Single Facets and the Whole of Psychopathology: A Critique of Jasper‘s Nosology

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Jasper‘s Nosological Approach and Recent Diagnostic Systems in Psychiatry
Agenda

1. How do Young Psychiatrists enter the Field?
2. The Risks of Neglecting Psychopathology for Psychiatric Training
3. The Impact of Karl Jaspers for Assessment and Diagnosis in Psychiatry
4. The Differentiation between Understanding and Explaining
5. Jasper's Method as Subjective Psychopathology
6. Operationalism as the New Paradigm for Diagnosis in Psychiatry
7. A Critique of recent Diagnostic Systems
8. Is there a Need for „Ganzheitliche“ (Holistic) Approaches?
Phenomenology

- *science of phenomenology* = philosophical analysis of *mental phenomena* (Kräupil Taylor, Psychopathology it‘s causes and symptoms 1979)

- the empirical method of enquiry maintained solely by the fact of the *patients* communications (Jaspers, General Psychopathology 1913)

- …the task of phenomenology in psychiatry was to depict as clearly as possible the various psychological conditions as they are *experienced by the patient*. (Hamilton, Fishs Clinical Psychopathology 1974)
Phenomenological-descriptive psychopathology

Basic epistemological principles

- “…sorting out, defining, differentiating and describing specific psychic phenomena, which are thereby actualized and are regularly described in specific terms.”
- “…grouping related phenomena on a purely phenomenological basis” – i.e. by those aspects of phenomena which can be clearly differentiated by the patient’s self-descriptions, excluding any notion or theory, focusing on ‘the modes in which the experience comes to expression’

The polarity of Explanation and Understanding

• Because of the junction between mind and brain, the phenomenal world *must* be viewed from several different perspectives if it is to be fully appreciated.

• The polarity of explanation and understanding was introduced into psychiatry by Karl Jaspers.

• Philosophical forerunners were: Johann Gustav Droysen, Wilhelm Dilthey, Max Weber.

• For Jaspers there could be no choice between explanation and understanding, since his patients were both agents *and* organisms … they had both mind *and* brain.

(Slavney, McHugh Psychiatric Polarities 1987)
Scientific analysis of connections (Jaspers 1913)
(Wissenschaftliche Erfassung von Zusammenhängen)

Natural Sciences
Perception of causal connection
Explanation (Erklären)

Humanities
Perception of meaning
Understanding (Verstehen) (Psychopathology)

static understanding (Phenomenological Psychopathology)
genetic understanding (Psychopathology of understanding)

Saß und Hoff in: Möller, Laux, Kapfhammer, 2010
Establishing the Validity of Psychiatric Diagnoses

1. clinical description (including symptom profiles, demographic characteristics, and typical precipitants)
2. laboratory studies (including psychological tests, radiology and post-mortem findings)
3. delineation from other disorders (by means of exclusion criteria)
4. follow-up studies (including evidence of diagnostic stability)
5. family studies

Robins and Guze, 1970
Operationalization - defining variables into measurable factors

- **Operationalization** is the transformation of an abstract, theoretical "concept" into something concrete, observable, and measurable.

- Each "concept" is defined by the measuring operations used.

Principles of „operational“ diagnoses

- descriptive approach
- explicit inclusion- and exclusion-criteria
- algorithms for the criteriology of every single diagnosis
- nominalistic (and not realistic) understanding of psychiatric diagnoses
- etiological neutrality („free of theories“)
- comorbidity principle
- multiaxial (realized, until now, mainly in the DSM-system)
- focus on severity („quantitative approach“)
Ancestors of operational Classification Systems

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<tr>
<th>description</th>
<th>short cut</th>
<th>author(s)</th>
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<td>First Rank Symptoms (Symptome 1. Ranges)</td>
<td>FRS</td>
<td>K. Schneider (1938)</td>
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<td>St. Louis Criteria</td>
<td>SLK</td>
<td>Feighner et al. (1972)</td>
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<td>Present State Examination m. Computer-CATEGOM-System</td>
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DSM-System

1952  DSM-I: as alternative to ICD-6 (1948). Glossar containing descriptions of diagnostic categories, centered on clinical practice. Based on A. Meyers model of „reaction“ for psychic disturbances.

1959  WHO authorized the british psychiatrist E. Stengel with a revision of the psychiatric classification system. He claims explicit definitions as basis of reliable clinical diagnoses.

1968  DSM-II: similar to DSM-I. No definitions. The concept of „reaction“ was deleted.

1980  DSM-III by the APA: 1. official operationalisation of mental disorders, multiaxial classification, field studies prior to initiation. Goal to present a universal inventory of definitions for researchers and practitioners.

1987  Revision of DSM-III to correct diagnostical inconsistencies and ambiguities. DSM-III-R: introduced the comorbidity principle.

1994  DSM-IV: large empirical data basis, reorganization of organical mental disorders, many new subgroup and subtype specifications.

2000 DSM-IV-TR: actualization of characterizing texts because of new empirical data, further specifications.

2013 (?) DSM-5, Hybrid Conception.
Shortcomings of modern Classification Systems

- inflation of diagnostic categories (DSM-III 229; DSM-IV 395)
- consensus-politics and scientific-imperialism
- rarification of psychopathological differentiations and symptomatology
- danger of reification of verbalized syndroms based on conventions
- abandoning crucial concepts (neurosis, endogene depression, psychosis)
- abandoning conceptual history and psychopathological traditions
- abandoning psychodynamic and psychostructural factors
- disregarding aspects of subjective experience and biography
- lack of predictive validity, e.g. therapeutic response and course
- restriction to observable behaviour
- horizontalisation instead of verticalisation via comorbidity-principle („Schichtenregel“)
The Nosological Hierarchy (1) (Schichtenregel)

This logical structure was recognized for the first time by Jaspers, and it is uncertain until today, if it is based in the nature of the mental illnesses or only formed like this by mankind.

n. Kendell, 1974
The Nosological Hierarchy (2) (Schichtenregel)

- organic psychosis
- Schizophrenia
- manic-depressive disease
- neurosis
- abnormal personality

Every diagnosis excludes the presence of symptoms of all higher in hierarchy ranked diseases, whereas the symptoms of all lower ranked diseases are being included.

n. Kendell, 1974
Nosological Hierarchy (3) According to Jaspers and K. Schneider

- psychopathic-neurotic
- depressiv-manic
- schizophrenic
- psychoorganic

In each case the lowest „layer“ is crucial for the diagnosis.

For depressive-manic and schizophrenic disorders „Reversion“ of the „Schichtenregel“ in ICD 10/DSM III/IV.

(Huber, 2005)
Contemporary Models of "Nosological Hierarchy"

Psychosis
- schizophrenic
- affective
- schizotypal
- paranoiac
- zyklothymic
- depressiv
- schizoid
- borderline
- narcissistic
dissocial
- obsessive
- uncertain self
- histrionic
- dependent

Personality traits
- "Normality"

The Heterogenous Elements of Nosology

Jaspers, 1913 distinguishes

- „true diseases“ (e.g. general paresis) with clear boundaries between themselves and with normality
- „circles“ (e.g. manic-depressive insanity and schizophrenia) with clear boundaries with normality but not among themselves
- „types“ (e.g. neuroses and abnormal personalities) with no clear boundaries either among themselves or with normality
The Concept of Comorbidity

• „a distinct clinical entity“ occurs during the course of an index disease (Feinstein, 1970)
• Australian Survey of Mental Health: 21 % of people fulfilling DSM-IV criteria for any mental disorder met the criteria for three or more „comorbid“ disorders (Andrews et al., 2002)
• Critique: „The use of imprecise language may lead to correspondingly imprecise thinking“ (Lilienfeld et al., 1994)
Psychiatric comorbidity as By-Product of Recent Diagnostic Systems

• The rule in DSM-III (APA, 1980), that the same symptoms should not occur in more than one disorder
• The proliferation of diagnostic categories in the evolution of diagnostic systems
• The reliance on operational criteria instead on the „essence“ of each diagnostic entity and a „Gestalt“
DSM-V Proposal: Under Discussion

- Factors that cut across all diagnoses (e.g., gender and cultural issues)
- Use of the multi-axial system to record clinical variables of interest:
  - Axes I, II, and III will be collapsed into one axis that contains all psychiatric and general medical diagnoses.
  - Axis IV is being compared with the codes in the 10th edition of the ICD that might be comparable to the concepts presented in DSM-IV.
  - Axis V, allows clinicians to rate a patient’s overall level of functioning, is discussed in ways in which disability and distress can be better assessed in DSM-V.
  - This changes will bring DSM-5 into greater harmony with the single-axis approach used by the international community in the World Health Organization’s (WHO) International Classification of Diseases (ICD).

www.dsm5.org
WPA-Proposal for ICD 11

• Person centered Integrative Diagnostic Model (PID)
• Idiographic Personalized Formulation
• Jointly made by clinican, patient, and family
• Incorporates contextualized perspective and positive aspects of health

cf. Mezzich, 2007
On Diagnostic Approaches in Psychiatry

Anyone speaking about the mind must know

„what one knows, how one knows it and what one does not know.“


There is no single “optimal method“ for the study of mind and brain. It is rather the task of the researcher to find the right method for the question at hand.