Psychiatric diagnosis and classification from the European perspective

C. Höschl

Prague Psychiatric Centre, Czech Republic

> For Kraepelin, diagnosis by symptoms was a temporary fall back, to be used only because diagnosis by pathology and aetiology was not possible. This „fallback" has dominated our thinking for more than a century, and it is time to press forward, with all deliberate speed (3, p. 297).

Classification (*lat.* classis = category, class; facere = to do) is a basic human process that we all use to form abstract concepts in order to understand our environment. The substantial features of respective objects are usually selected as classification criteria (natural classification). In some other cases, criteria for a specific purpose, but without a relationship to the subject are used, e.g. alphabet (artificial classification). In psychiatry, classification is a fundamental step that is mandatory if we are to understand psychopathology. We need a classification of psychopathology in order to help us understand what we clinicians deal with – people who have problems in living (*1*). Paradoxically, (the classification of) psychopathology as such has been a neglected topic during the 20th century, especially in North American schools and textbooks. In the US, which is the birthplace of DSM, there are in fact two prominent approaches to the psychiatric classification: *neo-Kraepelinian* and the *quantitative*. The former term refers to a popular diagnostic and classification way of thinking used in clinical psychiatry. The latter term refers to researchers, mostly psychologists, who have used multivariate statistical techniques to create classificatory systems.

The European less operational and more traditional approach to psychopathology offers a more complicated scene. Europe, a multi-language and multi-cultural continent crossed through by many political (East-West), religious (several Christian denominations, Islam, Judaism), economical (North-South) and other frontiers, had several crystallogenic nuclei of psychiatric thinking. Contemporary European psychiatry is derived mainly from French (Esquirol, Morel and others) and German (Griessinger, Kraepelin, Bleuler and others) schools arising mainly in the 19th century.

A classification system should reflect, among other things, also the purpose for which it has to be used. ICD (International Statistical Classification of Diseases, Injuries and Causes of Death), which was introduced by the WHO (*7*), was originally designed to catch the causes of death and only later on to assess the reasons for hospitalizations. It was not too pertinent for clinical psychiatry.

The first European attempt for international classification of psychiatric diseases is dated to 1885, when M. Morel established a classification committee during the psychiatric congress in Antwerp. Later on, the International Congress of Mental Science in Paris adopted Morel's classification:

- mania (including acute maniform deliria)
- melancholia
- periodical mental illnesses („folie à double forme")
- progressive systemic mental illnesses
- dementias
- organic and senile dementias
- paralysis
- neuroses (hysteria, epilepsy (!), hypochondria etc.)
- toxic mental illnesses
- moral and impulse mental illnesses
- idiocy, etc.

Since that, European psychiatry under the strong influence of the German organopathological school (*Gehirn Psychiatrie* = brain psychiatry) repeatedly tried to incorporate the etiopathogenetic aspects into the classification („toxic", „organic", „endogenous-exogenous"), which might be not far from the clinical relevance, but made the classification almost impossible, because of a lack of knowledge of neurobiology and etiopathogenesis of mental disorders covering the whole „problem area".

Meanwhile, majority of members of the Royal Medico-Psychological Association in Great Britain refused to comply with such a system. In the US, there was a similar level of non-compliance until 1913, when the APA (American Psychiatric Association) adopted the new nomenclature of Emil Kraepelin (manic-depressive psychosis, involution melancholy and dementia praecox)(*5*). Nevertheless, the New York State Commission in Lunacy kept its own classification until 1968!

The increasing need for a largely acceptable international system led the WHO to request the British psychiatrist Erwin Stengel to evaluate the situation and propose a solution (so called „Stengel-Report", *6*). Stengel proposed to clear out of the classification all etiological implications and formulate only „simple operational definitions". The main goal was „the standardization" of psychiatric diagnoses. Nevertheless, even afterwards ICD-8 was not satisfying in this respect. Some disorders were classified according to symptomatology, some according to the concept of a disease, others according to aetiology or using the mixture of all of it.

It was only the Diagnostic and Statistical Manual – DSM of APA, which approached closest to a fully atheoretical, operationally defined system. DSM-III and IV undoubtedly increased the reliability of the psychiatric diagnostic process. The price we pay now for it is a lack of validity and clinical relevance at the same time. Hand in hand with the tremendous progress in clinical neuroscience and psychopharmacology, the call for clinical relevance of the psychiatric classification will require in a near future to implement again etiopathogenetic criteria and practical clinical aspects: the course of the disease, neurobiology (brain imaging), genetic background, therapeutic response, prognosis, social aspects etc. For this, Europe – and particularly AEP – can play again a major role, offering its deep tradition both in „Gehirn Psychiatrie" concept and in psychopathology. Our psychiatry can now come back to the roots enriched with the global progress in neuroscience, genomics and American „atheoretical" DSM experience.

What is the AEP role in this perspective? First of all, we have to evaluate the European experience with ICD-10 and other current diagnostic systems. Second, to explore a framework for relatively universal standards, but to pay attention to local realities and needs at the same time. It is essential to validate any nosological and classification systems with regard to their application in clinical settings, in further research, in education, in forensic medicine, in mental health care policy, and in international and transcultural communication. We have to harmonize the European concept of psychiatry as a medical discipline with that of an individual, value based approach to a life-story of a particular human being.

This process involves both the political consensus about the role of psychiatry and its limits (*2*), and the research to construct future diagnostic systems, in which nosology will eventually move towards a focus less on symptomatology and more on aetiology and ultimate causation. As research into mental disorder progresses and knowledge of genetic and environmental contributions to psychopathology accumulates, it is possible that later classifications could ultimately become significantly more objective (*4*).

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Correspondence to

Prof. MU Dr. Cyril Höschl, Dr Sc., FRC Psych.
AEP-President 2007/2008
Director, Prague Psychiatric Centre
Ustavni 91
18103 Praha 8, Czech Republic
Phone: +420–266003131
Fax: +420–266003134
E-Mail:hoschl@pcp.lf3.cuni.cz

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