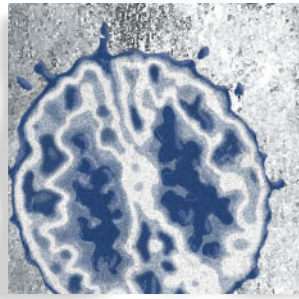


Basic research

Evolution of diagnostic criteria in psychoses

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The term psychosis was first introduced in the mid-19th century for the separation of psychiatric disorders from neurological disorders within the neuroses. The concept of psychosis has become gradually restricted from a generic term for psychiatric disorders to one of the major classes of mental illness, which was assumed to be the result of a disease process, and, more recently, to a symptom present in many psychiatric disorders. In the course of this development, the diagnostic criteria for psychosis shifted from the severity of the clinical manifestations and the degree of impairment in social functioning to the presence of one or more symptoms in a set of psychopathological symptoms, which include hallucinations, formal thought disorder manifest in disorganized or odd speech, delusions, flat/inappropriate affect, avolition/apathy, disorganized behavior, catatonic motor behavior, and depersonalization/derealization. The changes in the conceptualization of psychosis and in the diagnostic criteria for psychosis are documented in the various editions of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (from DSM-I to DSM-IV) and the International Classification of Diseases of the World Health Organization (from ICD-9 to ICD-10).

Keywords: case history; classification; diagnostic criteria; disease process; psychosis; psychotic behavior; severity-based criteria; sociomedical concept; symptom-based criteria

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Introduction: from neurosis to psychosis

The term *neurosis* was introduced to the medical literature by William Cullen¹ in the mid-1780s.² Cullen believed that “life is a function of nervous energy, muscle a continuation of nerve, and disease mainly nervous disorder,” and classified illness into fever, cachexias, local diseases, and neuroses,³ ie, diseases that were assumed to have their seat in the nervous system.⁴

To shift emphasis in the conceptualization of insanity¹ from the nerves to the soul (anima or psyche), the term *psychiaterie* was introduced by Johann Christian Reil in 1803.⁵ It was adopted by Johann Christian Heinroth,⁶ and changed to *psychiatrie* in his influential text published in 1818. Introduction of the term *psychiatry* profoundly affected the subject matter and the development of the field; for well over 100 years, psychiatric opinion remained divided as to whether psychiatry deals with Cullen’s¹ disorders of the nerves (body) or Reil’s⁵ disorders of the soul (mind).⁷

The terms neurosis and psychiatry were used interchangeably during the second quarter of the 19th century.² Recognition, however, that not every defect of the nervous system was accompanied by mental disorder led to the introduction of the term *psychosis* by Ernst Feuchsterleben⁸ in 1845. In his *Textbook on Medical Psychology*, Feuchsterleben⁸ declared that “every psychosis is a neurosis, because, without the nerves as intermediaries, no psychological change can be exhibited, but not every neurosis is a psychosis,” thus using the term psychosis for the first time in the psychiatric literature.²

By separating the disorders of the nerves with mental pathology from the disorders of the nerves without mental pathology, ie, psychiatric disorders from neurological disorders, the concept of psychosis provided the necessary orientation points for the development of the discipline that we now call psychiatry.⁹

Basic research

The unitary concept of psychosis

In the middle of the 19th century, psychosis was an all-embracing diagnostic concept, which included all the different general forms of insanity separated by Esquirol,¹⁰ ie, lypemania (melancholia of the ancient), monomania (partial insanity), mania (pure insanity), dementia, and imbecility (or idiocy), and all the different mental states described by Griesinger,¹¹ ie, mental depressions (lypemania), mental exaltations (monomania and mania), and mental weakness (dementia and imbecility).

Griesinger¹¹ perceived psychosis (insanity) as a symptom of brain disease and, considering Bayle's findings that the state of dementia was preceded by a state of monomania and a state of mania in chronic arachnoiditis,¹² he suggested that the various mental states are different developmental stages of one and the same disease process.¹³ In his classic text *Pathology and Therapy of Mental Illness*,¹³ Griesinger adopted Guislain's¹⁴ *unitary concept of psychosis (Einheitspsychose)* and postulated that, in mental syndromes in which neuropathological changes are absent, they will become detectable at a later stage of disease development.¹⁵

Morel's *theory of degeneration*¹⁶ is in keeping with the concept of *Einheitspsychose*, and constitutes the first genetic theory of mental illness. It is based on the assumption that psychosis is the result of an innate biological defect, which becomes manifest in increasingly severe mental syndromes in lineal descents.

Toward the end of the 19th century, Morel's theory¹⁶ was replaced by Moebius' *endogeny theory*,¹⁷ which implied only a "constitutionally determined predisposition" for developing psychosis. Nevertheless, genetic anticipation—the essential feature of Morel's¹⁶ theory—has lingered to this day and, in the 1990s, was linked to trinucleotide repeat mutations in molecular genetic research.^{18,19}

Classification of psychoses

By the dawn of the 20th century, the concept of neurosis—which once embraced both the psychiatric and the neurological disorders—became restricted to one major class of psychiatric disease, and the concept of psychosis—which once embraced all psychiatric disorders—became restricted to the other. Instrumental to this development was Freud's²⁰ separation of the neu-

roses into *actual neuroses* and *psychoneuroses*, and Kraepelin's²¹ adoption of the terms psychosis (infection psychoses, exhaustion psychoses, intoxication psychoses, thyrogenous psychoses, and involution psychoses) and neurosis (psychogenic neuroses) in the sixth edition of his *Textbook of Psychiatry*. Furthermore, by introducing his diagnostic concepts of manic depressive insanity and dementia praecox in the same edition, he set the foundation of the Kraepelinian dichotomy of endogenous psychoses,²² and opened the path for the division of psychoses into *organic* and *functional*.

A further important development in the classification of psychoses was Bonhoeffer's²³ separation of exogenous or symptomatic psychoses (associated with toxic agents, infections, or systemic disease) from organic psychoses (associated with course brain disease), ie, dividing the somatically determined psychoses into *organic* and *symptomatic*. Another important development was Wimmer's separation of psychogenic psychoses²⁴ (triggered by psychic trauma or stressful life events) from endogenous psychoses, ie, dividing the functional psychoses into *reactive* and *endogenous*.

Concepts of psychoses

Psychosis as a disease process

In spite of its frequent use, the term psychosis remained vaguely defined⁹ until Jaspers²⁵ separated the disease process from personality development in 1910. Three years later, in his classic text *General Psychopathology*,^{26,27} Jaspers defined psychosis as a disease, which "seizes upon the individual as a whole, regardless whether it is a hereditary disorder beginning at a certain time of life, or a nonhereditary disorder, which is called into being by an exogenous lesion." To qualify for Jaspers' criteria for psychosis,²⁶ the pathological process displayed in a patient's case history has to be sufficiently strong to override normal development, displayed in the life history; and the patient's behavior has to be sufficiently different that it cannot be understood as an extension of the normal or as an exaggerated response to ordinary experience.

Jaspers'²⁶ conceptual framework was adopted by Kurt Schneider²⁸ in his rudimentary classification in which psychoses, ie, the effects of illness, were separated from the abnormal variations of psychic life, ie, anomalies of development, which might become manifest in abnor-

mal intellectual endowment, abnormal personality, or abnormal psychic reactions. Schneider²⁸ defined psychoses as diseases with psychic symptomatology and somatic etiology, and divided psychoses into *somatically determined psychoses*, *cyclothymia* (the term he used for Kraepelin's²¹ manic depressive insanity), and *schizophrenia*,²⁹ a term he retained in spite of his belief that "there is nothing to which one could point as a common element in all the clinical pictures" subsumed under this diagnostic category.

Sociomedical concept of psychosis

Jaspers⁷⁶ concept of psychosis as a disease was transformed into a *sociomedical concept* by Fish³⁰ with consideration that the characteristic features of psychosis include psychopathological manifestations, such as lack of insight, distortion of the whole personality by the illness, construction of a false environment out of subjective experiences, and gross disorder of basic drives, including self-preservation, coupled with an inability to make a reasonable social adjustment.

The interaction between psychopathology and social adjustment was further elaborated in the Diagnostic Criteria for Research (DCR) Budapest-Nashville,³¹ in which psychosis was defined as a nonspecific syndrome characterized by lack of insight and psychopathological symptoms of sufficient severity to disrupt everyday functioning with collapse of the customary social life, which may call for psychiatric hospitalization. In the DCR, psychosis is the nadir in the process of psychiatric illness, the point at which the patient's case history (ie, pathological process) displayed in psychopathological symptoms, such as hallucinations or autism, becomes dominant over the patient's life history (ie, normal development). During psychosis, there is a forced withdrawal from everyday life, accompanied by a tendency to suspend social adjustment, and during the period of hospitalization, social adjustment may collapse to the extent that it may not be possible to assess social adjustment at all. Without encountering such a nadir at least once in the course of the illness, the prerequisite for a DCR diagnosis of psychosis is not fulfilled.

In the DCR, psychoses are divided into *somatically determined* and *functional*. Functional psychoses are divided into reactive^{24,28} and endogenous³² with the delusional psychoses^{33,36} in between. Endogenous psychoses are divided into affective (including manic depressive

illness, pure melancholia, pure mania, pure depressions, and pure euphorias), cycloid, and schizophrenic, with the latter being divided into unsystematic (cataphasia, affect-laden paraphrenia, and periodic catatonia) and systematic (paraphrenias [ie, phonemic, hypochondriacal, confabulatory, grandiose, fantastic, and incoherent], hebephrenias [ie, autistic, eccentric, shallow, and silly], and catatonias [ie, parakinetic, proskinetik, speech prompt, speech inactive, manneristic, and negativistic]).³²

Psychosis in consensus-based classifications

To overcome the difficulties created by using different diagnostic criteria for the same diagnostic terms by different schools of psychiatry and in different cultures and language areas, consensus-based classifications were developed by the World Health Organization (WHO)³⁷⁻³⁹ and the American Psychiatric Association (APA).⁴⁰⁻⁴⁴ A consensus-based classification is a set of diagnostic formulations agreed upon by a body of experienced and well-informed psychiatrists.⁴⁵

DSM-I

The first consensus-based classification with a description of diagnostic terms was the first edition of the APA's *Diagnostic and Statistical Manual of Mental Disorders (DSM-I)* published in 1952.⁴⁰ It was based on Adolf Meyer's⁴⁶ psychobiological view that mental disorders represent reactions of the personality to social, psychological, and biological factors, and that psychoses are whole reactions, unlike the other psychiatric disorders, which are only part reactions.^{47,48}

Mental disorders in *DSM-I* are divided into two—or three with the inclusion of mental deficiency—classes of illness: (i) organic disorders, caused by or associated with impairment of brain tissue function; and (ii) disorders of psychogenic origin or without clearly defined physical cause or structural changes in the brain. Psychotic disorders, including involuntional, affective (manic depressive reactions and psychotic depressive reactions), schizophrenic, and paranoid reactions, are one of the five categories in the second class.

In *DSM-I*,⁴⁰ psychotic disorders are defined as diseases characterized by personality disintegration, failure to test and evaluate correctly external reality, and inability to relate effectively to people or work. In affective reac-

Basic research

tions, the psychosis is characterized by severe mood disturbance, with the mood alterations of thought and behavior in consonance with affect. In schizophrenic reactions, the psychosis is defined by fundamental disturbances in reality relationships and concept formation with associated affective, behavioral, and intellectual disturbances marked by a tendency to retreat from reality, regressive trends, bizarre behavior, disturbances in the stream of thought, and delusions.

In addition, the qualifying phrase, “with psychotic reaction,” is used in *DSM-I* to amplify the diagnosis of any psychiatric disorder with clinical manifestations that fulfill the criteria for psychosis.

DSM-II

The second consensus-based classification with a description of its diagnostic terms was the *DSM-II*,⁴¹ published in 1968. It was based on the eighth revision of the *International Classification of Diseases (ICD-8)* of the WHO,³⁷ with a glossary of definitions added to the classification by the American contributors.

In *DSM-II*,⁴¹ mental disorders are divided into two—or three with the inclusion of mental retardation—classes of illness: (i) psychoses; and (ii) neuroses, personality disorders, and other nonpsychotic mental disorders. Included among the psychoses are organic conditions (senile and presenile dementia, alcoholic psychoses, psychoses associated with intracranial infection, other cerebral conditions, and other physical conditions), affective psychoses, schizophrenia, and paranoid states.

In the *DSM-II*,⁴¹ psychosis is defined as a mental disorder in which mental functioning is impaired to the degree that it interferes with patient’s ability to meet the ordinary demands of life and recognize reality. Hallucinations and delusions may distort perceptions; alterations of mood may affect the capacity to respond appropriately; and deficits in perception, language, and memory may interfere with grasping situations effectively. In affective psychoses, it is the disorder of mood, either extreme depression or extreme elation, that dominates mental life and is responsible for the patient’s loss of contact with the environment. In schizophrenia, characteristic disturbances of thinking, mood, and behavior dominate. The disturbances of perception and thinking are marked by hallucinations and alterations of concept formation, misinterpretations, and delusions. Corollary mood changes include ambivalent, constricted, and

inappropriate emotional responsiveness, and loss of empathy with others. Behavior may be withdrawn, regressive, or bizarre. In paranoid states, a delusion, generally persecutory or grandiose, is the essential abnormality and the disturbances in mood, behavior, and thinking, including hallucinations, are secondary to this primary pathology. Organic conditions can be classified as psychosis only if the patient is psychotic during the episode in which the diagnostic evaluation is made.

ICD-9

The first consensus-based classification of the WHO³⁸ with a description of diagnostic terms was the mental disorders section of the 9th revision of the *International Classification of Diseases (ICD-9)* published in 1977. It is based on the division between psychotic disorders and nonpsychotic disorders introduced in *ICD-8*,³⁷ and adopted in *DSM-II*.⁴¹ The definition of psychosis in *ICD-9*³⁸ was, in turn, adopted from *DSM-II*.⁴¹

Unlike *DSM-II*,⁴¹ there is a clear separation of organic and nonorganic psychoses in *ICD-9*³⁸ with the organic syndromes characterized by impairment of orientation, memory, comprehension, calculation, learning capacity, and judgment. Other organic features include shallowness and lability of affect, persistent disturbance of mood, lowering of ethical standards, exaggeration of old and emergence of new personality traits, and diminished capacity for independent decisions. The term delirium defines one set of organic psychoses in which the characteristic features of organicity are overshadowed by clouded consciousness, confusion, disorientation, delusions, illusions, and vivid hallucinations; and the term dementia defines another set of organic psychoses, which are chronic, progressive, and, if untreated, irreversible. While the definitions of affective psychoses and paranoid states are the same in *ICD-9*³⁸ and *DSM-II*,⁴¹ the scope of other nonorganic psychoses in *ICD-9*³⁸ is restricted to a small group of psychotic conditions, which are largely or entirely attributable to recent life experiences. The definition of schizophrenic psychoses is also changed to include Kurt Schneider’s⁴⁹ first rank symptoms. Thus, schizophrenic psychoses are defined in *ICD-9*³⁸ as a group of psychoses with a fundamental disturbance of personality, a characteristic distortion of thinking, a sense of being controlled by alien forces, delusions which may be bizarre, disturbed perceptions, abnormal affect, and autism. In schizophrenic psychoses, the disturbance of

personality involves those basic functions that give each person a feeling of individuality, uniqueness, and self-direction. The most intimate thoughts, feelings, and acts are often felt to be known to—or shared by—others and explanatory delusions may develop to the effect that natural or supernatural forces are at work to influence thoughts and actions in ways that are often bizarre. Hallucinations, especially of hearing, are common and may comment on or address the patient.

DSM-III and DSM-III-R

In 1980, *DSM-II*⁴¹ was replaced by *DSM-III*,⁴² the first consensus-based classification with a multi-axial evaluation and operationalized diagnostic criteria. In *DSM-III*,⁴² all traditional dichotomies, eg, organic versus functional, psychotic versus neurotic, are dismissed, and psychiatric syndromes are assigned to one of 15 categories of disease. All the different syndromes in three of these categories, ie, schizophrenic disorders, paranoid disorders, and psychotic disorders not elsewhere classified, and some of the syndromes in two of the other categories, ie, organic mental disorders and affective disorders, qualify as psychotic disorders.

In *DSM-III*,⁴² the term psychotic is used to describe a patient at a given time, or a mental disorder in which at some time during its course all patients with the disorder evaluate incorrectly the accuracy of their perceptions and thoughts, and make incorrect inferences about external reality, even in the face of contrary evidence. However, the term psychotic does not apply to minor distortions of reality that involve matters of relative judgment, but gross impairment of reality testing and the creation of new reality. Thus, a depressed person who underestimates his/her achievements would not qualify as psychotic, whereas one who believes he/she caused a natural catastrophe would qualify. Direct evidence of psychotic behavior is the presence of either delusions or hallucinations without insight into their pathological nature and/or grossly disorganized behavior from which a reasonable inference can be made that reality testing is markedly disturbed.

In 1987, *DSM-III*⁴² was replaced by *DSM-III-R*⁴³ with some minor modifications relevant to psychotic disorders, for example, the diagnostic term schizophrenic disorders was replaced by schizophrenia; the term paranoid disorders was replaced by delusional (paranoid) disorder; the term shared paranoid disorder was replaced by

induced psychotic disorder; and the term affective disorders was replaced by mood disorders.

ICD-10 and DSM-IV

The traditional division between psychosis and neurosis is also dismissed in *ICD-10*,³⁹ which was introduced in 1992 to replace *ICD-9*.³⁸ The term psychotic was retained in *ICD-10*³⁹ only as a convenient descriptive term, which simply indicates the presence of certain symptoms, such as hallucinations, delusions, gross excitement and over-activity, marked psychomotor retardation, and catatonic behavior in some of the psychiatric disorders. Nevertheless, it is also used in the diagnosis of a newly introduced category of illness, acute and transient psychotic disorders, in which psychotic symptoms are the prevailing feature of the clinical picture.

Similar to *ICD-10*,³⁹ in the *DSM-IV*,⁴⁴ which was published in 1994, the diagnosis of psychosis is no longer based on the severity of the functional impairment, ie, on gross interference with the capacity to meet ordinary demands of life, but on the presence of certain symptoms. Included among these symptoms are delusions and hallucinations (with the hallucinations occurring in the absence of insight into their pathological nature), prominent hallucinations (perceived by the patient as hallucinatory experiences), and some other positive symptoms, such as disorganized speech and grossly disorganized or catatonic behavior.

Diagnostic criteria: past and present

There has been a gradual shift in emphasis in the diagnostic criteria for psychosis. While in the past, ie, prior to the introduction of the *DSM-III*,⁴² the diagnostic criteria for psychosis were based on the degree of the severity of the clinical manifestations, and on the interference of the manifestations with social adaptation, today's diagnostic criteria for psychoses are based on the presence of certain psychopathological symptoms and on the psychotic behavior displayed.

For well over 50 years, in Campbell's *Psychiatric Dictionary*,^{47,48} psychoses were differentiated from other psychiatric disorders and especially from psychoneuroses by one or more of the following five variables: (i) severity (more severe, intense, and disruptive); (ii) degree of withdrawal (less able to maintain effective object relationships); (iii) affectivity (emotions are

Basic research

qualitatively different from normal or exaggerated quantitatively); (iv) intellect (language and thinking disturbed, judgment fails, hallucinations and delusions appear); and (v) regression (generalized failure of functioning with falling back to early behavioral levels). Other frequently used variables in the differentiation of the psychoses from the psychoneuroses were insight and sociability (lost in psychoses and retained in psychoneuroses), personality (wholly involved in psychoses and partially involved in psychoneuroses), and unconscious processes (verbally expressed in psychoses and symbolically expressed in psychoneuroses).⁵⁰ In current diagnostic manuals, psychotic behavior is detected by the presence of one or more of the following psychopathological symptoms: hallucinations, formal thought disorder (disorganized or odd speech), delusions (including disturbances of ego integrity, such as thought insertion, thought withdrawal, or feelings of being controlled), disturbances of affect (flat/inappropriate), avolition/apathy, alogia, disorganized behavior, catatonic motor behavior, and depersonalization/derealization. Since the disorders that qualify for psychosis, and in which psychotic behavior may be displayed, are differentiated from each other by operationalized diagnostic criteria, which may or may

not be based on the symptoms that signal psychosis, psychotic behavior is today perceived as a symptom of many psychiatric disorders.⁵¹

Concluding remarks

Since the time of the introduction of the term psychosis for the separation of psychiatric disorders from neurological disorders,⁸ well over 150 years have passed. During this time, the concept of psychosis has become restricted from a generic term for psychiatric disorders to a symptom present in many psychiatric disorders.⁵¹ Recently, a set of psychopathological symptoms have been identified that signal the presence of psychosis regardless of the underlying disorder in which the psychotic behavior is displayed. Since all the psychotic symptoms identified represent different aspects of the pathology in the processing of mental events in the brain,⁵² psychotic behavior with the diagnostic criteria for psychosis may provide suitable end points for neuropsychopharmacological research in the study of the relationship between signal transduction⁵³ and processing of mental events in the central nervous system. □

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Evolución de los criterios diagnósticos en las psicosis

El término psicosis fue introducido a mediados del siglo XIX al separarse los trastornos psiquiátricos de los trastornos neurológicos; ambos trastornos estaban incluidos dentro de las neurosis. El concepto de psicosis se ha restringido gradualmente desde un término genérico utilizado para referirse a los trastornos psiquiátricos a uno que se aplica a una de las clases principales de enfermedades mentales –en este caso representa el resultado de un proceso patológico– y más recientemente a un síntoma que puede estar presente en varios trastornos psiquiátricos. A lo largo de este desarrollo los criterios diagnósticos de psicosis han variado desde la severidad de las manifestaciones clínicas y el grado de deterioro en el funcionamiento social a la presencia de uno o más síntomas dentro de un conjunto de síntomas psicopatológicos, los cuales incluyen alucinaciones, trastornos formales del pensamiento que se manifiestan en lenguaje desorganizado o curioso, delirios, afecto aplanado / inapropiado, abulia / apatía, conducta desorganizada, conducta motora catatónica y despersonalización / desrealización. Los cambios en la conceptualización de la psicosis y en los criterios diagnósticos para la psicosis están documentados en las diferentes ediciones de los Manuales Diagnósticos y Estadísticos de la Asociación Psiquiátrica Americana (desde el DSM-I al DSM-IV) y en las Clasificaciones Internacionales de Enfermedades de la Organización Mundial de la Salud (desde la CIE-9 a la CIE-10).

Évolution des critères diagnostiques dans les psychoses

Le terme de psychose a été introduit pour la première fois au milieu du 19^e siècle afin de différencier les maladies psychiatriques des maladies neurologiques au sein des névroses. Le concept de psychose, à l'origine un terme générique caractérisant les maladies psychiatriques, a vu son utilisation progressivement limitée à l'une des classes les plus importantes des maladies mentales considérée comme résultant d'un processus pathologique et, plus récemment, à un symptôme présent dans beaucoup de maladies psychiatriques. Au cours de cette évolution, les critères diagnostiques de la psychose se sont déplacés de la sévérité des manifestations cliniques et du degré d'altération du fonctionnement social à la présence d'un ou de plusieurs parmi un ensemble de symptômes psychopathologiques comprenant les hallucinations, les troubles du cours de la pensée se manifestant par un discours désorganisé ou étrange, les idées délirantes, un affect émoussé ou discordant, une perte de volonté/apathie, un comportement désorganisé ou catatonique et une dépersonnalisation/dérealisation. Les modifications dans la conceptualisation de la psychose et celles de ses critères diagnostiques sont reflétées dans les différentes éditions du Diagnostic and Statistical Manual of Mental Disorders de l'American Psychiatric Association (du DSM-I au DSM-IV) et de l'International Classification of Diseases de l'Organisation mondiale de la santé (de l'ICD-9 à l'ICD-10).

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