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British Phenomenological and Psychopathological Concepts: A Comparative Review

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For a foreign observer who has been trained in German and French psychopathology, British psychiatry is very attractive at first glance for a number of reasons. Its eclectic and principally non-theoretical approach (Cooper, 1975), characterized by an open acceptance of foreign concepts and by the tendency to question traditional structures and hypotheses and to test them by means of statistical methods, appears most impressive. The substantial contribution British authors have made toward the development of structured tools in psychopathology, like for instance the Present State Examination or the Hamilton Rating Scale in order to facilitate such a statistical evaluation, which reflects clearly the inheritance of Sir Francis Galton, is also a cause of sincere admiration. The European observer realizes furthermore that the British approach is rooted mainly in continental, especially in German, clinical psychiatry, and is not as heavily influenced by psychodynamic theories as, for instance, the American schools were, at least until recently. This provides him with a comfortable feeling of familiarity and he is not inclined to question certain British tenets until his involvement progresses and he becomes aware of the comparative lack of attention paid by British schools to some of the fundamentals of continental psychopathology.

The non-British psychiatrist, confronted with Max Hamilton's introduction to Fish's *Clinical Psychopathology*, (the first edition of which appeared in 1967), which bluntly states that: "Anyone who is acquainted with Anglo-American literature will know that the careful description of psychiatric signs and symptoms in English is conspicuous by its absence", might be inclined to consider Hamilton's assertion an exaggeration due to circumstances of the past, as he knows that the English translation of Schneider's *Clinical Psychopathology* dates back to 1959, that of Jaspers' *General Psychopathology*—admittedly a heavy reading—has been available since 1963, and that Kräupl-Taylor's *Psychopathology* had its first edition in 1966.

Although the assumption seems justified that these books have been widely disseminated, thus providing British psychiatry at large with psychopathological theories and perceptions, the *Reading List in Psychiatry* released by the Royal College of Psychiatrists (R. E. Kendell and A. C. Smith) and published 1977 astonishingly enough, failed to mention these translations except for one single chapter—dealing with the synthesis of disease entities—of Jaspers' *General Psychopathology*, under the heading of 'Diagnosis and Classification'. The *Reading List*, of course, in part comprises articles which deal with psychopathological problems, but a systematic formation in phenomenology and psychopathology does not seem to be intended. [But see footnotes at end].

Since 1977, a further number of publications dealing with psychopathology have been released: Fish's *Clinical Psychopathology* had its third re-print, Kräupl-Taylor's *Psychopathology* its second edition in 1979, and Scharfetter's *General Psychopathology* appeared in an English translation in 1980. We are not in a position to judge whether these publications have attracted the attention they merit.

One reason for the lack of interest asserted by Hamilton in psychopathology might possibly be ascribed to British psychiatry's essentially practical approach which seems to aim mainly at a clear and easy to use definition of psychic abnormalities or to rely too heavily on symptoms which are easy to define. The obvious reluctance to use the term phenomenology—originally a philosophical notion and liable to assume a different meaning from one author to another—becomes understandable if this practical approach is kept in mind. The term actually has its origin in Kant's assertion that we experience only the surface, the appearance (phenomenon) of things rather than the thing itself.

According to Husserl, phenomenology describes the form and the content of subjective psychological experiences, while psychology explains these experiences and their causal relationship. For Jaspers, who differentiated between a static and a genetic comprehension, phenomenology is a cross-sectional realization of the subjective psychic state of another person. It is the clearest, most concrete representation possible of the isolated facts really experienced by an individual, without questioning connections (the latter being investigated by genetic comprehension).

Static, as well as genetic comprehension is obtained by empathy, and aims to delimit, to differentiate and to denominate the various psychological conditions. Phenomenology is thus the basis of so-called subjective psychopathology, which might be put against an objective one which investigates observable, objective behaviour. Comprehension in Jaspers' sense is opposed to interpretation, which attempts establishment of causal relations. Thus, interpretative psychology formulates "ideas which have been obtained by empathizing . . ." ". . . in terms of some general theory" (Hamilton, 1967).

What is called 'phenomenology' by Binswanger is indeed an interpretative psychology, namely an existentialist one, and has nothing in common with Jaspers' definition of phenomenology. Since this term is used in such different interpretations, the wish to eliminate it, as Hamilton does, becomes understandable. He feels that it is sufficient for practising psychiatrists to have access to a basic discipline called 'clinical psychopathology', the aim of which is ". . . to describe, in an objective way, the signs and symptoms which occur in neuropsychiatric disorders".

In the following we shall restrict our consideration to this definition, keeping in mind that the signs and symptoms we describe are, in Kant's sense, not things but phenomena. Our enterprise could, therefore, also be called 'reflections on descriptive phenomenology'.

It would not serve our purpose, to review the British description of symptoms by indicating solely which of them correspond to those of other psychiatric schools and which of them differ. In order to demonstrate the advantages and the disadvantages of British psychopathology, a broader approach, encompassing likewise problems of classification of psychiatric disorders and references to underlying psychopathological concepts, seems to be of more interest. In the following, we shall therefore not restrict ourselves to the static comprehension and description of isolated facts in the sense of Jaspers, but we shall also include the genetic comprehension which takes into consideration the connections existing between single symptoms and which subsequently leads to classification.

Finally, it seems necessary to expose some new concepts, not yet generally known in the United Kingdom, deriving from psychopathological observations by the process of interpretation. Since it is impossible to encompass the whole subject in this review, some examples will be selected.

The first example concerning symptom description will deal with the definition of phobias versus delusions. Secondly, classification problems will be discussed with special regard to the nosological versus syndromic approach. Finally, some reflections will be made on British concepts of affective psychoses in comparison with other psychopathological concepts.

Before we begin we must stress that what follows should not be understood as a comparison between British and German psychiatry. Nowadays, the latter has become so divergent that it is impossible to speak of a "German school of psychiatry". We shall therefore illustrate mainly the viewpoint of Viennese psychiatry and whenever necessary quote other psychopathological schools.

Problems of symptom description

In spite of the assertion contained in Hamilton's introduction to Fish's *Psychopathology*, it is undeniable that British psychiatry has recently supplied excellent contributions toward a clear and simple description of morbid symptoms. As in other countries this task has progressively been taken over by the authors of rating scales and diagnostic systems, since they perceived that a well defined descriptive psychopathology is the basic requirement for a reliable utilization of their scales and classification systems. Practical application being the main interest of these authors, they proceded, when compiling the glossaries of their instruments, in a more factual manner than professional psychopathologists would have employed. An undoubted advantage in some respects, in others this method caused a certain neglect of exact conceptualization.

Some examples, and especially the Present State Examination (Wing, Cooper and Sartorius, 1973) will demonstrate the basis of this assertion. Our critical remarks in reference to the PSE should not be misunderstood as globally negative appreciation. Quite the contrary, we consider the PSE a very valid tool for research purposes. Complemented by 71 additional items, the introduction of which became necessary in view of our psychopathological concepts, we use it in our own research.

(1) To begin with, the extension of the use of the term 'agoraphobic' to patients who experience autonomic anxiety when staying in *closed* rooms and who subsequently avoid such situations, must be critically reviewed. Persons acquainted with the Greek language, are somewhat shocked by such an incorrect use of the word 'agora'. The authors of DSM III provide us with the following definition of agoraphobia: "The individual has a marked fear of and thus avoids being alone or in public places from which escape might be difficult or help not available in case of sudden incapacitation, e.g. crowds, tunnels, bridges, public transportation". The British are here more attentive. Marks (1970) uses the term in the same sense but he admits that: ". . . the term of agoraphobia is not altogether a happy one to describe this syndrome

since these patients have fear not only of going to or remaining in public places but also of shopping, crowds, travelling and closed spaces". The PSE finally, logically uses the appropriate generic term of 'situational anxiety', comprising among others agora- and claustrophobic anxieties. The fact that "autonomic anxiety on meeting people" is rated as a separate group in item 16 although this phenomenon belongs under the heading of situational anxieties can certainly be justified from a practical viewpoint. Even in rating scales however, a systematically minded psychopathologist would very much appreciate increased categorical thinking.

(2) These reflections may of course be considered a superfluous subtlety. Such an objection cannot easily be sustained when we observe more carefully the psychopathology of phobias in their relation to delusions. Apart from the situational phobias we have just dealt with, and the well known object phobias (in British psychiatry sometimes termed 'specific phobias' among which animal phobias are prominent), there exist other types of phobias which we would call 'fact phobias' (*Sachverhaltsphobien*) and which Fish describes as "fears restricted to an idea". Since very frequently the 'facts' the patient is afraid of consist of the fear of being struck by an illness, these states are often called 'illness phobias' (Marks, 1970).

In the PSE, they do not appear among the phobias but are rated as a special item (9) called 'hypochondriasis', whereas Kräupl-Taylor (1966) has named them 'hypochondriacal phobias'. He stresses that in regard to their content these phobias are sometimes indistinguishable from hypochondriacal delusions, but represent of course neither absolute nor incorrigible convictions. The PSE requires that hypochondriacal ideas should be rated as hypochondriacal delusions if they are characterized by delusional elaborations or interpretations. In British psychiatry, but also in some other schools, this method of dealing with hypochondriacal ideas differs thus noticeably from the way other concepts are dealt with. From the phenomenological viewpoint, the fear of being persecuted or betrayed, for instance, cannot be considered as basically different from nosophobia. These conditions should therefore be ranged among 'fact phobias' and not be attributed to delusion, if the required criterion, namely absolute incorrigible conviction, is absent. In practice however and as a consequence of logical inconsistency, fears, such as persecution phobia for instance, are generally ranged among delusions. The utilization of different measures for identical contents frequently causes aggravation, since in psychiatric thinking delusions, even partial ones, rapidly point to psychotic disorders, especially schizophrenia, whereas phobias are primarily considered of psychogenic origin. This biased evaluation of 'fact-phobias' could be one of the reasons why the psychogenic or reactive paranoid psychoses, described by Scandinavian authors, are only rarely diagnosed in British psychiatric schools.

These considerations should not convey the impression that we neglect the well substantiated assumption that some psychotic conditions promote the appearance of ideas of persecution in a specific way, but we wish to underline that the inclination to develop such fears may also originate from personal experiences and could thus be independent of psychotic processes. According to Jasper's requirement that static comprehension should be purely descriptive and refrain from interpretation, we plead for an unbiased and equal psychopathological handling of phobic states, including persecution phobias.

Psychopathological considerations on nosology and use of syndromes

In spite of the fact that Bleuler is widely read in Great Britain, Cooper (1975) correctly pointed out that British psychiatry has been influenced mainly by Kraepelin, who shaped its nosological classification, and by K. Schneider whose concepts formed its cross-sectional symptomatology, at least as far as schizophrenia is concerned. It seems that Fish's (1976) detailed presentation of the Kleist-Leonhard school and of C. Schneider's and Conrad's psychopathological approach, has remained without much impact.

(1) This predominant reference to Kraepelin and K. Schneider has created a tendency to base classification to a very large extent on aspects of the disease course, on the one hand with a certain reluctance to accept sharp boundaries, and on the other with a strong adherance to K. Schneider's first rank symptoms. This somewhat paradoxical attitude may have its origin mainly in the fact that in spite of their different approaches the basic principles of classification as laid down by both authors overlap considerably. Kraepelin, however, proposes a nosological system in which great importance is attributed to the illness course plus the proof of specific aetiologies, whereas K. Schneider establishes a psychopathological system exclusively based on cross-sectional symptomatology. The British obviously considered Kraepelin's opinion, that the demarcation between the various disease entities could not yet be definitively determined, an attractive and realistic attitude. Like many German schools, the British have certainly also been influenced by some of Schneider's simplifications which are very appropriate for easy, practical handling.

Tölle (1980) calls Schneider the 'great simplifier' because, for example, of his strict drastic separation of variations and illnesses in the framework of his

classification, and the reduction of all endogenous psychoses to two types, cyclothymia and schizophrenia. One reproach against this is that Schneider failed to take into consideration the possible concurrence of several pathogenic influences, for instance, of hereditary predisposition and stressful life events. His major achievement is certainly the establishment of a set of symptoms which permit an easy and reliable identification of schizophrenic disorders.

British psychiatry has obviously adhered mainly to Kraepelinian classification and has only introduced some additional Schneiderian viewpoints. The Schneiderian boundaries between variations and illnesses, for instance, are not at all generally accepted, as is proved by the continuing discussion whether there is a continuum between neurotic and psychotic depression (Kendell, 1976). Kraepelin's reluctance to define the boundaries of schizophrenia is also followed in many British publications, as for example by Roth and McClelland (1979). British psychiatry seems nevertheless dominated by the myth of Schneider's first rank symptoms, which, according to Wing, Nixon, v. Cranach and Strauss (1977), are regarded by many clinicians as highly discriminating for schizophrenia if organic conditions can be excluded. The appearance of first rank symptoms in atypical or cycloid psychoses would therefore induce most British authors to place these psychoses firmly in the realm of schizophrenia. This means that the majority of British psychiatrists follow the hierarchical differential diagnosis described by Schneider: "The presence of a coarse brain disease excludes all other kinds of diagnoses". Here, Roth and McClelland differ, as they would speak of schizophrenia even in such cases, as long as first rank symptoms were identified, since they consider schizophrenia a phenomenological and not a nosological entity.

If coarse brain disease can be excluded, first rank symptoms override all others, including affective ones. A cyclothymic disease can thus be diagnosed solely in the absence of first rank symptoms. This attitude has been strongly opposed by a series of studies, mainly in the USA and the Scandinavian countries, recently summarized by Pope and Lipinsky (1978), who formed the same opinion as we did on the basis of our own research, namely that "classic schizophrenic symptoms, including catatonic features and first rank symptoms, are so generally non-specific as to be almost unsuitable for many research purposes". Since a presentation of data justifying this statement would exceed the frame of a review, Pope and Lipinsky's paper, or our own publications (1980, 1981) must be consulted here. For the time being the important point is the existence of major differences between British- and other schools in using first rank symptoms in the diagnosis of schizophrenia.

Considering the high regard for first rank symptoms, it appears somewhat astonishing that so far no corresponding effort has been made to identify discriminating signs for affective disorders. This represents a marked difference from certain American schools which have completely reversed the common British, and originally Schneiderian, approach by holding the opinion that affective symptoms diagnostically override schizophrenic signs, including first rank symptoms. We will return to this subject below.

In other classificatory attributions British psychiatry does not appear very different from other psychiatric schools. Differentiation between abnormal personality and disease appears generally inadequately specified, and in spite of several promising British contributions in this field (for instance in Eysenck's work), the tricky state-trait problem remains a task for the future.

On the subject of neurotic disorders many British as well as other writers have shown that abnormal features previously considered as entities, occur under various completely different conditions, as Slater (1965), for instance, has demonstrated for hysterical symptoms. This conforms with the opinion that a phenomenology of neurotic disorders does not exist. There are symptoms which can be identified as 'learned' misbehaviour and others, for instance hysterical features, which are attributable to inherited primitive behaviour patterns not normally released because they are replaced by more appropriate reaction types. Whether the learning of misbehaviour or the release of primitive behaviour patterns is due only to psychogenic factors or is triggered or facilitated by organic or endogenous changes of brain function, cannot be deduced from the so-called 'neurotic' symptoms themselves, but only from other endogenous symptomatology or from anamnestic information. In this respect, however, British psychiatry does not seem to favour a viewpoint essentially different from that of the continental schools.

(2) A special feature, however, within British classification, is the entirely different approach to the subject of 'syndromatology'. English psychiatric literature gives the impression that not enough importance is attributed to this special issue, indeed the word does not exist in English. In Fish's '*Psychopathology*', for instance, the discussion of syndromes is restricted to three pages and in the *Clinical Psychiatry* by Slater and Roth (1977) syndromatology is not even mentioned. Since we are sure that British psychiatrists are aware that certain symptom constellations are much more effective for diagnostic assignment, prognosis and therapy, than single symptoms, we find this somewhat

disconcerting. Before commenting further, however, we will furnish some remarks on our view of the requirements for the establishment of a syndrome.

The most important of these requirements are the enumeration of obligatory criteria which must be present in order to assign a certain state to a specific syndrome, and the indication of excluding criteria, the presence of which necessitates attribution to another syndrome. Within the limits defined by these minimal and maximal requirements one may find symptoms which are not 'obligatory' although very characteristic for the syndrome. Together with the obligatory symptoms, they constitute the exemplary syndrome type. On the other hand, it is possible to identify symptoms between the minimal and maximal requirements which are uncharacteristic but tolerated, since they are not defined as 'excluding'.

Some syndromes are purely descriptive, while others point to pathogenetic pathways, justifying their classification as 'pathogenetic syndromes'. A general paralysis-like syndrome thus indicates a frontal lesion, whereas a phobic syndrome, with stimulus-released autonomic anxiety and passive avoidance behaviour, indicates a pathological learning process, without certainty, however, that the original anxiety in the development of this behaviour, was psychogenic.

Hoche introduced the term 'axial symptoms' into German psychopathology for symptoms considered indicative of an organic or endogenous disease. Since in fact individual symptoms rarely have such an indicative value, reference is generally made to 'axial syndromes'. Whereas the organico-morphous axial syndrome contains impairment of intelligence and memory, the endogenomorphous axial syndrome comprises those obligatory symptoms supposedly part of the basic disturbance or which, by experience, have been considered as typical indications of an endogenous disease. As most psychiatrists today agree that even symptoms highly characteristic of endogenous illness may be caused either by organic brain diseases or may be of purely psychogenetic origin, preference is given to the expression 'endogenomorphous' instead of 'endogenous' axial syndromes. Their presence lends high probability to a diagnosis of endogenous illness, but final decision depends on additional information, for instance about illness course and family history. The endogenomorphous cyclothymic axial syndrome, for example, consists of such symptoms as changes of energy (*élan vital*), of mood, of affective responsiveness, and of bio-rhythms (disturbed sleep patterns, diurnal variation of symptoms).

When comparing our own syndrome concepts with those of the British schools, it becomes obvious that most of what we have described is lacking. British psychiatrists almost never seem to differentiate between syndromes and symptom groups. The former, however, are precise symptom combinations, whereas the latter include symptoms considered to originate from the same cause, and sometimes appearing associated but frequently also separately; such being the case in hysterical or catatonic features. Therefore we avoid the terms 'catatonic' or 'hysterical' syndrome.

Whenever true syndromes corresponding to these definitions are discussed in the British literature, maximal and minimal requirements are practically never formulated. This becomes obvious for example when inspecting the CATEGO symptoms check-list which is considered a systematic approach to syndromes. It becomes immediately clear that most of these 38 so-called syndromes are merely symptom groups, and the presence of one symptom of each group seems to suffice in order to consider the syndrome as positively present, an obvious contradiction to the definition of a true syndrome. It is difficult to understand why some syndromes include only one symptom, for instance No 11 'flattening' which is constituted only by the symptom 'blunted affect'. One would assume that only a combination of some of the CATEGO-listed syndromes would, in fact, constitute an actual syndrome: for example No 6 (simple depression), No 21 (slowness), No 29 (lack of energy), etc.

The CATEGO syndrome check-list contains one syndrome, namely the 'nuclear syndrome' which, by definition, corresponds to an axial syndrome in the sense of Hoche and, in the German language, actually represents a synonym for the term axial syndrome. This nuclear syndrome is clearly Schneider-oriented and contains experienced thought disorders in addition to delusions of control and alien penetration. The constitution of this syndrome seems to represent a typical illustration of the hierarchical preponderance of schizophrenia in British classificatory habits and invites the question as to why no other nuclear syndromes, such as affective ones which would have been easy to establish, have been listed.

In the PSE list, one item that would be important for diagnosing a cyclothymic axial syndrome, namely diurnal change of mood and behaviour, is listed only under the heading 'depressed mood' and is missing within the symptoms grouped as 'expansive mood'. In the latter case it could therefore happen, that the establishment of a cyclothymic endogenomorphous axial syndrome in the sense discussed would not be possible with the PSE and if, in such a case, symptoms out of the aforementioned nuclear syndrome were present, it would necessarily follow that the concluded diagnosis would be schizophrenia.

Finally, the nuclear syndrome again demonstrates

the overwhelming importance attributed to Schneider's first rank symptoms. Our own endogenomorphous schizophrenic axial syndrome, briefly described for comparison, contains entirely different elements, namely: formal thought disorders (blocking and/or drivelling, and/or desultory thinking, and/or neologisms) plus affective blunting and/or parathymia.

Summarizing this chapter on classification, when diagnosing schizophrenia British psychiatry still seems to adhere in considerable measure more to K. Schneider's criteria than to other schools. Till now British psychiatry has failed to develop a systematic and well-defined syndromatology, although such an approach seems destined to develop into a tool for international communication on mental disorders, independent of highly ideologically loaded nosological concepts.

Concepts of affective disorder and schizophrenia

With the exception of Fish's disciples who follow Leonhard in distinguishing affective, cycloid and schizophrenic disorders, British psychiatry has adopted K. Schneider's dichotomy between cyclothymia and schizophrenia. Psychopathologically, the former is split only into manic and depressive states. For many years past, however, German psychopathology has developed a more differentiated approach to affective disorders which is not widely known in Great Britain but which represents an interesting attempt to explain theoretically the diminished value today attributed to first rank symptoms in the differential diagnosis between cyclothymia and schizophrenia.

Already in 1959, Janzarik (who actually holds K. Schneider's Chair in Heidelberg) in his book *Dynamic Basic Constellations in Endogenous Psychoses* advocated the view that first rank symptoms are ". . . psychopathological phenomena not confined to schizophrenia". Janzarik does not use the term 'dynamics', as it is generally used in psychoanalytic literature, but to devote a fundamental part of affectivity and emotionality, which he contrasts with the 'psychic structure' containing pre-programmed behaviour patterns and intellectually constructed inborn or acquired 'representations'. Parts of this structure are 'dynamically loaded', meaning that they are connected to positive, negative or ambivalent feelings. These dynamically loaded parts of the structure can be classified as 'values'. Apart from these 'bound dynamics', tied to structural elements, every individual has at his disposal a certain amount of 'free floating dynamics' which can be, especially in the course of mental illness, subject to alterations. These alterations can be divided into 'derailments' and 'depletion'.

According to Janzarik, the dynamic derailments can be categorized into three different forms: 'dynamic expansion', typical for manic states; 'dynamic restriction', in depressive states; and a rapid fluctuation between these forms which he calls 'dynamic instability'.

Dynamic depletion, on the other hand, corresponds to clinical states of affective flatness, found in poor-prognosis schizophrenia.

The different dynamic derailments result in an accentuation of specific values: in depressive states mainly negative values, positive values in manic-expansive states. In states of dynamic instability, especially ambivalently invested values are accentuated with rapid changes from positive to negative. In dynamic depletion on the other hand, the entire ability to realize values is decreased. The intensified realization in dynamic derailments can influence the perceptive process through falsification, by realizing dynamically loaded elements of the structure, according to the type and the degree of the derailment. Higher degrees of derailment can therefore lead to illusions, especially misidentifications, delusional perceptions and hallucinations. This will be the case especially in states of dynamic instability which can therefore also be considered as the main source of first rank symptoms. Since, according to Janzarik, dynamic derailments may occur in abnormal mental conditions of various origin, in endogenous as well as organic psychoses, possibly under stress conditions, and even in persons constitutionally sensitive but not genetically predisposed to affective psychoses or schizophrenia, first rank symptoms can be evaluated as an expression of an abnormal thymopsychic function, rather than as an indication of a specific illness, and would have no nosological implications.

Dynamic derailments therefore appear to be nosologically unspecific. They can even be observed among the poor-prognostic group of schizophrenia, where dynamic depletion is the prominent dynamic alteration, and may be attributed to states of dynamic instability occasionally also clinically observable. Wing and Nixon (1975) and Carpenter *et al* (1973), however, showed that first rank symptoms occurred in less than 50 per cent of investigated poor-prognosis cases.

Investigation of illness courses characterized by typical manic-depressive phases showed that during such phases they occasionally undergo untypical periods of dynamic instability, which have been classified by Mentzos (1967) as 'mixed pictures'. They are frequently accompanied by first rank symptoms. Such mixed pictures may appear as untypical episodes preceeding typical manic depressive episodes, or they can be interspersed in a typical bipolar illness course.

Sometimes, such cases are characterized by recurrent mixed pictures and never develop typical manic or depressive states. If first rank symptoms are used as a diagnostic tool such cases will be classified as schizophrenia or at least as schizo-affective disorder.

Janzarik's psychopathological concept, in our opinion, supports the assumption that first rank symptoms are an inadequate diagnostic tool, permitting only the grouping of states of dynamic instability of a very heterogenous origin. This helps to explain why there exists such astonishing diagnostic overlapping when Schneider's and Bleuler's criteria are used for diagnosis in schizophrenia. Many of the symptoms considered as basic or primary by the Bleulerian school (for instance ambivalence, depersonalization and derealization) can be attributed to dynamic derailments, particularly but not only to dynamic instability, since depressive depersonalization and derealization are well known phenomena. This explains the fact that both diagnostic methods, in spite of their completely different theoretical backgrounds, reach virtually the same demarcation line between affective psychoses and schizophrenia—a line which seems very debatable in view of the new psychopathological concepts.

The issue, however, appears even more complicated. At the end of the 19th century, Specht had already claimed that dysphoria, a state of hostile tension, in addition to mania and depression must be considered as a 'third affective psychosis', and that delusions of persecution must be classified as 'mood congruent' to these dysphoric states, in the same way as delusions of guilt and grandeur are considered 'mood congruent' to depressed or manic states. Not only will these delusions of persecution thus become understandable, but they will, if also attributable to the group of affective disorders, change their nosological position. If looked for, dysphoric states may frequently be observed in the course of affective illness. English psychiatry refers to them under the heading of 'hostile depression'. Even the appearance of typical delusions of persecution or jealousy in such cases will thus not exclude them from the cyclothymic group. This does not, however, signify that every dysphoric state is cyclothymic, but if it is characterized by an endogenomorphous axial syndrome, that is by tense retention of energy, dysphoric hostile mood, affective responsiveness restricted to hostile reactions accompanied by diurnal variations, we believe that it belongs to the manic-depressive illness group, rather than to schizophrenia.

When examining affective disorders with this perspective, the differentiation between stable and unstable dynamic derailments seems of importance. Stable derailments are represented in mania, depression and dysphoria, but also in stable mixed pictures, for example the so-called retarded mania described by Kraepelin. Unstable dynamic derailments are represented by the aforementioned rapidly changing mixed pictures. Dysphoric states and mixed pictures are frequently the basis for productive symptoms, classically attributed to schizophrenia.

A brief and very schematic exposure of these newer psychopathological theories seemed necessary in order to stimulate the dialogue between British and German psychopathological schools. Some of the ideas formulated in the last part of this article, however, have also recently and independently been the subject of a British publication. In 1979, Nunn contributed an article to this *Journal* under the title of 'Mixed Affective States and the Natural History of Manic-depressive Psychosis' which appears to have been based on ideas similar to Janzarik's Mentzos' and our own. It is completely natural for the process of scientific development, that our theoretical interpretation is entirely different from the model which Nunn offered in his article.

We are of course aware of the fact that in this review it has been possible to spot-light only some selected items in an effort to draw special attention to discrepancies between British psychopathology and other concepts. We realize that the general lines of the British and our own descriptive psychopathology are increasingly convergent, and if this article contributes to a better mutual understanding of the issue under debate it will have adequately served its purpose.

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Note 1. As to Schneider's first-rank symptoms, see also recent articles by C. S. Mellor, *British Journal of Psychiatry*, March 1982, **140**, 423, and by R. Lewine *et al*, May 1982, **140**, 498 (Eds).

Note 2. Page 1. The *Reading List* was intended to include only articles in journals and occasionally individual chapters in books. The books mentioned in column 1 are included in Special Publication No 12 *List of Books Suitable for a Psychiatric Library* (Royal College of Psychiatrists 1977).

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