Part I

History and concepts

1

Psychiatric sculptors and psychiatric sculptures: the unformed clay and Kraepelin's visions

The efforts to define homogenous groups of mental disorders are very similar to the work of a sculptor. The artist usually has to cut small, but also sometimes larger, pieces of wood, marble or clay in an attempt to give the material an identifiable feature. But the material that has been cut continues to exist, not as part of the sculpture, but as material left in the sculptor's workshop.

The history of psychiatry from ancient times to the present is full of the efforts of scientists to create identifiable diagnostic groups (Leibrand and Wettley, 1961; Alexander and Selesnick, 1966; Ackerknecht, 1968; Marneros and Angst, 2000; Angst and Marneros, 2001). But the material of the psychiatric sculptor is not similar to marble or wood, but rather similar to clay. Psychiatrists usually change the form of the diagnosis like the artist the shape of the clay. While the volume remains the same, the shape changes. Even the introduction of longitudinal and prognostic features for defining mental disorders (see p. 16) did not essentially change that reality. A new kind of conceptualisation began only after the pharmacological revolution in the middle of the twentieth century. The introduction of the new pharmacopsychiatry involving antipsychotics, antidepressants and mood stabilisers did not simply offer new modes of treatment, but also cleared the way for deeper and more fundamental consequences: they were social, ideological, methodological, conceptual, clinical, therapeutic and biological. The diagnosis and classification of mental disorder became more operationalised and standardised than in previous decades. Because of this, diagnosis in psychiatry became international and global, causing regional or national diagnostic concepts to gradually lose their importance. Diagnoses like 'schizophrenia' or 'affective disorders' were no longer 'private' or 'national' diagnoses. The separation, however, of the operationally defined schizophrenia from affective disorders left an undefined group of psychotic disorders belonging neither to schizophrenia, nor to affective disorders. Schizophrenia and affective disorders became more or less the sculptures, but other psychoses that were difficult to define remained the unformed and confused clay material left in the workshop of the sculptor – in this case, of the psychiatrist. Efforts to give even

Fig. 1.1. Emil Kraepelin (1856–1926): the Great Sculptor.

this material a form by naming it 'schizoaffective disorders' were only partially successful (Marneros and Tsuang, 1986; Marneros *et al.*, 1991b; Marneros, 1999, 2003; Marneros and Angst, 2000). Even after the creation of a smaller sculpture: 'schizoaffective disorders', some material remained undefined, confused and unnamed, but nevertheless unable to be ignored. It is present, which means that many people are suffering from some psychotic disorders that are not schizophrenia, that are not an affective disorder, and that are not a schizoaffective disorder, but something else. Since the beginning of scientific psychiatry, but especially after Kraepelin's dichotomous division of the so-called endogenous psychoses into schizophrenia (dementia praecox) and affective disorders (manic-depressive insanity), various concepts in many countries around the world have tried to define and describe this difficult part of the psychotic material: the non-schizophrenic, non-affective, non-schizoaffective, psychotic disorders (see Chapter 2).

One hundred years ago, Emil Kraepelin (Fig. 1.1) had the vision or the hope to have disease entities in psychiatry – as in the other domains of medicine. According to his principle, disease entities in psychiatry have to be determined by identical symptoms, identical course, identical aetiology, identical pathomorphology and identical treatment. Kraepelin's vision of disease entities still remains, however, only a dream of psychiatrists. Nevertheless, after the psychopharmacological revolution in psychiatry at the beginning of the 1950s, the speed of the psychiatric research aiming to achieve the goal defined by Kraepelin accelerated significantly. Biological research – including the biochemical and pathomorphological correlates demanded by Kraepelin – although still far from a conclusion, is also far from the beginning. Genetic research in psychiatry has been revitalised, partly as a result of the new operationalism following the pharmacopsychiatric revolution. But the fundamental condition for successful biological, pharmacological and genetic research, in other words, the *conditio sine qua non* for the realisation of Kraepelin's vision of

nosological entities in psychiatry, is the reliable definition of syndromes and their homogeneous clustering or classification.

The modern positions: ICD-10 and DSM-IV definitions

The modern diagnostic systems such as the International Classification of Diseases (ICD-10; WHO, 1992) and the *Diagnostic and Statistical Manual* (DSM-IV, APA, 1994) recognise the area between schizophrenia, affective and schizoaffective disorders. They tried to homogenise the various regional and national concepts creating the group of 'Brief Psychoses' (DSM-IV) or 'Acute and Transient Psychotic Disorders' (ICD-10). Before we discuss the concepts leading to the definition of 'Brief Psychoses', as well as those leading to the definition of 'Acute and Transient Psychotic Disorders' (ATPD), we describe the modern definitions (DSM-IV and ICD-10).

DSM-IV definitions

DSM-IV defines the category of 'Brief Psychotic Disorder' (298.8). The essential feature of Brief Psychotic Disorder, according to DSM-IV, is a disturbance that involves *the sudden onset of delusions, hallucinations, disorganised speech or grossly disorganised or catatonic behaviour.* At least one of the psychotic symptoms has to be present. An episode of the disorder lasts *at least 1 day, but less than 1 month, and the individual eventually has a full return to the premorbid level of functioning* (see Table 1.1).

The DSM-IV recognises *three specifications* for Brief Psychotic Disorder based on the presence or absence of precipitating factors. To the diagnosis 'Brief Psychotic Disorder' can be added the specification 'With Marked Stressor(s)' if psychotic symptoms occur shortly after, and apparently in response to, one or more events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the person's culture. The subtype 'Brief Psychotic Disorder With Marked Stressor(s)' of DSM-IV is identical to the 'Brief Reactive Psychosis' of DSM-III-R. The problem of determining whether a specific stressor is a precipitant or a consequence of the psychotic disorder is recognised by DSM-IV. In such instances, the decision depends on factors such as the temporal relationship between the stressor and the onset of the symptoms, ancillary information from the spouse or friend about the level of functioning prior to the stressor, and the history of similar responses to stressful events in the past.

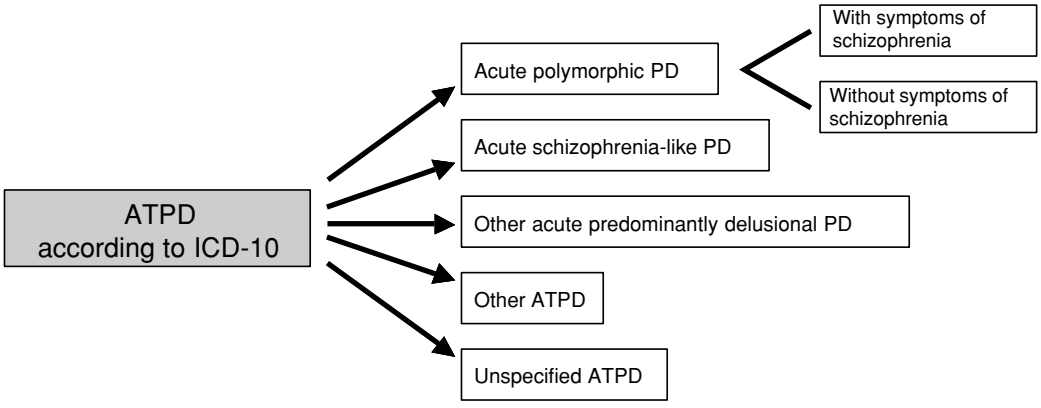
The specifier 'Without Marked Stressor(s)' may be noted if the psychotic symptoms do not occur shortly after, or are not apparently in response to, events that would be markedly stressful to almost anyone in similar circumstances in the person's culture.

Table 1.1. Diagnostic criteria for Brief Psychotic Disorder according to DSM-IV

A	Presence of one (or more) of the following symptoms: • delusions • hallucinations • disorganised speech (e.g. frequent derailment or incoherence) • grossly disorganised or catatonic behaviour *Note:* Do not include a symptom if it is a culturally sanctioned response pattern.
B	Duration of an episode of the disturbance is at least 1 day but less than 1 month, with eventual full return to premorbid level of functioning.
C	The disturbance is not better accounted for by a Mood Disorder With Psychotic Features, Schizoaffective Disorder, or Schizophrenia and is not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition. Specify if: *With Marked Stressor(s) (brief reactive psychosis):* if symptoms occur shortly after and apparently in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the person's culture *Without Marked Stressor(s):* if psychotic symptoms do not occur shortly after, or are not apparently in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the person's culture *With Postpartum Onset:* if onset within 4 weeks postpartum

The third specifier 'With Postpartum Onset' may be noted if the onset of the psychotic symptoms is within 4 weeks postpartum. Apparently, DSM-IV recognised this specifier not only as an unspecific stressor, but also because of its possible etiological relevance (Lanczik *et al.*, 1990; Rohde and Marneros, 1992; Schöpf and Rust, 1994a,b).

The relation of 'Brief Psychotic Disorder' to cycloid psychosis (see p. 18) or to the bouffée délirante (see p. 24) is evident when we consider the 'associated features and disorders' listed in DSM-IV: individuals with Brief Psychotic Disorders typically experience emotional turmoil or overwhelming confusion. They may have rapid shifts from one intense affect to another. Although brief, the level of impairment may be severe, and supervision may be required to ensure that nutritional and hygienic needs are met and that the individual is protected from the consequences of poor judgement, cognitive impairment or acting on the basis of delusions. There appears to be an increased risk of mortality, with a particularly high risk of suicide, especially among younger individuals. Pre-existing personality disorders (e.g. paranoid, histrionic, narcissistic, schizotypical or borderline personality disorder) may predispose the individual to the development of the disorder.



ATPD : Acute and Transient Psychotic Disorder
PD : Psychotic Disorder

Fig. 1.2. Subtypes of ATPD (F23, ICD-10).

When making a diagnosis of 'Brief Psychotic Disorder', it is necessary to be aware of culturally sanctioned response patterns. In some religious ceremonies, for example, an individual may report hearing voices, but these do not generally persist and are not perceived as abnormal by most members of the person's community. Although this reference of DSM-IV is very important, it is nevertheless also problematic. The perception of hallucinations as not 'abnormal' by the members of a cultural community cannot always be a tip for the psychiatrist not to assume that they are indeed psychotic.

Brief Psychotic Disorder as defined by DSM-IV may appear in adolescence or early adulthood, with the average age at onset being in the late 20s or early 30s. By definition, a diagnosis of Brief Psychotic Disorder requires a full remission of all symptoms and a return to the premorbid level of functioning within 1 month of the onset of the disturbance. In some individuals, the duration of psychotic symptoms may be quite brief (e.g. a few days).

The Brief Psychoses in ICD-10

There is no definition of 'Brief Psychotic Disorder' in ICD-10, but there is an equivalent group – although more voluminous than in DSM-IV – namely, the 'Acute and Transient Psychotic Disorders' group (ATPD) (F23). The 'Acute and Transient Psychotic Disorders' group of ICD-10 is not only more voluminous than the 'Brief Psychotic Disorder' group of DSM-IV, but also much more differentiated. It is nominally divided into five subgroups, as shown in Fig. 1.2. However, the World Health Organization (WHO) points out that the present state of knowledge does not allow the reliable definition of this group and its subgroups. In the absence of a tried and tested multiaxial system, a diagnostic sequence was constructed that

reflects the order of priority given to selected key features of the disorder (WHO, 1992).

The WHO requested that the features used for the definition of ATPD conform to the following order of priority:

1. acute onset within 2 weeks as the defining feature of the whole group
2. presence of typical syndromes
3. presence of acute stress.

Regarding 1:
Acute onset is defined as the change from a non-psychotic to a clearly psychotic state within 2 weeks or less. The distinction between 'abrupt' and 'acute' onset is recommended because there is some evidence that the prognosis of ATPD with abrupt onset could be more favourable (more than 48 hours, but less than 2 weeks).

Regarding 2:
Typical syndromes are firstly, the quickly changing and variable manifestations called 'polymorphic', and secondly, the presence or lack of typical schizophrenic symptoms.

Regarding 3:
The association with *acute stress* follows the tradition of the 'reactive' or 'psychogenic' psychoses (Strömgren, 1986). Nevertheless ATPD can be manifested without an association with acute stress; therefore making its presence not decisive for the diagnosis.

According to the WHO, a full remission can be achieved within 2 or 3 months, but often even after a few weeks or a few days. Nevertheless, some patients may develop persistent alterations. The present state of knowledge, however, does not allow for a definition of prognostic predictors.

Diagnostic criteria for the general category of ATPD can be found in Table 1.2. As with DSM-IV, the ICD-10 determines that the onset of the disorder occurs:

- '*with associated acute stress*' (the first psychotic symptoms occur within about 2 weeks of one or more events that would be regarded as stressful to most people in similar circumstances, within the culture of the person concerned)
- or '*without associated acute stress*'.

For research purposes, it is recommended that the change of the disorder from a non-psychotic to a clear psychotic state could be specified further as either:

- *abrupt* (onset within 48 hours) or
- *acute* (onset in more than 48 hours, but less than 2 weeks).

The definition of Acute and Transient Psychotic Disorders by the WHO aims to take into account various more or less national concepts, definitions and nomenclatures, as can be seen in Table 1.3. In the following paragraphs, the subgroups of Acute and Transient Psychotic Disorders are described.

Table 1.2. Acute and Transient Psychotic Disorders according to ICD-10 (F23)

G1	There is acute onset of delusions, hallucinations, incomprehensible or incoherent speech, or any combination of these. The time interval between the first appearance of any psychotic symptoms and the presentation of the fully developed disorder should not exceed 2 weeks.
G2	If transient states of perplexity, misidentification, or impairment of attention and concentration are present, they do not fulfil the criteria for organically caused clouding of consciousness as specified for F05, criterion A.
G3	The disorder does not meet the symptomatic criteria for manic episode (F30), depressive episode (F32), or recurrent depressive disorder (F33).
G4	There is insufficient evidence of recent psychoactive substance use to fulfil the criteria for intoxication (F1x.0), harmful use (F1x.1), dependence (F1x.2), or withdrawal states (F1x.3 and F1x.4). The continued moderate and largely unchanged use of alcohol or drugs in amounts or with the frequency to which the individual is accustomed does not necessarily rule out the use of F23; this must be decided by clinical judgement and requirements of the research project in question.
G5	Most commonly used exclusion clause. There must be no organic mental disorder (F00–F09) or serious metabolic disturbances affecting the central nervous system (this does not include childbirth). (The duration of the disorder must not exceed 3 months in subtypes F23.0, F23.3 and F23.8; it must not exceed 1 month in the subtypes F23.1 and F23.2, which include schizophrenic symptoms.)

Table 1.3. Synonyms for ATPD

- acute (undifferentiated) schizophrenia
- bouffée délirante
- cycloid psychoses
- oneirophrenia
- paranoid reaction
- psychogenic (paranoid) psychosis
- reactive psychosis
- schizophrenic reaction
- schizophreniform attack or psychosis
- remitting schizophrenia
- good prognosis schizophrenia

Acute Polymorphic Psychotic Disorder

Together, the first two subcategories of ATPD (F23.0 and F23.1) form the group of 'Acute Polymorphic Psychotic Disorder'. This group is *characterised by a rapidly changing and variable state (the 'polymorphic' state), in which symptoms change*

Table 1.4. Acute Polymorphic Psychotic Disorder Without Symptoms of Schizophrenia (F23.0)

A	The general criteria for acute and transient psychotic disorders (F23) must be met.
B	Symptoms change rapidly in both type and intensity from day to day or within the same day.
C	Any type of either hallucination or delusion occurs, for at least several hours, at any time from the onset of the disorder.
D	Symptoms from at least two of the following categories occur at the same time: emotional turmoil, characterised by intense feelings of happiness or ecstasy, or overwhelming anxiety or marked irritability; perplexity, or misidentification of people or places; increase or decreased motility, to a marked degree.
E	If any of the symptoms listed for schizophrenia (F20.0–F20.3), criterion G(1) and (2), are present, they are present only for a minority of the time from the onset, i.e. criterion B of F23.1 is not fulfilled.
F	The total duration of the disorder does not exceed 3 months.

Table 1.5. Acute Polymorphic Psychotic Disorder With Symptoms of Schizophrenia (F23.1)

A	Criteria A, B, C, and D of acute polymorphic psychotic disorder (F23.0) must be met.
B	Some of the symptoms for schizophrenia (F20.0–F20.3) must have been present for the majority of the time since the onset of the disorder, although the full criteria need not be met, i.e. at least one of the symptoms in criteria G1(1)a to G1(2)c.
C	The symptoms of schizophrenia in criterion B above do not persist for more than 1 month.

rapidly in both type and intensity from day to day or even within the same day. Other features of Acute Polymorphic Psychotic Disorder are emotional turmoil, which may involve intense feelings of happiness or ecstasy, overwhelming anxiety or marked irritability, perplexity, the misidentification of people or places and markedly increased or decreased motility. The similarity to the 'cycloid disorder' (see p. 18) is obvious.

The Acute Polymorphic Psychotic Disorder is divided into a subtype '*without*' and a subtype '*with symptoms of schizophrenia*' (see Tables 1.4 and 1.5). Included in the group of 'Acute Polymorphic Psychotic Disorder with Symptoms of Schizophrenia' are – in addition to the features listed in Table 1.4 – some of the symptoms of schizophrenia, as listed in Table 1.6. The relation of Acute Polymorphic Psychotic Disorder *with* Symptoms of Schizophrenia to Acute Polymorphic Psychotic Disorder *without* Symptoms of Schizophrenia, and the question of whether there is any necessity for such a distinction, has been one of the topics of the Halle Study on Brief and Acute Psychoses (HASBAP). The discussion of this issue can be found on page 176.

Table 1.6. Schizophrenic symptoms according to ICD-10

(a)	thought echo, thought insertion or withdrawal, or thought broadcasting
(b)	delusions of control, influence, or passivity, clearly referred to body or limb movements or specific thoughts, actions, or sensations; delusional perception
(c)	hallucinatory voices giving a running commentary on the patient's behaviour, or discussing the patient among themselves, or other types of hallucinatory voices coming from some part of the body
(d)	persistent delusions of other kinds that are culturally inappropriate and completely impossible (e.g. being able to control the weather, or being in communication with aliens from another world)
(e)	persistent hallucinations in any modality, when occurring every day for at least 1 month, when accompanied by delusions (which may be fleeting or half-formed) without clear affective content, or when accompanied by persistent over-valued ideas
(f)	neologisms, breaks, or interpolations in the train of thought, resulting in incoherence or irrelevant speech
(g)	catatonic behaviour, such as excitement, posturing or waxy flexibility, negativism, mutism, and stupor.

Table 1.7. Acute Schizophrenia-like Psychotic Disorder (F23.2)

A	The general criteria for acute and transient psychotic disorders (F23) must be met.
B	The criteria for schizophrenia (F20.0–F20.3) are met, with the exception of the criterion for duration.
C	The disorder does not meet criteria B, C, and D for acute polymorphic psychotic disorder (F23.0).
D	The total duration of the disorder does not exceed 1 month.

Acute Schizophrenia-like Psychotic Disorder (ICD-10: F23.2)

For the diagnosis of *Acute Schizophrenia-like Psychotic Disorder*, in addition to the general criteria of ATPD, the criteria of schizophrenia must be fulfilled, with the exception of the criterion of time. Hence, this disorder distinguishes itself from schizophrenia mainly through the duration of the symptoms: if the total duration of the 'schizophrenic' symptoms is more than 1 month, then 'schizophrenia' should be diagnosed (Table 1.7). The relation of 'Acute Schizophrenia-like Psychotic Disorder' to 'Acute Polymorphic Disorder' is discussed, based on the findings of the HASBAP, on page 179.

Other Acute Predominantly Delusional Psychotic Disorders (F23.3)

The main features of these disorders are relatively stable delusions and/or hallucinations which do not fulfil the symptomatic criteria for schizophrenia (see Table 1.8).

The category 'Other Acute and Transient Psychotic Disorders' is to be diagnosed in patients with ATPD not belonging to the above-mentioned categories (Table 1.9).