

Nosology & Diagnosis

A Special Challenge in Developing Countries

It was before twenty years when the first issue of this periodical had seen light. We were about to celebrate this occasion, but we decided at the last moment to wait for another five years, hoping to have some sort of over-view of what has been achieved. We are also hoping to elaborate a definite objective self-criticism as well as an organized bibliography. In that first publication the author (Rakhawy 1978) stated: "No honest observer can claim that psychiatry, as an independent science, has established its definite identity. If this is true in the so-called "developed countries", it is expected to be even more so in the so called "developing countries" (a more diplomatic term than its real underlying concept, "underdeveloped" countries)."

Since then, many happenings have occurred in Egypt, in the Arab world as well as all over the world. In Egypt, the number of psychiatrists has been tripled or quadrupled. More psychiatric associations have been founded. The Arab Federation of Psychiatrists have been established and many Pan Arab congresses of Psychiatry were held. The Arab Board of Psychiatry has been established and some colleagues have been graduated with such common degree. As a matter of fact, all such movements and expansions did not make us more independent or less illuded.

Two decades before, the nosological stand as well as the theory and practice of psychiatry in Egypt have been reviewed by the author. It looked then that we were hoping to contribute (not only to copy or reduplicate). Where does this attitude exist now ?

I do not intend to follow-up in detail what had happened during these two decades. On the contrary I shall try to focus on the coming days. Even if it is simply a personal view, it may act as an invitation to think it over.

In a detailed paper published earlier (Rakhawy, 1991), the state of psychiatric nosology was revised and matched by our actual practice. Certain old remarks are worth reported as starting points:

(1) Although the DMP-I has been officially recommended as the Arab reference for Psychiatric nosology (DMP-I, 1979) one can hardly admit that this recommendation has been adequately put into action. This fact necessitates revision and re-orientation. The author (Rakhawy, 1978) has ended his discussion about the critical issues of the DMP-I by asking few questions, which after more than two decades, are still waiting for some more well-defined answers. Such questions were essentially about the rationale of having our independent national nosological discipline, as well as the relation of the claimed Egyptian views in psychiatry to classification and management,

Unfortunately, the answers, after 20 years is definitely negative. The DSM-IV (after the DSM-III and DSM-III-R) (American Psychiatric Association, 1994) have invaded (rather colonized territories). The ICD-10 (WHO, 1992) is now available as a complementary aid to the DSM-IV rather than a competitive alternative. However, the future inclination is to make both disciplines (DSM-IV and ICD-10) (Kaplan *et al.*, 1998) unified in one international nosological system. This is

perhaps more harmonious with the current historical era where the New World System colors almost all aspects of human existence all over the world.

The conclusion mentioned by the author some 8 years before was " *There is no point in blaming Americans for successfully marketing their intellectual goods. What we need to investigate more is how we, allover the world, accept, so easily, such adulterated goods. This may need some real search in the psychopathology of our speciality (i.e ourselves) some way or another.*" This could partly be related to our long standing inferiority feelings as a result of the long lasting ill-defined etiology of our disorders as well as our increasing intolerance of ambiguity. The rush to be sheltered by the misnomer *medical model* is another factor (referring to chemical rather than medical (Rakhawy, 1980). Lastly, the tendency to computerize our information is tempting just as some other modern fashion to follow. If we add all these factors to the need to communicate with advanced people in developed countries by using a common clear, understandable verbal, written or listened to language tools, the result could not be other than sticking common well-defined labels at the expense of identifying genuine objective truth.

Allover the literature, as well as in the actual practice, it is repeated that criteria oriented nosological disciplines (especially the DSM-IV) are definitely reliable (inter-rater reliability) but not valid enough. This fact could be translated into a lay saying "using such disciplines , *"we do agree about identifying some definite concepts which we do not actually know"*. As if we became more and more interested to agree with each other than to know about what we have agreed upon, the fact which would definitely influence our actual practice.

The following are some hazards or shortcomings which result from such invasion of the criteria-oriented disciplines in our practice, especially the DSM-IV:

i- The multiaxial approach has neither been used in our clinical practice nor in research. The whole story has been reduced practically to the first axis.

ii-The DMP-I, is now suffering from some sort of disuse atrophy. Apart from Kasr El-Eini school of psychiatry, and to a lesser extent Mansoura University and Dar EL-Mokattum Hospital, it is not the least used or even known.

iii- A "divorce" has been established between the longitudinal etiologically loaded and dynamically oriented life history on one hand and the presenting concrete criteria in the present mental state on the other hand.

iv- Gradually, as being more and more detached from our patients, we are left only with drugs given symptomatically to alleviate, control, tranquilize *and neutralize*. Some working hypotheses have been proposed (Rakhawy 1991) to compensate for such shortcomings. These summarized as followed:

1- The discovery of organic basis of the so-called functional disorders does not mean that they are, or could be, considered as one and the same as organic disorders. Delineating one from the other on a more existentially significant (still biological) basis looks to be now more essential than at any other time. *What counts is the basic differences in the biological setting, the level and nature of pathology, the existential meaning, the march of handicap and the how of organization.* For the so-called organic disorders the term **Discomposition-Deficit** disorders is suggested (Rakhawy, 1989a) to refer to the type of basic pathology as well as the nature of the derangement. *The term discomposition refers more to the dissolution of the holism of the matrix of consciousness, while the term deficit is more related to the specific handicap, resulting from destruction or outfall of neurones in a*

particular domain or locality. On the other hand, the term *Mal-organizational-Pathological Goal seeking* is used to replace the dying term functional.

2-It may be necessary to reconsider the dichotomy between what is **acute** and what is **chronic**. This would be based *not only* on the duration *but essentially* on the *pace, stability* and *degree of disruption* and *alienation*. This is particularly essential in relation to the so called "organic disorders", where delirium and subacute delirious states had to be delineated from irreversible deficit of dementias.

3-The *active-established* dimension is not synonymous with the *acute-chronic* one (Rakhawy, 1983). While acute-chronic axis is related to both the duration and the floridity of symptoms. Acute-established scale is more related to biological and psychopathological reactivation of actual organizational levels.

In our experience, the clinical use of both acute-chronic scale and active-established one is no matter of theoretical differentiation. They have their direct radical effect on both management, prognosis and, more essentially, prevention and re-channeling. There is more overlap between the term chronic and established than between acute and active. We have also to remember that Jasper has preceded the hepatologists in describing such chronic active syndrome in psychiatry some decades before (Jasper, 1962).

4-The connotation of the terms "psychotic" and "non-psychotic" worths re-considering both for clinical, therapeutic, and medicolegal assessments. We should remember here that by *psychotic* we do not mean the mere presence or absence of delusions and hallucinations, as both the DSM-IV and the ICD-10 do in most cases. The acceptance of hallucinations, and to a lesser extent delusions, as possible normal variants in our culture may lie behind the caution to consider their mere presence as the main criteria for diagnosing psychotic intensity. By psychotic we mean *a definite degree of disorganization of the personality, detachment from reality, severe handicap in performance and/or dangerousness to the self or others* (as a result of mental derangement).

5-It seems that it is high time to consider the pathology as well as the psychopathology of epilepsy as *etiologically relevant* and *phenomenologically parallel* as well as *equivalent* to psychiatric disorders in general. The rationale of keeping epilepsy as an independent category in the DMP-I is getting more and more poor.

6-Revision of the various uses of the term *affective* (Rakhawy 1990a) is essential. Using the term 'affective' to denote the presence or absence of affective symptoms (depression, elation, guilt, etc..) is completely different than using the same term '*affective*' to refer to some sort of *integration of personality, periodicity, warmth and vivid presence*. The latter connotation is perhaps more understandable in our culture as the word "wijdan" in Arabic. This word denotes something more profound and comprehensive than describing simply a stirred up state of feelings.

7- Depressive syndrome should be further differentiated and detailed, perhaps as an independent category with different variants.(Rakhawy, 1990b) As just mentioned, the possibility of separating an apparently paradoxical syndrome labelled *non-affective* (or better, non-wijdanic) *depressive syndrome* (!!) away from affective group is worth considering. This is to be partly related to the atypical depression of the French classification (Pichot,1986) categorized under schizophrenia and perhaps with the post schizophrenic depression innovated by the ICD-10.

8-Differentiation of mania into dissociative (productive) type and regressive (nonproductive) childish type (Rakhawy 1979, c) may have some place until we admit the concept of regressive psychosis as an independent category (Rakhawy 1989, b).

9-Schizophrenia should be diagnosed essentially by two main parameters viz, *the degree of disorganization* and *the extent of deterioration*. In the current approach to schizophrenia, Schneider's symptoms are too much emphasized so far. It is a rather common experience in certain normals in our culture to admit some sort of phenomena similar to Schneiderian symptoms without being psychiatrically ill.

In the present revision, it is advised to identify three stages of the so called schizophrenic process, viz: *early active schizophrenia* (could be called *Schneider's disease*), *intermediate split schizophrenia* (could be called *Bleuler's disease*) and *late deficit schizophrenia* (could be called *Kraepelin's disease*). In addition we may invite to consider *autistic syndrome* in adulthood as another variant of schizophrenic existence.

10-Much more attention should be paid to the pre-schizophrenic states. This could be specially relevant from a preventive (morally responsible) point of view. A trial to identify and diagnose the group of pre-schizophrenic states would help to prevent further evolution to schizophrenia, or at least, to handle the consequences as early as possible. However, from a nosological point of view, this area should be thoroughly investigated to differentiate, for instance, the pseudo-neurotic state (which is definitely pre-schizophrenic and incipient), and the active variant (which denotes that *the process*, not necessarily the schizophrenic process, has already started). This would open the file of borderline states (not border line personality as the DSM-IV misused the term).

However, terms like *incipient psychosis* would refer to starting psychotic process as indicative for some stand along possible psychotic outcome. It should not be taken simply as synonymous to the newly suggested term *cross-road crises* (Rakhawy, 1979a, b) where the outcome is not commonly psychotic and positive outcome (growth unfolding) is possible.

If we admit to accept *incipient psychosis* as independent category, it should be included apart from schizophrenia. However, this would be a new controversial problem, since psychotic intensity, as just defined in the so called incipient psychosis, is lacking at the outset. I am not sure how much we could agree to revive using terms like potential psychosis or potential schizophrenia.

11- Paranoid states should be sharply separated into two *different* categories. The *active vivid and periodical* group (very near to the sub-category 08.0 of the DMP-I labelled subacute or acute paranoid episodes) which are manageable by drugs and physical restoring rhythmic therapy (BST, still mis-named as ECT). It is also noticed that occasionally added anti-depressants may help the patient to respond readily. This is contrary to what was believed that antidepressants are rather contraindicated in paranoid states.

Chronic group as a whole (delusional, hallucinatory and fantastic) is, at least structurally, a *stable personality transformation*. The structural organization, as well as the management of this latter group, is more like that of a personality pattern disorder. The psychoactive drugs are not effective unless this stable structure is dislodged and the whole biological constitution is reactivated.

12-The group called other functional psychoses (09 DMP-I) worth receiving

more serious attention. The term *functional* has a weak rationale to prolong its life time. Other independent psychoses such as : impulsive psychosis, obsessive compulsive psychosis, regressive psychosis, dissociative psychosis, disorganization psychosis (periodical and otherwise) (Rakhawy, 1989a) as well as polymorphic psychosis and cycloid psychosis are perhaps justified to find their place here. Nevertheless this category should not be the least used as a waste basket.

13-The neuroses still have their place and dignity in our practice. We found no point to go on denying their existence in recent nosological disciplines, simply because they are predominantly dynamically described categories. It is not the least a weak point to base the diagnosis on dynamic interpretation to start with.

However, apart from the reactive and situational neuroses it is hardly possible to face neurosis as an acute superimposed clinical problem. This drags us to the area of the personality disorder which agrees with the idea of grouping personality disorders and neuroses in one main category (Mayer Gross *et al*, 1972).

Post-psychotic and late onset personality disorder are commonly met with in our clinical practice and thus worth considering as independent categories. This group is particularly increasing with the extensive use of long term neuroleptics.

14- It is not sufficient to categorize drug use (abuse) disorders according to the used drug or to the phase of intoxication, detoxification, state of remission or duration of chronicity. A trial should be made, in addition, to categorize group of addicts in terms of meaning of addiction, goal of abuse, personality background and co-morbidity. All such factors are liable to influence both management and prognosis.

The above mentioned revision should not be taken simply as a theoretical point of view. In the countries of origin of such sophisticated criteria-oriented disciplines (such as in the USA), it is easy to delineate the use of such discipline to serve statistical goals, cost-benefit economy, insurance business and structured legal requirements. They are the least used as preliminary tools in training.

In our countries, junior trainees start to know what is schizophrenia from the scattered alternative criteria rather than from the actual presentation of the clinical picture of loosing the integrating "ONENESS" (i.e. disorganizing process) and the alarming signs of deterioration. The reflux of such mal-training influences management, prognosis and making up good psychiatrists.

In a recent lecture in Ein Sams Center for Psychological Medicine on the Future of Psychiatry (Rakhawy, 1998). The author has suggested that the Egyptian Psychiatric Association would start to make some sort of culturally oriented axis or dimension to be added independently on certain categories of the ICD-10 whenever necessary. This would make us stop hoping to renew the DMP-I into the DMP-II. At the same time, it would give us a chance to show special cultural difference.

Training, especially in unstructured cultures like ours, should put more and more emphasis on clinical picture, management and prognosis, rather than on nosological labelling and criteria gathering.

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