcoholic Hallucinatory Dementia
	Alcoholic Paranoia
	Alcoholic Paresis
	Alcoholic Pseudoparesis
	B. Morphinism
	Acute Morphine Intoxication
	Chronic Intoxication
	C. Cocainism
	Active Cocain Intoxication
	Chronic Cocain Intoxication
	Cocain Hallucinosis
IV.	Thyrogenous Psychoses
	A. Myxoedematous Insanity
	B. Cretinism
V.	Dementia Praecox
	Hebephrenic Form
	Catatonic Form
	Paranoid Form
VI.	Dementia Paralytica
	Demented Form
	Expansive Form (megalomania)
	Agitated Form (galloping paresis)
	Depressed Form
VII.	Organic Dementias
	Gliosis of Cortex (Diffused Cerebral Sclerosis)
	Huntingdon's Chorea
	Multiple Sclerosis
	Cerebral Syphilis
	Tabetic Psychoses
	Arteriosclerotic Insanity
	Cerebral Tumor
	Brain Abscess
	Cerebral Apoplexy
	Cerebral Trauma
	Traumatic Delirium
	Traumatic Dementia
VIII.	Involution Psychoses
	A. Melancholia
	B. Presenile Delusional Insanity
	C. Senile Dementia
	Severe Grade of Senile Dementia
	Presbyophrenia
	Senile Delirium
	Senile Delusional Insanity
IX.	Manic-depressive Insanity
	Manic States
	Hypomania
	Mania
	Delirious Mania
	Depressive States
	Simple Retardation
	Delusional Form
	Stuporous States
	Mixed States
	Irrascible Mania
	Depressive Excitement
	Unproductive Mania
	Manic Stupor
	Depression with Flight of Ideas
	Depressive State with Flight of Ideas and Emotional Elation

Table III (con't)

No.	Disease Forms and Subforms
X.	Paranoia Querulent Insanity
XI.	Epileptic Insanity Befogged States Pre-epileptic Insanity Post-epileptic Insanity Psychic epilepsy Somnambulism Epileptic Stupor Anxious Deliria Conscious Delirium Dipsomania
XII.	Psychogenic Neuroses A. Hysterical Insanity Befogged States Delirious States Hysterical Lethargy Somnambulism Silly Excitement B. Traumatic Neurosis (Traumatic Hysteria) C. Dread Neurosis
XIII.	Constitutional Psychopathic States (Insanity of Degeneracy) A. Nervousness B. Constitutional Despondency C. Constitutional Excitement
	D. Compulsive Insanity Tormenting Ideas Onomatomania Arithmomania Grubelsucht Folie du Doute Erythrophobia Phobias Agoraphobia Mysophobia Delire du Toucher Crises Impulsions
	E. Impulsive Insanity Impulse to Tramp Pyromania Kleptomania Impulse to Kill
	F. Contrary Sexual Instincts
XIV.	Psychopathic Personalities A. Born Criminals Moral Insanity Delinquente Nato Moral Imbecility B. The Unstable C. The Morbnid Liar and Swindler D. The Pseudoquerulants
XV.	Defective Mental Develoment A. Imbecility Stupid Form Lighter Grades Energetic Type B. Idiocy Severe Cases Light Cases

Kraepelin's (1903-1904) classification of psychiatric disorders based on the English adaptation of the seventh edition of his textbook by Diefendorf (1907).

"melancholia," classified as a "specific dissease," among the "involution psychoses" in the seventh (1903-1904) edition, with "manic-depressive insanity" in the eighth (1908-1915) edition.

Kraepelin (1903-1904) firmly believed in Kahlbaum's (1874) "nosological postulate," i.e., a close correspondence between etiology, brain pathology and symptom pattern (Jablensky, 1981). Accordingly, he maintained that "if we possessed a comprehensive knowledge of any of these three fields--etiology, pathological anatomy, or symptomatology--we would at once have a uniform and standard classification of mental disease." However, regardless of his belief, Kraepelin's (1898) classification--from the time of his adoption of a "disease-oriented" approach--remained firmly based on "clinical development" (Pichot, 1983).

Bleuler's Classification

Kraepelin's (1908-1915) nosology was adopted with few modifications by BLEULER in his LEHRBUCH DER PSYCHIATRIE, first published in 1916. While Bleuler (1924) argued that it is "impossible to base a classification of morbid pictures exclusively on the course of the disease," he acknowledged that "through the services of Kraepelin" a "point of view was attained" in the "classification of mental disease" which "compared with the earlier one is entirely satisfactory" and "from which it is possible to gain new ground steadily." Other important contributing factors to Bleuler's (1924) decision to adopt Kraepelin's (1908-1915) nosology was his recognition that neither "organic" and "functional," nor "endogenous" and "exogenous" psychiatric disorders can be clearly separated from each other, because their "symptomatologies intermingle"; and his own failure "to classify on the basis of causes," because the "same causes produce very different morbid pictures" and "conversely, the same morbid pictures might be produced by different causes."

In Bleuler's (1924) "nosology," psychiatric disorders were classified into 14 diagnostic categories (Table IV), of which ten, i.e., "insanity in brain diseases," "dementia paralytica," "toxic psychoses," "infectious psychoses," "thyrogenous psychoses," "schizophrenias," "epilepsy," "manic-depressive insanity," "psychopathies" and "oligophrenias," showed close correspondence with Kraepelin's (1903-1904) diagnostic categories (Table V). On the other hand, there were considerable, although not essential differences in the remaining diagnostic categories between the two classifications. These were to the effect that one of the 15 diagnostic categories of Kraepelin (1903-1904), i.e., "exhaustion psychoses," was dropped, and two categories, i.e., "paranoia" and "psychogenic neuroses" were degraded by Bleuler (1924) from diagnostic categories to diagnostic groups and then integrated with the diagnostic category of "constitutional psychopathic states" or "insanity of degeneracy." A fourth diagnostic category of Kraepelin (1903-1904), i.e., "involution psychoses," was dissolved by Bleuler (1924) and two of its three diagnostic groups, i.e., "presenile delusional insanity" and "senile dementia" were pooled together into the new diagnostic category of "senile and presenile insanity" or "senile psychoses." The remaining diagnostic group i.e., melancholia, was integrated with "constitutional psychopathic states," i.e., with the same diagnostic category as "paranoia" and "psychogenic neuroses." Finally, two of the ten diagnostic groups from Kraepelin's (1903-1904) diagnostic category of "organic dementias," i.e., "cerebral syphilis" and "cerebral trauma," were elevated by Bleuler (1924) into the new diagnostic categories of "syphilitic psychoses" and "insanity in injuries to the brain" respectively. By elevating four diagnostic groups into three diagnostic categories, and pooling together these new categories with the diagnostic categories of "insanity in brain diseases" and "dementia paralytica," Bleuler (1924) created a cluster of "organic syndromes" or the class of "acquired

Table IV

No.	Disorders Categories & Subcategories
I-V.	Acquired Psychoses with Coarse Brain Disturbances. The Organic Syndromes
I.	Insanity in Injuries to the Brain
II.	Insanity in Brain Diseases
III.	Syphilitic Psychoses
IV.	Dementia Paralytica
V.	Senile and Presenile Insanity (Senile Psychoses) Presenile Insanity Arteriosclerotic Insanity Senile Dementia (Simple Dementia Senilis) Presbyophrenia
VI.	Toxic Psychoses
1.	Acute Toxemias Pathological Drunkeness
2.	Chronic Intoxication
	A. Chronic Alcoholic Poisoning Simple Drinking Mania Delirium Tremens Alcoholic Hallucinosis Alcoholic Psychoses with Organic Symptoms Alcoholic Korsakoff Psychosis Alcoholic Pseudoparesis Polioencephalitis Superior Alcoholic Leukoencephalitis of the Corpus Callosum Chronic Delusions of Jealousy in Alcoholics and Alcoholic Parents Dipsomania Alcoholic Epilepsy Alcoholic Melancholia
	B. Morphinism
	C. Cocainism
VII.	Infectious Psychoses
	A. Fever Deliria
	B. Infectious Deliria
	C. Acute Confusion, Amentia
	D. Infectious States of Weakness
VIII.	Thyreogenic Psychoses Psychoses in Basedow's Disease Myxoedema (Cachexia Strumimpriva) Endemic and Sporadic Cretinism
IX.	Schizophrenias Paranoid Catatonia Hebephrenia Schizophrenia Simplex
X.	Epilepsy
XI.	Manic-depressive Insanity
XII.	Psychopathic Forms of Reaction (Situation Psychoses)
1.	Paranoia
2.	The Delusion of Persecution of the Hard of Hearing
3.	Litigious Insanity
4.	Induced Insanity (Folie a Deux)
5.	Reactive Mental Disturbance of Prisoners
6.	Punitive Reactions
7.	Reactive Depressions and Exaltations
8.	Reactive Impulses (Impulsive Insanity of Kraepelin)
9.	Reactive Changes of Character
10.	Neurotic Syndromes
	A. Hysterical Syndrome
	B. Neurasthenic Syndrome Neurasthenia Pseudoneurasthenia
	C. Expectation Neurosis
	D. Compulsion Neurosis
	E. Accident Neurosis

Table IV (con't)

No.	Disorders Categories & Subcategories	No.	Disorders Categories & Subcategories
XIII.	Psychopathies A. Nervosity B. Aberrations of the Sexual Impulse C. Abnormal Irritability D. Instability E. Special Impulses F. The Eccentric G. Pseudologia Phantastica H. Constitutional Ethical Aberrations I. The Contentious (Pseudo-Litigious)	XIV.	Oligophrenia

Bleuler's (1916) classification of psychiatric disorders based on the authorized English edition by Brill (1924).

Table V

Kraepelin No.	Kraepelin Diagnosis	Bleuler No.	Bleuler Diagnosis
I.	Infection Psychoses	VII.	Infectious Psychoses
II.	Exhaustion Psychoses		
III.	Intoxication Psychoses	VI.	Toxic Psychoses
IV.	Thyrogenous Psychoses	VIII.	Thyrogenic Psychoses
V.	Dementia Praecox	IX.	Schizophrenias
VI.	Dementia Paralytica	IV.	Dementia Paralytica
VII.	Organic Dementias	II.	Insanity in Brain Diseases
	Gliosis of Cortex		
	Huntingdon's Chorea		
	Multiple Sclerosis		
	Brain Abscess		
	Cerebral Apoplexy		
	Tabetic Psychoses		
	Cerebral Syphilis	III.	Syphilitic Psychoses
	Cerebral Trauma	I.	Insanity in Injuries to the Brain
	Arteriosclerotic Insanity. .		
VIII.	Involution Psychoses		
	Presenile Dementia	IV.	Senile and Presenile Insanity
	Senile Dementia.		
	Melancholia.		
IX.	Manic-depressive Insanity	XI.	Manic-depressive Insanity
XI.	Epileptic Insanity	X.	Epilepsy
X..	Paranoia		
XII.	Psychogenic Neuroses	XII.	Psychopathic Form of Reactions
XIII.	Constitutional Psychopathic States		
XIV.	Psychopathic Personalities	XIII.	Psychopathies
XV.	Defective Mental Development	XIV.	Oligophrenia

Corresponding diagnostic categories in the classifications of Kraepelin (1903-1904) and Bleuler (1916). The Roman numerals indicate the order of presentation of each diagnostic category in the two respective classifications. The arrows indicate the diagnostic category to which one or another diagnostic category (or group) from Kraepelin's (1903-1904) classification is assigned in Bleuler's (1916) classification.

psychoses with coarse brain disturbances." Furthermore, by degrading the diagnostic criteria of "paranoia" to a diagnostic group, and integrating the diagnostic category of "melancholia" with "manic-depressive insanity," Bleuler (1924) attained the "Kraepelinian dichotomy" of "endogenous psychoses."

An important aspect of Bleuler's (1916) work was the introduction of "understanding psychopathology," the discipline dealing with "meaningful connections" ("psychodynamics") in the study of psychiatric patients. In spite of this, Bleuler's (1916) classification did not differ in any essential feature from Kraepelin's (1908-1919) classification, which was based on the "dynamic totality" (Ban, 1987) of "clinical development" (Pichot, 1983). On the other hand by employing "understanding psychopathology" and thereby a "psychopathological approach" instead of a purely "clinical one" (Pichot, 1983), Bleuler (1924) opened the path for the "third epoch" in the history of "nosological development."

Third Epoch

The "third epoch" in the development of psychiatric nosology was triggered by the publication of Jaspers' (1913) General Psychopathology, and his contention, that a prior knowledge of "a definite illness" is an essential prerequisite in the diagnostic process. Recognition that information on the "dynamic totality" does not suffice, i.e., that diagnosis cannot be reduced to the sum of information from the different developmental stages of the illness, focused attention on the diagnostic importance of the "determining structure" of the total (clinical) picture. Accordingly, the essential difference between the "second" and the "third epochs" was in the shift of emphasis from the description of "events" and/or "contents" displayed during the different developmental stages of the "dynamic totality" of an illness, to the recognition of "patterns" generated and/or "structures" affected in a predetermined manner by different "disease processes." Because of this, instrumental for the

development of the "third epoch" was the separation of "contents," corresponding with "events," from "forms," corresponding with "patterns"; and the recognition of the distinction between "development," expressed in "contents," i.e., in terms of the "events" of the "life history," and (disease) "process," displayed in "forms," i.e., in terms of the "patterns" of the "case history."

Schneider's Classification

The first nosology based on the application of principles set out in Jaspers (1913) "General Psychopathology" was the classification of SCHNEIDER, presented in his KLINISCHE PSYCHOPATHOLOGIE, published in 1950. It heralded the beginning of a new era in psychiatry in which "clinical psychopathology and clinical psychiatry share a conceptual framework."

The underlying principle of Schneider's (1950) classification was JASPERS distinction between "personality development" and "disease process," described in his classic paper EIFERSUCHTSWAHN; ENTWICKLUNG EINER PERSOENLICHKEIT ODER PROZESS, published in 1909. Schneider (1950) believed that one "can gain no insight into clinical psychopathology" without the recognition of this distinction, because "development," which is expressed in "events" and their corresponding "contents," can be explored through the study of "meaningful psychic connections," dealt with in "understanding psychopathology," whereas the disease process, which is expressed in "patterns" and their corresponding "forms," cannot. Since he also believed that "mental illness," i.e., "psychic anomalies," which are the result of "disease process," need to be explored through the study of "causal connections of psychic life," dealt with in "explanatory psychopathology," Schneider (1853) considered the separation of "developmental anomalies" and "disease process induced illnesses" as one of the essential prerequisites for psychiatric practice and research dealing with these conditions. Consequently, he classified "psychic abnormalities" into two classes ("groups") of which class one ("group I")

consisted of "developmental anomalies," i.e., "abnormal variations of psychic life," and class two ("group II") consisted of "effects of illness and defective structure." Included in class one were "abnormal intellectual endownment," "abnormal personality" and "abnormal psychic reaction"; and included in class two, were the "psychoses" (a term adopted from Feuchtersleben) i.e., the "effects of illness and defective structure," such as the "somatically based psychoses," "schizophrenia" and "cyclothymia," the term used for "manic-depressive insanity" by Schneider (1950) (Table VI).

The practical and theoretical implications of Schneider's (1950) nosology cannot be overemphasized. By employing a truly "psychopathological approach," with consideration to all the four component disciplines of "general psychopathology," he attained order at a higher level than achieved in prior classifications. Within this new "order," the "psychoses," i.e., disorders with "psychic symptomatology" and "somatic etiology" (regardless whether already identified) are clearly outside the scope of "understanding psychopathology"; and "somatically based psychoses," in which "the psychic symptoms are notably unspecific" and the "acute symptoms merge and overlap with chronic ones," are clearly distinct from "endogenous psychoses." Although in Schneider's (1950) classification, the "Kraepelinian dichotomy" is retained, because "so far no one has succeeded in bringing to light any further types of endogenous psychoses," he questioned the validity of at least one of the two "endogenous diagnoses," i.e., schizophrenia. Furthermore, by maintaining that "there is nothing to which (one) can point as a common element in all the clinical pictures that are today christened schizophrenia," Schneider (1950) concurred with the view, that Kraepelin's (1895) concept of "endogenous psychoses" and especially his "dichotomy of endogenous psychoses," need to be re-examined.

Leonhard's Classification

The re-evaluation of Kraepelin's (1899, 1903-1904) "nosology,"

Table VI

Abnormal Variations of Psychic Life Anomalies of Development	Effects of Illness and Defective Structure Psychoses
Abnormal Intellectual Endowment	Psychoses of the Feebleminded
Abnormal Personality Psychopathic Personalities	Somatically Based Psychoses
Abnormal Reaction to Experience Psychic Reaction	Cyclothymia and Schizophrenia

Schneider's (1950) classification of mental illness, including "anomalies of development" and "psychoses."

culminated in the presentation of LEONHARD'S monograph on THE CLASSIFICATION OF ENDOGENOUS PSYCHOSES, first published in 1957. Howver, Leonhard's (1957) classification is more than merely a re-evaluation of Kraepelin's (1895) classification of "endogenous psychoses." It is a novel approach to "nosology," based on the recognition of "patterns," representing different "forms" and "subforms," generated in a predetermined manner by different "disease processes."

Instrumental for the development of Leonhard's (1957) classification, was his adoption of Wernicke's (1900) "model" of "psychic functioning" based on a hypothetical "psychic reflex arch," comprising of "afferent" or "psychosensorial" (also referred to as "perceptual-cognitive"), "central," or "intrapsychic" (also referred to as "relational-affective") and "efferent" or "psychomotor" (also referred to as "motor-adaptive") segments, each of which subject to "increased," "decreased" or "disturbed" functioning. By the integration of information, obtained by the "exploration of psychopathology," on the functional state of the different segments (of the "psychic reflex arch") with the information obtained on the "dynamic totality" of the disease, in terms of "form of onset," "formal characteristics" of "course" and "outcome" and "holistic" features, Leonhard (1957) identified four "general patterns" or "categories" within the "endogenous psychoses," each represented by one or more diagnostic "patterns," i.e., groups (forms) and subgroups (subforms). Because of his special attention paid to the "totality" of the "disease," "polarity," i.e., whether "bipolar" or "unipolar" in "course," and correspondingly, whether "multiform" or "simple" in overall presentation, played the role of the primary organizing principle in Leonhard's (1957) classification of "endogenous psychoses."

The four "general patterns" or "disease categories" in Leonhard's (1957) classification are: "phasic psychoses," "cycloid psychoses," "unsystematic

schizophrenias" and "systematic schizophrenias." Of them, one i.e., "systematic schizophrenias," consists of disorders with "simple disease pictures" and a "unipolar--deteriorating--course" exclusively; two consist of disorders with "multiple disease pictures" and "bipolar course," one, i.e., "cycloid psychoses" with "full remissions" and the other, i.e., "unsystematic schizophrenias" with "partial remissions" between "episodes"; and the remaining one, i.e.,"phasic psychoses," consists of three groups of disorders of which one, i.e., "manic-depressive disorder," displays a "multiform disease picture" and a "bipolar--remitting--course," whereas the other two groups display "simple disese pictures" with "unipolar--remitting--course" (Table VIIa&b).

In support of Leonhard's (1957) classification are findings in family genetic studies which indicate the distinctiveness of "unipolar" and "bipolar phasic psychoses" (Angst, 1966; Perris, 1966); the distinctiveness of "cycloid psychoses" and "unsystematic schizophrenias" (Perris, 1974; Ungvari, 1985a); and the distinctiveness of "unsystematic schizophrenias" and "systematic schizophrenias" (Trostorff, 1975; Ungvari, 1985b). Furthermore, in favor of the distinctiveness of the three diagnostic groups within the "systematic schizophrenias," and also within the "unsystematic schizophrenias" are the findings of a clinical psychopharmacological study, carried out by Fish (1963). Undoubtedly, "if not two but rather many endogenous psychoses are to be differentiated, psychiatry becomes a difficult science." However, Leonhard (1957) maintained that "this differentiation cannot be avoided, if one wants to get out of the dead end of the present theory of endogenous psychoses," an essential prerequisite of psychiatric progress.

Fish's Classification

Fish's classification of "psychiatric disorders" represents an integration of the two major nosologies of the "third epoch," i.e., Schneider's (1950) and Leonhard's (1957) in the "history of nosological development." It

Table VIIa

Diagnosis	Simple Unipolar	Multiform Bipolar	Episodic	Continuous	Full Remission	Partial Remission	Deterioration	Afferent	Central	Efferent	Combine
Phasic Psychoses			+		+						
Manic-depressive Disease		+	+		+						+
Pure Melancholy	+		+		+						+
Pure Mania	+		+		+						+
Pure Depressions	+		+		+				+		
Pure Euphorias	+		+		+				+		
Cycloid Psychoses		+	+		+						
Confusion		+	+		+			+			
Anxiety-happiness		+	+		+				+		
Motility		+	+		+					+	
Unsystematic Schizophrenias		+	+			+					
Cataphasia		+	+			+		+			
Affect-laden paraphrenia		+	+			+			+		
Periodic catatonia		+	+			+				+	
Systematic Schizophrenias	+			+			+				
Simple	+			+			+				
Paraphrenias	+			+			+	+			
Hebephrenias	+			+			+		+		
Catatonias	+			+			+			+	
Combined	+			+			+				
Paraphrenia	+			+			+	+			
Hebephrenia	+			+			+		+		
Catatonia	+			+			+			+	

Schematic presentation of the differential pattern of diseases in Leonhard's (1957) classification of "endogenous psychoses." "Affere as "+" if the "psychosensory" segment, "central" is marked as "+" if the "intrapsychic" segment and "efferent" is marked "+" if the "p segment of the "psychic reflex arch" is primarily affected by the "disease process," whereas "combined" is marked "+" if all three seg affected simultaneously.

Table VIIb

Diagnoses	Psychosensory			Intrapsychic			Psychomotor		
	Incr.	Decr.	Dist.	Incr.	Decr.	Dist.	Incr.	Decr.	Dist.
Pure Depressions	+					Hypochondriacal			
			+			Suspicious			
			+			Self-torturing			
						Harried	+		
						Non-participatory		+	
Pure Euphorias	+					Hypochondriacal			
			+			Confabulatory			
						Enthusiastic	+		
		+				Unproductive			
						Non-participatory		+	
Systematic Paraphrenias	+			Phonemic					
	+			Hypochondriacal					
				Confabulatory					
				Expansive					
				Fantastic					
				Incoherent					
Systematic Hebephrenias					+	Autistic			
						Eccentric			
						Silly			
					+	Shallow			
Systematic Catatonias							+		Proskinetic
									Parakinetic
							+		Speech-prompt
								+	Speech-inactive
									Manneristic
								+	Negativistic

Schematic presentation of the different patterns of "subforms" of disease in Leonhard's (1957) classification of "endogenous psychoses." The pattern is characterized by "increased," "decreased" or "disturbed" functioning in one segment of the "psychic reflex arch" and is associated with (+) "increased," "decreased" or "disturbed" functioning in another.

was presented in his CLINICAL PSYCHOPATHOLOGY, a term he used for "general psychopathology," first published in 1967. The classification follows Schneider's (1950) nosology by separating "abnormal variations in mental life" from "mental illness," and within the latter "organic states" from "functional psychoses"; and Leonhard's (1957) nosology by distinguishing within the "functional psychoses" three categories of illness, i.e., "affective disorders," corresponding with "phasic psychoses," "cycloid disorders," corresponding with "cycloid psychoses" and "schizophrenias," comprising both, "unsystematic" and "systematic schizophrenias." (Table VIII). Although Fish (1967) subsumed two of Leonhard's (1957) diagnostic categories, i.e., "unsystematic schizophrenias" and "systematic schizophrenias," under the diagnostic umbrella of "schizophrenias," he recognized the distinctiveness of these two categories of disorders and also the distinctiveness of the three disorders, i.e., "cataphasia," "affect-laden paraphrenia" and "periodic catatonia" within the "unsystematic category" and the distinctiveness of the three groups of disorders, i.e., "paraphrenias," "hebephrenias" and "catatonias" within the "systematic category."

In spite of Fish's (1967) early attempt in classifying psychiatric disorders in a manner which is in-keeping with the conceptual development of the "third epoch," neither Schneider's (1950), nor Leonhard's (1957) nosology has been fully adopted and integrated with the currently used classifications in psychiatric practice, education and research.

Conceptual Development

From its systematic beginning in the early 19th century, psychiatric nosology has been plagued by the lack of agreement regarding the nature of the manifestations in which mental illness is expressed. In-keeping with this are the changes in the nature of manifestations which served as the basis for the different classifications from the "first" to the "third epoch."

Table VIII

Abnormal Variations in Mental Life	Mental Illnesses
a. Abnormal Intellectual Endowment	a. Functional Psychoses
b. Abnormal Personalities	I. Affective Disorders
I. Antisocial	II. Cycloid Psychoses
II. Abnormal Personality	III. Schizopphrenias
III. Sexual Deviations	
c. Abnormal Personality Developments	
d. Abnormal Reaction to Experience	b. Organic States

Fish's (1967) classification of psychiatric disorders.

Nosologies of the "first epoch" were "descriptive-syndromic" classifications, based on the identification of the differential profile of "mental symptoms" at a point of time. There was no attempt to explore possible relationships between the "mental symptoms" and "internal" ("meaningful") and/or "external" ("causal") factors. However, in both classifications of the "first epoch," careful attention was paid to "social behavior," because of the special interest of their authors in legal-forensic matters. In spite of this, the classifying principle of both "nosologies" remained exclusively in the constellation of mental symptoms displayed cross-sectionally.

"Nosologies" of the "second epoch" were "descriptive-clinical" classifications, based on the identification of the differential picture of "psychopathological symptoms" during the consecutive developmental stages, i.e., dynamic totality of mental illness. The detailed and elaborate descriptions of "mental symptoms" in the classifications of the "first epoch" were replaced by a systematic presentation of "psychopathology" in the classifications of Kraepelin (1899) and Bleuler (1916) and supplemented with information on "performance" in the former, on "meaningful connections" in the latter, and on "social behavior" in both. The classifying principle of both "nosologies" was in the "course" and "outcome" of the disease with consideration to the clinical presentation of the manifest syndrome. As a result, the five categories of "mental disease," identified and first described in the classification of Pinel (1801)--verified and further elaborated in the classification of Esquirol (1838)--were redistributed into 15 categories of "mental disease" in the classifications of Kraepelin (1903-1904), and into 14 categories in the classification of Bleuler (1916). The majority of these diagnostic categories were "causally" linked to "brain disease" or "systemic disease"; and only three of Kraepelin's (1909-1915) categories, i.e., manic-depressive insanity," "dementia praecox" and "paranoid deterioration," and two

of Bleuler's (1916) i.e., "manic-depressive insanity" and "schizophrenias" were identified as "endogenous psychoses."

In contradistinction to the "descriptive" classifications of the "first" and the "second epochs," nosologies of the "third epoch" are "integrative-psychopathological" classifications; they are based on the recognition of the different "patterns" displayed and/or "structures" affected in the different psychiatric disorders. Descriptive presentations of psychopathology, in terms of subsequent developmental stages of the disease, employed in the classifications of the "second epoch" were replaced by an integration of information obtained by independent exploration of "subjective psychopathology," "objective psychopathology," "understanding psychopathology" and "explanatory psychopathology." The classifying principle in the nosologies of the "third epoch" is in the separation of "development," which can be explored by the study of "meaningful connections," i.e., "understanding psychopathology," from "disease process"; and in the separation of the "non-specific syndromes" of "somatically based disorders" which can be explored by "objective psychopathology" and studied by "explanatory (causal) psychopathology," from the distinctive "forms" of "sui generis" psychiatric disorders, the subject of "phenomenology," i.e., "subjective psychopathology."

Within the frame of reference of the "third epoch" the diagnostic categories of Kraepelin (1909-1915) and Bleuler (1916) were first redistributed into two major classes of "disorder" by Schneider (1950), one dealing with "anomalies of development," the subject of "conditioning" and "learning," and the other with "effects of illness." Subsequently the class subsumed under "effects of illness" was separated into two major categories, i.e., one dealing with the "non-specific syndromes" related to "neuropathological process," accessible to "objective (performance) psychopathology" and "brain imaging," and the other, dealing with the "distinctive patterns"--presented in Leonhard's

(1957) classification--related to "psychopathological process," accessible to "general psychopathology" and "nosology."

Finally, one may consider the possibility that the "nosologies" of the "first epoch," which consist of "state-dependent," "syndrome-based" classifications are eminently suited for a "neurobiological approach" in research, i.e., for the study of the biological correlates of "syndromes," whereas "nosologies" of the "second epoch," which consist of "trait-dependent," "disease-based" classifications, are eminently suited for a "psychopharmacological approach" in research, which has the capability to verify categories of disease on the basis of the therapeutic response in the different developmental stages of the illness. There is also a good possibility that "nosologies" of the "third epoch," which consist of "pattern based" classifications, is eminently suited for a "molecular genetic" approach in research, which has the capability to verify categories of disease by "genetic-linkage studies." Another possible approach is based on "non-linear mathematics" and "chaos theory," employed in "population biology," which is suitable for the exploration of "patterns" of "constrained randomness" in "deterministic systems" with "sensitive dependence on original condition" (Pool,1989).

Concluding Remarks

In the foregoing the historical development of psychiatric "nosology" was outlined with special reference to the shift from "syndrome-based" classifications ("first epoch") to "disease-based" classifications ("second epoch") and to "pattern-based" classifications ("third epoch"). It was pointed out that in "syndrome-based" classifications psychiatric disorders are grouped with primary considerations to manifest symptoms and signs at a point, cross-section, of time; in "disease-based" classifications, they are grouped with primary considerations to "course" and "outcome"; and in "pattern-based" classifications, with primary consideration to the "patterns" generated and

"structures" affected in a seemingly "predetermined" manner by the "disease process."

The relationship between the "nature" of the manifestations, which serve as the basis for the classifications, and the "nature of the classifications" was examined. It was revealed that "syndromic classifications" are primarily based on "mental symptoms" and "signs," with an emphasis on "contents" and with consideration to "behavior," whereas "clinical--disease oriented--classifications" are primarily based on "psychopathological symptoms," "performance changes" and "social behavior." In "pattern-based" classifications the classifying principle is "psychopathology," and depending on the "nature" of the "pattern," it is primarily "subjective psychopathology," "objective psychopathology," "understanding psychopathology" and/or "explanatory psychopathology."

At present it is not known which, if any of the classifications of the "three epochs," could open the path for psychiatric progress by providing a valid "nosology" of "psychiatric disorders." Because of this, a methodology was developed, which, by allowing for the comparison of conceptually different systems of diagnostic classifications, should make it possible to identify the diagnoses which approximate the most closely naturally occurring mental illness. The methodology is referred to as the CODE (Composite Diagnostic Evaluation) System (Ban, 1989). It consists of a diagnostic instrument, which, by specially devised algorithms can assign patients to diagnoses in several diagnostic systems simultaneously. If psychopathology and nosology can provide clinically meaningful and biologically homogenous valid diagnostic categories, it is reasonable to assume that they will be identified by the CODE-System. Would this be the case, the CODE-System should also be able to identify the "nature" of the manifestations, which contributed the most to diagnostic decisions.

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 along 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 1960's, 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 1970's 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 "neuropathologic process" were recognized first, and "sui generis psychiatric disorders" based on an identifiable psychopathologic process," and "personality disorders," based on "anomalies of development," were recognided 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) desribed 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 his classic text, entitled TRAITE DES MALADIES DU CERVEAU ET DE SES MEMBRANES, published in 1826, and confirmed by CALMEIL in his monograph DE LA PARALYSIE CONSIDEREE CHEZ LES ALIENES, in the same year.

Dementia Symdrome

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 dissease" (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 ten different

classes of disorders, such as "degenerative," "vascular," "myelinoclastic," "traumatic," hydrocephalic," "inflammatory," "infectious," "neoplastic," "toxic" and "metabolic" (Cummings, 1987). Among the different etiologies the most frequent is Alzheimer's disease, representing 50 to 60 percent of the total population. It is followed by multi-infarct dementia, representing 10 to 20 percent and drug-induced dementia representing approximately 10 percent (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, subsumed under "neuropsychiatric disorders: the "amnestic syndrome" and "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 "sui 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

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.

"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), "l'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."

From Morel's Demence Precoce

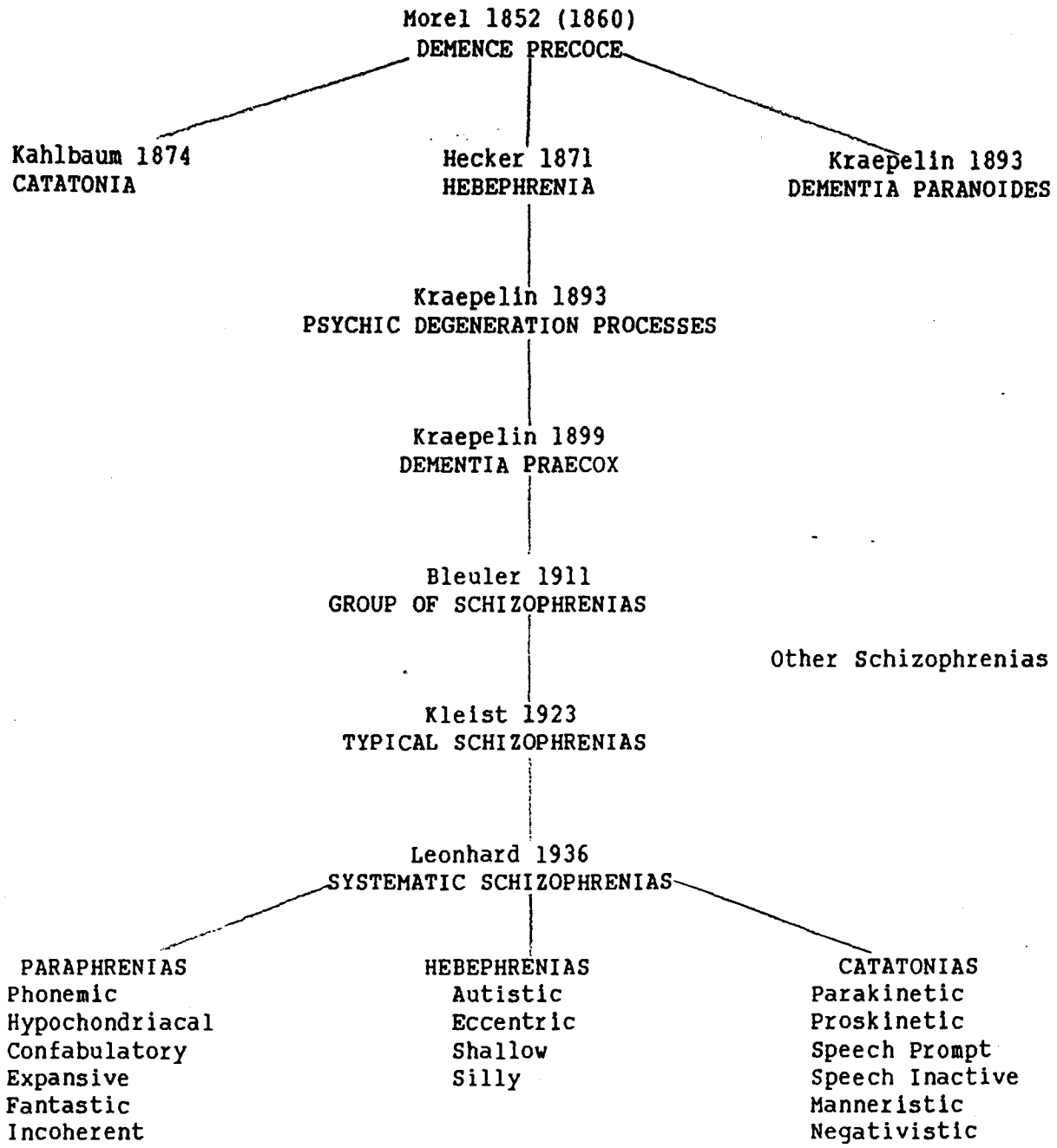
The origin of the first diagnostic category within the "sui generis psychiatric disorders" was in MOREL's diagnostic concept of "demence precoce," he first recognized and described in his ETUDE CLININQUES in 1852 (although the term "demence precoce" was first used in his TRAITE DES MALADIES MENTALES published in 1960). He used the term in reference to a maturally 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 heterogenous 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 charac- teristics 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 a 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 diagnosstic 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

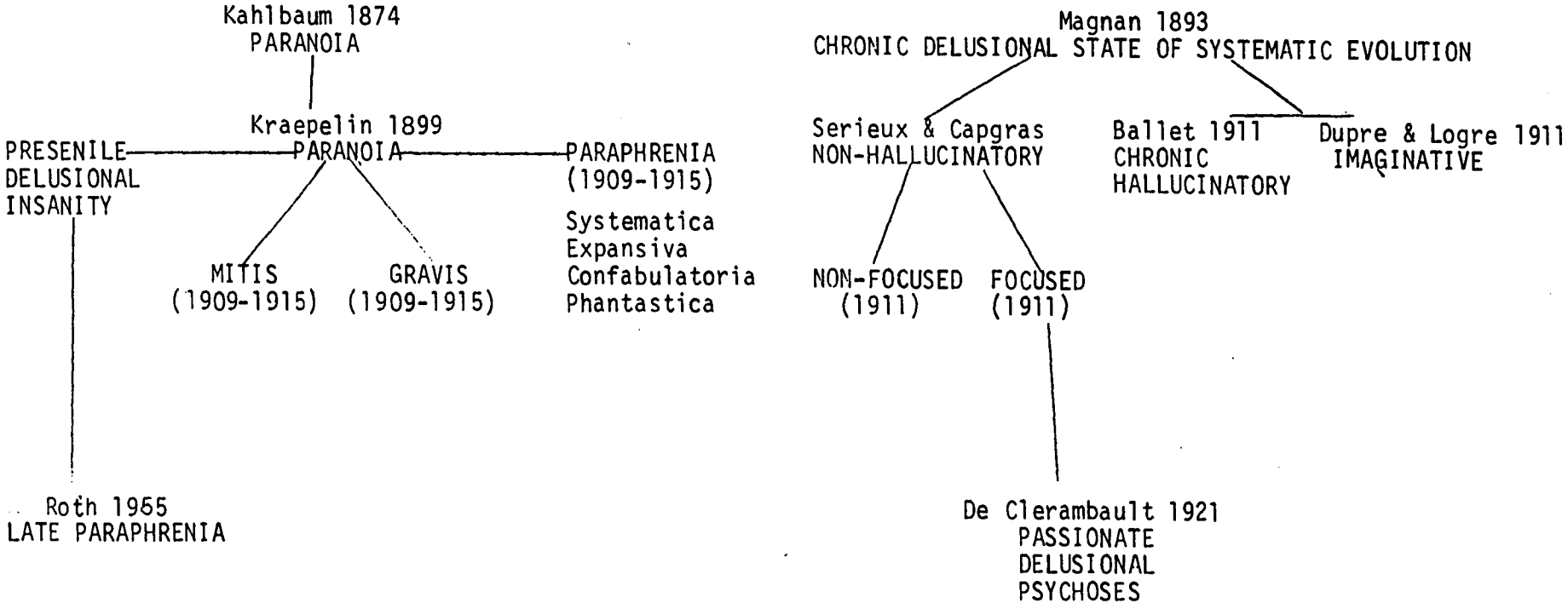
psychosis," corresponding with Kraepelin's (1909-1915) diagnostic concept of "paraphrenia"; and Dupre and Logre (1911) separated the diagnostic concept, "les delires d'imagination," i.e., "chronic imaginative psychosis." Finally in their follow-up publication, entitled "Le delire interpretation et la folie systematisee," Serieux 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 rstricted) in the "chronic delusional psychoses," than in the "systematic schizophrenias."

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. Folie circulaire refers to a same naturally occurring mental illness in which the "psychopathologic"

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.

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 textbook. 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).

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"), charactrerized 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

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.

"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).

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 on Zur Frage der exogenen Psychosen, published in 1909; and

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	PANIC DISORDER
Monophobic	Depersonalization-
Polyphobic	Derealization
Agoraphobia	Syndrome

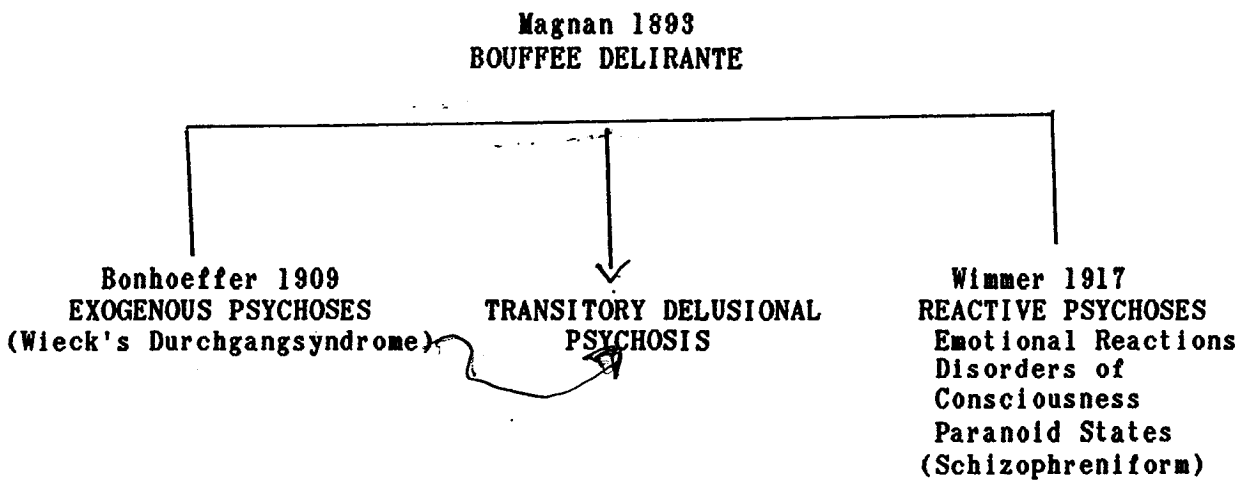
From Briquet's (1859) "l'hysterie" to current diagnostic concepts of "anxiety disorders," "obsessive-compulsive disorder" and "somatization disorder."

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.

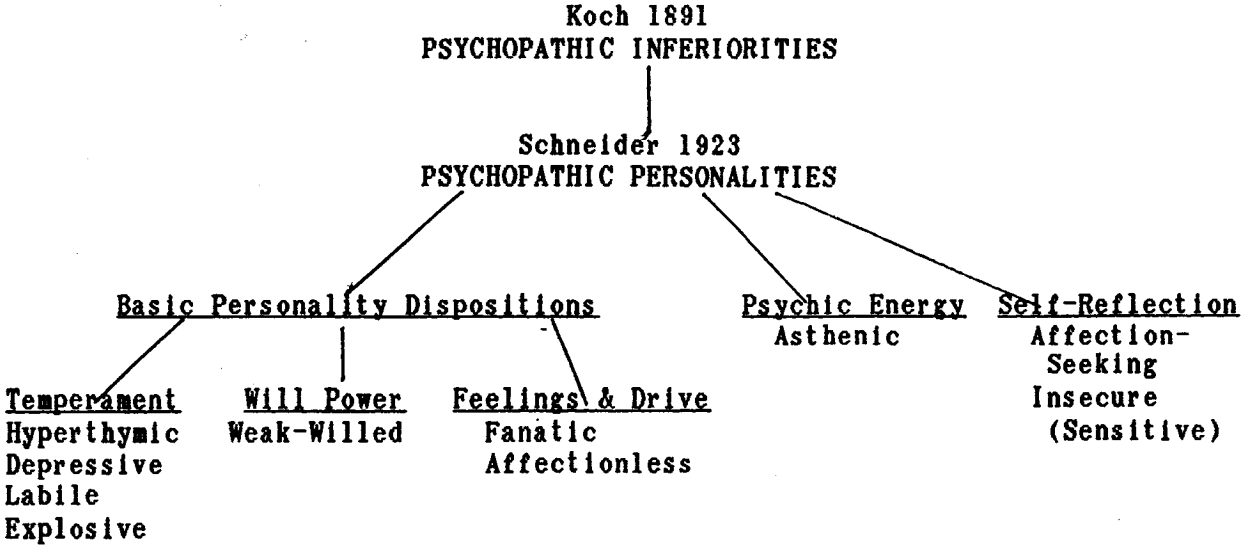
Instrumental in the conceptual development of "personality disorders" was Jaspers' (1909) separation of "personality development" and "disease process"; and the recognition that "personality disoders," in contradistinction to "neuropsychiatric disorders" and "sui generis psychiatric disorders," are not 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 ten different types of "psychopathies," of which seven, i.e., "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 ten 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 ten "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

Table VII



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

in "character formation." The same applies to psychodynamic principles, such as for example "identification" (Jaspers, 1959).

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," characrterized 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 greeater "homogeneity" in terms of "responsiveness to treatment" and new "end-points" for research in the development of new "psychotropic drugs."