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Lecture

The French Approach to Psychiatric Classification

P. J. PICHOT

The Alienists: clinical syndromes

It is common knowledge that the French school of psychiatry began with Pinel (1745–1826) at the end of the 18th century. Pinel is credited with having delivered the insane from their chains in the two hospitals of Paris where they were detained, Bicêtre and la Salpêtrière: his near contemporaries in the humanization of the treatment of the insane were Tuke in England, Chiarugi in Tuscany and Daquin in Savoy. Pinel's essential achievement was the creation of the 19th-century French tradition in psychiatry, encompassing the medical, clinical, descriptive and nosological fields. Pinel's breadth of outlook was shared by his pupil Esquirol (1772–1840), who dominated the so-called 'classical' school of the 'Alienists of the Salpêtrière' via his numerous disciples and his treatise, published in 1838, *Des Maladies Mentales Considérées sous le Rapports Médical, Hygiénique et Médicol-légal.*

Both Pinel and Esquirol were mistrustful of philosophy, particularly of metaphysics. Pinel, although a friend of the philosophers of the school of the 'Idéologues', rejected their teaching: 'One must be on one's guard', he wrote, 'against mixing metaphysical discussions, or certain disquisitions of the ideologists, with a science which consists of carefully observed facts.' Although Pinel and Esquirol were followers of Locke and Condillac in psychology, they did not let their psychological theories influence their empirical observations. Indeed, the American historian of psychiatry Zilboorg has said that the ideal of their school was a 'psychiatry without psychology'. Moreover, their mistrust of 'speculations' also made these psychiatrists cautious of organic interpretation of aetiology, in whch they were probably rather biased (Pinel was a friend of the ideologue Cabanis) and they had little use for Gall's phrenology.

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The approach of the classical French school was admirably delineated by Esquirol in the preface to *Des Maladies Mentales:* 'The work I offer to the public is the result of forty years of study and observation. I have observed the symptoms of madness; I have studied the ways, the habits and needs of lunatics, among whom I have spent my life . . . In adhering to facts, I have brought together those of a similar character. I narrate them as I saw them. I have rarely sought to explain them, and I have never tarried before systems which have always seemed to me to attract by their brilliance rather than their usefulness in their application'.

Esquinol's description of his clinical approach ended with a nosology which was based predominantly on the symptoms displayed by the patient at one particular time, rather than during the course of the disease. Taking Pinel's description of four types of insanity—*mania, melancholy, dementia* and *idiotism*—Esquirol completed the system by defining *lypemania* and creating the category of *monomanias*. This descriptive, syndromic approach to classification is the first root of the French tradition.

Bayle: organic causes and the course of disease

On the 21st of September 1822, Antoine Laurent Jessé Bayle, 'Bachelor of Arts, sometime second-class resident of the civilian hospitals and homes of Paris, resident of the Royal Hospital of Charenton', aged only 23, presented and defended an inaugural thesis entitled *Recherches sur les Maladies Mentales* before the Medical School of Paris. In the first part of his thesis he undertook 'to prove that insanity is sometimes the symptom of chronic inflammation of the arachnoid'. After reporting on six cases which involved autopsy of the patients, including two in which there is reference to a previous history of syphilis, Bayle concludes: 'The symptoms of chronic arachnitis can all be reduced to a general and incomplete paralysis and to the derangement of the intellectual faculties . . .

These two orders of phenomena proceed at an equal and proportional pace and allow the disease to be divided into three periods'. In 1826 Bayle published the *Traité des Maladies du Cerveau et des Membranes* which contained a collection of detailed case histories, sixty of them his own.

The importance of Bayle's thesis resides in two facts. *Firstly,* at the very moment when the so-called 'anatomo-clinical method' was taking shape in medicine, he crystallized out from 'essential insanity' a disease entity, *general paralysis,* which was in accord with the medical model. It had a specific cause, 'chronic arachnitis', which was clearly defined in terms of pathological anatomy. It also had a specific symptomatology which combined motor and mental signs. *Secondly,* Bayle stressed that the disease had a specific pattern of development comprising three phases, each marked by different symptoms: first, exaltation *(délire monomaniaque);* second, ideas of dominance *(délire maniaque);* and third, *l'état de démence.*

The two principles put forward by Bayle were of basic importance for the future of psychiatry. The first, the medical model, has remained an ideal for many psychiatrists right up to the present time, although attempts to isolate 'diseases' by correlating specific patterns of symptoms with biological abnormalities have taken many different forms. The search for anatomical changes in the brains of patients continues even today—it suffices here to quote the work of Oskar Vogt. At the end of the last century, progress in neurophysiology suggested that the biological correlates of clinical symptoms might be found in abnormalities in the functioning of the pathways of the central nervous system: the psychiatric nosologies of Meynert and Wernicke, and Pavlov's psychiatry, are typical results of such an approach. Given recent advances in molecular biology, abnormalities of the neurotransmitters or of specific pre- or post-synaptic receptors are now more fashionable lines of thought, but they rely on the same basic model.

The second, profoundly influential, principle put forward by Bayle was that each disease had a characteristic course. This upset the traditional classification of Pinel, in which *monomania, mania* and *dementia* were held to be so many specific diseases: Bayle combined them to form a single disease in which they merely characterized phases of development.

In the second quarter of the 19th century, French psychiatry, although respecting the legacy of Pinel and Esquirol in the importance given to clinical description, moved progressively towards an adoption of Bayle's medical model. However, despite the progress made in pathological anatomy, no typical lesions were found in the brains of most mental patients.

The only way forward appeared to lie with the adoption of Bayle's second principle, that a particular course was typical of a specific disease. This led to the description, not solely from the syndromal aspect but also with reference to its pattern of development, of what we would now call manic-depressive psychosis. Jules Baillarger, writing in 1843, described the disease under the title of *folie à double forme;* Jean Pierre Falret, in 1854, used the term *folie circulaire.*

Morel: the theory of degeneration

The third source of the French tradition is to be found in the theory of degeneration developed by Benedict Auguste Morel (1809–1873). This psychiatrist combined a vast knowledge of biology with a taste for philosophy (he translated the works of the German mentalists like Heinroth), a deep religious faith, and a good training in clinical psychiatry which he had received at the Salpêtrière. In 1857 he published his *Traité des Dégénérescences Physiques, Intellectuelles et Morales de l'Espèce Humaine,* which was to have a major influence for more than half a century.

Morel's starting point was that man was created perfect by God, and that original sin made him the prey of the forceps of his environment. (This theological premise was later abandoned, but this did not affect the structure of the theory). He observed that all living beings are variations from an ideal type. Some of the variations are normal, such as the diversity of human races; others are pathological, the result of the aggressive influence of the environment, and can be described as 'degeneration'. Morel pointed out that local climate and customs, the nature of the soil, housing conditions, work and diet, produce pathological variations which are particularly common in specific human groups. He quoted Magnus Huss and his studies on the part played by alcohol in the degeneration of the Swedish people; the influence of opium in China; the effect of consanguinity among the Portuguese colonists of Macao. He also referred to his personal studies of cretinism in Switzerland and France. The degenerations thus produced, he said, are hereditary. (One must recall that at that time the heredity of acquired characters, postulated by Lamarck and extended into a psychiatric concept by Prosper Lucas, was an accepted dogma). Morel deduced that degenerative hereditary strains would become progressively worse in lineal descent, since the continued existence of the causes could not fail to aggravate the severity of the effect in successive generations, causing a decline marked finally by sterility and ultimate extinction. The pathological variations produced by the environment, transmitted by heredity and growing worse from one generation to the next, were supposed to be manifest as physical

abnormalities and also as mental abnormalities which reflected the particular susceptibility of the nervous system to the noxious degenerative influences. According to Morel, mental disorders were in very many cases, nothing but a pre-eminent expression of degeneration.

This theory provided him with the biological principle that enabled him to establish a general psychiatric system; namely that specific clinical manifestations correspondent to the level of degeneration affecting the individual presenting them. Since degeneration was progressive and inherited, the expression of the degenerative changes altered in the descendants: for instance, an individual with a simple 'nervous temperament' might, after several generations, produce a child affected with cretinism. This process came to be known as the *heredity of transformation*.

Following this theory, Morel divided all mental disorders into two classes: those which were the result of degeneration, and those which were not.

Morel's description of démence précoce

Morel was an outstanding clinician and in 1860, in his *Traité des Maladies Mentales* he described a new disorder. He proposed to name it *démence précoce* as it affected young people, presenting a 'sudden immobilization of all the faculties . . . idiotism and dementia being the sad fate that will terminate the course'. He considered *démence précoce* to be one of the degenerative processes. His definition of the disease was to have a lasting effect on French psychiatric classification.

Developments in Germany: Kahlbaum and Kraepelin

In Germany, the turning point in modern psychiatric classification was marked by the description of *catatonia* by Kahlbaum in 1874. Kahlbaum (1828–1899) was convinced that 'only an intensive and general use of the clinical method can bring psychiatry forward and increase our understanding of the pathological processes'. One must remember that such a position was radically new in his country, where the dominance of Griesinger meant that the leading psychiatrists of the day, such as Meynert and Wernicke, were trying to build their classification of diseases on anatomy and neurophysiology. Kahlbaum claimed to be returning to the tradition of the French psychiatrists 'who discovered the first form of mental disease *(general paralysis)* and who are now virtually alone in making fresh attempts to achieve new advances in the clinical approach'. By way of illustration, he quoted the description of *folie circulaire* by Jean Pierre Fabret. Kahlbaum also drew a parallel between *catatonia* and Bayle's *general paralysis*, writing: 'Clinically it may be said that this disease *(catatonia)* has certain characteristics which may be regarded as producing a picture similar to that of *general paralysis*. In its clinical course, marked by the passage through various phases of different mental states, the one is similar to the other'.

By 1880 the clinical approach, with special emphasis on evolution, was becoming the basic principle on which both the French and the German schools were beginning to build psychiatric classifications. In Germany Kraepelin was taking over the method of Kahlbaum, while in France Magnan was developing the work of his predecessors. Their starting points were identical, so why did the Kraepelinian system finally become accepted all over the world, and, with minor modifications, remain in force until today, while Magnan's nosology developed along different paths which led to the peculiarities of the French diagnostic system? The answer to this question is, in my opinion, crucial for an understanding of the present French approach to classification.

Kraepelin's position in the early editions of his textbook was not original: Sir Aubrey Lewis has rightly pointed out that the fourth edition was in no way superior to Maudsley's textbook, which Zilboorg has in turn called 'unenlightened'. However, in the fifth edition of 1896, Kraepelin announced that he was abandoning completely the syndromic approach, and intended henceforth to describe diseases *(Krankheitsbilder)* on the basis of their clinical evolution, including the terminal state. In so doing, he was following the principles laid down by Kahlbaum. The main consequence of Kraepelin's decision was his description of the two great functional psychoses, *dementia praecox* and *manic-depressive psychosis*.

Magnan's nosological system

The reason why Magnan's efforts to describe and classify mental diseases on the basis of their specific course led in another direction altogether from Kraepelin's work is to be found in his adherence to one particular aspect of the French tradition, namely Morel's doctrine of degeneration. Whereas Kraepelin, although alluding to the degenerative process as a *possible* cause of *some* of the psychiatric diseases he described, never really gave it any importance as a principle of classification, Magnan made it the axis of his system. His starting point, though, was the description of a specific disease, with a chronic and systematic course, which he did *not* regard as being due to degeneration. He called it *délire de persécution à évolution systématique,* and described it in the following way: 'A chronic delusion state which usually occurs in an adult who has never previously shown signs of disordered mind, manner or mood. The main characteristics of the disorder are a protracted course (up to fifty years or more) and a relentlessly invariable progression through four easily recognizable consecu-

tive phases with distinctly contrasting affective tone in the second and third phase.' The first phase was prodromal, the second was characterized by delusions of persecution, the third by delusions of grandeur, and the fourth by dementia. This disease, the organic disorders, and the affective states, which corresponded roughly to Kraepelin's *manic-depressive psychosis,* were supposedly not related to degeneration. All other diseases, according to Magnan, were expressions of the degenerative processes. In this large 'degenerative' category he included:

(a) The *démence précoce* of Morel.

(b) The *acute delusional states,* termed *bouffés délirantes des dégénérés.*

(c) The *chronic delusional states* without a systematic course.

One can recognize here features specific to the French system of classification. Like Kraepelin's system, Magnan's was based on the symptomatology and evolution of a disease, but by trying to retain as a separate entity Morel's *démence précoce,* by stressing the importance of obviously exceptional cases of chronic states with systematic evolution, and by using the theory of degeneration as a basis for the whole system, Magnan committed French psychiatry to a distinct path. It must be added that around 1900 the political antagonism between France and Germany probably played a role. French psychiatrists clung tenaciously to their own traditions and supported the *démence précoce* of Morel against the *dementia praecox* of Kraepelin.

The French reaction to Kraepelin

Around 1910 the doctrine of degeneration lost its prestige, and the basic distinction between Magnan's chronic systematic delusional state *(délire de persécution à évolution systématique)* and the chronic non-systematic delusional states of the degenerates lost its theoretical basis. At the same time the French also accepted, reluctantly, Kraepelin's terminology, although still retained the concept of *démence précoce.* One of the main features of Kraepelin's system was the tendency to build very large nosological categories, eventually encompassing cases with very different symptomatologies but with a common final state: the creation of the two broad categories of *dementia praecox* and *manic-depressive psychosis* were the most typical results. The French baulked at the breadth of the German concept of *dementia praecox,* and although they were compelled to adopt the category in part, they restricted its boundaries, separating out not only the acute delusional states *(bouffées délirantes)* but also the chronic delusional states, the *délires chroniques* incorporated by Kraepelin in the paranoid form of *dementia praecox.* This left French nosology recognising the following categories of mental disease:

(a) The *acute delusional states (bouffées délirantes).*

(b) Morel's *démence précoce,* later assimilated into Kraepelin's *hebephrenie.* The catatonic form of hebephrenie was also included in this category (the term *hebephreno-catatonic* is still usual in France).

(c) A small proportion of Kraepelin's cases showing the paranoid form of *dementia praecox.*

(d) The *chronic delusional states,* irrespective of the systematic or non-systematic character of their course.

To protect the chronic delusional states from incorporation into *dementia praecox,* the French minimized the importance of Kraepelin's basic diagnostic determinant, the terminal state, and stressed that whereas true *dementia praecox* exhibited intellectual deterioration, the chronic delusional states could coexist for years, sometimes indefinitely, with relatively intact intellectual functioning. The theory of degeneration having been abandoned, they reverted to the clinical approach of Esquirol, and distinguished between chronic delusional states on the basis of what they claimed to be the pathological mechanisms which generated the delusional ideas. Between 1911 and 1913 they divided the chronic delusional states into three main categories:

(a) The chronic interpretative delusional state *(délire chronique d'interprétation).*

(b) The chronic hallucinatory delusional state *(psychose hallucinatoire chronique).*

(c) The chronic imaginative delusional state *(délire chronique d'imagination).*

In a previous paper (Pichot, 1982) I have given details of the definitions of the different types, of the criteria proposed: to distinguish between them, and about further French efforts to subdivide some of the categories. However, what is important here is that a large number of patients, considered by Kraepelin and therefore by most subsequent schools of psychiatry to be suffering from the paranoid form of *dementia praecox,* were diagnosed by the French as having another mental disease, namely a chronic delusional state.

Bleuler's concept of schizophrenia

When the Swiss, Bleuler (1857–1939), coined the the term *'schizophrenia'* to replace *'dementia praecox,'* he also substituted for Kraepelin's diagnostic criterion of terminal state criteria which he called *permanent* or *basic* symptoms *(Dauersymptome* or *Grundsymptome).* (I shall not discuss here an error made even in very well documented studies, confusing Bleuler's *permanent* or *basic* symptoms with his *primary symptoms*). The basic symptoms were always present (hence the alternative name of *Dauersymptome)* and

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allowed a symptomatic diagnosis. They were, essentially:

(a) Abnormalities of the associative processes *(Spaltung)*.

(b) Abnormalities of affectivity.

(c) Ambivalence.

To these Bleuler added symptoms resulting from a combination of the three basic elements, the main one being autism.

In considering Bleuler's conceptualization of *schizophrenia,* two points must be stressed. In the first place, all the basic symptoms are negative, in the sense that they refer to a deficit in intellectual, affective or volitional functioning. Secondly, they are not really clear-cut: they may be obvious, or they may be of such a light degree that they are hardly recognizable as pathological. Bleuler himself noted that in some forms of schizophrenia, e.g. the simple form, the symptoms could only be detected by a highly experienced psychiatrist.

Criteria for diagnosing schizophrenia

Two consequences of Bleuler's concept of schizophrenia interest us. The first is that the French school adopted the principle of using basic symptoms, especially dissociation of personality, as the criterion for distinguishing schizophrenia proper from the chronic delusional states. Of course for French psychiatrists the dissociation in schizophrenia had to be obvious and unequivocally pathological, since it replaced the former kraepelinian criterion of final deterioration.

Bleuler's work also had consequences in Germany, where Kurt Schneider, convinced of the lack of reliability of the basic symptoms described by Bleuler, proposed a method for the diagnosis of schizophrenia using 'first-rank symptoms', each one having a pathognomonic value. Schneider's first-rank symptoms were taken from the elements considered by Bleuler as 'accessory', i.e. not always present in the course of the diseases. These included hallucinations, delusions, and symptoms, such as thought withdrawal, subsumed in France under the name of *automatisme mental.*

French classification today

To describe clearly the present French view of the boundaries between schizophrenia, chronic hallucinatory psychosis and *bouffees délirantes,* I shall refer to the results of a recent study I conducted with my coworkers (Erpelding-Pull, 1983). We considered only the hallucinatory form of the chronic delusional states, since it raises the most typical problems.

We first established a list of all the criteria proposed for the diagnosis of schizophrenia, including the evolutive criteria of Kraepelin, the *Dauersymptome* of Bleuler, the first-rank symptoms of Kurt Schneider, the 'typical symptoms' of Langfeldt, the criteria of St Louis, the Schizophrenic Index of New Haven, the criteria of Taylor, the criteria of DSM III and the discriminant symptoms of the Pilot Study of Schizophrenia of the WHO. The list, which we named LICET–S, and which finally included 70 items, was given to one hundred French psychiatrists, a sample that can be considered as fairly representative. Each one was requested to select, from among the patients he knew well, one case that he had diagnosed as *schizophrenic,* one that he had diagnosed as *bouffée délirante,* and one that he had diagnosed as *chronic hallucinatory psychosis,* according to his usual practice. He was then asked to check on the presence or absence of every one of the 70 items for each patient, and if he wished, to add items not included in the list which he had used as diagnostic criteria. He was finally asked, for each category, to rank the items in order of diagnostic value, greatest first. Without going into details, I shall now present the main results.

For French psychiatrists, *schizophrenia* is a disease whose first symptoms appear before the age of 30. Its beginning can be either acute or progressive. It is considered chronic: only in 6 per cent of all cases recorded was the patient considered cured after an episode. The diagnosis is based primarily on the symptomatology, the symptoms given most weight being those proposed by Bleuler, i.e. alterations of logical thinking and inadequacy of affectivity. Delusional ideas are usually present, but they are never organized in a cohrent system. The main symptoms are generally subsumed by French psychiatrists under the terms 'dissociation' and 'discordance'. Schneider's first-rank symptoms are considered of secondary importance.

Chronic hallucinatory psychosis, as now defined in France, is a disease beginning between the ages of 30 and 55 either progressively or acutely. Its course is chronic: complete remission is mentioned in only 3 per cent of cases. The diagnosis is based primarily on the symptomatology, with an emphasis on Schneider's first-rank symptoms. A delusional system is always present, and is characterized by its systematization. Intellectual functioning and affectivity are generally well preserved: Bleuler's basic symptoms are absent or not obvious.

Bouffée délirante is a disorder appearing between the ages of 20 and 40. Its beginning is always acute, the patient having no previous psychiatric history, although *bouffées délirantes* do themselves recur. The symptoms disappear completely in a few weeks (in 95 per cent of the cases in less than 6 months), leaving absolutely no residual anomalies. The symptoms are characterized by their polymorphism: delusions with

multiple themes, without any coherence, with or without hallucinations of any type; depersonalization and/or derealization, with or without confusion; depression or euphoria. All symptoms vary from day to day and even from hour to hour.

It is striking to note that the above descriptions, given by present-day French psychiatrists, show how stable their system of classification is. The concept of *bouffée délirante* has not changed in one hundred years, the only difference from the disorder described by Magnan being that the theory of degeneration is no longer used. The modern description of *chronic hallucinatory psychosis* is identical with Gilbert Ballet's initial description in 1913.

The adherence by the French school to its original principles of classification makes it difficult to translate French diagnoses into other systems. Dr Johnson Sabine (personal communication) and co-workers from London have examined 22 detailed clinical histories of patients diagnosed according to traditional French criteria, in the Department of Psychiatry of Professor Deniker in Paris, as *bouffée délirante*. The cases were rediagnosed according to ICD 9. Ten were rediagnosed as *schizophrenic psychosis,* (one paranoid, three acute, five schizo-affective, one unspecified), eight as *affective psychosis,* (one manic, one depressed, six circular), and the others as *alcoholic jealousy, psychogenic paranoid psychosis* (two), and obsessive-compulsive disorder. The same situation recurs with cases of *chronic hallucinatory psychosis,* and even with French-diagnosed *schizophrenia.*

In the previously mentioned paper (Pichot, 1982), I have tried to give some indication of the relations between the French system, ICD 9, and the new American classification, DSM III. Although translation is possible in some cases (e.g. the new American category *schizophreniform disorder* is very similar to the French *bouffée délirante*), the problems are considerable. For example, some of the *chronic hallucinatory psychoses* beginning before the age of 45 would be included by the DSM III in the *schizophrenic disorders* (since beginning before 45 is one of the criteria for schizophrenia in DSM III), the remaining ones being relegated to the residual category *atypical psychoses.*

Conclusion

In this presentation I have only discussed the specificities of the French system of classification corresponding to schizophrenia and to the acute and chronic delusional states, because these are the only areas where there are obvious differences between the French and other national or international systems. I am certainly not claiming that the principles used in our country have special merits, but I hope I have shown that the present position is the result of a logical historical development. At the present time, there are widely differing views on psychiatric classification in different parts of the world, and great efforts are being made to clarify and improve psychiatric nosology. The development of diagnostic criteria, the claims of empirical validity for various categories, the rediscovery of Schneider's first-rank symptoms by our American colleagues for DSM III, are but a few manifestations of the new interest in the subject. I would point out that French diagnostic categories could, without any difficulty, be subjected to the validation procedures proposed in recent investigations.

By presenting a short survey of the peculiarities of French diagnosis, my purpose has been not only to acquaint you with our exotic behaviour, but to contribute to a better understanding of our mode of thought and to promote international cooperation in a field of fundamental importance to the future of psychiatry.

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P. Pichot, M.D., *Professor, Centre Hospitalier Sainte-Anne, 100 rue de la Santé, 75674 Paris Cedex 14, France*