A

INTRODUCTION

The functional psychoses continue to be classed as illnesses of unknown origin. Diagnostic concepts for this category can be considered only as hypotheses, the validity of which depends on extrinsic criteria such as course and outcome, genetic data, response to treatment, and results of biological investigation. The requirement for validation is that the procedure for diagnostic attribution in question be set up in an unequivocal and reproducible manner. The operational diagnostic criteria, which have been developed primarily within the last fifteen years, issue from this concern.

Our intentions in presenting this collection of diagnostic criteria are twofold: first, to offer a comprehensive view of the present state of diagnostic formulations for functional psychoses; second, to encourage greater involvement in a 'polydiagnostic approach' (Berner and Katschnig, 1983) to psychiatric research, an endeavor consisting of the simultaneous application of as many diagnostic criteria as possible to the same patient population. After rendering a brief historical account of the principles which have governed diagnosis in our area of concern, this introductory chapter goes on to present the polydiagnostic approach.

Functional psychoses, principles of diagnosis

Kraepelin, building on the knowledge of his French and German predecessors and taking course and outcome of morbid states as the most important guidelines, presented the fundamentals of his psychiatric nosology in 1899. He conceived dementia praecox and manic-depressive illness as the main categories of disorders of unknown origin, but maintained paranoia – and in some elaborations of his classification also paraphrenia – as separate entities. This concept established the frame in which all further divergent developments with regard to the differential diagnosis of functional psychoses took place, a process fueled by the search for criteria permitting a cross-sectional diagnosis instead of relying

on a long-term observation. These developments were centered around two basic problems that are still reflected in the various classificatory approaches presented in this book. The first one concerns the diagnostic distinction between dementia praecox, for which Bleuler's term 'schizophrenia' soon became the habitual denomination, and manic-depressive illness. It requires not only a clear decision as to which symptomatological or other criteria should be regarded as characteristic for schizophrenic and affective disorders but also raises the question of whether cases presenting a simultaneous or consecutive combination of schizophrenic and manic-depressive features should be attributed to the former or latter category or be regarded as an independent 'schizoaffective' disorder. The second problem relates to the maintenance of functional psychoses as entities distinct from the schizophrenic, manic-depressive, or – if this diagnosis is accepted – schizoaffective category. The most important subject of disagreement in this respect has always been the nosological independence of certain delusional disorders. The different standpoints with regard to this question and the etio-pathogenetic considerations sustaining them are discussed in the sections on paranoid and schizoaffective psychoses.

A historical review of the attempts to propose solutions for the differential diagnostic problems outlined above demonstrates that their basic requirement is a clear concept as to how schizophrenia and manic-depressive illness should be defined. Although Kraepelin, because of the emphasis he put on course and outcome, came up with no obligatory symptoms for his categories, his description of dementia praecox and manic-depressive insanity already contained most of the criteria which were to serve later as a matrix for the selection of cross-sectional symptoms determining diagnosis. For the most part, subsequent contributions to the description of these illnesses have served only to complete and to define more precisely their symptomatology. In this respect the precise definition of schizophrenia appeared to be the most delicate problem; subsequently, classic psychiatric literature had concerned itself far more with the definition of this disorder than with diagnostic problems linked to affective psychoses.

Eugen Bleuler's (1911) distinction between basic and accessory symptoms represents a first step in the direction of operational criteria in this field, whereby basic symptoms are drawn upon for cross-sectional diagnosis of schizophrenia. Bleuler also replaced Kraepelin's nosological hypothesis with a pathogenetic one. This states that various etiologies – finally taken by Bleuler as well as Kraepelin to be of somatic nature – may lead to those pathogenetic stages which manifest through characteristic basic symptoms. These basic symptoms, however, are not considered to be the immediate expression of the supposed underlying somatic process but essentially to represent 'mechanisms' through which the patient tries

to cope with the disturbances of brain function. 'Primary symptoms' emanating directly from the somatic process are thus, in Bleuler's opinion, difficult to perceive in the clinical picture. He therefore recommends that diagnosis be established by means of basic symptoms. The suspicion that some of them may be completely nonspecific subsequently instigated several schools to select for diagnostic purposes only those basic symptoms which seemed to reflect at least to a certain degree the underlying 'primary disturbances,' among which Bleuler assigns special importance to the 'dissociation' of psychic functions. In this perspective formal thought disorders or inappropriate affect acquired a specific diagnostic weight in some systems. These symptoms are frequently used to demarcate schizophrenic from non-schizophrenic delusional disorders.

Drawing upon Kraepelin's concept of dementia praecox as a deteriorating process, many authors also refer to affective blunting for the same purpose in spite of the fact that this feature – although belonging to the basic symptoms – is considered by Bleuler to be a purely secondary mechanism.

Kurt Schneider (1939) established a pragmatic system for assessing schizophrenic symptoms. His point of departure is based on Karl Jaspers' (1963) distinction between disturbances of experience and disturbances of behavior. Since the former are much easier to grasp, Schneider built his diagnostic system mainly on them, separating these disturbances of experience into two categories: first rank symptoms and second rank symptoms. Schizophrenic disturbances of thought, affect, and contact with others are behavioral; therefore Bleuler's basic symptoms were divested of nearly all their diagnostic and theoretical weight, for Schneider maintained that his rules for diagnostic classification were based exclusively on psychopathological evaluation. From this position one often deduces that Schneider's diagnostic procedure is atheoretical, purely pragmatic. This conclusion is only partly true: Kurt Schneider never gave reason to doubt that he supported the endogeny theory (Moebius, 1893), which, although avoiding any etiological or pathogenetic commitments, does consider functional psychoses to be constitutionally predetermined in the long run.

Another theoretical element in the Schneiderian system concerns the differentiation between cyclothymia* (denomination by which Schneider replaces the term 'manic-depressive illness') and schizophrenia, whereby Jaspers' (1913, 1946) hierarchical principle (of 'levels') comes into play. This principle is based on the assumption that neurotic symptoms or personality disorders are relatively 'superficial,' whereas affective, schizophrenic, and organic symptoms lie deeper. When several symptoms

* Throughout this book cyclothymia is used as a synonym for endogenous affective disorder.

which belong to various 'levels' occur simultaneously or consecutively, diagnosis is determined by the deepest 'level' reached. The hierarchical principle is accepted by many schools as a guideline for distinguishing functional psychoses from neurotic, personality, or organic disorders. Opinion is currently very divided, however, over the hierarchical relationship between affective and schizophrenic symptoms, and this situation is reflected by differences in modern diagnostic criteria.

The application of the hierarchical principle to differentiate between schizophrenia and manic-depressive illness leaves, of course, no room for schizoaffective disorders. Therefore, when forwarding his concept of 'schizoaffective psychoses' in America, Kasanin (1933) had to abolish Jaspers' (1963) principle, a standpoint which is maintained as a distinct category in all systems comprising these disorders.

The observation that the illness of patients diagnosed as schizophrenic according to Bleuler's criteria did not always follow an unfavorable course led Langfeldt (1937, 1939, 1956) to search for criteria which could distinguish between a bona fide 'process schizophrenia' and 'schizophreniform psychoses' having a good prognosis. Many Scandinavian authors, finding that the latter often manifested as a result of triggering life events, felt that these 'schizophreniform psychoses' should at least in part be considered 'psychogenic' disorders. The concept of 'psychogenic psychoses' introduced in Scandinavia by Wimmer (1916) linked well with the reflections of German authors such as Gaupp (1910) and Kretschmer (1950), who suggested that some delusional disorders could, at least partially, be of psychogenic origin. These considerations do not at all deny the possibility of the existence of independent non-schizophrenic and non-manic-depressive endogenous psychoses. But Kasanin's and Langfeldt's publications stimulated considerably the search for a more precise definition of schizophrenia.

Whatever the nosological position of the schizoaffective psychoses may be, Kasanin found that such cases frequently followed a benign course. This prompted supporters of the Kraepelinian dementia praecox concept to draw upon the affective components of these patients' symptomatology and any additionally ascertainable non-symptomatological particularities as well for the discrimination from genuine nuclear schizophrenia. The contributions of Kasanin and Langfeldt instigated the elaboration of partly symptomatological and partly non-symptomatological indicators for a favorable and unfavorable prognosis. The former have become incorporated into many operational systems for diagnosis of schizophrenia as *exclusion criteria*, the latter as *inclusion criteria*.

Recent investigations, such as those reported by Pope and Lipinski (1978), Koehler (1979), Pope *et al.* (1980), and Berner (1982), prompted a number of researchers to assume that schizophrenic, and not affective, symptoms had no differential diagnostic weight for distinguishing

between schizophrenia and cyclothymia. This idea is tantamount to a reversal of the hierarchical principle; the consequence of its application is that not only current but also previous cyclothymic symptoms and perhaps even a positive family history for major affective disorder will be used as excluding criteria for the diagnosis of schizophrenia. This leads, though, to the notion that schizophrenic symptoms in general are fully non-specific phenomena which may appear under various 'psychotic conditions.' Diagnostic procedures taking this point of view into account will give schizophrenic symptoms a positive rating solely when not only organic and affective but also psychogenic disorders can be excluded.

A theoretical explanation for the non-specificity of at least part of the 'classic' schizophrenic symptoms has been provided by Janzarik (1959) in his concept of the 'structural-dynamic coherency model'. Since this appears to be an important and fertile approach for finding solutions to the problem of differentiating between schizophrenic and affective psychoses, it will be mentioned here in greater detail. Janzarik designated as 'dynamic' a fundamental realm embracing affectivity and drive, which he contrasted with the 'psychic structure' containing behavior patterns and representations (cognitive notions), both inborn and acquired largely throughout the developmental period. Parts of this structure become dynamically invested, meaning that they are connected with positive, negative, or ambivalent feelings. Those markedly invested or 'dynamically loaded' parts of the structure are called 'values' and comprise the 'value structure'.

'Dynamics' however, are not entirely tied to structural elements. Everybody has at his disposal a certain amount of 'free floating dynamics,' subject to alterations called basic dynamic constellations. When attaining a level of morbidity, these modifications correspond either to 'dynamic depletion,' seen clinically as affective blunting, or to 'dynamic derailments.' There are three types of derailment: dynamic 'expansion', as in mania, 'restriction', as in depression, and 'instability', characterized by rapid fluctuations or 'swings' between the first two states. Dynamic derailments affect an actualization of specific values: in states of expansion, for example, the positive elements of the structure are actualized, while in states of restriction the negative ones prevail, since positive values find no actualization. In states of dynamic instability, rapid changes in actualization of differently invested parts of the structure occur, whereby 'ambivalently' invested elements of the value structure also become conscious. Higher levels of instability lead to 'delusional impressions'*, delusional perceptions, illusions, and hallucinations. The

* 'Delusional impressions' (*Anmutungserlebnisse*) resemble delusional mood in that one's surroundings are felt to be changed in a way that is striking and puzzling. In the former, however, these changes are limited to certain perceived objects or details thereof.

rapid swings in drive, emotional resonance, and affectivity are overpowering, making one feel at their mercy; this may explain how feelings of will-deprivation, alien influence, depersonalization, derealization, and ambivalence arise.

In the light of this theory, dynamic instability appears to be the source of Schneider's first rank symptoms and a part of Bleuler's basic symptoms. Janzarik's assumption that the dynamic instability may arise in abnormal mental conditions, stemming from various origins, creates doubts as to the specificity of these phenomena. These suspicions were also strengthened by a series of investigations (those reported by Mellor (1982), for example). In particular, experiences with rapidly alternating, 'unstable' manic-depressive mixed states (Carlson and Goodwin, 1973; Nunn, 1979), which the school of Hamburg calls '*Mischbilder*' (or 'mixed pictures', Mentzos, 1967), and with '*bouffées délirantes*' (Magnan, 1893) support the point of view that instability, giving rise to the aforementioned symptoms, occurs often in affective psychoses.

In contrast to schizophrenia, whose definition since Kraepelin had continually been the subject of scientific disagreements and new attempts at formulation, the original concepts of mania and melancholia by Falret (1854), Baillarger (1854), and Kraepelin (1913) were generally accepted without a murmur. Only since the development of operational criteria for attribution to psychiatric diagnoses during the last decade have the affective psychoses again become a subject of discussion, centering on three main points: the delimitation from schizophrenia, the distinction between unipolar and bipolar affective psychoses, and the differentiation between subtypes in depression.

Kasanin (1933) and Janzarik (1959) can be regarded as forerunners of the current discussion on the discrimination of affective disorders from schizophrenia. Leonhard (1957), Angst (1966), and Perris (1966) have made important contributions to the bipolar–unipolar dichotomy hypothesis.

In the middle of the 1960s two groups of authors developed scales for distinguishing between an endogenous (psychotic) type and a reactive (neurotic) type of depression on the basis of the two-type hypothesis (Newcastle scale (NCS), Carney *et al.*, 1965; depressive category type scale (DCTS), Sandifer *et al.*, 1966). The endogenous/non-endogenous dichotomy led to a second Newcastle scale (Gurney, 1971). Since the first Newcastle scale serves as a basis for the French diagnostic criteria for depression and both of them are widely used, they are included along with the French criteria among this book's criteria.

Also worthy of mention is that, on the basis of empirical evidence and theoretical considerations (Jung, 1952), biorhythmic disturbances are taken into several definitions. The distinction between primary and secondary disturbances introduced in the early 1970s (Robins *et al.*, 1972) is to be considered as a purely pragmatic principle of attribution.

If one tries to group the particular elements of the various diagnostic criteria for endogenous psychoses with respect to the reasons leading to their selection, one can schematically distinguish between theory-oriented pragmatic and empirical approaches. The most important theoretical concepts are:

1. The endogeny hypothesis
2. Kraepelin's nosological hypothesis based on course and outcome
3. Bleuler's pathogenetic primary disturbance hypothesis for schizophrenia
4. Jaspers' hierarchical principle
5. Janzarik's model of structural-dynamic coherency
6. The biorhythmic disturbance hypothesis for affective psychoses
7. The bipolar–unipolar dichotomy hypothesis

Examples for pragmatic approaches are Kurt Schneider's (1939) hierarchy of disturbances of experience and Robins' distinction between primary and secondary affective disorders (Robins *et al.*, 1972). Empirical elements are, above all, those criteria which have proved their worth on the basis of past validation studies (for example, prognostic indicators). Conditions under which criteria normally taken as relevant cannot be given a positive rating (such as blunting of affect when very tired) also belong here.

All criteria for diagnosis presented in this book contain elements stemming from various approaches. Depending on which elements are employed and in which combination the diagnostic instrument in question puts them together, the patient population selected will vary. Consequently, the commentaries on the particular systems will refer to the fundamental considerations and hypotheses mentioned in this introduction.

The polydiagnostic approach in psychiatric research

The simultaneous use of several diagnostic formulations embracing one and the same patient population in psychiatric research projects was dubbed the 'polydiagnostic approach' by Berner and Katschnig (1983). This approach was systematically developed at the Psychiatric Clinic of the University of Vienna and pursued in several research projects during the late seventies and early eighties (Berner *et al.*, 1983*c*; Katschnig, 1984*a*; Katschnig, 1984*b*; Katschnig and Berner, 1985). During the same period many publications applying the same principle have appeared in England and in the USA (Brockington *et al.*, 1978; Overall and Hollister, 1979; Helzer *et al.*, 1981; Stephens *et al.*, 1982; Young *et al.*, 1982; Endicott *et al.*, 1982; Kendell, 1982). In the last few years the 'polydiagnostic approach' has been further elaborated by us (Katschnig and Seelig, 1985; Katschnig

et al., 1986*a*, *b*; Berner *et al.*, 1986*b*, *c*; Lenz *et al.*, 1986; Katschnig and Simhandl, 1986).

The polydiagnostic approach represents, in our point of view, a new paradigm in psychiatric research, which can contribute to the solution of many controversies and to the resolution of many contradictions in the results of research to date.

The 'Babel of differing formulations in psychiatric diagnosis' (Brockington *et al.*, 1978) prompted the elaboration of compromise classification systems – achieved only after a great deal of effort – at national and international levels. It was hoped that these compromises would enable a standardization of psychiatric diagnostics in even larger regions or throughout the world. The prototype of these compromise classification systems is the international classification of diseases of the World Health Organization (WHO), whose 9th revision appeared in 1978 (ICD–9, 1978) and whose 10th revision is under way (ICD–10, 1989*a*, *b*). The American Psychiatric Association developed its own compromise classification system parallel to the ICD–9, the diagnostic and statistical manual of mental disorders, now in its third revised edition (DSM–III–R, 1987). Both these classification systems suffer from all the imperfections inherent in any compromise: for reasons of general and psychiatric policy, conflicting positions and formulations had to be incorporated into each system often at the expense of clarity, theory and logic. That 'operational definitions' for phenomena leading to diagnosis appear here and there, and inclusion and exclusion criteria are defined, should not be misleading in this respect (Berner *et al.*, 1983*b*).

The compromise character of these large diagnostic systems makes them unsuitable for psychiatric research. However, diagnostic formulations developed by just a few authors or small research groups are as a rule much more logically construed, although they may at the same time be biased by their ideology. Nevertheless, when one considers such formulations as hypotheses accessible to scientific evaluation, the one-sidedness of their contents becomes less important. It has also proved possible to examine the same patient population employing various diagnostic formulations for a given illness concept, for example for schizophrenia, and thus to investigate the various correlations existing between 'factors' and various definitions of the same concept. That is what we mean by the 'polydiagnostic approach.'

Katschnig *et al.* (1986*b*) were able to show that the relationship between life events and subtypes of depression depended primarily on the particular diagnostic formulation of the subtypes of depression. Not only life events but also other 'factors' such as the dexamethasone suppression test, genetic factors, or illness course could be investigated concerning their relationship to various definitions of the same illness concept (Davidson *et al.*, 1984*a*; Schanda *et al.*, 1986; Katschnig *et al.*, 1986*a*). Such a

procedure enables comparison with other investigations which have used only one specific diagnostic system for patient selection. Moreover, for generalizing the validity of the results of research projects, comparable results obtained by means of the application of various diagnostic formulations serve as confirmatory evidence; conflicting results using different diagnostic formulations call for a more reserved appreciation.

Another suitable application of the polydiagnostic approach concerns the analysis of the contents and logic of specific diagnostic formulations. The approach could become a kind of 'comparative psychiatric nosology' fostering a greater mutual understanding among psychiatrists in different countries and cultures. Thus it should be possible to diminish gradually, on a worldwide scale, the differences in psychiatric diagnostics.

The polydiagnostic approach may look rather cumbersome at first glance, for it is more difficult to gather a sufficient number of cases if several diagnostic formulations are used simultaneously. Nevertheless, its application has proved to be quite feasible. At the Vienna University Psychiatric Clinic in the late seventies a 'core instrument,' based on the present state examination by Wing *et al*. (1974), was developed for enabling the collection of the basic information needed for all the diagnostic systems to be employed. With the help of this information, a given patient could be diagnosed according to the most diverse diagnostic systems. A computer program had also been developed for the polydiagnostic subclassification of depression into 'endogenous (psychotic)' and 'reactive (neurotic)' types (Katschnig *et al*., 1981). Recently a more elaborate instrument, called 'polydiagnostic system 2 (PS2)' has been developed which covers all current diagnostic formulations for depression, mania, schizophrenia, schizoaffective disorders, paranoid disorders and anxiety disorders (Katschnig *et al*., 1987). Results to date have shown that, when the basic requirements of a comprehensive data-gathering 'core instrument' and a computer program have been satisfied, the polydiagnostic approach works.

The application of a single, in many areas also operationally inadequate, compromise diagnostic system may be sufficient for clinical practice and health statistics; for psychiatric research, however, the use of compromise systems should be rejected, because their very nature tends to conceal conflicting views. Therefore, we feel that the simultaneous employment of diagnostic formulations which partly overlap and partly contradict each other is indispensable for the probity and fertility of psychiatric research. The intention of this book is to encourage research workers around the world both to think and to work in a 'polydiagnostic' way and thus to contribute to the growth of a coherent body of knowledge in psychiatry.