

## S38. Should nosological classification continue to ignore biologic reality and psychopharmacological treatment?

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### S38-1

#### VALIDITY OF NOSOLOGICAL CLASSIFICATION

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The term "nosological classification" has been used relatively often in the connection with medical classificatory systems. It could be confusing in relation to the term "nosological diagnosis" and its validity. If the medical classification has to be realistic and easy to handle with great reliability, nosological systems can be based not only on established facts, but also on theoretical assumptions regarding the nature of disease.

The appearance in 1980 of DSM-III and later ICD-10 introduced a new epoch in psychiatric classification. Paying less attention to etiologic factors, both systems focused on symptoms and course and created easily recognisable diagnostic criteria for mental disorders. Whereas there was general agreement concerning the high reliability, there was much less confidence in the validity of the diagnosis obtained.

From the scientific point of view we could consider the two nowadays most actual psychiatric classificatory systems DSM-IV and ICD-10 as the theoretical background for the contemporary psychiatric nosology. According to Karl Popper, if any theory had been postulated we should try to demonstrate first of all the theory was false. If it did not survive an attempt at falsification, then it should be replaced by another.

The author tries to demonstrate the validity of the operational DSM-IV and ICD-10-RDC diagnoses of Schizophrenia is low. During the stay in the Mental Health Clinical Research Centre of the University of Iowa Hospitals and Clinics he could take part in the study which demonstrated relatively low level of the validity of the DSM-IV and ICD-10-RDC criterial diagnoses of Schizophrenia.

### S38-2

#### GENETIC RESEARCH IN RELATION TO ICD-10 AND DSM III/IV CLASSIFICATION

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All common psychiatric syndromes are under genetic control with of the genetic basis widely unknown. Various strategies are available for unraveling the genetic basis of these disorders. All these strategies strongly rely on a reliable and valid classifications of the phenotype.

Most promising in this respect are criteria based diagnoses with maximal intrafamilial diagnostic homogeneity and maximal interfamilial diagnostic dissection. Both, DSM-IV and ICD-10 systems propose diagnostic entities which try to fit these requirements. Empirical tests of the validity of the proposed diagnostic boundaries of these disorders and their subtypes are provided by family studies.

We present controlled family studies in schizophrenia, affective and anxiety disorders exploring the boundaries of the transmitted phenotypes.

Empirical evidence emerging from the studies suggests for both criteria (intrafamilial homogeneity, intrafamilial dissection) is not convincing neither for schizophrenia nor for affective disorders or anxiety disorders.

### S38-3

#### MODERN NOSOLOGY: HOW DO BIOLOGICAL FINDINGS AND THERAPY FIT?

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The introduction of the standardized diagnostic classification systems DSM III/IV and ICD10 organized by the WHO offered great advantages for research and treatment of psychiatric patients. For the first time a common language in psychiatry, which was comparable world-wide, made it possible to identify psychiatric patients with the same psychiatric disorders. Although both classification systems claim not to identify disease entities they are a sine qua non condition for research, treatment and publications. The major aim was reliability. However, to exclude etiologic aspects was most probably premature and too naive and the major problem, the development of valid diagnoses like in somatic medicine, is unsolved. The recent progress in biological psychiatry is limited by a lack of specificity for diagnostic categories. Genetic studies show that the limit of the transmitted phenotypes in families is not congruent with the limits of diagnostic categories in DSM III/IV and ICD10. Not convincing attempts for solving these problems are the introduction of spectrum disorders and comorbidity. Similarly, the evaluation of biological markers like the neuroendocrine challenge tests, sleep parameters and neurophysiological results show a low specificity as well. Psychopharmacological treatment of patients in ordinary clinical practice is mostly not guided by the diagnostic categories, but oriented to target symptoms which occur in different nosological categories. Treatment response and non-response are hints for different causes of the disorders and can lead to additional criteria. In order to overcome these discrepancies, psychopathology must consider these biological findings for identifying better and more valid diagnostic categories in the future.

### S38-4

#### CLASSIFICATORY OBSTACLES IN BIOLOGICAL PSYCHIATRY AND PSYCHOPHARMACOLOGY

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Nosological classification in psychiatry, in the way it is presently applied, does not facilitate biological and psychopharmacological research. Some of the reasons why will be discussed.

1. Syndromal acuity has disappeared. Consequently it is impossible to determine: a) whether a particular drug affects a particular symptom configuration, b) what exactly the behavioral correlate is of a particular disturbance.
2. The border between distress and disorder is ill-defined.
3. Symptom configuration and certain non-symptomatological variables such as duration and severity are prematurely linked, as to conceptualize categorical entities. The validity of those constructs has not been sufficiently demonstrated. This undermines the validity of biological studies and leads to "nosologomania", i.e. an ever growing series of undervalidated psychiatric "disorders".
4. The nosological disease model is unconditionally and uncritically accepted. Alternative models are ignored; particularly the