

DAS
DIAGNOSTIC ASSESSMENT SCALE
for
DIAGNOSTIC CRITERIA FOR RESEARCH

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The Diagnostic Assessment Scale (DAS) presented in this document is based on a paper by Pethő B, Ban TA, Kelemen A, Ungvári G, Karczag I, Bitter I & Tolna J, published in Hungarian, in *Idegyógyászati Szemle* (37: 102-131, 1984) with the title KDK Budapest, Kutatási Diagnosztikai Kritériumok Functionális Psychosisok Korismézéséhez.

The paper was edited and translated into English and published by Bertalan Pethő and Thomas A. Ban in collaboration with András Kelemen, Gábor Ungvári, István Karczag, István Bitter, Judith Tolna (Semmelweis University, Budapest); Marek Jarema, Francois Ferrero, Eugenio Aguglia, Giovanni Luca Zurria, Olaf Fjetland (Vanderbilt University, Nashville) with the title DCR Budapest-Nashville in the Diagnosis and Classification of Functional Psychoses, in *Psychopathology* (21: 152-240, 1988).

The DAS was prepared, in the mid-1980s, to provide an introduction to the prospective use of the DCR Budapest-Nashville for those unfamiliar with the diagnoses and classifications integrated in the KDK Budapest.

The DAS is presented here without any change, as prepared, in the mid-1980s.

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INTRODUCTION

Development of new experimental methods during the past decades yielded a renewed interest in diagnostic research in psychiatry. The impetus has been sufficiently great to stimulate the formulation of operationally defined diagnostic criteria; and the rapid increase in clinical-experimental activities has created a need to employ these new diagnostic criteria with increasing frequency.

Operationally defined diagnostic criteria are the prerequisites for meaningful comparisons of psychiatric epidemiological data from different cultures and/or language areas. The same applies to genetic-biological research and psychopharmacology. While it is hoped that biological markers will provide for clinically valid diagnostic differentiation, the fact remains that separation of homogeneous patient populations is an essential prerequisite for the identification of biological markers. The same applies to the detection of responsiveness to psychotherapeutic drugs.

Progress in clinical psychopharmacology has resulted in an unprecedented increase in research activities in conditions usually subsumed under functional psychoses. While psychopharmacology has provided further substantiation for the concepts of schizophrenia and manic depressive illness, it also focused attention to the diagnostic crack, i.e., that not every patient with functional psychosis fits the diagnoses of schizophrenia or manic depressive illness, and to the diagnostic gap, i.e., the heterogeneity of patient populations within the diagnoses and consequently low prognostic validity of the diagnoses.

During recent years a number of diagnostic classifications with operationally defined criteria have been proposed. To further these classifications the followings are proposed:

1. Synthesis of the experience of different schools and research groups. For example, in the diagnosis of schizophrenic psychoses instead of using Schneider's first rank symptoms or the St. Louis criteria both Schneider's first rank symptoms and St. Louis criteria, as well as the contributions of others should be utilized (Carpenter and Strauss, 1975; Feighner et al., 1972; Petho, 1969, 1974a; Skinner, 1981).
2. Ascertain primacy of the phenomenological approach. Psychopathological symptoms, psychological disturbances and social adjustment changes are well defined and there is substantial evidence to believe that they are essential features of mental illness. Consequently they provide for a "natural basis" of the variables included in diagnostic criteria for research. The same does not apply to variables derived from the case history and/or from family data. Inclusion of these variables might dilute clinical descriptions and reduce the power of discrimination among the diagnostic groups.
3. Render the phenomenological approach comprehensive. Experience (Erlebnis), behavior, performance and possibly social adjustment are four complementary aspects of phenomenology. By having a disproportionately strong emphasis on the experiential aspects of phenomenology pathognomic behavioral manifestations, such as catatonic psychomotor disorders, may easily be overlooked. A one dimensional approach may also preclude the recognition of "double-entry book-keeping." Characteristic of this is the dissociation between the experiential aspects of phenomenology and social adjustment. This is best exemplified in patients whose severe paranoid hallucinatory

syndrome is associated with unexpectedly good social adjustment (Astrup, 1975; Spitzer et al., 1978).

4. Supplementing atomistic descriptions with holistic characterization. It is considerably more difficult to operationalize holistic, "background-type," than structural, "figure-type," characteristics. However, characteristics of the overall picture, whether it is amorphous, monomorphous, or polymorphous and whether it is fluctuating, stabilized or systematized (Petrilowitsch, 1969) are at least as important for diagnostic decisions than the presence or absence of any particular psychopathological symptom. The same applies to the protopathic change of the "background" or "Gestalt" (Conrad, 1958), such as experienced in case of "emotional blunting" (Fish, 1961), and the recognition of the delusional structure, whether logical or paralogical and whether hallucinatory or interpretative (Berner, 1972).
5. Shift emphasis to pathognomic characteristics of disease. To correspond with clinically meaningful syndromes, there is a need for broadening the diagnostic spectrum. This, however, needs to be done with the identification of pathognomic characteristics of each diagnostic category.
6. Transform classification from multi-axial to structural. A structural classification can be achieved by taking into consideration the psychopathological characteristics of the index psychosis, the formal characteristics of the course of illness, and the outcome of disease, i.e., the residual dimension which includes personality and social adjustment changes (Petho, 1977, 1983b). Instead of

evaluating the different areas in a parallel manner as customary in multi-axial (Helmchen, 1980; DSM-III, 1980) and multi-area (Berner, 1982) classifications, there is a need for integration of the information as they evolve.

7. Evolve diagnosis from syndromatological through provisional to final.

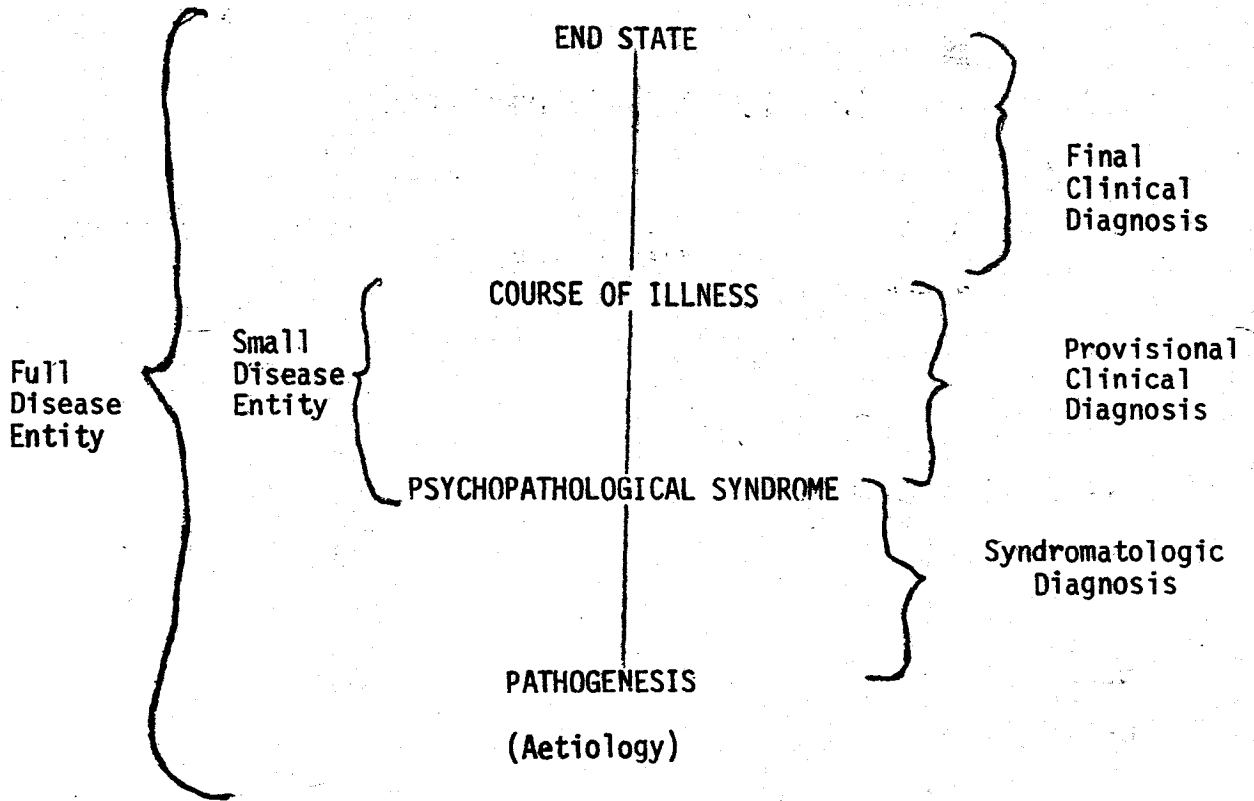
The syndromatological diagnosis of the index psychosis is extended into a provisional diagnosis by taking into consideration the course of the disease and into a final diagnosis by taking into consideration the end-state (Figure 1).

In this Manual a new diagnostic classification of functional psychoses is described. Since we believe that the proposed classification provides biologically homogeneous populations, and has high prognostic validity, we hope that it will be increasingly employed--tested, validated--by those involved in research.

The proposed diagnostic classification for research is primarily based on Leonhard's (1957, 1979) classification of endogenous psychoses. It is not restricted, however to Leonhard's system but takes into consideration French and Scandinavian contributions to psychiatric phenomenology and American and English operationalizational efforts (Ban, 1982; Fish, 1958). Although deeply rooted in past and contemporary work, the classification, as presented, reflects the clinical experience of the Authors (Petho, 1977; Petho et al., 1979, 1983a).

We have chosen Leonhard's classification as the basis for the proposed diagnostic criteria for research. Our primary reason for this is that this classification, which is based on the contributions of the Wernicke school and especially of Kleist's work is more detailed and subtle than the classifications based on the contributions of Kahlbaum, Kraepelin and Eugen Bleuler

Figure 1



Conceptual continuum of disease; diagnoses at different stages of development

(Petho, 1974b). Another reason for adopting Leonhard's system is that it contains more detailed descriptions of behavior and performance (both cross-sectionally and longitudinally). In favor of Leonhard's classification are the findings of Angst and Perris (1968). They were able to verify the validity of Leonhard's distinction between unipolar and bipolar depression.

The proposed diagnostic classification for research, however, differs from Leonhard's by the following:

1. Experiential (Erlebnisses) and behavioral (Verhaltens) aspects of psychopathology are sharply distinguished;
2. The characteristics of form (Gestalt) and overall (general) picture are elaborated beyond that is found in Leonhard's (1973) work by the contributions of Berner (1972), Conrad (1958), Ey, Bernard and Brisset (1967) and Petrilowitsch (1969);
3. Course of illness (Petho, 1984) and characteristics of the outcome in terms of psychopathological symptoms, personality changes and alterations in social adjustment are taken into consideration in the residual dimension;
4. The index psychosis, instead of the end state (Leonhard, 1967), is taken as the point of departure.

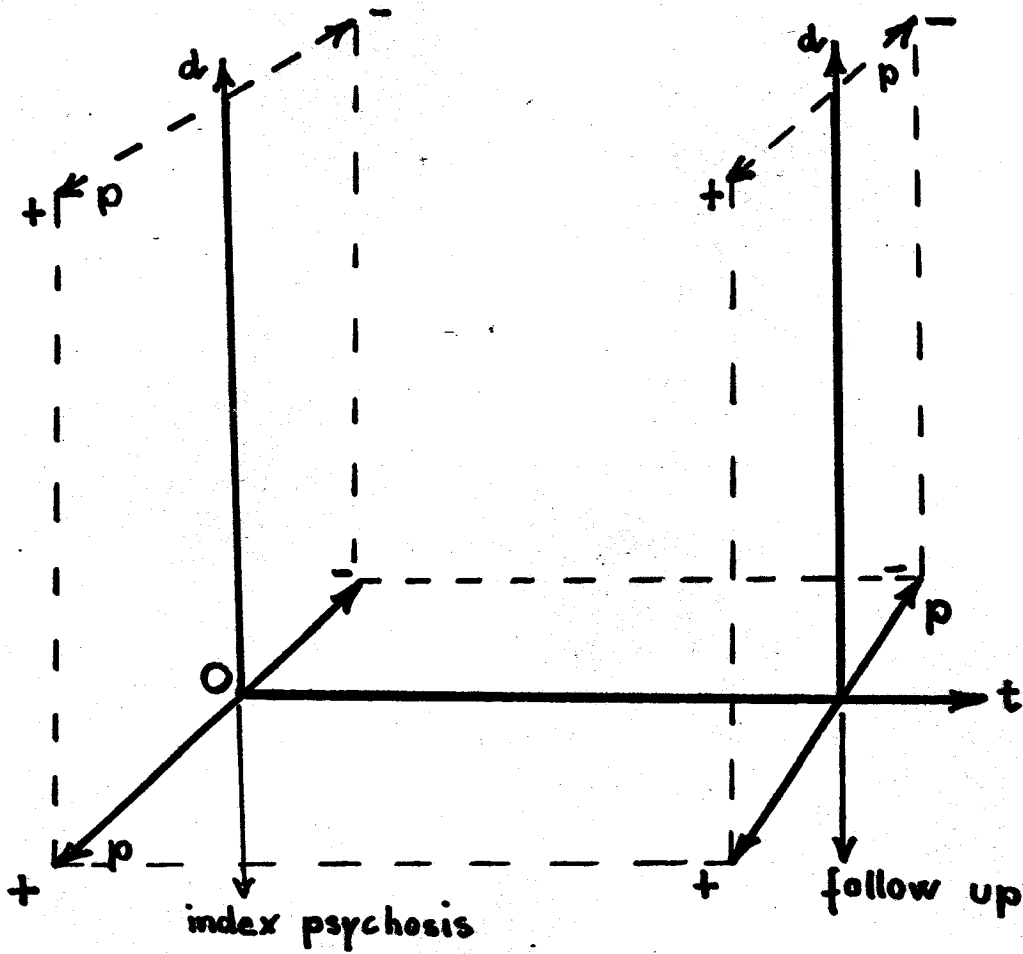
One of the important contribution of Leonhard was the recognition of the importance of the different end states in patients previously labeled with the same diagnosis. To some extent it was by working backward how Leonhard's system of classification of endogenous psychoses evolved. Systematic clinical observations during the past 30 years, have provided the necessary information for diagnosing at the onset, or at an early stage of the disease. Prognostic validity of these early diagnoses remains to be seen.

METHOD

The methodology employed is based upon a decision tree. The decision making process, however, is not restricted to a given set of cross-sectional data, but includes the steadily accumulating information over time. To improve both validity and reliability of the information the following guidelines should be taken into consideration in the collection of data:

1. The presence of psychosis can usually be determined with a single examination. In case of difficulties, however, it should be possible to derive to a decision within a period of eight days.
2. The nature of the psychosis cannot usually be determined by a single examination. It requires at least two weeks of continuous observations and two or more careful assessments to derive to a specific (syndromatologic) diagnosis. This does not imply that the psychosis must continue for at least two weeks; and the treatment should be withheld for a two-week observation period. Some psychoses may actually subside within a considerably shorter time period than 14 days; and salient features of the disease remain recognizable despite treatment.
3. The course of illness cannot be determined by short-term observations. At least 5 years are required to reveal characteristics of the course of illness for (provisional clinical) diagnostic decisions. Characteristics of the form of the course of illness should be distinguished from the characteristics of the content of the course, such as for example time spent in hospital, duration of pharmacological treatment. Among the formal characteristics periodicity (irregular or rhythmic), polarity (unipolar or bipolar) and progressiveness (remitting or deteriorating) should be considered. (Figure 2).

Figure 2



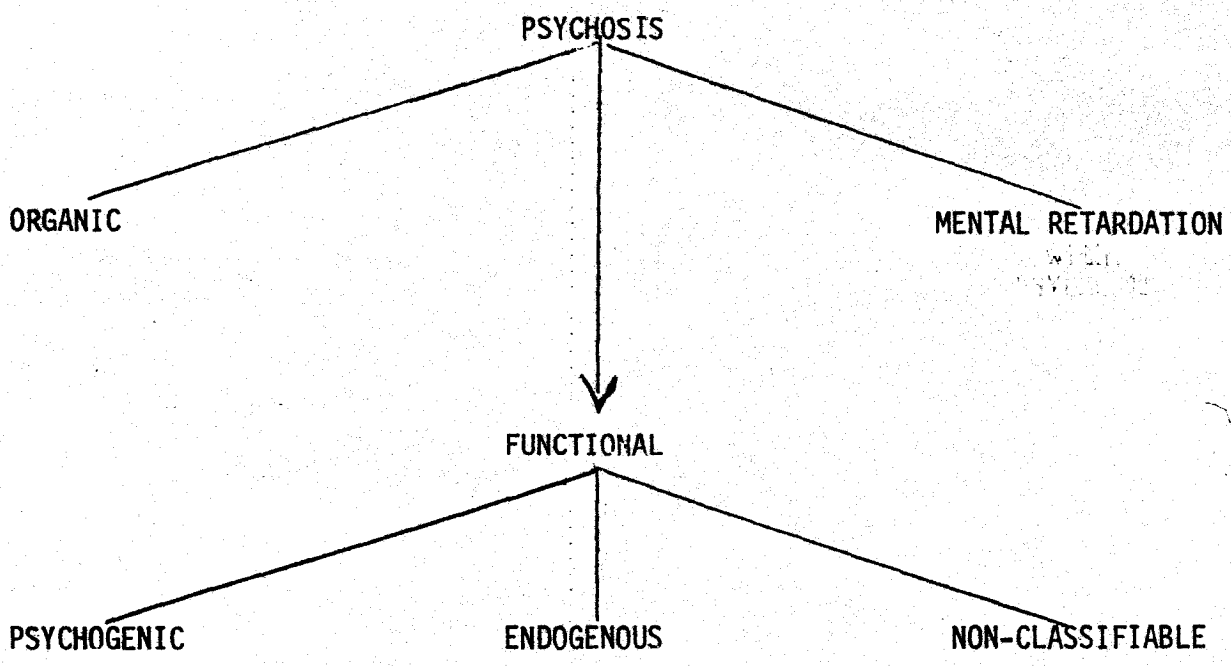
Course of illness: three dimensional model of formal characteristics

- O = starting point of psychosis
- t = time
- p = polarity
- d = deterioration

Level of deterioration should be determined on basis of the final assessment with consideration, in case of fluctuating course, to the best and to the worst periods encountered during the 5 year observation.

4. Outcome refers to the end state of the disease (final clinical diagnosis) after a predetermined time interval, e.g., ten years, subsequent to the onset of the index psychosis. Assessments must include an examination of psychopathological symptoms and level of social adjustment.

FUNCTIONAL PSYCHOSES



Differential diagnosis of psychoses with special reference to the functional psychoses. The arrow indicates how to proceed on the decision tree.

The diagnostic criteria presented in this Manual will be restricted to patients with functional psychoses, i.e., endogenous and psychogenic (reactive). The definition of the latter is based on contributions by Faergeman (1963), Jaspers (1964) and French (Ey, Bernard and Brisset, 1967) and Scandinavian (Retterstol, 1978) workers. No attempt was made to classify and/or develop operationally defined diagnostic criteria for the population which does not fit either the psychogenic or the endogenous category, usually subsumed under the broad category of non-classifiable functional psychosis.

The essential prerequisite to be included for diagnostic differentiation is the presence of functional psychosis, identified on the basis of "positive" inclusion criteria. If the necessary criteria for functional psychosis are not fulfilled, it is assumed that patient suffers from a minor psychiatric disorder. Borderline patients, patients with personality disorders and patients with anxiety disorders (neuroses) are not included.

To ascertain a "pure population" with functional psychosis, patients with organic disorders and mental retardation are excluded.

The decision making process will follow in three steps:

- A. Identification of functional psychosis (for inclusion)
- B. Identification of organicity (for exclusion)
- C. Identification of mental retardation (for exclusion)

A. FUNCTIONAL PSYCHOSIS (INCLUSION)

An essential prerequisite for the diagnosis of functional psychosis is the presence of psychosis, or evidence of verified and adequately documented psychosis in the past, without a coexisting somatic illness of sufficient severity that it could be considered responsible for the psychopathological manifestations. The requirement of "good physical health" might be

compromised, provided there is evidence that the somatic disease has no bearing on the variables used as criteria for the identification of psychosis.

To qualify for the presence of functional psychosis at least three of the following four criteria must be present:

Inclusion Criteria I

	<u>Present</u>
1. Psychopathological symptoms sufficiently severe to disrupt equilibrium with surroundings (e.g., hallucinations)	+
2. Lack of insight, i.e., unable to evaluate situation realistically	+
3. Collapse of customary (usual) way of (social) life without an adequate reason. ("Adequate reason" might be an illness, loss of job, divorce, etc.)	+
4. Psychiatric hospitalization (in mental institution or psychiatric unit of general hospital)	+
	<hr/>
Maximum Possible Score	4
Minimal Qualifying Score	3

In questionable cases the ultimate decision about the presence of psychosis should be based on the opinion of three independent psychiatrists.

Inclusion Criteria II

	<u>Present</u>
1. Patient is considered to be psychotic by at least 2 of 3 independent psychiatrists	+
2. Patient is diagnosed as suffering from one of the accepted diagnostic categories of functional psychosis by at least 1 of 3 independent psychiatrists	+
	<hr/>
Maximum Possible Score	2
Minimal Qualifying Score	1

B. ORGANIC ILLNESS (EXCLUSION)

Presence of somatic illness (e.g., intoxication, cerebral atrophy) which is of sufficient severity that it could provide for a "sufficient cause" of the psychosis is an exclusion criterion.

<u>Exclusion Criteria</u>	<u>Present</u>
1. Somatic illness which is of sufficient severity to cause disturbance of consciousness and/or mental deterioration	+
2. Somatic illness that coincides in time with the psychopathological changes (mental disturbances)	+
3. Somatic illness and mental disturbance(s) run a parallel course	+
Maximum Possible Score	3
Minimal Exclusion Score	2

C. MENTAL RETARDATION (EXCLUSION)

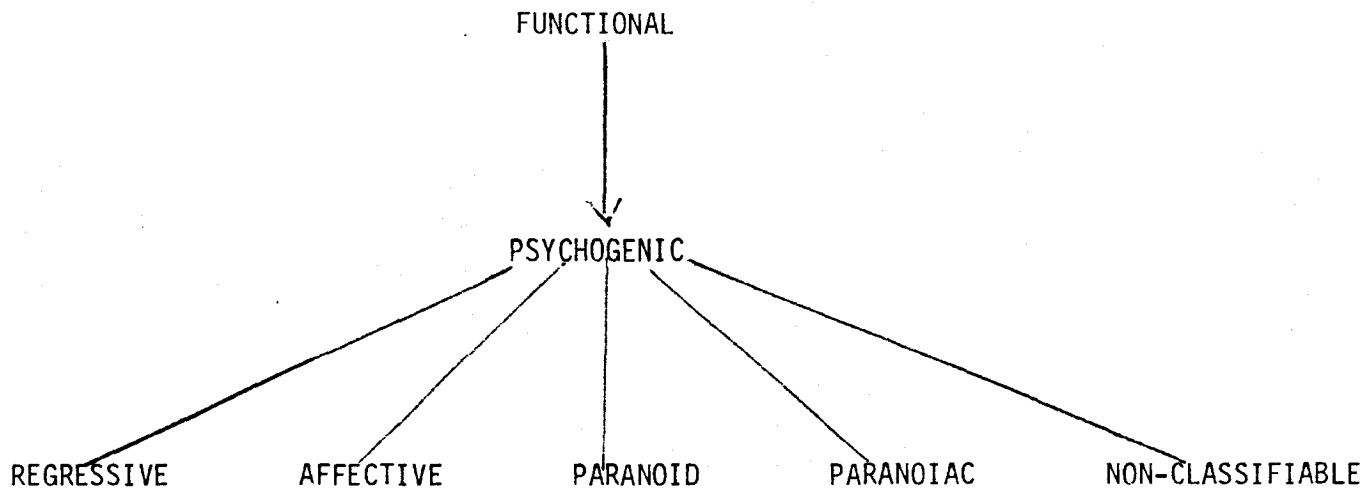
Mental retardation, i.e., an I.Q. of 69 or below, is an exclusion criterion. If no IQ test is available from the time prior to the onset of illness, or present episode of illness, an IQ test has to be performed. This, however, should be done only at a time after the overtly psychotic manifestations remit. Since patient's mental state might have a bearing on the performance of the intelligence test, for these cases the exclusion criterion should be lowered to an IQ of 65 or below.

<u>Exclusion Criteria</u>	<u>Present</u>
1. IQ of 69 or below prior to onset of illness or present episode of illness	+
2. IQ of 65 or below after the present episode of illness	+
Maximum Possible Score	2
Minimal Exclusion Score	1

D. EVALUATION

1. If patient does not meet qualifying criteria for functional psychosis, no further assessment.
2. If patient meets both qualifying criteria for functional psychosis, and for organic illness and/or mental retardation, no further assessment.
3. If patient meets qualifying criteria for functional psychosis without meeting qualifying criteria for organic illness and/or mental retardation, proceed to I.

I. PSYCHOGENIC PSYCHOSES



Differential diagnosis of functional psychoses with special reference to the psychogenic psychoses.

Psychogenic or reactive psychosis is one of the two major diagnostic categories included in this Manual.

Psychogenic psychosis may manifest in one of four phenomenological types, i.e., psychogenic regressive psychosis, psychogenic affective psychosis, reactive paranoid psychosis and paranoiac development. If patient fulfills criteria for psychogenic psychosis but does not qualify for any one of the four phenomenological types he/she should be diagnosed as psychogenic psychosis, non-classifiable.

Patients with a psychogenic psychosis are identified on the basis of general (holistic) characteristics and certain specific (inclusion and exclusion) criteria.

The decision making process will follow in three steps:

- A. Identification of general characteristics
- B. Identification of specific inclusion criteria
- C. Identification of specific exclusion criteria.

A. GENERAL CHARACTERISTICS

Psychogenic psychosis have three general characteristics and the presence of at least two is an essential prerequisite for the diagnosis.

<u>General Characteristics</u>	<u>Present</u>
1. The onset (emergence) of psychosis must be attributable beyond reasonable doubt to precipitating life event	+
2. The psychotic content (content of psychosis) must be fully understandable in the light of the precipitating life event and/or on the basis of patient's life history and/or personality.	+

	<u>Present</u>
3. The psychosis is an integral part of patient's life history, i.e., it forms a holothymic life event	+
Maximum Possible Score	3
Minimal Qualifying Score	2

It should be noted that understandability (comprehensibility) refers exclusively to the comprehensibility of the psychotic content and not to the psychotic form (form of psychosis). Without introducing a pathophysiological (somatic) mechanism any alleged understanding about the form of a psychosis should remain questionable (Petho, 1969; Schneider, 1922). Attempts to understand the form of the psychosis (Faergeman, 1963) have led to the conceptual development of diagnoses such as psychogenic and reactive schizophrenia (Higgins, 1964; Noyes and Kolb, 1963) and schizophrenic reaction types (Popper, 1920). These artificially conceived diagnoses are not based on a careful analysis of psychopathological symptoms and do not seem to correspond with well definable psychiatric patient groups.

B. SPECIFIC INCLUSION CRITERIA

Psychogenic psychosis have three specific characteristics and the presence of at least two is an essential prerequisite for the diagnosis.

<u>Specific Inclusion Criteria</u>	<u>Present</u>
1. The intensity (severity) of the traumatic experience (stressful life experience) sufficiently explains the emergence (onset) of the psychosis	+
2. Thematic continuity between traumatic experience and psychotic content, i.e., the subject matter of the psychosis is directly related to (and organized around) the traumatic experience	+

3. There is a meaning (Sinn) to the psychosis, a purpose (secondary gain) which is appropriate to the situation (e.g., prison psychosis) with manifestations, such as theatricality and protest, directed towards the onlookers

Present

+

Maximum Possible Score

3

Minimal Qualifying Score

2

C. SPECIFIC EXCLUSION CRITERIA

Certain characteristic symptoms of endogenous psychosis should not be present in psychogenic psychosis and the presence of even one of these symptoms is an exclusion criterion.

Specific Exclusion Criteria

Present

1. Disease specific formal disorder of thought (i.e., inhibited, retarded, circumstantial, restricted, pressured and/or tangential thinking; flight of ideas; perseveration, rumination, and/or blocking; neologisms and/or incoherence; contamination, condensation, substitution and/or derailment)
2. Apathy and/or blunted affect
3. Autistic behavior and/or dereistic thinking

+

+

+

Maximum Possible Score

3

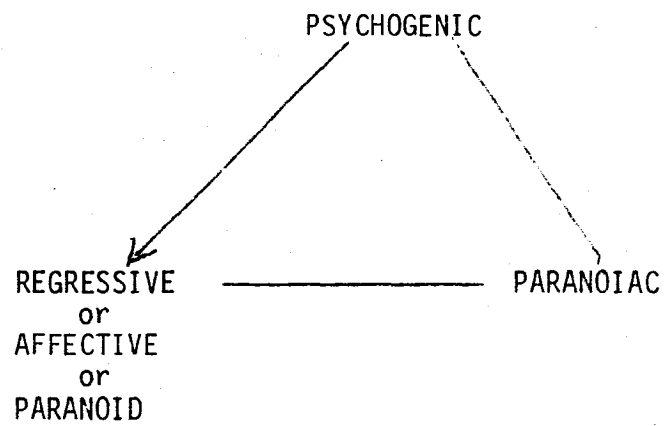
Minimal Exclusion Score

1

D. EVALUATION

1. If patient does not meet qualifying criteria for psychogenic psychosis proceed to II.
2. If patient meets qualifying criteria for psychogenic psychosis proceed to I/I-I/II-I/III.

- I/I. PSYCHOGENIC REGRESSIVE PSYCHOSIS
- I/II. PSYCHOGENIC AFFECTIVE PSYCHOSIS
- I/III. REACTIVE PARANOID PSYCHOSIS



Differential diagnosis of psychogenic psychoses with special reference to regressive, affective and paranoid phenomenological types.

Three of the four phenomenological types of psychogenic psychosis shares several common characteristics relevant to course and outcome. The three phenomenological types are psychogenic regressive psychosis, psychogenic affective psychosis and reactive paranoid psychosis.

The decision making process will follow in three steps:

- A. Identification of prevailing psychopathological symptoms
- B. Identification of characteristics of course
- C. Identification of characteristics of outcome

A. PSYCHOPATHOLOGICAL SYMPTOMS

Pathogenic^{omic} of psychogenic regressive psychosis is the presence of clouding of consciousness with impaired orientation; of psychogenic affective psychosis the presence of exaltation or depression; and of reactive paranoid psychosis, the presence of delusions of reference.

<u>Psychopathological Symptoms</u>	<u>Present</u>
1. Clouding of consciousness with impaired orientation	+
2. Exaltation or depression	+
3. Delusions of reference	+
Maximum Possible Score	3
Minimal Qualifying Score	1

B. COURSE OF DISEASE

Course of illness shows the following common characteristics:

<u>Course</u>	<u>Present</u>
1. Acute illness with fast onset and limited duration	+
2. Remission with dissolution of traumatic experience	+
3. Unipolar manifestations (i.e., no polarity)	+

4. Lack of rhythmicity and/or periodicity

	<u>Present</u>
	<u>+</u>
Maximum Possible Score	4
Minimal Qualifying Score	4

Lack of rhythmicity (and/or periodicity) does not imply that these psychoses cannot recur with repeated exposure to similar or different traumatic situations. "Flash-back" phenomena have been observed in case of repeated occurrences.

C. OUTCOME OF ILLNESS

Complete recovery is the characteristic outcome. No defect of personality or even maladjustment is left behind.

Outcome

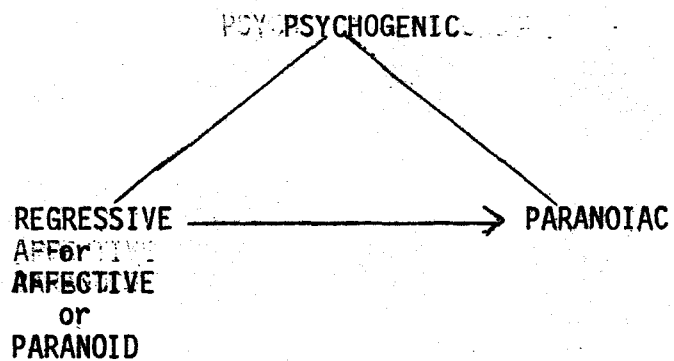
Full remission

	<u>Present</u>
	<u>+</u>
Maximum Possible Score	1
Minimal Qualifying Score	1

D. EVALUATION

1. If patient does not meet qualifying criteria for one of the three phenomenological types of psychogenic psychosis proceed to I/IV
2. If patient's score is greater than 1 on A (Psychopathological Symptoms) he/she should be diagnosed as psychogenic psychosis, non-classifiable (I/V).
3. If patient meets qualifying criteria for one of the three phenomenological types, he/she should be diagnosed as psychogenic psychosis, regressive type (I/I); psychogenic psychosis affective type (I/II); or reactive paranoid psychosis (I/III), respectively.

I/IV. PARANOIAC DEVELOPMENT



Differential diagnosis of psychogenic psychoses
with special reference to paranoiac development

Paranoiac development is the fourth phenomenological type of psychogenic psychosis. The origin of this concept is in the work of Lasegue (1852), Snell (1865) and Ey, Bernard and Brisset (1967). Meyer (1910) used the term to describe an anomalous development in which the nature of the reaction depends on the interaction between personality disposition and situation. In contradistinction to reactive paranoid psychosis, paranoiac development evolves over a long period of time in predisposed individuals. Thus, paranoiac development is a subacute illness with a discernably prolonged latency period.

The decision making process will follow in four steps:

- A. Identification of general characteristics
- B. Identification of cross-sectional syndromes or subtypes
- C. Identification of characteristics of course
- D. Identification of characteristics of outcome

A. GENERAL CHARACTERISTICS

Pathognomic of paranoiac development is the logical-organized structure of delusions which arise and spread in a specific-restricted area of the personality, leaving the rest of the personality unaffected.

General Criteria

	<u>Present</u>
1. Predisposition; paranoid personality trait	+
2. Key experience, followed by delusional development	+
3. Logical-organized delusional structure (Figure 3) spreading to a restricted-specific area of personality, leading to a change of personality, but not to a disintegration of personality (obligatory feature!)	+

Maximum Possible Score 3

Minimal Qualifying Score 2

Figure 3

		Reactive Paranoid Psychosis	Paranoiac Development	Affect- Laden Paraphrenia	Systematic Paraphrenias
Structure of delusion	Paralogic Disorganized (Hallucinatory)	///////// ///////// /////////		///////// ///////// /////////	
	Logical Disorganized (Hallucinatory)	///////// ///////// /////////		///////// ///////// /////////	
	Paralogic Organized (Interpretative)	///////// ///////// /////////		///////// ///////// /////////	
	Logical Organized (Interpretative)		///////// ///////// /////////		///////// ///////// /////////
Constituents of delusion interpretation and/or explanation of	Normal perceptions	/////////	/////////	/////////	/////////
	Unfalsified memories	/////////	/////////	/////////	/////////
	Hallucinations			/////////	/////////
	Illusions			/////////	/////////
	Disaesthesias			/////////	/////////
	Feelings of alien influences			///////// /////////	///////// /////////
	Autochthonous, primary, sudden delusional ideas			/////////	/////////
	Confabulations			/////////	/////////

Structure and constituents of delusions in diagnostically different groups (Berner, 1972) .

B. CROSS-SECTIONAL SYNDROMES

Cross-sectional syndromes or subtypes are based on delusional content. They fall into four major groups: passionate, litigious, symbiotic (induced) and monosymptomatic-hypochondriacal.

<u>Subtypes</u>	<u>Present</u>
1. Passionate	+
a. Passionate idealists Passionate fanatics	
b. Amorous paranoia Conjugal paranoia	
c. Erotomania (Liebeswahne or Othello syndrome)	
2. Litigious	+
a. Querulous paranoia (Kohlhaas syndrome)	
b. Reformatory zealotry Delusions of Mignon	
3. Monosymptomatic-hypochondriacal	+
a. Delusions of parasitosis	
b. "Eigenruchswahne" (Videbach syndrome)	
4. Symbiotic or Induced (for subtypes 1-3)	+
a. Folie a deux	
b. Folie a trois	
	<hr/>
Maximum Possible Score	4
Maximum Acceptable Score	2
Minimal Qualifying Score	1

C. COURSE OF DISEASE

Delusions are usually present for some time prior to diagnosis; they have a tendency to become chronic and an integral part of patient's personality.

<u>Course</u>	<u>Present</u>
1. Subacute illness, delusions are usually revealed only after a long latency period	+
2. Psychosis is personality-specific rather than situation-specific and have a strong tendency to become chronic and an integral part of patient's personality	+
3. Unipolar manifestations (or no polarity)	+
Maximum Possible Score	3
Minimal Qualifying Score	2

D. OUTCOME OF ILLNESS

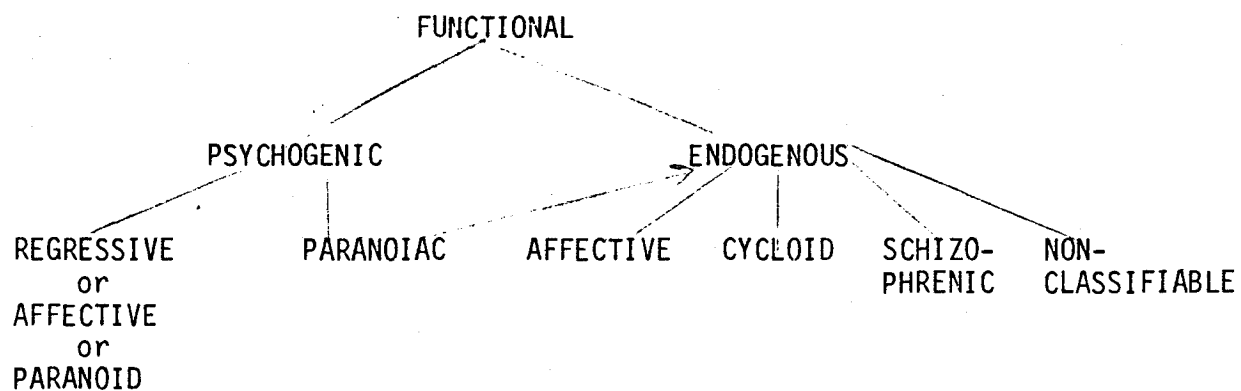
Transformation of personality with maladjustment

<u>Outcome</u>	<u>Present</u>
Transformation of personality	+
Maladjustment	+
Maximum Possible Score	2
Minimal Qualifying Score	1

E. EVALUATION

1. If patient does not meet minimal qualifying criteria for paranoid development, he/she should be diagnosed as psychogenic psychosis, non-classifiable (I/V).
2. If patient meets qualifying criteria for paranoid development he/she should be diagnosed as paranoid development (I/IV).

II. ENDOGENOUS PSYCHOSES



Differential diagnosis of functional psychoses with special reference to the endogenous psychoses.

Endogenous psychosis is the other major diagnostic category included in this Manual.

Endogenous psychosis may manifest in one of three groups of psychoses, i.e., affective, cycloid or schizophrenia spectrum. If a patient fulfills criteria for endogenous psychosis but does not qualify for any one of the three major groups of endogenous psychosis he/she should be diagnosed as endogenous psychosis, unclassifiable.

Patients with endogenous psychosis are identified on the basis of general (holistic) characteristics and certain specific (inclusion) criteria.

The decision making process will follow in two steps:

- A. Identification of general characteristics
- B. Identification of specific inclusion criteria

A. GENERAL CHARACTERISTICS

Endogenous psychosis have two general characteristics and the presence of both is an essential prerequisite for the diagnosis.

<u>General Characteristics</u>	<u>Present</u>
1. The onset (emergence) of psychosis cannot be attributable to a life event, and cannot be understood (Verstehen) on the basis of a life event within the framework of patient's life history, even if there is a traumatic experience	+
2. The psychotic content is bizarre and/or (at least in part) disorganized and incomprehensible	+
Maximum Possible Score	2
Minimal Qualifying Score	2

B. SPECIFIC (INCLUSION) CRITERIA

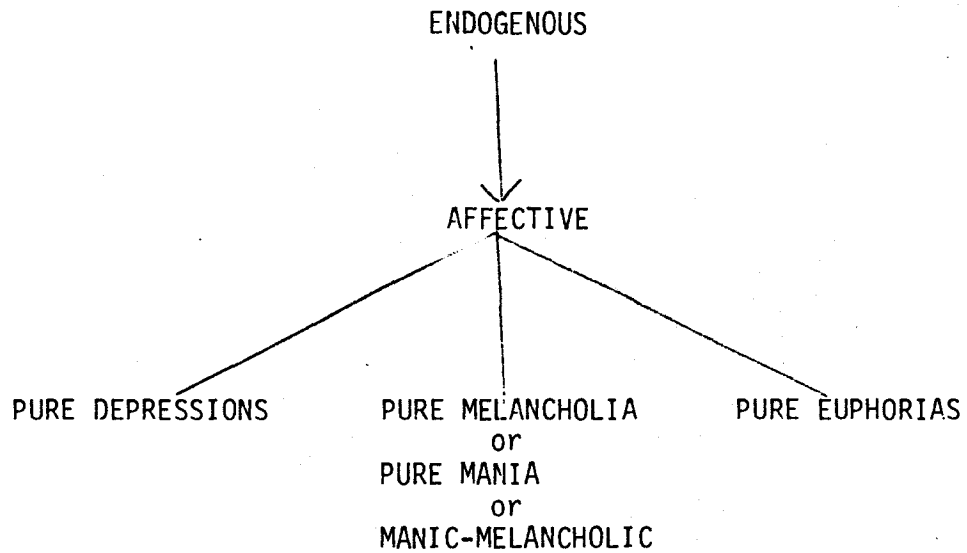
Endogenous psychoses have four specific characteristics and the presence of at least three is an essential prerequisite for the diagnosis.

<u>Specific Criteria</u>	<u>Present</u>
1. Lack of precipitating traumatic experience (stressful life event); and even if there is a trauma, it is not sufficient to explain the emergence (onset) of the psychosis	+
2. There is no thematic continuity between the trauma and the content of the psychosis and attempts to connect the two are done in a. an entangled bizarre way or b. in a holothymic (in-keeping) manner with a pathologic mood state	+
3. There is no meaning to the psychosis; it is purposeless and undermines patient's livelihood	+
4. There is a discernable syndrome present which is classifiable in the spectrum of affective, cycloid or schizophrenic psychoses	+
Maximum Possible Score	4
Minimal Qualifying Score	3

C. EVALUATION

1. If patient does not meet qualifying criteria for endogenous psychosis he/she should be diagnosed as functional psychosis, non-classifiable.
2. If patient meets qualifying criteria for endogenous psychosis proceed to II/I.

II/I. AFFECTIVE (PHASIC) PSYCHOSES



Differential diagnosis of endogenous psychoses with special reference to affective psychoses.

Affective psychosis is one of the three major diagnostic categories of endogenous psychoses.

Affective psychosis may manifest in the form of one of two major syndromes, i.e., depression and/or mania.

Patients with affective psychosis are identified on the basis of three general (holistic) characteristics.

A. GENERAL CHARACTERISTICS

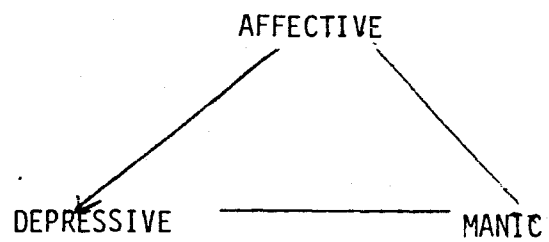
Affective psychosis have three general characteristics and the presence of two is an essential prerequisite for the diagnosis.

<u>General Characteristics</u>	<u>Present</u>
1. Experience, behavior and performance change in a uniform, holothymic manner in keeping with mood	+
2. If there are delusions, they are holothymic, i.e., content of delusions corresponds with mood	+
3. Monomorphous or polymorphous overall picture	+
Maximum Possible Score	3
Minimal Qualifying Score	2

B. EVALUATION

1. If patient does not meet qualifying criteria for affective psychosis proceed to II/II.
2. If patient meets qualifying criteria for affective psychosis proceed to II/I/I.

II/I/I. DEPRESSIVE SYNDROME



Differential diagnosis of affective psychoses with special reference to the depressive syndrome.

The depressive syndrome is one of the two major syndromes of affective psychosis.

The depressive syndrome may manifest in the form of definitive depressive syndrome or depressive psychosis (vital depression), possible depressive syndrome or non-psychotic depression (hypo-or subdepressive state) and incomplete depressive syndrome or incomplete depression.

Patients with a depressive syndrome are identified on the basis of general (holistic) characteristics, and specific, cross-sectional and longitudinal (inclusion) criteria.

A. GENERAL CHARACTERISTICS

Depression (i.e., the depressive syndrome) is a state of lowered affect (dysthymia), a mood of prevailing sadness which transforms all experiences, i.e., how one perceives, relates to and acts upon the world. The term "vital depression" (Schneider, 1959) coins depression which is part of a depressive illness.

<u>General Characteristics</u>	<u>Present</u>
1. Depressive mood, i.e., feels dejected, dispirited, worried and hopeless; complains about lack of interest and gloomy future	+
Maximum Possible Score	1
Minimal Qualifying Score	1

B. SPECIFIC INCLUSION CRITERIA I

There are eight prevailing cross-sectional psychopathological symptoms and signs which characterize the depressive syndrome. Not all of them are present in every patient; 5 or more needs to be present to qualify for a definitive depressive syndrome while 2 suffice for an incomplete depressive syndrome. At least 3 symptoms need to be present to qualify for a possible depressive syndrome, i.e., sub-or hypodepressive state.

Cross-Sectional PsychopathologyPresent

- | | |
|--|---|
| 1. Decreased appetite and/or weight (without diet) or increased appetite and/or weight. A weight change of 0.5 kg per week over a period of several weeks, or a weight change of 5 kg over a year is pathognomic | + |
| 2. Sleep disturbance: insomnia or hypersomnia | + |
| 3. Lack of energy with increased fatiguability and/or exhaustion | + |
| 4. Observable psychomotor agitation or retardation | + |
| 5. Anhedonia; has no interest and cannot get pleasure from everyday activities including sex and social intercourse | + |
| 6. Self-condemnation with feelings of guilt which may or may not be delusional | + |
| 7. Concentration difficulties with retarded thinking characterized by slow, laborious flow of ideas and inability to make decisions | + |
| 8. Suicidal ideas, impulses and/or attempts with the wish to die | + |

Maximum Possible Score	8
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Minimal Qualifying Score	
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Definitive	5
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Possible	3
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Incomplete	2
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C. SPECIFIC INCLUSION CRITERIA II

For the diagnosis of a definitive depressive syndrome it is necessary that the depressive state has continued longer than two weeks, or longer than 1 day

if it was preceded by or switched into a manic syndrome. On the other hand for the diagnosis of an incomplete depressive syndrome, a duration of 1 to 2 weeks suffice. For the diagnosis of possible depressive syndrome it is necessary that the depressive state has continued longer than 1 week or longer than 1 day if it was preceded by or switched into manic syndrome.

<u>Longitudinal Inclusion Criteria</u>	<u>Present</u>
1. Depression has continued for longer than 2 weeks from the time it started to cause observable changes in patient's customary life	+
2. Depression has continued for 1 to 2 weeks from the time it started to cause observable changes in patient's customary life	+
3. Depression has continued for less than a week, but it was preceded by and/or switched into mania	+
Maximum Possible Score	1
Minimal Qualifying Score	1

D. SPECIFIC EXCLUSION CRITERIA

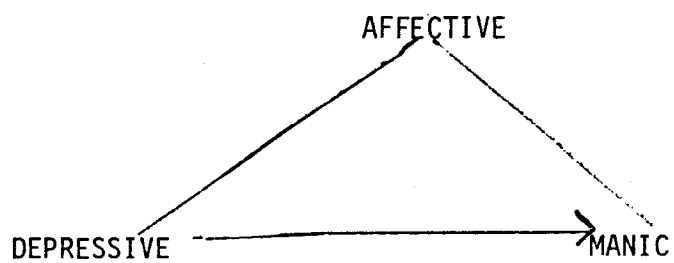
In patients with overlapping psychopathological symptoms with the cycloid psychoses and/or the schizophrenia spectrum psychoses the respective other endogenous psychosis dominates.

<u>Specific Exclusion Criteria</u>	<u>Present</u>
1. Characteristic symptoms of cycloid psychoses	+
2. Characteristic symptoms of schizophrenia spectrum psychoses	+
Maximum Possible Score	1
Minimal Exclusion Score	1

E. EVALUATION

1. If patient does not meet qualifying criteria of a depressive syndrome proceed to II/I/II.
2. If patient meets qualifying criteria of a depressive syndrome but meets also exclusion criteria proceed to II/II.
3. If patient meets qualifying criteria of depressive syndrome without meeting exclusion criteria proceed to II/I/III.1-3.
4. If patient meets qualifying criteria of incomplete depressive syndrome without meeting exclusion criteria proceed to II/I/IV.1-5.

II/I/II. MANIC SYNDROME



Differential diagnosis of affective psychoses with special reference to the manic syndrome.

The manic syndrome is the other one of the two major syndromes of affective psychosis.

The manic syndrome may manifest in the form of definitive manic syndrome or manic psychosis, possible manic syndrome or hypomania and incomplete manic syndrome or incomplete mania.

Patients with a manic syndrome are identified on the basis of general (holistic) characteristics, and specific, cross-sectional and longitudinal (inclusion) criteria.

A. GENERAL CHARACTERISTICS

Mania (i.e., the manic syndrome) is a state of heightened affect, a mood of prevailing exaltation which transforms all experience, i.e., how one perceives, relates to, and acts upon the world. The manic syndrome is characterized by a predominantly elevated, expansive, and/or irritable mood.

<u>General Characteristics</u>	<u>Present</u>
1. Elevated and expansive mood (obligatory feature!)	+
2. Irritability	+
	<hr/>
Maximum Possible Score	2
Minimal Qualifying Score	1

B. SPECIFIC (INCLUSION) CRITERIA I

There are nine prevailing cross-sectional symptoms and signs which characterize the manic syndrome. Not all of them are present in every patient; 5 or more needs to be present to qualify for a definitive manic syndrome and 6 or more if irritability is among the general characteristics of the prevailing features. On the other hand, the presence of 2 symptoms would suffice for an incomplete manic syndrome, i.e., a mania in which euphoria, instead of

hyperthymia is the prevailing feature. At least 3 symptoms need to be present to qualify for a possible manic syndrome, i.e., hypomania.

<u>Cross-Sectional Psychopathology</u>	<u>Present</u>
1. Hyperthymia (obligatory feature of mania)	+
2. Euphoria (obligatory feature of incomplete mania)	+
3. Hyperactivity, i.e., increase in activity (i.e., social, work, home, sex) with or without restlessness	+
4. Increased talkativeness and/or pressure of speech	+
5. The subjective experience that ones thoughts are racing with or without flight of ideas	+
6. Inflated self-esteem with grandiosity which may or may not be delusional	+
7. Decreased need for sleep	+
8. Distractibility; hypervigilance	+
9. Tactless and/or reckless behavior characterized by excessive spending sprees, sexual indiscretion, etc.	+
Maximum Possible Score	9
Minimal Qualifying Score	
Definitive	5(6)
Possible	3
Incomplete	2

C. SPECIFIC (INCLUSION) CRITERIA II

For the diagnosis of a definitive manic syndrome it is necessary that the manic state has continued longer than 2 weeks, or longer than 1 day if it was preceded by or switched into a depressive syndrome. On the other hand, for the diagnosis of an incomplete manic syndrome a duration of 1 to 2 weeks suffice.

For the diagnosis of possible manic syndrome it is necessary that the manic state has continued longer than 1 week or longer than 1 day if it was preceded by or switched into a depressive syndrome.

<u>Longitudinal Criteria</u>	<u>Present</u>
1. Mania has continued for longer than 2 weeks from the time it started to cause observable changes in patient's customary life	+
2. Mania has continued for 1 to 2 weeks from the time it started to cause observable changes in patient's customary life	+
3. Mania has continued for less than a week but it was preceded by and/or switched into depression	+
Maximum Possible Score	1
Minimal Qualifying Score	1

D. SPECIFIC EXCLUSION CRITERIA TO BE PRESENT

In patients with overlapping psychopathological symptoms with the cycloid psychoses and/or the schizophrenia spectrum psychoses the respective other endogenous psychosis dominates.

<u>Specific Exclusion Criteria</u>	<u>Present</u>
1. Characteristic symptoms of cycloid psychosis (protopathic change of form, feeling of uncertainty and/or emotional involvement in symptoms)	+
2. Characteristic symptoms of schizophrenia spectrum psychosis (autism, inappropriateness of affect, specific type of thought disorders and/or catatonic symptoms)	+
Maximum Possible Score	1
Minimal Exclusion Score	1

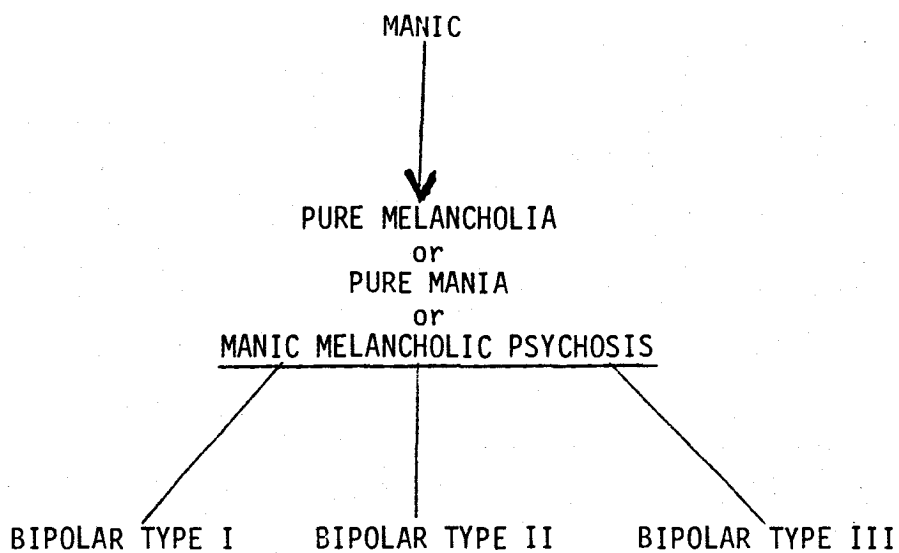
E. EVALUATION

1. If patient does not meet qualifying criteria of a manic syndrome or exclusion criteria he/she should be diagnosed as endogenous psychosis, non-classifiable (II/IV).
2. If patient does not meet qualifying criteria of a manic syndrome but meets exclusion criteria proceed to II/II.
3. If patient meets qualifying criteria of a manic syndrome, but meets also exclusion criteria proceed to II/II.
4. If patient meets qualifying criteria of manic syndrome without meeting exclusion criteria proceed to II/I/III.1-3.
5. If patient meets qualifying criteria of incomplete manic syndrome without meeting exclusion criteria proceed to II/I/IV.1-5.

II/I/III.1 PURE MELANCHOLIA

II/I/III.2 PURE MANIA

II/I/III.3 MANIC-MELANCHOLIC PSYCHOSIS



Differential diagnosis of affective psychosis with special reference to pure melancholia, pure mania and manic-melancholic psychosis.

Affective (phasic) psychoses are characterized by intermittent periodicity with full remission between the episodes (phases).

The three major disorders with the presence of full depressive, manic or both syndromes are pure melancholia, pure mania and manic-melancholic psychosis. For the diagnosis of these conditions cross-sectional assessment does not suffice and needs to be supplemented with information on the course of disease and outcome of illness.

A. COURSE OF DISEASE

All three psychoses manifest in the form of an acute or subacute illness. They differ, however, in terms of polarity, i.e., unipolar (manic or depressive), or bipolar (manic and depressive).

<u>Course</u>	<u>Present</u>
1. Acute or subacute form of illness	+
2. Unipolar with strong tendency for rhythmicity	+
3. Bipolar with rhythmicity	+
Maximum Possible Score	2
Minimal Qualifying Score	2

B. OUTCOME OF ILLNESS

In theory the characteristic outcome of phasic psychoses is full recovery. This, however, is not always the case.

<u>Outcome</u>	<u>Present</u>
1. Full recovery	+
Maximum Possible Score	1
Minimal Qualifying Score	0

C. EVALUATION

The diagnosis of bipolar affective psychosis can be made with certainty, while the diagnosis of unipolar affective psychosis can be made only with a certain level of probability.

It is a common contention that unipolar and bipolar affective psychoses cannot be differentiated cross-sectionally (Roth and Barnes, 1981). This, however, is not necessarily the case, because bipolar patients often display polymorphous, varied symptomatology of changing intensity and frequently exhibit switches during certain stages of their illness. In contradistinction to the bipolars, unipolar patients display monomorphous symptomatology with considerable steadiness over time and without exhibiting switches.

Taylor and Abrams (1980) recommend the following criteria to be used in the differentiation of patients with unipolar and bipolar illness:

<u>Variables</u>	<u>Polarity</u>
a. Premorbid personality	
a. Cyclothymic	Bipolar
b. Typus melancholicus (Tellenbach, 1961)	Unipolar
b. Family history	
a. Unipolar	Unipolar
b. Bipolar	Bipolar
c. Three episodes of identical type, i.e., manic or depressive in 5 years or more after the index psychosis	Probably unipolar
d. Four episodes of identical type, i.e., manic or depressive in 5 years or more after the index psychosis	Definitive unipolar
e. Three episodes of identical type, i.e., manic or depressive in 10 years or more after the index psychosis	Definitive unipolar
1. If depression(s) only (incomplete depression excluded), he/she should be diagnosed pure melancholia (II/I/III.1).	
2. If mania(s) only (incomplete mania excluded), he/she should be diagnosed as pure mania (II/I/III.2).	
3. If both depression(s) and mania(s), he/she should be diagnosed as manic-melancholic psychosis (II/I/III.3).	

- a. Bipolar Type I: definitive depression(s) with definitive mania(s) (II/I/III.3a).
- b. Bipolar Type II: definitive depression(s) with hypomania(s) (II/I/III.3b).
- c. Bipolar Type III: definitive mania(s) with subdepression(s) (II/I/III.3c).

II/I/IV. INCOMPLETE (PURE) DEPRESSIONS

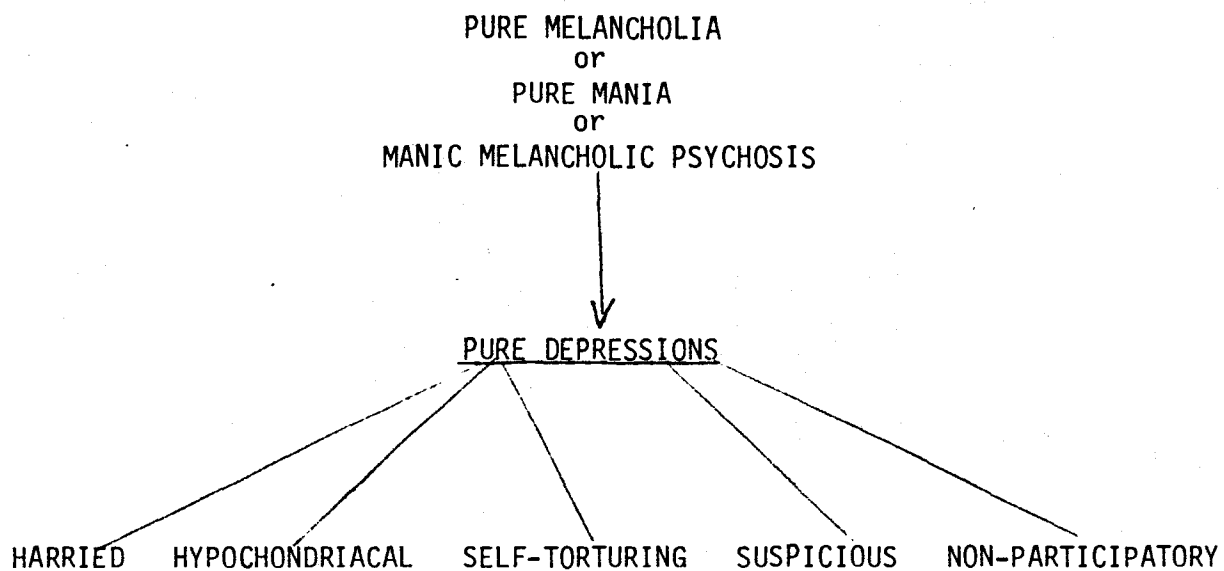
II/I/IV.1 HARRIED DEPRESSION

II/I/IV.2 HYPOCHONDRIACAL DEPRESSION

II/I/IV.3 SELF-TORTURING DEPRESSION

II/I/IV.4 SUSPICIOUS DEPRESSION

II/I/IV.5 NON-PARTICIPATORY DEPRESSION



Differential diagnosis of affective psychosis with special reference to pure depressions.

Incomplete depressions are pure depressions which manifest in five distinct monomorphus syndromes. On the basis of the prevailing characteristics of these syndromes five distinct subtypes have been described, i.e., harried depression, hypochondriacal depression, self-torturing depression, suspicious depression and non-participatory depression.

Patients with pure depression are identified on the basis of certain general characteristics and special (inclusion) criteria with consideration to the course and outcome of the illness.

A. GENERAL CHARACTERISTICS

There are three general characteristics of pure depression and all three must be present for the diagnosis.

<u>General Characteristics</u>	<u>Present</u>
1. Incomplete depression (see II/I)	+
2. Monomorph disease picture	+
3. One of five distinct syndromes	+
Maximum Possible Score	3
Minimal Qualifying Score	3

B. SPECIAL INCLUSION CRITERIA

Prevailing features of the five subtypes are distinctly different. Harried depression is characterized by anxious restlessness; hypochondriacal depression by bodily misperceptions; self-torturing depression by feelings of guilt with thoughts of pending catastrophe; suspicious depression by ideas of reference; and non-participatory depression by feelings of alination with lack of initiative and retardation. Each subtype has three distinct characteristics; all three characteristics need to be present to qualify for subtype.

SubtypesPresent

- | | |
|---|---|
| 1. Harried depression | + |
| a. Marked tension and anxiety | |
| b. Motor restlessness with poor thematization | |
| c. Complaintativeness (driven quality) | |
| 2. Hypochondriacal depression | + |
| a. Bodily misperceptions - homonom | |
| b. Feeling sick and/or diseased | |
| c. Complaintativeness (hopeless quality) | |
| 3. Self-torturing depression | + |
| a. Feelings of guilt which may or may not be delusional
(includes self-denigration, self-accusation and
micromanic delusions) | |
| b. Loss of self-esteem and/or thoughts of pending
disaster | |
| c. Lamentativeness | |
| 4. Suspicious depression | + |
| a. Ideas of reference with feelings of inferiority | |
| b. Paranoid ideation with depressed mood and anxiety | |
| c. Suspiciousness without irritability and hostility | |
| 5. Non-participatory depression | + |
| a. The painful experience of the inability to
experience emotions; the feeling of loss of feeling | |
| b. Feelings of alienation with self-condemnation | |
| c. Lack of will power and/or initiative | |

 Maximum Possible Score

6

Qualifying Score

1

C. COURSE OF DISEASE

Pure depressions are unipolar diseases with questionable rhythmicity. They have a tendency to become chronic.

<u>Course</u>	<u>Present</u>
1. Unipolar disease (obligatory feature!)	+
2. Tendency for chronicity	+
3. Questionable rhythmicity	+
	<hr/>
Maximum Possible Score	3
Minimal Qualifying Score	2

D. OUTCOME OF ILLNESS

In spite of the tendency for chronicity, outcome is characterized by full recovery.

<u>Outcome</u>	<u>Present</u>
Full recovery	+
	<hr/>
Maximum Possible Score	1
Minimal Qualifying Score	1

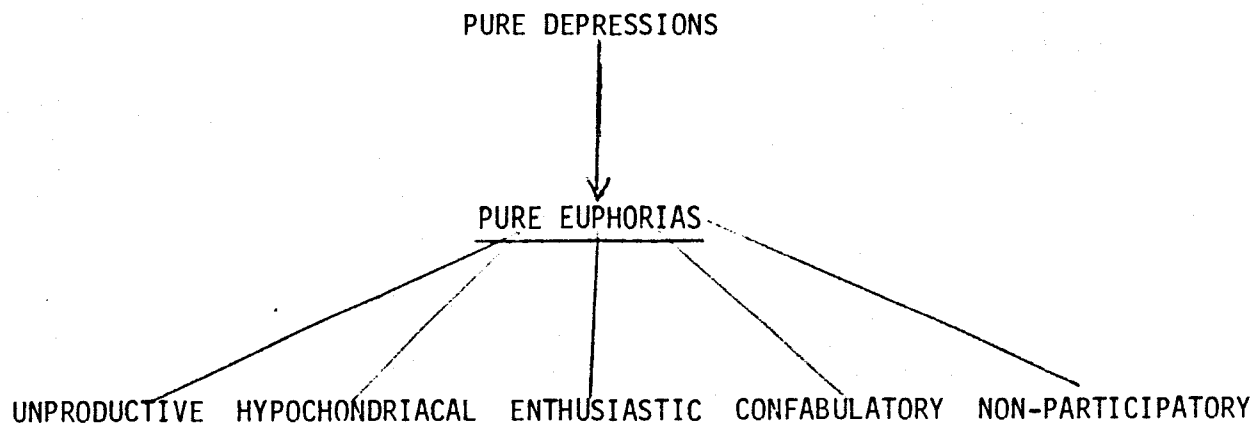
E. EVALUATION

1. If patient does not meet qualifying criteria for any one of the five syndromes he/she should be diagnosed as affective psychosis, non-classifiable.
2. If patient meets qualifying criteria for any one of the five syndromes, he/she should be diagnosed accordingly, i.e., harried depression (II/I/IV.1), hypochondriacal depression (II/I/IV.2), self-torturing depression (II/I/IV.3), suspicious depression (II/I/IV.4), or non-participatory depression (II/I/IV.5).

3. If patient meets qualifying criteria for more than one of the five syndromes he/she should be diagnosed as affective psychosis, non-classifiable.

II/I/V. INCOMPLETE MANIAS OR PURE EUPHORIAS

- II/I/V.1 UNPRODUCTIVE EUPHORIA
- II/I/V.2 HYPOCHONDRIACAL EUPHORIA
- II/I/V.3 ENTHUSIASTIC EUPHORIA
- II/I/V.4 CONFABULATORY EUPHORIA
- II/I/V.5 NON-PARTICIPATORY EUPHORIA



Differential diagnosis of affective psychoses with special reference to the pure euphorias.

Pure euphorias are incomplete manias which manifest in five distinct monomorphus syndromes. On the basis of the prevailing characteristics of these syndromes five distinct subtypes have been described, i.e., unproductive euphoria, hypochondriacal euphoria, enthusiastic euphoria, confabulatory euphoria and non-participatory euphoria.

Patients with pure euphoria are identified on the basis of certain general characteristics and special (inclusion) criteria with consideration to the course and outcome of the illness.

A. GENERAL CHARACTERISTICS

There are three general characteristics of pure euphoria and all three must be present for the diagnosis.

<u>General Characteristics</u>	<u>Present</u>
1. Incomplete mania (see II/II)	+
2. Monomorphous disease picture	+
3. One of five distinct syndromes	+
Maximum Possible Score	3
Minimal Qualifying Score	3

B. SPECIAL (INCLUSION) CRITERIA

Prevailing features of the five subtypes are distinctly different. Unproductive euphoria is characterized by unmotivated feeling of happiness with inactivity; hypochondriacal euphoria by cheerfully enumerated somatic complaints; enthusiastic euphoria by excessive happiness with a desire to make others happy; confabulatory euphoria by grandiose confabulations; and non-participatory euphoria by a subjectively felt and objectively recognizable impoverishment of will and emotions which does not seem to bother patient.

<u>Subtypes</u>	<u>Present</u>
1. Unproductive euphoria	+
a. Euphoria with a radiant facial expression	
b. Lack of motivation; decrease in purposeful activities	
2. Hypochondriacal euphoria	+
a. Euphoria with numerous homonom somatic complaints	
b. Transient talkativeness	
3. Enthusiastic euphoria	+
a. Feeling of excessive happiness with a desire to make others happy	
b. Ideas of grandeur with or without pseudohallucinations	
4. Confabulatory euphoria	+
a. Grandiose and happy confabulations	
b. Easygoing, lively and playful	
5. Non-participatory euphoria	
a. Euphoria with subjectively felt and objectively recognizable diminished volition	
b. Complaining about lack of interest and/or inability to get involved	
	<hr/>
Maximum Possible Score	5
Qualifying Score	1

C. COURSE OF DISEASE

Pure euphorias are unipolar diseases with questionable rhythmicity. They have a tendency to become chronic.

<u>Course</u>	<u>Present</u>
1. Unipolar disease (obligatory feature!)	+
2. Tendency for chronicity	+
3. Questionable rhythmicity	+
	<hr/>
Maximum Possible Score	3
Minimum Qualifying Score	2

D. OUTCOME OF ILLNESS

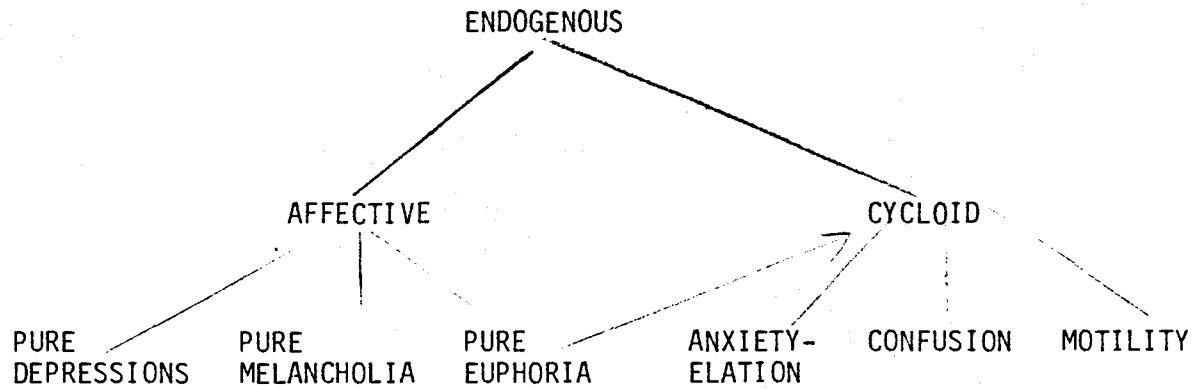
In spite of the tendency for chronicity, outcome is characterized by full recovery.

<u>Outcome</u>	<u>Present</u>
Full recovery	+
	<hr/>
Maximum Possible Score	1
Minimum Qualifying Score	1

E. EVALUATION

1. If patient does not meet qualifying criteria for any one of the five syndromes he/she should be diagnosed as affective psychosis, non-classifiable.
2. If patient meets qualifying criteria for any one of the five syndromes, he/she should be diagnosed accordingly, i.e., unproductive euphoria (II/I/V.1); hypochondriacal euphoria (II/I/V.2); enthusiastic euphoria (II/I/V.3); confabulatory euphoria (II/I/V.4); or non-participatory euphoria (II/I/V.5).
3. If patient meets qualifying criteria for more than one of the five syndromes he/she should be diagnosed as affective psychosis, non-classifiable.

II/II. CYCLOID PSYCHOSES



Differential diagnosis of endogenous psychoses with special reference to cycloid psychoses.

Although listed as second in this Manual, cycloid psychosis is usually referred to as the third major diagnostic category of endogenous psychoses.

Separation of patients with schizophrenic and affective psychoses is not always possible by cross-sectional psychopathological assessment; a considerable number of patients do not fit either of the two Kraepelinian categories, i.e., dementia praecox and manic depressive insanity.

Patients who fell into the "diagnostic crack" have been classified alternately with the schizophrenias and with the affective psychoses, but have never found a comfortable place in either category. Among the various diagnostic labels they have received schizoaffective disorder is the one most extensively employed in the Anglo-American literature. The term "schizoaffective psychosis" gradually replaced the term "mixed psychosis," the most frequently employed diagnosis for these patients in the British literature.

The diagnosis of schizoaffective disorder was accepted by the International Classification of Diseases and has been listed among the schizophrenic psychoses. Nevertheless, Hamilton (1976) maintains that it is not always easy to know what the average psychiatrist means by the words "schizoaffective psychosis." While Spitzer (1978) suggests that for qualifying for the diagnosis of schizoaffective psychosis, manic and/or depressive symptoms on the one hand and hallucinations and/or delusions on the other must be observable separately for at least a week, Petho (1984) maintains that by employing such an "atomistic" approach the essential features of the disease are overlooked.

The obvious difficulties with the concept are reflected in the DSM-III, according to which "the term schizoaffective disorder has been used in many different ways since it was first introduced and at present there is no consensus on how this category should be defined."

Diagnostic difficulties are compounded by low prognostic validity and heterogeneity of responsiveness to pharmacological agents. As a result the diagnostic concept of schizoaffective disorder, as one single disease, is losing grounds, and the concept of cycloid psychosis, a group of psychoses which resemble affective psychoses in their course and schizophrenic psychoses in their content is gaining increasing acceptance. The concept of cycloid psychosis, or rather "cycloid marginal psychosis" was introduced by Kleist (1928) referring to at least two of the psychopathological syndromes, i.e., motility psychosis and confusion psychosis as distinct psychological illnesses. To these, a third disorder, anxiety-elation psychosis was added by Leonhard (1967), a pupil of Kleist.

Cycloid psychosis may manifest in the form of one of three illnesses. If a patient fulfills criteria for cycloid psychosis, but does not qualify for any one of the three illnesses he/she should be diagnosed as mixed cycloid psychosis.

Patients with cycloid psychosis are identified on the basis of general (holistic) characteristics, and specific cross-sectional (inclusion) criteria. In the verification of the diagnosis, the course of the disease and the outcome of the illness are of significance.

The decision making process will follow in four steps:

- A. Identification of general characteristics
- B. Identification of specific (inclusion) criteria
- C. Course of disease
- D. Outcome of illness

A. GENERAL CHARACTERISTICS

Cycloid psychoses have 7 general characteristics and the presence of 4 (possible) or 5 (definitive) of these characteristics is an essential prerequisite for the diagnosis.

In the diagnosis of cycloid psychosis identification of holistic characteristics play an especially important role.

General Characteristics

Present

1. The whole field of experience is transformed; the change corresponds with one of the three phases of protopathic change of form (Conrad, 1958):
 - a. Trema (The coherence of the patient's inner and outer world is loosening. It is experienced as loss of freedom. Patient feels hemmed in, surrounded by barriers, and unable to communicate with others. The feeling has also been compared to stage fright.)
 - b. Apophany (The coherence of the patient's inner and outer world is so loose that the essential properties--Wesenseigenschaften--stand out in marked relief and become independent resulting in misidentifications and delusional perceptions. All these give the patient the impression that he/she is the center of a changed world or of a transcendental experience)
 - c. Apocalyptic (Fragmentation of psychic life with a destruction of the sense of continuity. This is to the extent that only fragments of the total experience can be subsequently recalled.) (Hamilton, 1976)
2. Change is associated with a change in the state of mind and depth of emotions characterized by anxiety, happiness, apathy, or ecstasy

	<u>Present</u>
3. Experience, behavior and performance remain in harmony (like in affective psychoses and unlike in schizophrenic psychoses)	+
4. If there are delusions (logical-organized), they are holothymic, i.e., in keeping with mood and emotional state	+
5. Polymorphous-fluctuating disease picture with great variability of symptoms	+
6. Contradictory influences of healthy and pathological tendencies alternate or clash, creating a feeling of uncertainty and/or confusion	+
7. Strong emotional involvement in the symptoms	<u>+</u>
Maximum Possible Score	7
Minimal Qualifying Score	4

B. SPECIFIC (INCLUSION) CRITERIA

There are 3 prevailing cross-sectional psychopathological symptoms and signs which characterize cycloid psychoses. In some patients they overlap; for the diagnosis of cycloid psychosis, however, one should suffice.

<u>Specific Criteria</u>	<u>Present</u>
1. Misperceptions and/or ideas of reference and/or delusional perceptions	+
2. Increase (hyperkinesia) or decrease (hypokinesia) of expressive and reactive movements; in extreme cases akinetic stupor	+

3. Thematic incoherence (i.e., thought and consequently speech have no understandable connections) or paralogia (i.e., overinclusive thinking)

Present

+

 Maximum Possible Score 3

Minimal Qualifying Score 1

C. SPECIFIC EXCLUSION CRITERION

Patients with overlapping psychopathological symptoms with the schizophrenia spectrum psychoses will be excluded.

Specific Exclusion Criterion

Present

1. Characteristic symptoms of schizophrenia spectrum psychoses

+

 Maximum Possible Score 1

Minimal Exclusion Score 1

D. COURSE OF DISEASE

All three psychoses manifest in the form of acute or subacute illnesses. They are bipolar disorders which may show marked rhythmicity in their course. Chronic courses are exceptionally rare, but if they occur, cycloid psychoses lose their tension after repeated phases of hospitalization.

Course

Present

1. Acute or subacute form of illness (obligatory feature!)
 2. Rhythmicity (which may be marked)
 3. Bipolar; if patient shows changes in both directions they follow one another and do not occur at the same time

+

+

+

 Maximum Possible Score 3

Minimal Qualifying Score 2

E. OUTCOME OF ILLNESS

Characteristic outcome of cycloid psychosis is full recovery; even if the illness recurs no defect should be left behind. However, cycloid psychosis is not uncommon in patients with accentuated personalities and/or patient's personality may become accentuated and/or social adjustment problematic after one or more psychotic episodes. Proper and prompt appraisal of course and outcome is especially important in cycloid psychosis.

<u>Outcome</u>	<u>Present</u>
1. Full recovery	+
2. Development of accentuated personality	+
Maximum Possible Score	1
Minimal Qualifying Score	1

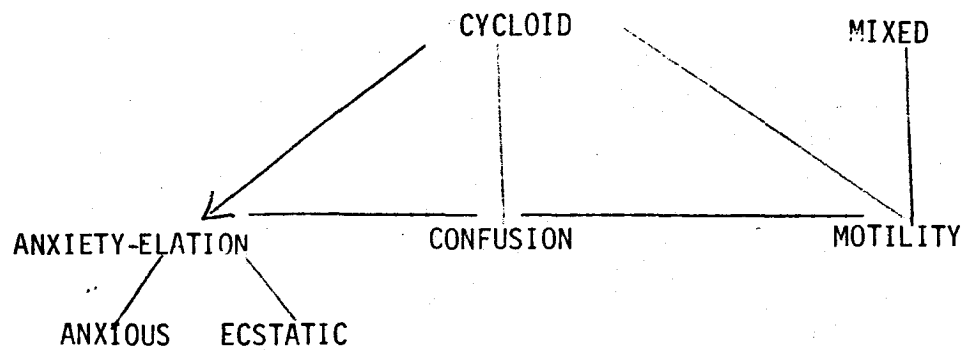
F. EVALUATION

1. If patient does not meet qualifying criteria for cycloid psychosis proceed to II/III.
2. If patient meets qualifying criteria for cycloid psychosis proceed to II/II/I. To qualify for cycloid psychosis, the psychosis must be present for at least 1 week from the appearance of the initial psychopathological symptoms.

II/II/I. ANXIETY-ELATION PSYCHOSIS

II/II/I.1 ANXIOUS TYPE

II/II/I.2 ECSTATIC TYPE



Differential diagnosis of cycloid psychoses with special reference to motility psychosis.

Anxiety-elation psychosis is one of the three illnesses of cycloid psychosis. It is named after the two syndromes which provide for its content. However, since usually only one of the two syndromes is present during an episode of the illness, some consider anxiety psychosis and elation psychosis (also referred to as happiness psychosis or psychosis extatica) as two distinct conditions.

Anxiety-elation psychosis is primarily a disorder of affectivity in which anxiety and ecstasy occur. While at the anxiety pole the anxiety is associated with ideas of reference, the content of which corresponds with the affect, in the elation pole expansive ideas are produced.

Both anxiety psychosis and elation psychosis are characterized by three sets of psychopathological symptoms.

The decision making process will follow in two steps:

- A. Identification of characteristics of anxiety psychosis
- B. Identification of characteristics of happiness psychosis

A. CHARACTERISTICS OF ANXIETY PSYCHOSIS

Anxiety psychosis manifests in three sets of psychopathological symptoms and the presence of both symptoms of the first set is an essential prerequisite for this diagnosis. In addition, for the possible diagnosis of anxiety psychosis at least 1 symptom from both the second and third sets of psychopathological symptoms are required; and for the definitive diagnosis of anxiety psychosis at least 2 symptoms from both the second and third sets of symptoms are necessary.

First Set of Symptoms

Present

- | | |
|--|---|
| 1. Delusions of reference and/or delusional perceptions
of persecutory nature | + |
|--|---|

	<u>Present</u>
2. Marked anxiety and/or tension	+
	<hr/>
Maximum Possible Score	2
Minimal Qualifying Score	2

Second Set of Symptoms

	<u>Present</u>
1. Perplexed	+
2. Phonemic hallucinations and/or illusions with or without secondary delusions	+
3. Olfactory illusions and/or hallucinations	+
4. Bodily (coenesthetic) hallucinations and/or illusions with or without the feeling of alien influences	+
	<hr/>
Maximum Possible Score	4
Minimal Qualifying Score	1

Third Set of Symptoms

	<u>Present</u>
1. Inhibited or agitated	+
2. Feelings of guilt and/or inferiority	+
	<hr/>
Maximum Possible Score	2
Minimum Qualifying Score	1

B. CHARACTERISTICS OF ELATION PSYCHOSIS

Elation psychosis manifests in three sets of psychopathological symptoms and the presence of all symptoms from both the first and second sets is an essential prerequisite for this diagnosis. In addition, for the definitive diagnosis of elation psychosis, at least 1 symptom from the third set of symptoms is required.

<u>First Set of Symptoms</u>	<u>Present</u>
1. Feeling of happiness (elation) with or without secondary delusions	+
2. The desire to make others happy	+
Maximum Possible Score	2
Minimal Qualifying Score	2
<u>Second Set of Symptoms</u>	<u>Present</u>
1. Exaggerated self-esteem	+
2. Misperceptions and/or delusional perceptions of grandiose nature	+
Maximum Possible Score	2
Minimal Qualifying Score	2
<u>Third Set of Symptoms</u>	<u>Present</u>
1. Psychomotor stimulation or excitation	+
2. Thematic incoherence or confusion	+
Maximum Possible Score	2
Minimal Qualifying Score	0

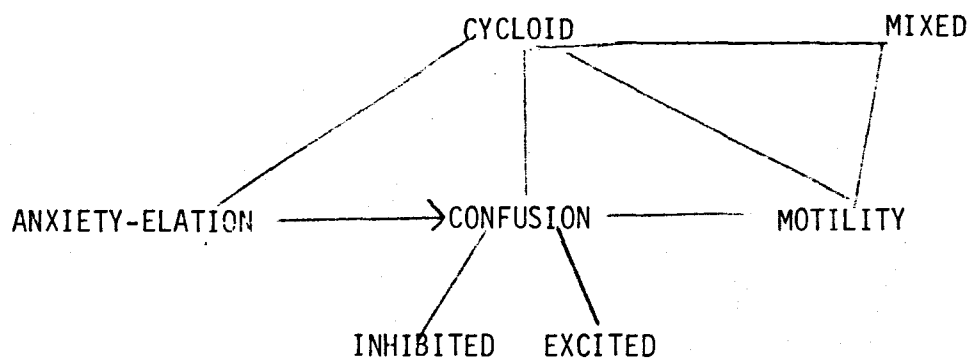
C. EVALUATION

1. If patient does not meet qualifying criteria for anxiety-elation psychosis proceed to II/II/II.
2. If patient meets qualifying criteria he/she should be diagnosed as anxiety-elation psychosis (II/II/I) with the qualification of anxious (II/II/I.1) or ecstatic (II/II/I.2) type.

II/II/II. CONFUSION PSYCHOSIS

II/II/II.1 INHIBITED TYPE

II/II/II.2 EXCITED TYPE



Differential diagnosis of cycloid psychoses with special reference to confusion psychosis.

Confusion psychosis is the second of the three illnesses of cycloid psychosis. It includes two distinct syndromes, i.e., inhibited and excited confusion. However, since usually only one of the two syndromes is present during an episode of the illness, some consider inhibited confusion psychosis, also referred to as confusiophrenia inhibita and excited confusion psychosis, also referred to as confusiophrenia agitata, as two distinct conditions.

Confusion psychosis is primarily a disorder of thinking in which the thought disorder on the excited pole (type) of the illness manifests in the form of incoherence, while on the other inhibited pole (type) the inhibition of thought may lead to mutism and/or perplexed stupor.

Both inhibited confusion psychosis and excited confusion psychosis are characterized by three sets of psychopathological symptoms.

The decision making process will follow in two steps:

- A. Identification of characteristics of inhibited confusion psychosis
- B. Identification of characteristics of excited confusion psychosis

A. CHARACTERISTICS OF INHIBITED CONFUSION PSYCHOSIS

Inhibited confusion psychosis manifests in three sets of psychopathological symptoms and the presence of all the symptoms of the first set is an essential prerequisite for this diagnosis. In addition, for the possible diagnosis of inhibited confusion psychosis the presence of all the symptoms of the second or third set of psychopathological symptoms are required; and for the diagnosis of definitive inhibited confusion psychosis all the symptoms of all three sets of psychopathological symptoms are necessary.

First Set of SymptomsPresent

1. Decreased talkativeness and activity with diminished expressive movements
2. Confused thinking with perplexed facial expression; in severe cases stupor

+

+

Maximum Possible Score

2

Minimal Qualifying Score

2

Second Set of SymptomsPresent

1. Incoherence or confusion
2. Reactive stupor (Severity of this reaction is in linear relationship with the complexity of the task, i.e., the more complex the task, the more severe the reaction)

+

+

Maximum Possible Score

2

Minimal Qualifying Score

2 or 0

Third Set of SymptomsPresent

1. Misperceptions and/or phonemic hallucinations

+

Maximum Possible Score

1

Minimal Qualifying Score

1 or 0

B. CHARACTERISTICS OF EXCITED CONFUSION PSYCHOSIS

Excited confusion psychosis manifests in three sets of psychopathological symptoms and the presence of the symptom of the first set is an essential prerequisite for this diagnosis. In addition for the definitive diagnosis of excited confusion psychosis, 1 symptom from each, the second and the third sets of psychopathological symptoms are required, while for the possible diagnosis

of excited confusion psychosis 1 symptom from the second or the third sets of psychopathological symptoms are necessary.

First Set of Symptoms

1. Excitement

Present

+

Maximum Possible Score

1

Minimal Qualifying Score

1

Second Set of Symptoms

1. Confusion; content of thought and speech is independent of environmental events
2. Pressure of speech; thematic incoherence; fragmentation of thought; no detectable link between ideas

Present

+

+

Maximum Possible Score

2

Minimal Qualifying Score

1 or 0

Third Set of Symptoms

1. Misperceptions with or without misidentifications
2. Fragmentary hallucinations, most often auditory (phonemic), but also visual and bodily (coenesthetic)

Present

+

+

Maximum Possible Score

2

Minimal Qualifying Score

1 or 0

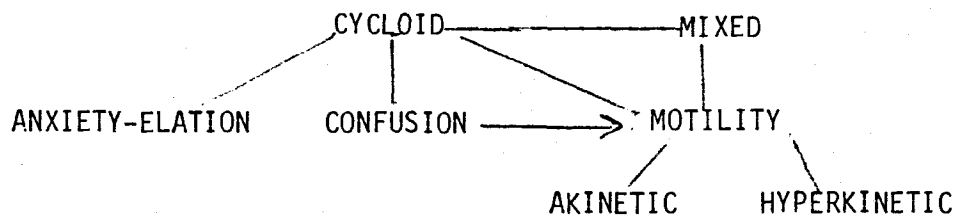
C. EVALUATION

1. If patient does not meet qualifying criteria for confusion psychosis proceed to II/II/III.
2. If patient meets qualifying criteria he/she should be diagnosed as confusion psychosis (II/II/II) with the qualification of inhibited (II/II/II.1) or excited (II/II/II.2) type.

II/II/III. MOTILITY PSYCHOSIS

II/II/III.1 AKINETIC TYPE

II/II/III.2 HYPERKINETIC TYPE



Differential diagnosis of cycloid psychoses with special reference to anxiety-happiness psychosis.

(3)

Motility psychosis is the third of the three illnesses of cycloid psychosis. It includes two distinct syndromes, i.e., akinetic and hyperkinetic. However, since usually only one of the two syndromes is present during an episode of the illness, some consider akinetic motility psychosis and hyperkinetic motility psychosis as two distinct conditions.

Motility psychosis is primarily a psychomotor illness with prevailing hyperkinesia or akinesia. The increase or decrease of motor activity concerns the reactive and expressive movements and is quantitative in nature. Accordingly, when patients are hyperkinetic they relate to all events in the environment and exhibit a large number of reactive and expressive movements, i.e., facial expressions and gestures. Both reactive and expressive movements cease in akinesia; even the necessary reactions to external events and bodily needs may be absent.

Both akinetic motility psychosis and hyperkinetic motility psychosis are characterized by two sets of psychopathological symptoms.

The decision making process will follow in two steps:

- A. Identification of characteristics of akinetic motility psychosis
- B. Identification of characteristics of hyperkinetic motility psychosis

A. CHARACTERISTICS OF AKINETIC MOTILITY PSYCHOSIS

Akinetic motility psychosis manifests in two psychopathological symptoms and the presence of one or the other (or alternately one and the other) is the prerequisite for the diagnosis.

Characteristic Symptoms

Present

- | | |
|--|---|
| 1. Confused stupor (characterized by lack of purposeful, goal directed activities with diminished reactive and expressive movements) | + |
|--|---|

	<u>Present</u>
2. Akinesia (characterized by lack of purposeful activities and reactive movements with stilted-rigid-expressive movements)	+
	<hr/>
Maximum Possible Score	2
Minimal Qualifying Score	1

B. CHARACTERISTICS OF HYPERKINETIC MOTILITY PSYCHOSIS

Hyperkinetic motility psychosis manifests in two sets of psychopathological symptoms and the presence of at least 1 symptom from the first set is an essential prerequisite for this diagnosis. For a definitive diagnosis of motility psychosis, 1 symptom from each set of psychopathological symptoms is necessary.

First Set of Symptoms

	<u>Present</u>
1. Substantial increase with a noticeable acceleration of expressive and reactive movements (e.g., stamping feet, squinting, grimacing) with a lively facial mimicry (expressing worry, anger, disappointment, eroticism etc.)	+
2. Hyperkinesia with restlessness and disintegration of activities (which in the most serious cases manifest in the form of Stauder's catatonia)	+
	<hr/>
Maximum Possible Score	2
Minimal Qualifying Score	1

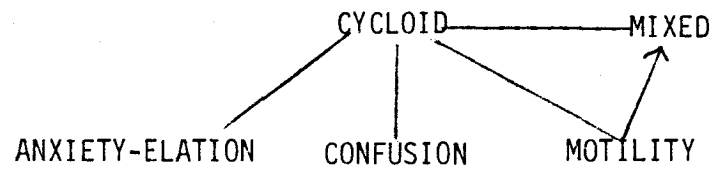
Second Set of Symptoms

	<u>Present</u>
1. Speech is characterized by short phrases and long pauses with occasional emotionally charged cries (outbursts)	+
2. Thematic incoherence	+
	<hr/>
Maximum Possible Score	2
Minimal Qualifying Score	0

C. EVALUATION

1. If patient does not meet qualifying criteria for motility psychosis proceed to II/II/IV.
2. If patient meets qualifying criteria, he/she should be diagnosed as motility psychosis (II/II/III) with the qualification of akinetic (II/II/III.1) or hyperkinetic (II/II/III.2) type.

II/II/IV. MIXED CYCLOID PSYCHOSES



Differential diagnosis of cycloid psychoses with special reference to the mixed form.

Cycloid psychoses are characterized by a great variability (polymorphous) of fluctuating psychopathological symptoms. Accordingly cycloid psychosis frequently manifests in a number of different mixed forms. In these mixed forms the three different syndromes (illnesses) and the two different (polar) types within each syndrome, are present in various combinations. In several of these combinations the same patient may show changes in both directions, e.g., elation and anxiety, successively or simultaneously. In case of motility psychosis if there are changes in both directions, they follow one another and do not occur in the same time. (Simultaneous presence of hyperkinetic and akinetic pathology is indicative of periodic catatonia.)

A. SYNDROMES

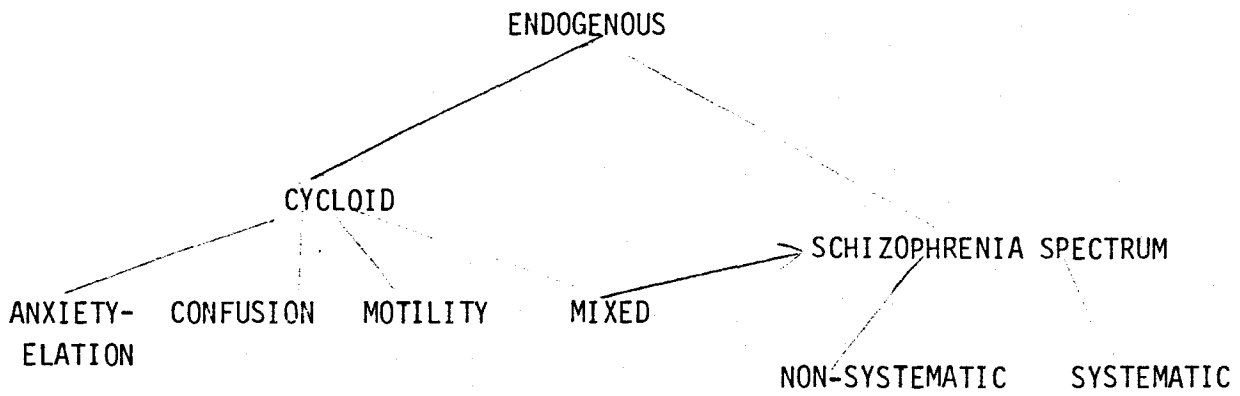
The following are the most frequently occurring forms of mixed cycloid psychoses:

1. Simultaneous presence of the anxiety and the elation syndrome of anxiety-elation psychosis
2. Simultaneous presence of the inhibited and the excited syndrome of confusion psychosis
3. Alternating presence of the hyperkinetic and the akinetic syndrome of motility psychosis
4. Mixture of syndromes of the same polarity from the three cycloid psychoses
5. Mixture of syndromes of different polarity from the three cycloid psychoses
6. Complete mixture of syndromes.

B. EVALUATION

1. If patient meets qualifying criteria of cycloid psychosis but does not fit into one of the three illnesses of cycloid psychosis he/she should be diagnosed as mixed cycloid psychosis (II/II/IV)..

II/III. SCHIZOPHRENIA SPECTRUM PSYCHOSES



Differential diagnosis of endogenous psychoses with special reference to the schizophrenia spectrum psychoses.

Schizophrenia spectrum psychosis is distinct from schizophrenia spectrum disorder (Reich, 1976). While schizophrenia spectrum psychosis is one of the three major diagnostic categories of endogenous psychosis, schizophrenia spectrum disorder is a borderline state or a schizotypal personality disorder (Spitzer, 1978).

Schizophrenia spectrum psychosis embraces the two major groups of schizophrenias, i.e., non-systematic schizophrenias and systematic schizophrenias.

Patients with schizophrenia spectrum psychosis are identified on the basis of general (holistic) characteristics and specific (inclusion) criteria which consists of three sets of symptoms.

A. GENERAL CHARACTERISTICS

Schizophrenia spectrum psychosis has 3 general characteristics and the presence of 2 is the prerequisite for a definitive diagnosis. The presence of 1 of the 3 general characteristics suffices for the possible diagnosis of schizophrenia spectrum psychosis.

<u>General Characteristics</u>	<u>Present</u>
1. Psychosis has no meaning, it is imcomprehensible and it is not part of patient's life history but an intruding event	+
2. Experience, behavior and performance change seperately in a dissociated manner giving the impression of a split ("schizis") for an outside observer and/or for the patient	+
3. Content of psychosis and/or delusions is not holothymic in nature, but evolve in a catathymic manner or through other mechanisms	+

Maximum Possible Score	3
Minimal Qualifying Score	1

B. SPECIFIC (INCLUSION) CRITERIA

Schizophrenia spectrum psychosis manifests in three sets of characteristics; set one consisting of 4, set two of 2 and set three of 1 features. For the diagnosis of possible schizophrenia spectrum psychosis, 1 of the 4 characteristics of set one, and the characteristic of set three suffice. However for the diagnosis of definitive schizophrenia spectrum psychosis 2 of the 4 characteristics of set one and all the characteristics of set two and three are necessary.

First Set of Characteristics	Present
1. Formal disorders of thought that may substantially disturb comprehensibility of verbal communication	+
a. primary incoherence (including paralogia and paragrammatism)	
b. tangential thinking (including derailment)	
c. blocking and/or incomplete desultory thoughts	
d. onomatopoesis (including contamination, condensation and neologisms)	
2. Delusions and/or hallucinations	+
3. Blunted, inadequate and/or inappropriate affect	+
4. Marked personality change	+
a. abandonment of habits, tasks and/or goals	
b. change in life style without adequate reason	
d. incomprehensibility of behavior	
e. autistic behavior	
Maximum Possible Score	4
Minimal Qualifying Score	1

Second Set of Characteristics

Present

- 1. Clear consciousness
- 2. Mood disorder, if present, does not adequately explain prevailing psychopathological symptoms

+
+

Maximum Possible Score

2

Minimal Qualifying Score

0

Third Set of Characteristics

Present

- 1. Duration of illness at least two weeks from onset of psychopathological symptoms

+

Maximum Possible Score

1

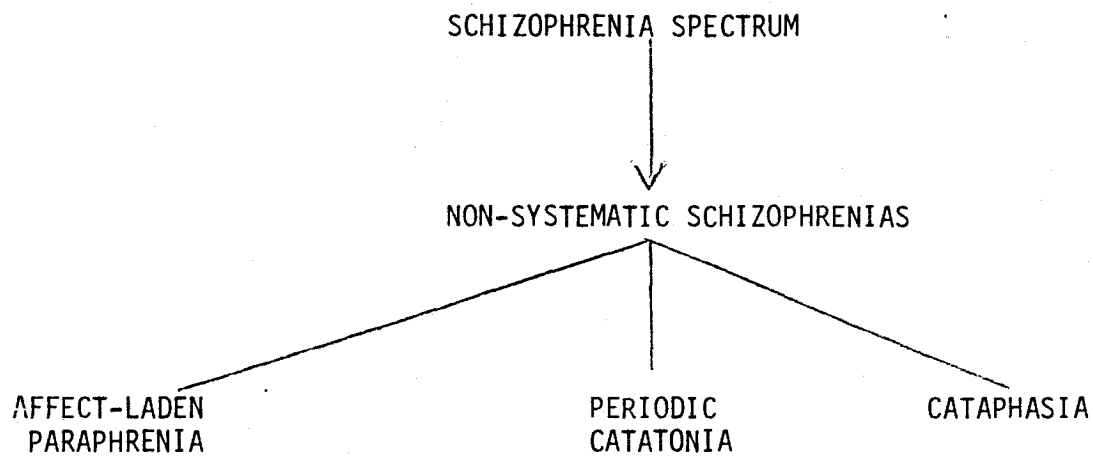
Minimal Qualifying Score

1

C. EVALUATION

- 1. If patient does not meet qualifying criteria for schizophrenia spectrum psychosis, he/she should be diagnosed as endogenous psychosis, non-classifiable (II/IV).
- 2. If patient meets qualifying criteria for schizophrenia spectrum psychosis proceed to II/III/I.

II/III/I. NON-SYSTEMATIC SCHIZOPHRENIAS



Differential diagnosis of schizophrenia spectrum psychoses with special reference to the non-systematic schizophrenias.

Non-systematic schizophrenias are a group of bipolar psychoses in which the rhythmicity and/or periodicity may resemble (in course) phasic and cycloid psychoses. In contradistinction to phasic and cycloid psychoses, however, in the non-systematic schizophrenias remissions are characterized by residual psychopathological symptoms.

There are indications that bipolarity is less marked in the non-systematic schizophrenias than in the cycloid psychoses; holistic (general) characteristics might fade to the extent that a correct diagnosis can only be made on the basis of information from the initial or the first few psychotic episodes. The originally polymorphous clinical picture is gradually replaced by a monomorph illness.

Patients with non-systematic schizophrenias are identified on the basis of general (holistic) characteristics, and specific cross-sectional (inclusion) criteria. In the verification of the diagnosis the course of the disease and the outcome of the illness are of significance.

The decision making process will follow in four steps:

- A. Identification of general characteristics
- B. Identification of specific (inclusion) criteria
- C. Course of disease
- D. Outcome of illness

A. GENERAL CHARACTERISTICS

Non-systematic schizophrenias have 3 general characteristics and the presence of all of these characteristics is an essential prerequisite for a definitive and the presence of at least 2 for a possible diagnosis.

General Characteristics

Present

- 1. Polymorphous clinical picture

+

	<u>Present</u>
2. The whole personality is affected and transformed by the psychosis, i.e., there is no double-entry book-keeping	+
3. Emotional availability with active affective participation in symptoms; frequently with hyperthymic or dysthymic features	+
	<hr/>
Maximum Possible Score	3
Minimal Qualifying Score	2

B. SPECIFIC (INCLUSION) CRITERIA

There are 3 prevailing cross-sectional psychopathological symptoms and signs which characterize non-systematic schizophrenias. In some patients they overlap; for the diagnosis of non-systematic schizophrenia, however, the presence of 1 should suffice.

<u>Specific Criteria</u>	<u>Present</u>
1. Hallucinations and/or emotionally loaded delusions	+
2. Catatonic symptoms	+
3. Schizophrenic type of formal disorders of thought (i.e., inhibited, blocking, tangential, onomatopoesis, primary incoherence)	+
	<hr/>
Maximum Possible Score	3
Minimal Qualifying Score	1

C. COURSE OF DISEASE

Onset is acute or subacute. They are essentially bipolar disorders with rhythmicity (periodicity) of the "schub" type (progressing) episodes.

<u>Course</u>	<u>Present</u>
1. Acute or subacute	+
2. Rhythmicity (periodicity) with "schub" type episodes	+
3. Essentially bipolar	+
	<hr/>
Maximum Possible Score	3
Minimal Qualifying Score	2

D. OUTCOME OF ILLNESS

In spite of the remitting course, there is no full recovery and outcome is characterized by residual symptoms.

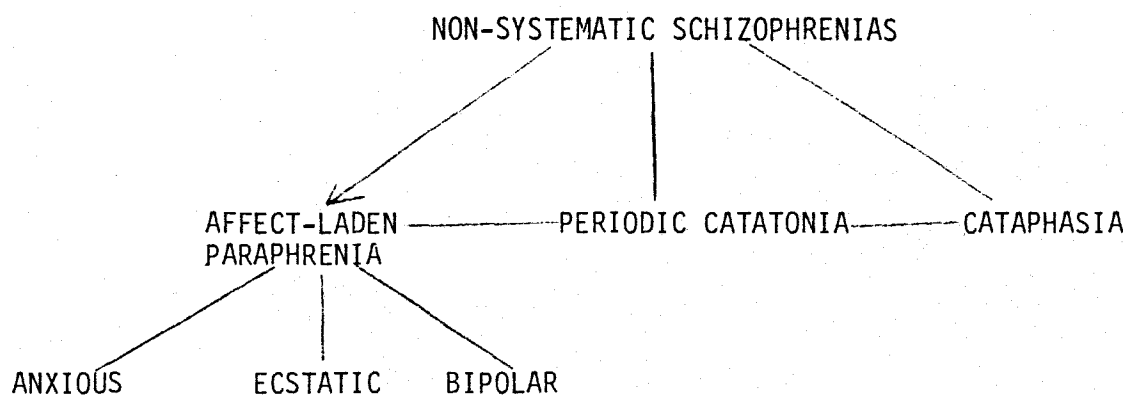
<u>Outcome</u>	<u>Present</u>
1. Transient remissions	+
2. Residual symptoms	+
	<hr/>
Maximum Possible Score	2
Minimal Qualifying Score	1

E. EVALUATION

1. If patient does not meet qualifying criteria for non-systematic schizophrenia proceed to II/III/II.
2. If patient meets qualifying criteria for non-systematic schizophrenia proceed to II/III/I.

II/III/I/I. AFFECT-LADEN PARAPHRENIA

1. ANXIOUS
2. ECSTATIC
3. BIPOLAR



Differential diagnosis of non-systematic schizophrenias with special reference to affect-laden paraphrenia.

Affect-laden paraphrenia is one of the three psychoses of non-systematic schizophrenias. The illness is characterized by delusions with affective loading and mood swings. Patients are disgusted and irritated when their delusions are discussed and threatening when their delusions are challenged.

Patients with affect-laden paraphrenia are identified on the basis of certain general characteristics and special (inclusion) criteria. In addition, they are assigned to 1 of 3 phenomenological subtypes.

The decision making process will follow in three steps:

- A. Identification of general characteristics
- B. Identification of specific (inclusion) criteria
- C. Assignment to phenomenological subtype

A. GENERAL CHARACTERISTICS

There are three general characteristics of affect-laden paraphrenia and all three must be present for the diagnosis.

<u>General Characteristics</u>	<u>Present</u>
1. Overall picture is polymorphous-stabilized or polymorphous-systematized	+
2. Affectivity has central role; delusions are secondary to the pathologically changed affect; verbalization of the delusional material yields to irritability or enthusiasm and in some cases to threatening verbal and/or non-verbal behavior	+
3. Delusional structure is paralogical, organized or disorganized, or logical, disorganized	+
Maximum Possible Score	3
Minimal Qualifying Score	3

B. SPECIAL (INCLUSION) CRITERIA

Affect-laden paraphrenia manifests in three sets of psychopathological symptoms and the presence of the second set of psychopathological symptoms is a prerequisite only for a definitive diagnosis. For a possible diagnosis the presence of 1 symptom from the first and from the third set suffice.

<u>First Set of Symptoms</u>	<u>Present</u>
1. Anxiety	+
2. Irritability	+
3. Ecstasis	+
4. Fluctuating affective state	+
Maximum Possible Score	4
Minimal Qualifying Score	1

<u>Second Set of Symptoms</u>	<u>Present</u>
1. Hallucinations independent of mood state and/or delusional content	+
Maximum Possible Score	1
Minimal Qualifying Score	0

<u>Third Set of Symptoms</u>	<u>Present</u>
1. Delusions of reference	+
2. Delusions of grandeur	+
3. Fantastic delusions	+
4. Mixed delusions	+
Maximum Possible Score	4
Minimal Qualifying Score	1

C. PHENOMENOLOGICAL SUBTYPES

Prevailing features of the 3 phenomenological subtypes are distinctly different. While patients with anxious affect-laden paraphrenia are

characterized by anxiety or irritability associated with delusions of reference or fantastic delusions, patients with ecstatic affect-laden paraphrenia are characterized by ecstatic mood associated with delusions of grandeur. In contradistinction to these two subtypes patients with bipolar affect-laden paraphrenia are characterized by fluctuating affective state associated with mixed delusions.

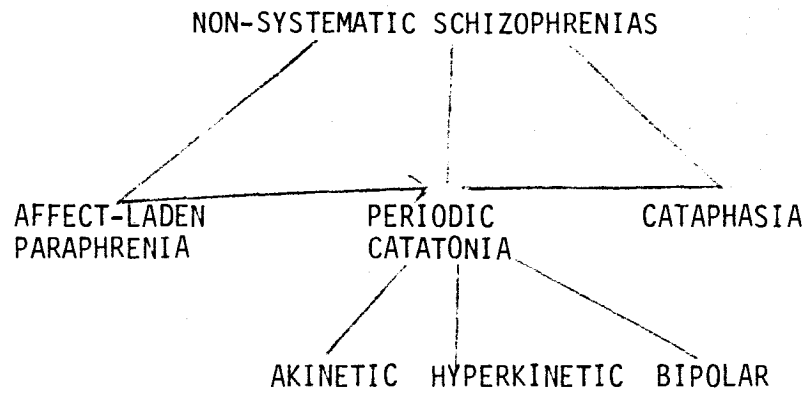
<u>Subtypes</u>	<u>Present</u>
1. Anxious affect-laden paraphrenia	+
a. anxiety and/or irritability	
b. delusions of reference and/or fantastic delusions	
2. Ecstatic affect-laden paraphrenia	+
a. ecstatic mood	
b. grandiose delusions	
3. Bipolar affect-laden paraphrenia	+
a. fluctuating affective states	
b. mixed delusions	
	<hr/>
Maximum Possible Score	1
Minimal Qualifying Score	1

D. EVALUATION

1. If patient does not meet qualifying criteria for affect-laden paraphrenia proceed to II/III/I/II.
2. If patient meets qualifying criteria he/she should be diagnosed as affect-laden paraphrenia (II/III/I/I) with the qualifications of anxious (II/III/I/I.1), ecstatic (II/III/I/I.2) or bipolar (II/III/I/I.3) type.

II/III/I/II. PERIODIC CATATONIA

1. AKINETIC
2. HYPERKINETIC
3. BIPOLAR



Differential diagnosis of non-systematic schizophrenias with special reference to periodic catatonia.

Periodic catatonia is the second of the three psychoses of non-systematic schizophrenias. The illness is characterized by episodic hyperkinesia or hypokinesia (akinesia) with loss of natural grace of movements or aimless movements. Mixed excitatory and inhibitory symptoms may be present. It has been noted that deterioration is considerably more severe in periodic catatonia than in the other two non-systematic schizophrenias and in some cases, after several episodes, an anergic-blunted state resembling the organic dementias, is left behind.

Patients with periodic catatonia are identified on the basis of certain general characteristics and special (inclusion) criteria. In addition, they are assigned to 1 of 3 phenomenological subtypes.

The decision making process will follow in three steps:

- A. Identification of general characteristics
- B. Identification of specific (inclusion) criteria
- C. Assignment to phenomenological subtype

A. GENERAL CHARACTERISTICS

There are three general characteristics of periodic catatonia and all three must be present for the diagnosis.

<u>General Characteristics</u>	<u>Present</u>
1. Overall picture is polymorphous stabilized or polymorphous fluctuating	+
2. Delusional structure is paralogical-disorganized or logical-disorganized	+
3. Psychomotor changes characterized by rigid, angular, graceless and/or fragmentary movements; decrease in expressive and/or reactive movements; natural harmony of movements is lost	+

Maximum Possible Score	3
Minimal Qualifying Score	3

B. SPECIAL (INCLUSION) CRITERIA

Periodic catatonia manifests in three sets of psychopathological symptoms and the presence of 1 symptom from each the first and third set and 2 symptoms from the second set are the prerequisites for a definite diagnosis. For a possible diagnosis 1 symptom from the first and from the second set suffice.

<u>First Set of Symptoms</u>	<u>Present</u>
1. Hyperkinesia	+
2. Hypokinesia or akinesia	+
3. Simultaneous presence of 1 and 2	+
	<hr/>
Maximum Possible Score	3
Minimal Qualifying Score	1

<u>Second Set of Symptoms</u>	<u>Present</u>
1. Parakinesia, i.e., qualitatively abnormal, complex movements which may affect gestures, facial expression and/or speech	+
2. Motor stereotypy, i.e., a tendency to repeat movements in exactly the same form and often for a long time	+
3. Impulsive acts, i.e., automatic, unintentional and unexpected complex actions, e.g., patient jumps up and knocks someone's hat off or suddenly shouts-out swear words	+
4. Postural stereotypes, e.g., waxy flexibility	+
5. Negativism, i.e., oppositional behavior	+
	<hr/>

Maximal Possible Score	5
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Minimal Qualifying Score	1
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Third Set of Symptoms

Present

- | | |
|---|---|
| 1. Hallucinations independent of mood state and/or delusional content | + |
|---|---|

Maximal Possible Score	1
------------------------	---

Minimal Qualifying Score	0
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C. PHENOMENOLOGICAL SUBTYPES

Prevailing features of the three phenomenological subtypes are distinctly different. While an excess of movements is the prevailing characteristic of hyperkinetic periodic catatonia, deficiency of movements is the prevailing feature of akinetic periodic catatonia. Simultaneous presence of hyper- and hypokinesia distinguishes bipolar periodic catatonia from mixed motility psychosis in which hyper- and hypokinesia follow one another (and does not occur simultaneously).

Subtypes

Present

- | | |
|--|-------|
| 1. Akinetic periodic catatonia | + |
| a. hypokinesia | |
| b. akinesia | |
| 2. Hyperkinetic periodic catatonia | + |
| a. hyperkinesia | + |
| 3. Bipolar periodic catatonia | + |
| a. hyper- and hypokinesia simultaneously | — — — |

Maximum Possible Score	1
------------------------	---

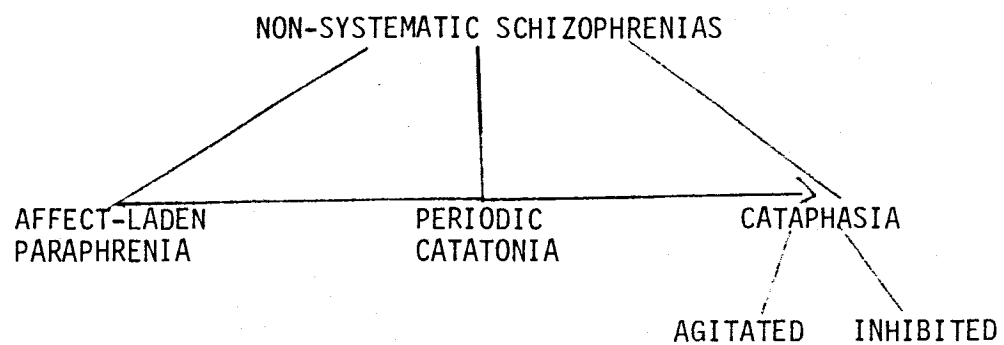
Minimal Qualifying Score	1
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D. EVALUATION

1. If patient does not meet qualifying criteria for periodic catatonia proceed to II/III/I/III.
2. If patient meets qualifying criteria, he/she should be diagnosed as periodic catatonia (II/III/I/II) with the qualification of akinetic (II/III/I/II.1), hyperkinetic (II/III/I/II.2) or bipolar (II/III/I/II.3).

II/III/I/III. CATAPHASIA

1. AGITATED
2. INHIBITED



Differential diagnosis of non-systematic schizophrenias with special reference to cataphasia.

Cataphasia, also referred to as schizophasia is the third of the three psychoses of non-systematic schizophrenias. The illness is characterized by confusion of speech with well ordered behavior. In some cases there is pressure of speech with grammatical mistakes, while in others there is inhibition of speech with neologisms.

Patients with cataphasia are identified on the basis of certain general characteristics and special (inclusion) criteria. In addition, they are assigned to 1 of 2 phenomenological subtypes.

The decision making process will follow in three steps:

- A. Identification of general characteristics
- B. Identification of specific (inclusion) criteria
- C. Assignment to phenomenological subtype

A. GENERAL CHARACTERISTICS

Overall picture differs in the two subtypes. Prerequisite for agitated cataphasia is a polymorphous-stabilized overall picture, and for inhibited cataphasia, a monomorphous overall picture.

<u>Special Characteristics</u>	<u>Present</u>
1. Overall picture is polymorphous-stabilized	+
2. Overall picture is monomorphous	+
Maximum Possible Score	1
Minimal Qualifying Score	1

B. SPECIAL (INCLUSION) CRITERIA

There are eight specific features of cataphasia (1 to 8); 4 specific features of agitated cataphasia (1 to 4) and 4 specific features of inhibited cataphasia (5 to 8). For a definitive diagnosis all 4 respective specific features need to be present, while for a possible diagnosis 3 suffice.

<u>Special Features</u>	<u>Present</u>
1. Agitation	+
2. Pressure of speech (with confusion)	+
3. Paralogia, including asyntaxis and paragrammatism	+
4. Behavior is more coherent than speech and responses to questions are more coherent than spontaneous speech	+
5. Inhibition	+
6. Taciturn or mute	+
7. Dull and empty facial expression	+
8. Neologisms	+
	<hr/>
Maximum Possible Score	4
Minimal Qualifying Score	3

C. PHENOMENOLOGICAL SUBTYPES

Prevailing features of the two phenomenological subtypes are distinctly different. Agitated cataphasia is characterized by a polymorphous-stabilized overall picture and special features such as agitation, pressure of speech and paralogia. On the other hand, inhibited cataphasia is characterized by a monomorphous overall picture and special features such as inhibition, mutism and a dull and empty facial expression.

<u>Subtypes</u>	<u>Present</u>
1. Agitated cataphasia	+
a. agitation	
b. pressure of speech	
c. confusion	
d. paralogia	
e. paragrammatism	
f. asyntaxis	

Present

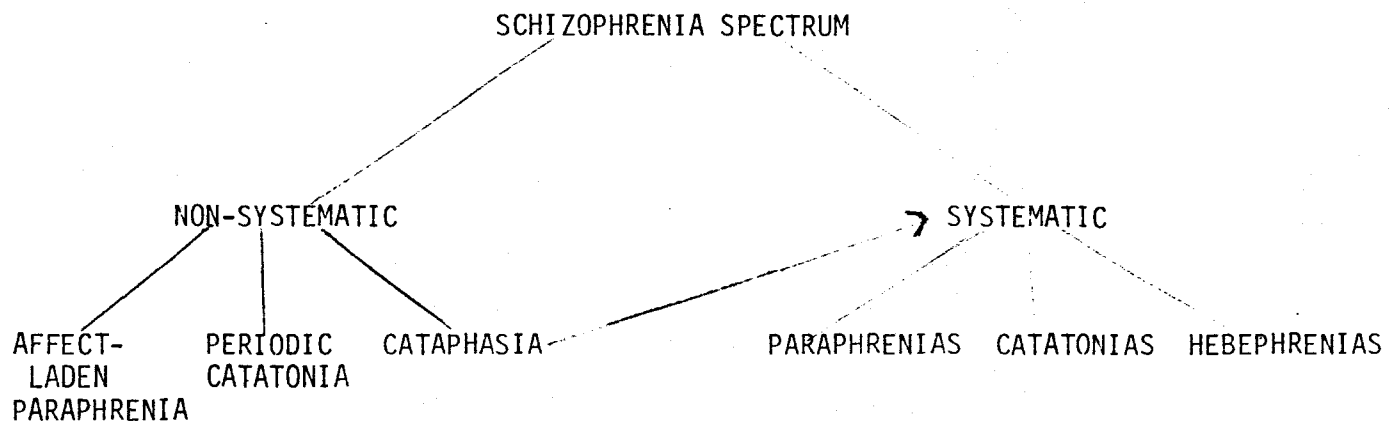
- g. behavior is more coherent than speech
- h. responses to questions more coherent than spontaneous speech
- 2. Inhibited cataphasia +
 - a. inhibition
 - b. taciturn
 - c. mutism
 - d. dull and empty facial expression
 - e. neologisms

Maximum Possible Score	1
Minimal Qualifying Score	1

C. EVALUATION

1. If patient does not meet qualifying criteria for cataphasia he/she should be diagnosed as non-systematic schizophrenia, non-classifiable (II/III/I/IV).
2. If patient meets qualifying criteria, he/she should be diagnosed as cataphasia (II/III/I/III) with the qualification of agitated (II/III/I/III.1) or inhibited (II/III/I/III.2).

II/III/II. SYSTEMATIC SCHIZOPHRENIAS



Differential diagnosis of schizophrenia spectrum psychoses with special reference to the systematic schizophrenias.

Systematic schizophrenias are the second group of disorders within the schizophrenia spectrum psychoses. They consist of 16 illnesses with the common characteristics of a "down hill," although sometimes episodic (at least during the initial period) course, that resembles more the organic dementias than manic depressive illness.

On the basis of the prevailing psychopathological manifestations the 16 disorders belong to three categories of disorders, i.e., paraphrenias, catatonias and hebephrenias. There are 6 paraphrenic illnesses, characterized by prevailing perceptual-cognitive psychopathologies; 6 catatonic illnesses, characterized by prevailing motor-adaptive psychopathologies; and 4 hebephrenic illnesses, characterized by prevailing relational-affective psychopathologies.

Patients with systematic schizophrenia are identified on the basis of general (holistic) characteristics and specific cross-sectional inclusion criteria. In the verification of the diagnosis the course of the disease and the outcome of the illness are of significance.

The decision making process will follow in four steps:

- A. Identification of general characteristics
- B. Identification of specific (inclusion) criteria
- C. Course of disease
- D. Outcome of illness

A. GENERAL CHARACTERISTICS

Systematic schizophrenias have 2 general characteristics and the presence of both is the prerequisite for a definitive diagnosis. For the diagnosis of possible systematic schizophrenia, 1 of the 2 characteristics suffice.

General CharacteristicsPresent

1. Monomorphous (or amorphous) clinical picture	+
2. Double-entry bookkeeping (i.e., the psychosis is restricted to certain psychopathological structures; to some extent patient retains his/her ability to interact with and adjust to environment in a fashion which corresponds with reality) (obligatory feature!)	+
Maximum Possible Score	2
Minimal Qualifying Score	1

B. SPECIFIC (INCLUSION) CRITERIA

There are three leading cross-sectional psychopathological symptoms which characterize systematic schizophrenias. In some patients they overlap; for the diagnosis of systematic schizophrenia, however, 1 should suffice.

Leading SymptomsPresent

1. Delusions and/or hallucinatory excitement	+
2. Catatonic symptoms	+
3. Emotional blunting	+
Maximum Possible Score	3
Minimal Qualifying Score	1

C. COURSE OF DISEASE

Onset is insidious although recognition of schizophrenia spectrum psychosis is usually linked with an acute psychotic episode. They are chronic diseases (no polarity), which progress either continuously or in episodes toward their "end-state."

<u>Course</u>	<u>Present</u>
1. Insidious onset with an acute psychotic episode	+
2. Chronic with continuous or episodic progression	+
3. No polarity	+
	<hr/>
Maximum Possible Score	3
Minimal Qualifying Score	2

D. OUTCOME OF ILLNESS

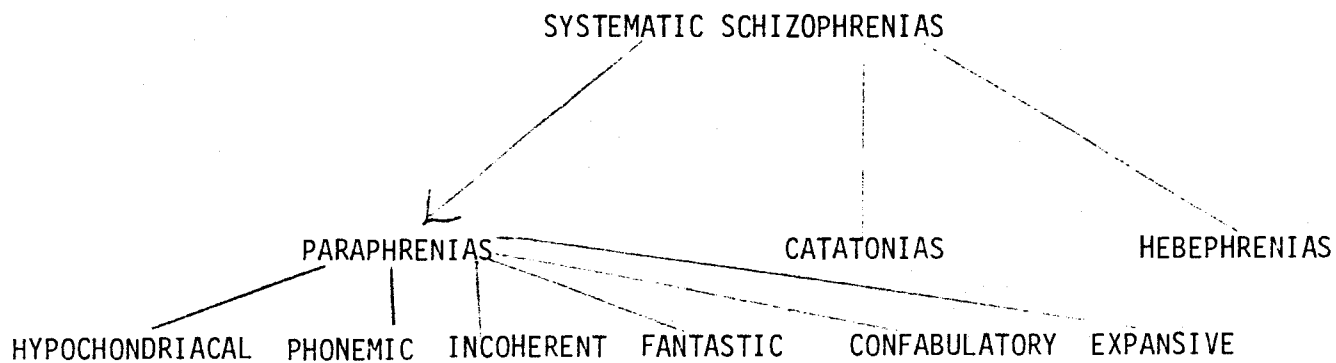
Leading symptom(s) become increasingly marked. Although it is a common contention that outcome in systematic schizophrenias is characterized by a defect syndrome, there are indications that in a considerable proportion of patients this is not the case (Petho et al., 1983b).

<u>Outcome</u>	<u>Present</u>
1. Leading symptom(s) marked	+
2. Defect syndrome	+
	<hr/>
Maximum Possible Score	2
Minimal Qualifying Score	1

E. EVALUATION

1. If patient does not meet qualifying criteria for systematic schizophrenia, he/she should be diagnosed endogenous psychosis, non-classifiable (II/IV).
2. If patient meets qualifying criteria for systematic schizophrenia proceed to II/III/II/I.

II/III/II/I. SYSTEMATIC PARAPHRENIAS



Differential diagnosis of systematic schizophrenias with special reference to the paraphrenias.

The paraphrenias are 1 of the 3 categories of systematic schizophrenias. They consist of six illnesses: hypochondriacal, phonemic, incoherent, fantastic, confabulatory and expansive.

The prevailing psychopathology in the paraphrenias is in perception and thinking with delusions and/or hallucinations as prerequisites for the diagnosis.

Paraphrenias are characterized by four sets of psychopathological symptoms. These are: formal disorders of thought, delusions, disorders of perception and disorders of ego.

The decision making process will follow in four steps:

- A. Identification of first set of symptoms
- B. Identification of second set of symptoms
- C. Identification of third set of symptoms
- D. Identification of fourth set of symptoms

A. FIRST SET OF SYMPTOMS

In the paraphrenias formal disorders of thought manifest in 6 psychopathological symptoms. However the presence of 1 of these 6 symptoms qualifies for a possible, and the presence of 2 suffices for a definitive diagnosis.

<u>Formal Disorders of Thought</u>	<u>Present</u>
1. Inhibited thinking	+
2. Circumstantial thinking	+
3. Tangential thinking	+
4. Blocking	+
5. Incoherence	+
a. Contamination	
b. Condensation	
c. Substitution	
d. Derailment	
e. Incomplete or desultory thought	

6. Neologisms

	<u>Present</u>
	+
Maximum Possible Score	6
Minimal Qualifying Score	1

B. SECOND SET OF SYMPTOMS

In the paraphrenias delusions manifest in 8 psychopathological symptoms. However, none of these 8 symptoms need to be present to qualify for the diagnosis.

<u>Delusions</u>	<u>Present</u>
1. Delusional mood	+
2. Delusional perceptions	+
3. Delusional ideas	+
4. Systematized delusions	+
5. Delusions of reference	+
6. Delusions of persecution	+
7. Hypochondriac delusions	+
8. Delusions of grandeur	+
Maximum Possible Score	8
Minimal Qualifying Score	0
(if scores are 1 or greater for third and fourth set of symptoms)	

C. THIRD SET OF SYMPTOMS

In the paraphrenias disorders of perception manifest in 7 psychopathological symptoms. However, none of the 7 symptoms need to be present to qualify for the diagnosis.

<u>Disorders of Perception</u>	<u>Present</u>
1. Illusions	+
2. Verbal hallucinations	+

	<u>Present</u>
3. Other auditory hallucinations	+
4. Visual hallucinations	+
5. Bodily hallucinations	+
6. Olfactory hallucinations	+
7. Gustatory hallucinations	+
	<hr/>
Maximum Possible Score	7
Minimal Qualifying Score	0
(if scores are 1 or greater for second and fourth set of symptoms)	

D. FOURTH SET OF SYMPTOMS

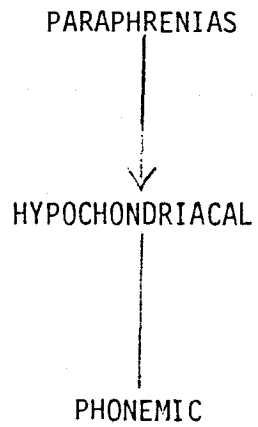
In the paraphrenias disorders of ego manifests in 6 psychopathological symptoms. However, none of these 6 symptoms need to be present to qualify for the diagnosis.

<u>Disorders of Ego</u>	<u>Present</u>
1. Derealization	+
2. Depersonalization	+
3. Thought broadcasting	+
4. Thought withdrawal	+
5. Thought insertion	+
6. Feelings of alien influences	+
	<hr/>
Maximum Possible Score	6
Minimal Qualifying Score	0
(if scores are 1 or greater for second and third set of symptoms)	

E. EVALUATION

1. If patient does not meet qualifying criteria for paraphrenia proceed to II/III/II/II.
2. If patient meets qualifying criteria for paraphrenia proceed to II/III/II/II.

II/III/II/I. HYPOCHONDRIACAL PARAPHRENIA



Differential diagnosis of paraphrenias with special reference to hypochondriacal paraphrenia.

Patients with hypochondriacal paraphrenia are characterized by bizarre bodily hallucinations with irritable, morose and/or dissatisfied mood. Verbal hallucinations are usually disconnected phrases. Passivity experience is common and especially the feeling that one's thoughts are under external control.

Hypochondriacal paraphrenia is characterized by leading symptoms which need to be supplemented with accessory symptoms.

The decision making process will follow in 2 steps:

- A. Identification of leading symptoms
- B. Identification of accessory symptoms

A. LEADING SYMPTOMS

Hypochondriacal paraphrenia has 4 leading symptoms and the presence of all 4 is the prerequisite for a definitive diagnosis. The presence of 3 of the 4 symptoms suffice for a possible diagnosis.

<u>Leading Symptoms</u>	<u>Present</u>
1. Bodily--heteronom--hallucinations (often with sexual content) with or without the feelings of alien influences (obligatory feature!)	+
2. Phonemic hallucinations usually brief unpleasant remarks with or without thoughts spoken aloud and/or broadcasting (obligatory feature!)	+
3. Unpleasant-dissatisfied mood often with irritability	+
4. Complains about hearing voices (but not about content of hallucinations)	+
	<hr/>
Maximum Possible Score	4
Minimal Qualifying Score	3

B. ACCESSORY SYMPTOMS

There are 3 accessory symptoms in hypochondriacal paraphrenia and the presence of 2 is a prerequisite for a definitive, and the presence of 1 for a possible diagnosis.

<u>Accessory Symptoms</u>	<u>Present</u>
1. Olfactory and/or gustatory and/or visual hallucinations	+
2. Explanatory (interpretative) paralogical-disorganized delusions	+
3. Tangential thinking with or without contaminations, condensations, substitutions and/or neologisms	+
	<hr/>
Maximum Possible Score	3
Minimal Qualifying Score	1

C. EVALUATION

1. If patient does not meet qualifying criteria for hypochondriacal paraphrenia proceed to II/III/II/I.2.
2. If patient meets qualifying criteria he/she should be diagnosed as hypochondriacal paraphrenia (II/III/II/II/I.1).

II/III/II/I.2. PHONEMIC PARAPHRENIA

HYPOCHONDRIACAL



PHONEMIC

INCOHERENT

Differential diagnosis of paraphrenias with special reference to phonemic.

Patients with phonemic paraphrenia are characterized by verbal hallucinations. Voices of people comment on or talk to patient and patient replies to hallucinatory voices. Thoughts spoken aloud and/or broadcasting is common.

Phonemic paraphrenia is characterized by leading symptoms which need to be supplemented with accessory symptoms.

The decision making process will follow in 2 steps:

- A. Identification of leading symptoms
- B. Identification of accessory symptoms

A. LEADING SYMPTOMS

Phonemic paraphrenia has 2 leading symptoms and the presence of both is required for a definitive diagnosis. For a possible diagnosis the presence of 1 of the 2 leading symptoms suffice.

Leading Symptoms

Present

1. Phonemic delusional hallucinations (Ey, 1973).

+

Characteristic of these hallucinations is that the voices take a position and express judgment about patient's affairs. Patient hears sentences and may even dialogues. The voices are perceived as real although they are usually pseudo-hallucinations (Jaspers, 1963), i.e., different from real speech, faint, come from a distance, or from ones own stomach. Not infrequently patient finds it impossible to describe whether the voice is a man's or a woman's.

2. Even mood with blunting of emotional responses (including relations to hallucinatory experience)

+

Maximum Possible Score

2

Minimal Qualifying Score

1

B. ACCESSORY SYMPTOMS

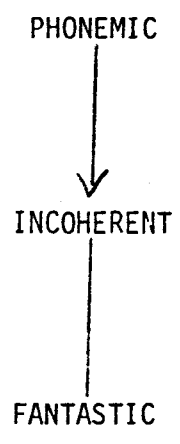
There are 3 accessory symptoms in phonemic paraphrenia and the presence of 2 is the prerequisite for a definitive, and the presence of 1 for a possible diagnosis.

<u>Accessory Symptoms</u>	<u>Present</u>
1. Audible thought (a kind of broadcasting in which patient can hear his/her own thoughts repeated aloud)	+
2. Explanatory--interpretative (paralogical-disorganized or logical-disorganized) delusions without persistent paranoid development	+
3. Woolly thinking; indefinite and changing remarks and references related to the topic of conversation. Patient is not capable to grasp the essence of conversation	+
Maximum Possible Score	3
Minimal Qualifying Score	1

C. EVALUATION

1. If patient does not meet qualifying criteria for phonemic paraphrenia proceed to II/III/II/I.3.
2. If patient meets qualifying criteria he/she should be diagnosed as phonemic paraphrenia (II/III/II/I.2).

II/III/II/1.3. INCOHERENT PARAPHRENIA



Differential diagnosis of paraphrenias with special reference to incoherent paraphrenia.

Patients with incoherent paraphrenia are characterized by incoherence of thinking and confusion of speech with disordered behavior. There are massive auditory hallucinations with a permanent hallucinatory distraction.

Incoherent paraphrenia is characterized by leading symptoms which need to be supplemented with accessory symptoms.

The decision making process will follow in 2 steps:

- A. Identification of leading symptoms
- B. Identification of accessory symptoms

A. LEADING SYMPTOMS

Incoherent paraphrenia has 2 leading symptoms and both need to be present for the diagnosis.

<u>Leading Symptoms</u>	<u>Present</u>
1. Hallucinatory "rich autism" (Minkowski, 1927); continuous hallucinations. Patient cannot be distracted from hallucinations by questions; turns inward, whispers to himself and argues aloud with hallucinatory voices	+
2. Primary incoherence often with paragrammatisms and/or neologisms	+
	<hr/>
Maximum Possible Score	2
Minimal Qualifying Score	2

B. ACCESSORY SYMPTOMS

There are 2 accessory symptoms of incoherent paraphrenia, but they need to be present only for a definitive diagnosis.

Accessory SymptomsPresent

1. Delusions (paralogical-disorganized) of persecution or
grandeur +

2. Hallucinatory excitements +

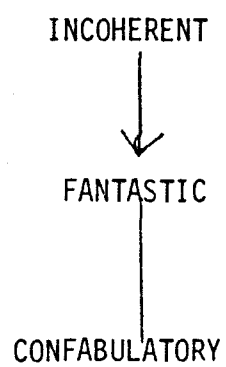
Maximum Possible Score 2

Minimal Qualifying Score 0

C. EVALUATION

1. If patient does not meet qualifying criteria for incoherent paraphrenia proceed to II/III/II/I.4.
2. If patient meets qualifying criteria he/she should be diagnosed as incoherent paraphrenia (II/III/II/I.3).

II/III/II/I.4. FANTASTIC PARAPHRENIA



Differential diagnosis of paraphrenias with special reference to fantastic paraphrenia.

Patients with fantastic paraphrenia are characterized by bizarre experiences with mixed verbal, auditory and bodily hallucinations. There is derailment of thinking, misidentification of people often with scenic hallucinations.

Fantastic paraphrenia is characterized by leading symptoms which need to be supplemented with accessory symptoms.

The decision making process will follow in 2 steps:

- A. Identification of leading symptoms
- B. Identification of accessory symptoms

A. LEADING SYMPTOMS

Fantastic paraphrenia has 2 leading symptoms and both need to be present for the diagnosis.

<u>Leading Symptoms</u>	<u>Present</u>
1. Visual, often scenic hallucinations with auditory and coenesthetic elements	+
2. Fantastic experiences; gives account, in great detail, of bizarre stories which are in no connection with each other	+
Maximum Possible Score	2
Minimal Qualifying Score	2

B. ACCESSORY SYMPTOMS

There are 3 accessory symptoms of fantastic paraphrenia and at least 2 of the 3 need to be present for a definitive and 1 of the 3 for a possible diagnosis.

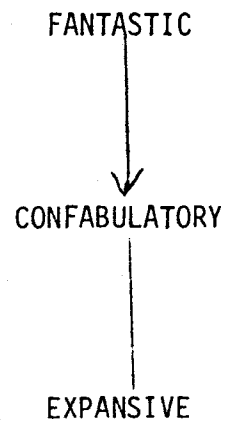
<u>Accessory Symptoms</u>	<u>Present</u>
1. Delusions (paralogical-organized or paralogical-disorganized) of grandeur	+

	<u>Present</u>
2. Contented mood even in case of horrifying experiences	+
3. Derailment, i.e., shifting or switching upon the main theme to a subsidiary one which intrudes disruptively	+
	<hr/>
Maximum Possible Score	3
Minimal Qualifying Score	1

C. EVALUATION

1. If patient does not meet qualifying criteria for fantastic paraphrenia proceed to II/III/III/I.5.
2. If patient meets qualifying criteria he/she should be diagnosed as fantastic paraphrenia (II/III/II/I.4).

II/III/II/I.5. CONFABULATORY PARAPHRENIA



Differential diagnosis of paraphrenias with special reference to confabulatory paraphrenia.

Patients with confabulatory paraphrenia are characterized by vivid and detailed descriptions of alleged experiences (falsification of memory). Sometimes patients refer to their experiences if they would have occurred in dreams.

Confabulatory paraphrenia is characterized by leading symptoms which need to be supplemented with accessory symptoms.

The decision making process will follow in 2 steps:

- A. Identification of leading symptoms
- B. Identification of accessory symptoms.

A. LEADING SYMPTOMS

Confabulatory paraphrenia is characterized by 2 leading symptoms and both need to be present for the diagnosis.

<u>Leading Symptoms</u>	<u>Present</u>
1. Continuous confabulations (sensational stories)	+
2. Falsification of memory. The paramnesias include delusional memories and false recognitions. They might be perceived by patient as dreams	+
Maximum Possible Score	2
Minimal Qualifying Score	2

B. ACCESSORY SYMPTOMS

There are 3 accessory symptoms of confabulatory paraphrenia and all 3 need to be present for a definitive diagnosis. For a possible diagnosis the presence of 2 of the 3 symptoms suffice.

<u>Accessory Symptoms</u>	<u>Present</u>
1. Elated mood, friendliness	+
2. Delusions (logical-disorganized) of grandeur	+

3. Concrete (visual-type) ideation (picture-like)

Present

+

Maximum Possible Score

3

Minimal Qualifying Score

2

C. EVALUATION

1. If patient does not meet qualifying criteria for confabulatory paraphrenia proceed to II/III/II/I.6.
2. If patient meets qualifying criteria he/she should be diagnosed as confabulatory paraphrenia (II/III/II/I.5).

II/III/II/I.6. EXPANSIVE PARAPHRENIA

CONFABULATORY



EXPANSIVE

Differential diagnosis of paraphrenias with special reference to expansive paraphrenia.

Patients with expansive paraphrenia are characterized by "expansive" delusions and a corresponding haughty pose. There is also a marked coarsening of thinking.

Expansive paraphrenia is characterized by leading symptoms which need to be supplemented with accessory symptoms.

The decision making process will follow in two steps:

- A. Identification of leading symptoms
- B. Identification of accessory symptoms

A. LEADING SYMPTOMS

Expansive paraphrenia has 3 leading symptoms and both need to be present for the diagnosis.

<u>Leading Symptoms</u>	<u>Present</u>
1. Systematized delusions of grandeur	+
2. Affected and demonstrative mannerisms corresponding with delusions of grandeur	+
3. Coarse (dull), paralogical thinking characterized by empty generalizations with loss of subtleties	+
	<hr/>
Maximum Possible Score	3
Minimal Qualifying Score	3

B. ACCESSORY SYMPTOMS

There are 3 accessory symptoms of expansive paraphrenia and at least 2 of the 3 need to be present for a definitive and 1 of the 3 for a possible diagnosis.

<u>Accessory Symptoms</u>	<u>Present</u>
1. Grandiose aspirations with secretiveness; secret signs, numbers and letters in writings	+
2. Impoverished thought content with monotonous ruminations and repetitive perseverations	+

Present

3. Ideas of reference and/or states of excitement. While there might be hallucinations at an early stage of the psychosis, this usually disappears in the course of the illness. Instead of a lasting paranoid state there is usually emotional blunting with lowered initiative

+

Maximum Possible Score

3

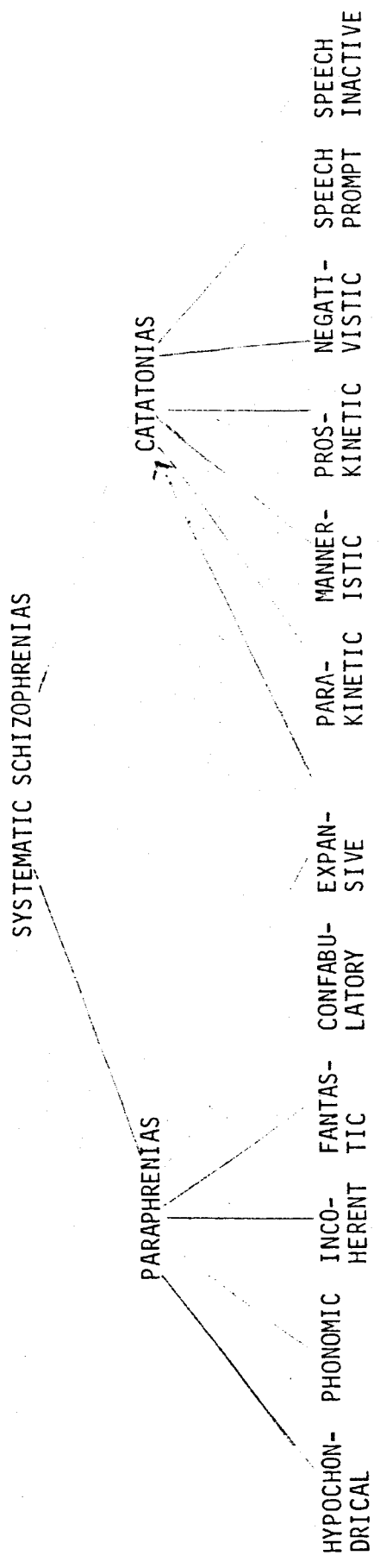
Minimal Qualifying Score

1

C. EVALUATION

1. If patient does not meet qualifying criteria for expansive paraphrenia proceed to II/III/II/II.
2. If patient meets qualifying criteria he/she should be diagnosed as expansive paraphrenia (II/III/II/I.6).

II/III/II/II. SYSTEMATIC CATATONIAS



Differential diagnosis of systematic schizophrenias with special reference to the catatonias.

The catatonias are the 2nd of the 3 categories of systematic schizophrenias. They consist of six illnesses: parakinetic, manneristic, prokinetic, negativistic, speech prompt and speech inactive.

It is a common contention that there is a decline in the occurrence of classical catatonic manifestations as a result of the introduction of pharmacological and social therapies in psychiatry. This, however, is not necessarily the case and there are indications that the incidence of different catatonic disorders has remained approximately the same, although the intensity of catatonic manifestations might have changed.

The prevailing psychopathology in the catatonias is in motor behavior.

Catatonias are characterized by leading symptoms which may need to be supplemented by accessory symptoms.

The decision making process will follow in 2 steps:

- A. Identification of leading symptoms
- B. Identification of accessory symptoms.

A. LEADING SYMPTOMS

There are 3 leading symptoms in systematic catatonias and the presence of all three is a prerequisite for a definitive diagnosis. However, for a possible diagnosis 2 of the 3 leading symptoms suffice.

<u>Leading Symptoms</u>	<u>Present</u>
1. Loss of gracefulness; angular, rigid, unnatural movements with or without paramimia and/or parapantomimia	+
2. Automatic nature of movements	+
3. Sluggish and unresponsive or high-strung and hyper-reactive	+
Maximum Possible Score	3
Minimal Qualifying Score	2

B. ACCESSORY SYMPTOMS

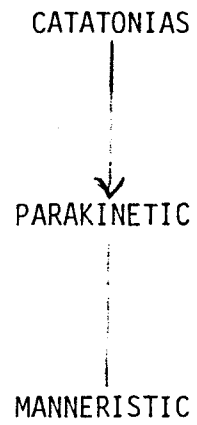
There are 6 accessory symptoms in systematic catatonia and the presence of 1 of the 3 is an essential prerequisite for a definitive diagnosis.

<u>Accessory Symptoms</u>	<u>Present</u>
1. Parakinesia	+
2. Mannerisms	+
3. Proskinesia	+
4. Negativism	+
5. Hyperloquacity	+
6. Hypoloquacity	+
	<hr/>
Maximum Possible Score	6
Minimal Qualifying Score	0

C. EVALUATION

1. If patient does not meet qualifying criteria for catatonia proceed to II/III/II/III.
2. If patient meets qualifying criteria for catatonia proceed to II/III/II/II.1.

II/III/II/II.1. PARAKINETIC CATATONIA



Differential diagnosis of catatonias with special reference to parakinetic catatonia.

Patients with parakinetic catatonia are characterized by excessive unnatural-awkward voluntary movements and jerky involuntary expressive movements with facial grimacing and chopped up speech. There is a jerky pattern of speech with short, ungrammatical sentences.

Parakinetic catatonia is characterized by leading symptoms which need to be supplemented with accessory symptoms.

The decision making process will follow in 2 steps:

- A. Identification of leading symptoms
- B. Identification of accessory symptoms

A. LEADING SYMPTOMS

Parakinetic catatonia has 4 leading symptoms and at least 3 of the 4 need to be present for a definitive diagnosis. For the possible diagnosis of parakinetic catatonia 2 of the 4 symptoms suffice provided 1 of the 2 is related to voluntary (symptoms 1 and 2) and the other is related to involuntary (symptoms 3 and 4) activities.

<u>Leading Symptoms</u>	<u>Present</u>
1. Continuous parakinesia, i.e., choreiform involuntary movements	+
2. Jerkiness, i.e., the continuity of intentional voluntary movements is broken by jerks, twitches and involuntary (handling, intertwining and kneading) movements	+
3. Increase in expressive (or rather pseudo-expressive) and reactive movements. There is fidgeting and touching of objects in new situations; facial grimacing, threatening movements, crying, waving and stumping the floor (alternately or simultaneously)	+

	<u>Present</u>
4. Jerky-choppy pattern of speech characterized by short agrammatical sentences (giving the impression of being ejected)	+
	<hr/>
Maximum Possible Score	4
Minimal Qualifying Score	2
(1 from 1 or 2 and 1 from 3 or 4)	

B. ACCESSORY SYMPTOMS

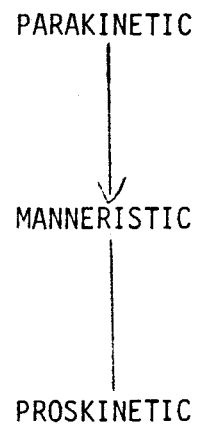
There are 2 accessory symptoms and both need to be present for a definitive diagnosis. For a possible diagnosis 1 of the 2 symptoms suffice.

<u>Accessory Symptoms</u>	<u>Present</u>
1. Derailment, i.e., shifting and switching upon the main theme to a subsidiary one which intrudes disruptively	+
2. Carefree; contented mood	+
	<hr/>
Maximum Possible Score	2
Minimal Qualifying Score	1

C. EVALUATION

1. If patient does not meet qualifying criteria for parakinetic catatonia proceed to II/III/II/II.2.
2. If patient meets qualifying criteria he/she should be diagnosed as parakinetic catatonia (II/III/II/II.1).

II/III/II/II.2. MANNERISTIC CATATONIA



Differential diagnosis of catatonias with special reference to manneristic catatonia.

Patients with manneristic catatonia (also referred to as catatonia ficta or affected catatonia) are characterized by stiff movements and postures with manneristic omissions and stereotype attitudes including waxy flexibility.

Manneristic catatonia is characterized by leading symptoms which need to be supplemented with accessory symptoms.

The decision making process will follow in 2 steps:

- A. Identification of leading symptoms
- B. Identification of accessory symptoms

A. LEADING SYMPTOMS

Manneristic catatonia has 2 leading symptoms and both need to be present to qualify for the diagnosis.

Leading Symptoms

Present

- | | |
|---|---|
| 1. Manneristic, stiff (rigid and often strange) postures with maintenance of imposed posture (Haltungsverharren) and resistance to change (Gegenhalten). These "hard" mannerisms are distinct from the "soft" mannerisms encountered in patients with eccentric hebephrenia. Often stereotyped gestures; an artificial strange way of handling objects and/or collecting valueless objects. | + |
| 2. Decrease or even absence of automatisms; stiff, expressionless face; moves as if made of wood, like one suffering from Parkinson's disease; monotonous speech or mutism | + |

Maximum Possible Score	2
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Minimal Qualifying Score	2
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B. ACCESSORY SYMPTOMS

There are 2 accessory symptoms of manneristic catatonia and the presence of 1 of the 2 is the prerequisite for a definitive diagnosis.

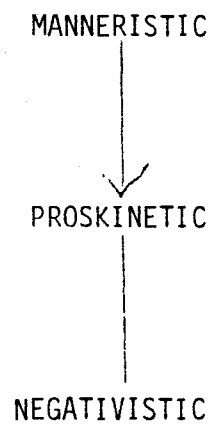
Accessory SymptomsPresent

1. Mannerisms resembling compulsive actions	+
2. Perceptual psychopathology and delusions are absent; affectivity is relatively well retained	+
	<hr/>
Maximal Possible Score	2
Minimal Qualifying Score	0

C. EVALUATION

1. If patient does not meet qualifying criteria for manneristic catatonia proceed to II/III/II/II.3.
2. If patient meets qualifying criteria he/she should be diagnosed as manneristic catatonia (II/III/II/II.2).

II/III/II/II.3. PROSKINETIC CATATONIA



Differential diagnosis of catatonias with special reference to proskinetica.

Patients with prokinetic catatonia are characterized by cooperation in movements; verbigeration of isolated phrases and monotonous mumbling speech with murmuring.

Prokinetic catatonia is characterized by leading symptoms which need to be supplemented with accessory symptoms.

The decision making process will follow in 2 steps:

- A. Identification of leading symptoms
- B. Identification of accessory symptoms

A. LEADING SYMPTOMS

Prokinetic paraphrenia has 3 leading symptoms and the presence of 2 is the prerequisite for a definitive diagnosis. For a possible diagnosis the presence of 1 symptom would suffice provided there is at least 1 identifiable accessory symptom.

Leading Symptoms

Present

- | | |
|--|---|
| 1. Proskinesis, i.e., increased readiness to respond to external stimuli; adopting corresponding posture to slight pressure (Mitgehen); increased cooperation with elicited movements (Mitmachen), e.g., tirelessly returning handshakes. Even in case of counter-suggestion, such as "don't do this," patient reverts to do it as soon as his/her attention is diverted (obligatory symptom!) | + |
| 2. Persistence of movements and speech; perseverations and/or verbigerations; handling, intertwining and/or kneading | + |

	<u>Present</u>
3. Mumbling; barely audible speech and/or fiddling, fumbling with objects that come within reach	+
	<hr/>
Maximum Possible Score	3
Minimal Qualifying Score	1
(if at least 1 accessory symptom present)	

B. ACCESSORY SYMPTOMS

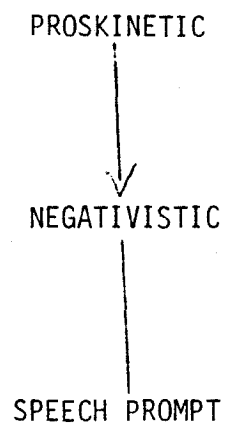
There are 2 accessory symptoms and the presence of 1 of the 2 is a prerequisite for a definitive diagnosis. The same applies for a possible diagnosis in case if only 1 of the 3 leading symptoms is present.

<u>Accessory Symptoms</u>	<u>Present</u>
1. Carefree; contented mood	+
2. Emotional blunting; ranting; episodic excitement	+
	<hr/>
Maximum Possible Score	2
Minimal Qualifying Score	0
(if at least 2 leading symptoms present)	

C. EVALUATION

1. If patient does not meet qualifying criteria for proskinetic catatonia proceed to II/III/II/II.4.
2. If patient meets qualifying criteria he/she should be diagnosed as proskinetic catatonia (II/III/II/II.3).

II/III/II/II.4. NEGATIVISTIC CATATONIA



Differential diagnosis of catatonias with special reference to negativistic catatonia.

Patients with negativistic catatonia are characterized by aversion, ambivalence, opposition, partial answers and negativistic excitements.

Negativistic catatonia is characterized by leading symptoms which need to be supplemented with accessory symptoms.

The decision making process will follow in 2 steps:

- A. Identification of leading symptoms
- B. Identification of accessory symptoms

A. LEADING SYMPTOMS

Negativistic catatonia has 3 leading symptoms and the presence of 2 is a prerequisite for a definitive diagnosis. For a possible diagnosis the presence of 1 symptom suffices.

<u>Leading Symptoms</u>	<u>Present</u>
1. Negativism, passive (resistance or lack of response) and/or active (obligatory symptom!)	+
2. Ambivalence and ambivalence (characterized by hesitance, resulting in half-executed movements which may lead to contorted and uncomfortable postures)	+
3. Even a weak attempt to break refusal result in negativistic excitement which may manifest in aggression, breaking and throwing, agitation and ranting	+
Maximum Possible Score	3
Minimal Qualifying Score	1

B. ACCESSORY SYMPTOM

There is 1 accessory symptom of negativistic catatonia, the presence of which is a prerequisite for a definitive diagnosis.

Accessory SymptomPresent

1. Blunted affect with instinctual outbursts

+

Maximum Possible Score

1

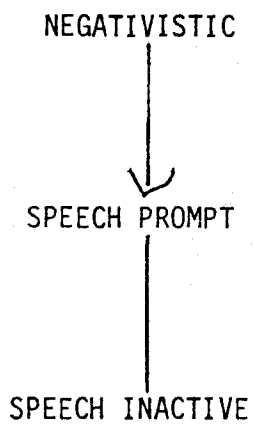
Minimal Qualifying Score

0

C. EVALUATION

1. If patient does not meet qualifying criteria for negativistic catatonia proceed to II/III/II/II.5.
2. If patient meets qualifying criteria he/she should be diagnosed as negativistic catatonia (II/III/II/II.4).

II/III/II/II.5. SPEECH PROMPT CATATONIA



Differential diagnosis of catatonias with special reference to speech prompt catatonia.

Patients with speech prompt catatonia (also referred to as catatonia hyperloquax or voluble catatonia) are characterized by obedient answering, while talking beside the point with an empty facial expression.

Speech prompt catatonia is characterized by leading symptoms which need to be supplemented with an accessory symptom.

The decision making process will follow in 2 steps:

- A. Identification of leading symptoms
- B. Identification of accessory symptom

A. LEADING SYMPTOMS

Speech prompt catatonia has 3 leading symptoms and all 3 need to be present for a definitive diagnosis. For a possible diagnosis 1 of the 3 symptoms suffice if the accessory symptom is present. If accessory symptom is absent the presence of 2 of the 3 symptoms are necessary for a possible diagnosis.

<u>Leading Symptoms</u>	<u>Present</u>
1. Replies promptly and without delay, but hardly speaks spontaneously. Replies are brief and not to the point; echolalia	+
2. Formal disorder of thought: perseverations and/or aggrammatisms and/or contaminations	+
3. Empty (vacant) autism (Minkowski, 1927). Impoverished and colourless emotional life. Patient is virtually inaccessible emotionally and has little if any initiative. No active adjustment, but adjusts passively to change	+
Maximum Possible Score	3
Minimal Qualifying Score	1
(if accessory symptom present)	

B. ACCESSORY SYMPTOM

There is 1 accessory symptom in speech prompt catatonia and its presence is a prerequisite for a definitive diagnosis. For a possible diagnosis the accessory symptom needs to be present only if less than 2 of the leading symptoms are present.

<u>Accessory Symptom</u>	<u>Present</u>
1. Stiff; absence of expressive movements. If questioned, patient turns towards examiner (adversion) with a stiff and expressionless face	+
Maximum Possible Score	1
Minimal Qualifying Score	0
(if at least 2 leading symptoms are present)	

C. EVALUATION

1. If patient does not meet minimal qualifying criteria for speech-prompt catatonia proceed to II/III/II/II.6.
2. If patient meets qualifying criteria he/she should be diagnosed as speech prompt catatonia (II/III/II/II.5).

II/III/II/II.6. SPEECH INACTIVE CATATONIA

SPEECH PROMPT



SPEECH INACTIVE

Differential diagnosis of catatonias with special reference to speech inactive catatonia.

Patients with speech inactive (sluggish or hypoloquax) catatonia are characterized by slow-delayed verbal responses. Patients whisper to inner voices; scream and gesticulate in response to inner experiences.

Speech inactive catatonia is characterized by leading symptoms which need to be supplemented by accessory symptoms.

The decision making process will follow in 2 steps:

- A. Identification of leading symptoms
- B. Identification of accessory symptoms

A. LEADING SYMPTOMS

Speech inactive catatonia has 2 leading symptoms and both need to be present for the diagnosis.

<u>Leading Symptoms</u>	<u>Present</u>
1. Responses (including verbal) are slow, sluggish, delayed or absent	+
2. Lack of initiative and motivation	+
Maximum Possible Score	2
Minimal Qualifying Score	2

B. ACCESSORY SYMPTOMS

Speech inactive catatonia has 5 accessory symptoms and at least 2 of these 5 symptoms need to be present for a definitive and at least 1 for a possible diagnosis.

<u>Accessory Symptoms</u>	<u>Present</u>
1. Persistent hallucinations	+
2. Hallucinatory distractions, i.e., stares ahead with muttering and whispering in response to "voices"	+
3. Perplexed (facial expression and behavior)	+

4. Hallucinatory excitements
5. Primary incoherence

Present

+

+

Maximum Possible Score

5

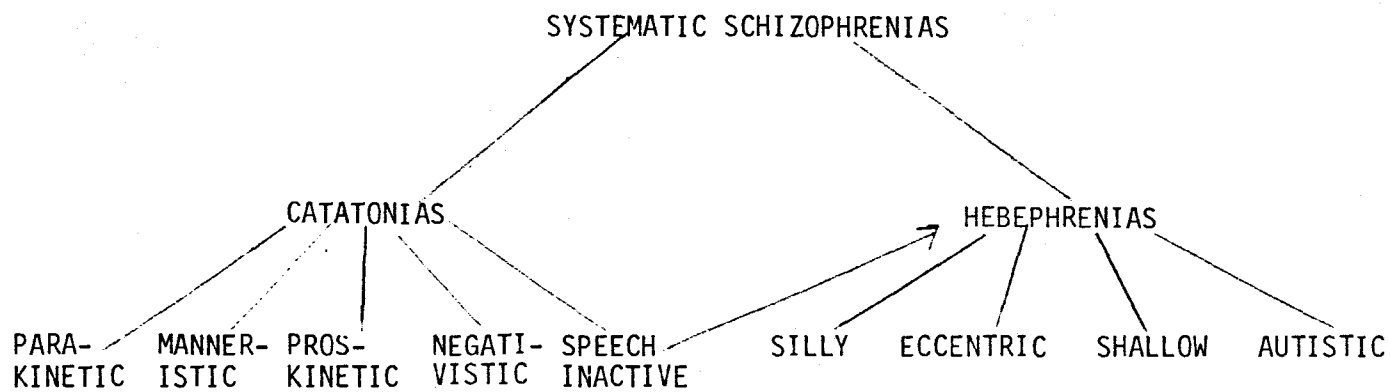
Minimal Qualifying Score

1

C. EVALUATION

1. If patient does not meet qualifying criteria for speech inactive catatonia proceed to II/III/II/III.
2. If patient meets qualifying criteria he/she should be diagnosed as speech inactive catatonia (II/III/II/II.6).

II/III/II/III. SYSTEMATIC HEBEPHRENIAS



Differential diagnosis of systematic schiozphrenias
with special reference to the hebephrenias.

The hebephrenias are the 3rd of the 3 categories of systematic schizophrenias. They consist of four illnesses: silly, eccentric, shallow and autistic.

The prevailing psychopathology in the hebephrenias is of the emotional-relational aspects of behavior.

Patients with hebephrenia are identified on the basis of general (holistic) characteristics and leading symptoms which may need to be supplemented by accessory symptoms.

The decision making process will follow in 3 steps:

- A. Identification of general characteristics
- B. Identification of leading symptoms
- C. Identification of accessory symptoms

A. GENERAL CHARACTERISTICS

There are two general characteristics of systematic hebephrenia and both need to be present for a definitive diagnosis. For the possible diagnosis of hebephrenia, 1 of the 2 symptoms suffice.

General Characteristics

Present

- | | |
|---|---|
| 1. Amorphous disease picture. (Symptoms and tendencies do not combine into a uniform picture; they do not crystallize and define themselves but remain transient and indefinite) | + |
| 2. Aloof, detached and uninvolved; responds as an outsider to own experiences. (Opposite to protopathic transformation of Gestalt.) Reactions to disturbing symptoms including delusions are weak (Sattes, 1948). Real life events appear as if they have occurred in patients' mind and not in reality; they are presented as recollections and/or reflections. Lack of depth of emotions. | + |

Maximum Possible Score	2
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Minimal Qualifying Score	1
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B. LEADING SYMPTOM

There is one leading symptom in systematic hebephrenia which needs to be present for the diagnosis.

<u>Leading Symptom</u>	<u>Present</u>
1. Blunted affect or impoverishment of emotional life	+
Maximum Possible Score	1
Minimal Qualifying Score	1

C. ACCESSORY SYMPTOMS

There are four accessory symptoms in systematic hebephrenia and the presence of 1 of the 4 is an essential prerequisite for a definite diagnosis.

<u>Accessory Symptom</u>	<u>Present</u>
1. Inane giggling with or without childish pranks	+
2. Eccentric, affected behavior	+
3. Severe emotional impoverishment	+
4. Withdrawal from all contacts	+
Maximum Possible Score	4
Minimal Qualifying Score	0

D. EVALUATION

1. If patient does not meet qualifying score for systematic hebephrenia he/she should be diagnosed as systematic schizophrenia, non-classifiable (II/III/II/IV).
2. If patient meets qualifying criteria for systematic hebephrenia proceed to II/III/II/III.1.

II/III/II/III. SILLY HEBEPHRENIA

HEBEPHRENIAS



SILLY

ECCENTRIC

Differential diagnosis of hebephrenias with special reference to silly hebephrenia.

Patients with silly hebephrenia (also referred to as hebephrenia inepta or immature hebephrenia) are characterized by inane giggling and smiling with spiteful tricks. Patients can answer simple questions but unable to carry out ordered conversation.

Silly hebephrenia is characterized by leading symptoms which may need to be supplemented by accessory symptoms.

The decision making process will follow in 2 steps:

- A. Identification of leading symptoms
- B. Identification of accessory symptoms

A. LEADING SYMPTOMS

Silly hebephrenia has 3 leading symptoms and the presence of all three need to be present for a definitive diagnosis. For a possible diagnosis of silly hebephrenia the presence of 2 of the 3 symptoms suffice.

<u>Leading Symptoms</u>	<u>Present</u>
1. Immature behavior resembling the behavior in puberty (i.e., clumsiness, laziness with playing silly and childish or malicious and spiteful tricks on others) (obligatory symptom!)	+
2. Contented, mildly cheerful (euphoric) mood alternating with dysthymic (dysphoric) mood; smiling and/or giggling - giggling becomes more pronounced when stimulated by others (obligatory symptom!)	+
3. Alogia, i.e., inability to use ideas in the formation (production) of new thoughts. Speech is characterized by superficial generalities. It is difficult to	+

Present

follow patient because he/she is lost in
irrelevant details .

Maximum Possible Score	3
------------------------	---

Minimal Qualifying Score	2
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B. ACCESSORY SYMPTOMS

Silly hebephrenia has 2 accessory symptoms and the presence of 1 of these 2 symptoms is a prerequisite for a definitive diagnosis.

Accessory Symptoms

Present

- | | |
|--|---|
| 1. Ethical blunting (lying and/or promiscuity).
Become criminals if opportunity presents itself | + |
| 2. Episodic irritability and outbursts with or without
periods of hallucinatory excitements | + |

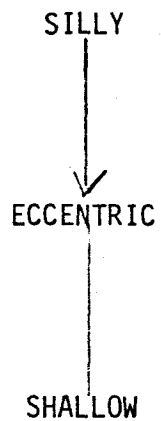
Maximum Possible Score	2
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Minimal Qualifying Score	0
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C. EVALUATION

1. If patient does not meet qualifying criteria for silly hebephrenia proceed to II/III/II/III2.
2. If patient meets qualifying criteria he/she should be diagnosed as silly hebephrenia (II/III/II/III.1).

II/III/II/III.2. ECCENTRIC HEBEPHRENIA



Differential diagnosis of hebephrenias with special reference to eccentric hebephrenia.

Patients with eccentric hebephrenia are characterized by querulous complaintativeness and eccentric, affected behavior. Performance of intellectual tasks is relatively well preserved; paralogia does not occur. Patients frequently become beggars, tramps or prostitutes.

Eccentric hebephrenia is characterized by leading symptoms which may need to be supplemented by accessory symptoms.

The decision making process will follow in 2 steps:

- A. Identification of leading symptoms
- B. Identification of accessory symptoms

A. LEADING SYMPTOMS

Eccentric hebephrenia has 4 leading symptoms and the presence of at least 2 is a prerequisite for a definitive diagnosis. For a possible diagnosis the presence of 1 of the 4 symptoms suffice if at least 1 of the 2 accessory symptoms is present.

<u>Leading Symptoms</u>	<u>Present</u>
1. Eccentric, affected behavior; mannerisms lack persistence and tension ("soft mannerisms"); precocious chattering in a flat voice about sophisticated matters with inadequate knowledge about them (obligatory symptom!)	+
2. Dysthymia-depressed mood	+
3. Querulous complaintativeness; same grievance repeated time and time again irrespective of listener's attitude and response. Patient sounds like a broken record as if he/she would not speak spontaneously, but presenting learned material.	+

4. Hypochondriacal complaints

Present

+

Maximum Possible Score 4

Minimal Qualifying Score 1

(if at least 1 accessory symptom present)

B. ACCESSORY SYMPTOMS

There are 2 accessory symptoms of eccentric hebephrenia and at least 1 needs to be present for a definitive diagnosis. The same applies for a possible diagnosis if only 1 of the 4 leading symptoms is present.

Accessory SymptomsPresent

1. Self-praise in a monotonous and uniform manner +

2. Rituals; collecting and/or hoarding of rubbish;
senseless stealing +

Maximum Possible Score 2

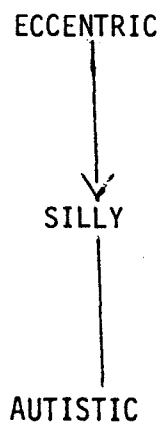
Minimal Qualifying Score 0

(if at least 2 leading symptoms are present)

C. EVALUATION

1. If patient does not meet qualifying criteria for eccentric hebephrenia proceed to II/III/II/III3.
2. If patient meets qualifying criteria he/she should be diagnosed as eccentric hebephrenia.

II/III/II/III.3. SHALLOW HEBEPHRENIA



Differential diagnosis of hebephrenias with special reference to shallow hebephrenia.

Patients with shallow (inept) hebephrenia are characterized by extreme flatness of affect with meager symptomatology. They are, however, episodic outbursts with hallucinatory excitements.

Shallow hebephrenia (also referred to as insipid hebephrenia or hebephrenia simplex) is characterized by leading symptoms which may need to be supplemented by accessory symptoms.

The decision making process will follow in 2 steps:

- A. Identification of leading symptoms
- B. Identification of accessory symptoms

A. LEADING SYMPTOMS

Shallow hebephrenia has 2 leading symptoms and the presence of both is the prerequisite for the diagnosis.

<u>Leading Symptoms</u>	<u>Present</u>
1. Extreme emotional impoverishment; lack of feeling of sympathy. Formal participation relatively well preserved; patients are readily accessible and will carry on a reasonable conversation in a factual way	+
2. Carefree euphoria with episodes of anxious mood and tension	+
	<hr/>
Maxium Possible Score	2
Minimal Qualifying Score	2

B. ACCESSORY SYMPTOMS

Shallow hebephrenia has 2 accessory symptoms and 1 of the 2 needs to be present for a definitive diagnosis.

Accessory SymptomsPresent

1. Episodes of hallucinatory excitement	+
2. Lack of initiative with decreased activity	+
	<hr/>
Maximum Possible Score	2
Minimal Qualifying Score	0

C. EVALUATION

1. If patient does not meet qualifying criteria for shallow hebephrenia proceed to II/III/II/III4.
2. If patient meets qualifying criteria he/she should be diagnosed as shallow hebephrenia (II/III/II/III.3).

II/III/II/III.4. AUTISTIC HEBEPHRENIA

SHALLOW



AUTISTIC

Differential diagnosis of hebephrenias with special reference to autistic hebephrenia.

Patients with autistic hebephrenia are characterized by extreme autism with stiff face and offputting verbal responses. There are episodic aggressive outbursts.

Autistic hebephrenia is characterized by leading symptoms which may need to be supplemented by accessory symptoms.

The decision making process will follow in 2 steps:

- A. Identification of leading symptoms
- B. Identification of accessory symptoms

A. LEADING SYMPTOMS

Autistic hebephrenia has 3 leading symptoms and all 3 need to be present for a definitive diagnosis. For a possible diagnosis the presence of 2 of the 3 symptoms would suffice.

<u>Leading Symptoms</u>	<u>Present</u>
1. Extreme (empty) autism with a stiff, impenetrable facial expression (obligatory symptom!)	+
2. A mood of displeasure and discontent with a feeling of rejection	+
3. Short, off-putting verbal responses	+
Maximum Possible Score	3
Minimal Qualifying Score	2

B. ACCESSORY SYMPTOMS

There are 2 accessory symptoms of autistic hebephrenia and at least 1 of the 2 needs to be present for a definitive diagnosis.

<u>Accessory Symptoms</u>	<u>Present</u>
1. Ill humoured states in which patient becomes very irritated; verbal and/or physical aggression; shouting, threatening, accusing and/or attacking	+

	<u>Present</u>
2. Episodes of hallucinatory excitement	<u>+</u>
Maximum Possible Score	2
Minimal Qualifying Score	0

C. EVALUATION

1. If patient does not meet qualifying criteria for autistic hebephrenia, he/she should be diagnosed as hebephrenic schizophrenia, non-classifiable (II/III/II/III.5).
2. If patient meets qualifying criteria he/she should be diagnosed as autistic hebephrenia (II/III/II/III.4).

CONCLUDING REMARKS

The following is a summary of the findings of the investigation. It is noted that the evidence indicates that the subject was involved in the activities described in the report. The subject's actions were found to be in violation of the applicable laws and regulations. It is recommended that appropriate action be taken against the subject.

Classifying refers to the process in which ideational reflections about a real world are ordered in a manner to conform to a conceptual model.

The organization, or partition of the universal set (Sutcliffe, 1965), in any system of classification is based on Aristotelian logic. From a formal point of view this implies that a proper classification is all inclusive and provides a place for each one of its members in a manner that its categories are mutually exclusive. Thus, while from the point of view of formal logic no member may occupy more than one place within the system, from the point of view of dialectic logic, the logically derived categories need to correspond with existing distinct entities of the real world. Naturally, a logically derived theoretical model yields to a rigid system. However, by employing a "typologic" approach dealing with diagnostic entities as hypothetical constructs, this rigid system can be rendered sufficiently flexible to become accessible for clinical testing.

In the classification described nosological entities are defined in terms of inclusion and exclusion criteria; the presence of all inclusion criteria is considered to be an "ideal." By attaining the maximum possible score, some patients remain distant from the "ideal." Other patients again do not fit any of the nosological categories. The proportion of these patients provide for an estimate of the comprehensiveness of the system.

Although the proposed classification differs essentially from the prevailing classifications in use, the proposed classification is not in conflict with any of the classifications used in the different language areas. It is more appropriate to conceive it as a classification which has evolved in the course of the natural validation of the different systems. Recognition of shortcomings of diagnostic categories within diagnostic systems and

identification of the place of distinct categories within the totality of functional psychoses have played an important role in its development.