

## EDITORIAL

# Revision of the Use of the Term "Affective" in Psychiatric Practice and Research

Some fundamental disturbance of emotion occurs in every diagnostic category in psychiatry. It could be the basic disturbance or a presenting symptom in whatever clinical picture. However, the phenomenon known as *emotion* is no more clear than it has ever been. "Emotion is (still) a complex phenomenon which is only incompletely understood" (Lane and Schwartz, 1987). The author has previously criticized the 29 definitions of emotion introduced by Blutchick (1980), and came to the conclusion that none is sufficiently comprehensive (Rakhawy, 1984). Intolerance of this ambiguity has led the recent criteria - oriented nosological disciplines to avoid facing the real everyday challenges practitioners face in clinical practice. Using seemingly well defined operational criteria could lead to certain mixing and misinterpretations, even though they fulfill pseudo-consensuality. For instance, a group of disorders said to be "non-mood" psychotic disorders include, for example, "schizophrenia, schizoaffective or delusional disorders" (DSM-III-R, APA, 1987).

In normal life it is still very difficult to delineate this phenomenon, emotion, as an independent psychological function or concept. Only emotional expression is partly defined. This expression in terms of verbal, social or autonomic manifestations does not necessarily cover the most important component of this complex phenomenon, i.e. the experiential aspect.

This misleading situation is augmented in most Arab countries including Egypt, since as we study and possibly practice psychiatry in a foreign language. As previously referred to, we used to start by importing, rather than translating, a foreign word from a foreign language having some foreign definition (Rakhawy, 1987). However, a diagnostic label is not defined through consulting a dictionary or encyclopedia. A concept in psychiatry is essentially derived from feedback in clinical practice.

If we revise how the term affective, and more specifically the term depression, have been used by the psychiatrists in actual practice over the last few decades, we could discover that on one hand we are recalling (or using) the term affective or depressive whenever we deal with a periodical, vivid, active, warm phenomenon. This may be the implicit basis of the empirical use of antidepressants in some many other syndromes not necessarily presenting with evident depression as a symptom in clinical picture. Revision of extending empirical use of certain antidepressants allowed Hudson and Pope (1990) to gather together what they called "affective spectrum disorders". On the other hand, strictly following only circumscribed operational criteria may include opposite phenomena under the same label. Rationalizing nihilistic depression, or nagging parasitic depression could lie on the extreme pole opposite to confrontation dialectic depression (Rakhawy, 1979). Similarly hyper-awareness anxiety is just the opposite of hypo-awareness anxiety although both may share the same behavioural operational criteria (Rakhawy, 1981).

The term affective as well as certain emotional labels such as depression or anxiety are more and more denatured and reduced as they are put in verbal test forms in order to assess this or that emotional behaviour in health and disease. Lane and Schwartz (1987) read: "for the present state of our knowledge about emotions, there is no consensus...". This perspective is best shown by researchers who view the objective measurement of physiological arousal and/or the objective measurement of behavioural expression to be

adequate measures of emotions. They continue, "...instruments such as the Taylor Manifest Anxiety State, ...The Hamilton Rating Scale for Depression...(etc) specify the emotion or mood and ask the respondent to quantify the intensity or frequency of that experience on a categorical or ordinal scale. The structure of the experience in question -its degree of differentiation and integration-is thus determined by the instrument. Results should be always debatable and should be restricted to tell us that the respondents tell us about their understanding of the words we put rather than about their actual affective life .

Any profound revision in a trial to assess our attitude to understand, detect or assess emotional life or emotional disorders would come to conclude that we are facing a rather inaccessible complex phenomenon the measurable aspect of which may prove to be the poorest and least significant. If so, it could be better to keep the specific words of particular emotions as the appropriate label for a particular syndrome instead of using a redundant poorly delineated term like affective. For instance, a term like manic - depressive disorder is better preserved in preference to terms like affective disorder or mood disorder. Also, studies totally or predominantly dependent on verbal response to certain emotional words based on our arbitrary conceptualization about emotions should not be taken directly as referring to the incidence or prevalence of this or that mood disturbance.

It may be quite reasonable and relatively objective to preserve a term like *affect* as an added dimension to whatever syndrome. Since this approach has been initiated and inspired from investigating an Arabic word, *wijdan*, the author proposed to introduce the word as such in English until they find the proper translation or keep it as such.

The word *wijdan* is more inclusive referring to some holistic existential tone with variable affective connotation as well as definite cognitive and volitional implications (Rakhawy, 1987). This hypothesis was detailed elsewhere (Rakhawy, 1990 a & b). To quote the essence of the idea, the hypothesis reads: "To judge a syndrome as *wijdanic* or *non-wijdanic* does not indicate directly the presence or absence of a particular affect. A schizophrenic disorder could be *wijdanic*, this may be the so - called schizo-affective disorder in the holistic interpretation provided earlier by the author (Rakhawy, 1982) but not necessary due to the presence of associated depression or elation. Also, we can meet sadistic dangerous paranoid states (*non-wijdanic*) on one side and on the other we may have warm smiling paranoid states (*wijdanic*). Even depressive illness could be *wijdanic* like in vivid periodic manic - depressive illness, or *non-wijdanic* as in parasitic or post-schizophrenic depression of the ICD-10 (WHO, 1988)".

To conclude the term affective seems to connote more than its reference to the presence or absence of a particular expressed mood. Hence it is better not to be attached to a particular category or syndrome or to be restricted to manic and depressive variants or illnesses.

If the term mood would refer to the behavioural level of symptom presentation, the term affective (or *wijdanic* ) may be better preserved for the holistic complex phenomenon referring to some periodic, integrative, cognitive-volitional-active presentation of whatever phenomenon or syndrome.

Y.T. RAKHAWY

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