

## Beyond the Kraepelinian dichotomy: acute and transient psychotic disorders and the necessity for clinical differentiation

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**Summary** The concept of acute and transient psychoses is, together with that of schizoaffective disorders, a challenge by the Kraepelinian dichotomy. Although these conditions have some similarities to schizophrenia, they differ significantly from schizophrenia regarding onset, duration, prognosis, gender and pre-morbid adaptation. They show some similarities with bipolar disorders. They do not fit into the dichotomous concept.

**Declaration of interest** None.

‘Nature does not take leaps,’ the scientist says, ‘There are always overlaps, bridges or something else in between.’ But why should Psyche – the most beautiful daughter of Physis (Nature) – take leaps, even when she is ill? ‘Because Emil Kraepelin decided so 110 years ago’, say some psychiatrists, and they add ‘The *Kraepelinian dichotomy* is – as we hope – well known to all of you’.

Yes, of course the Kraepelinian dichotomy – or at least that is what some psychiatrists call it – is well known to all of us. But did Kraepelin really think dichotomously? Definitely not – at least not as dogmatically as his epigones. In fact Kraepelin thought the Kraepelinian dichotomy was only a fiction. Anyone can see this in one of his most famous papers, published in 1920, ‘*Die Erscheinungsformen des Irreseins*’ or ‘The manifestation types of insanity’ (Kraepelin, 1920). I have translated two of the more important parts of this paper into English as follows.

‘No experienced psychiatrist will deny that there is an alarmingly large number of cases in which, despite the most careful observation, it seems impossible to arrive at a reliable diagnosis.

We therefore will have to get used to the fact that the symptoms we have used so far are not sufficient to always reliably distinguish between manic–depressive insanity and schizophrenia,

but that there are overlaps based on the origin of these symptoms from given preconditions’ (Kraepelin, 1920, translation by the author).

The developments in psychiatry in the past 110 years in fact have confirmed the doubts of Emil Kraepelin and have shown that the so-called Kraepelinian dichotomy is not the philosopher’s stone. Psychiatrists from all over the world – the Germans (regarding cycloid disorders), the French (regarding *bouffée délirante*), the Scandinavians (regarding psychogenic and reactive psychoses), the Swiss (regarding emotional psychoses), the Americans (regarding remitting schizophrenia or good-prognosis schizophrenia) and the Japanese (regarding atypical psychoses) drew attention to the bridges, the overlaps and the islands between the dichotomous categories. Many modern psychiatrists have rediscovered them (particularly after the psychopharmacological revolution and its enormous impact on all domains of psychiatric thinking) after having ignored them for decades. The ‘psychotic continuum’ (Marneros *et al*, 1995) and the ‘schizoaffective phenomenon’ (Marneros & Tsuang, 1986) again became interesting to clinicians and researchers.

Another focus of interest in the opposition against dichotomous thoughts is what we today call ‘acute and transient psychotic disorders’ in the language of ICD–10 (World Health Organization, 1992), or ‘brief psychoses’ in the language of DSM–IV (American Psychiatric Association, 1994). There is, in fact, a remarkable similarity between these (Marneros & Pillmann, 2004). The German concept of cycloid psychoses, the French concept of *bouffée délirante*, the Scandinavian concept of reactive or psychogenic psychoses, the Japanese concept of atypical psychoses, the German–Swiss concept of emotional psychoses and the American concept of good-prognosis schizophrenia/remitting schizophrenia have all influenced the World

Health Organization (WHO) category of acute and transient psychotic disorders.

Although the ICD–10 gives diagnostic criteria for acute and transient psychotic disorders, it points out that the present state of knowledge does not allow a reliable definition of this group and its subgroups. In the absence of a tried and tested multiaxial system, a diagnostic sequence was constructed reflecting the order of priority given to selected key features of the disorder: 1, acute onset within 2 weeks; 2, presence of typical syndromes; 3, presence of acute stress. Acute onset is defined as the change from a non-psychotic to a clearly psychotic state within 2 weeks or less.

The distinction between abrupt and acute onset is recommended because there is some evidence that the prognosis of acute and transient psychotic disorders with abrupt onset could be more favourable (more than 48 h but less than 2 weeks). The typical syndromes are, first, the quickly changing and variable manifestations, which ICD–10 calls polymorphic, and, second, the presence or absence of typical schizophrenic symptoms. The association with acute stress follows the tradition of reactive or psychogenic psychoses (Strömgen, 1986). Nevertheless, acute and transient psychotic disorders can be manifested without an association with acute stress, the presence of which is not crucial to the diagnosis. Our research actually showed that acute stress is associated with only a small minority of cases (Marneros & Pillmann, 2004).

The core group of the acute and transient psychotic disorders is the acute polymorphic psychotic disorders (with or without symptoms of schizophrenia). This group is characterised by a rapidly changing invariable state (the polymorphic state) in which symptoms alter swiftly in both type and intensity from day to day, or even within the same day, having remarkable similarities with the cycloid psychoses or *bouffée délirante* mentioned above.

### QUESTIONS CONCERNING ACUTE AND TRANSIENT PSYCHOTIC DISORDERS

There are many questions concerning these disorders; three, in my opinion, are crucial:

- (a) What are acute and transient psychotic disorders?
- (b) Do they constitute a type of schizophrenia?

(c) What is the real significance of this group for clinical and theoretical psychiatry?

In ICD-10 the WHO answers the above questions as follows:

'The nomenclature of these acute disorders is as uncertain as their nosological status' (p. 100). 'Systematic clinical information that would provide definitive guidance on the classification of acute psychotic disorders is not yet available, and the limited data and clinical tradition that must therefore be used instead do not give rise to concepts that can be clearly defined and separated from each other' (p. 99).

This is still partially true, even 15 years after the original WHO definition. Nevertheless, some progress has been made. The answers given by the rare, but ongoing, research are as follows.

### What are acute and transient psychotic disorders?

This is a group of disorder:

- (a) mainly affecting females;
- (b) with possible onset throughout adult life, but usually between the 30th and the 50th year;
- (c) having an acute or even abrupt onset;
- (d) the onset of which is only rarely dependent on acute severe stress;
- (e) with a very short psychotic period;
- (f) with a very good response to anti-psychotic drugs;
- (g) usually with a favourable outcome, in spite of the fact that they are frequently recurrent.

### Are they a type of schizophrenia?

These disorders do not constitute a type of schizophrenia. At least between their core group – the polymorphic psychotic disorders – and schizophrenia there are some significant differences, namely in:

- (a) gender distribution;
- (b) age at onset;
- (c) premorbid level of functioning and premorbid social interactions;

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(d) onset, development, duration and phenomenology, as well as structure of symptomatology;

(e) level of post-episodic functioning and outcome in general;

(f) stability of level of functioning over years.

### What is their significance in psychiatry?

From the clinical point of view the majority of people with acute and transient psychotic disorders occupy a special position different from that of people with schizophrenia or schizoaffective or affective disorders. They have an educational and occupational status and level of functioning not significantly different from those of the mentally healthy population. They also have an average level of social interaction and activities, as well as the same frequency of stable heterosexual partnerships as mentally healthy people. In spite of the recurrence of their illness and the possibility of exclusion from the labour market at times of high unemployment, they do not usually lose their autarchy. Their illnesses have symptoms, course and outcome which distinguish them from other psychotic disorders (Marneros & Pillmann, 2004).

The theoretical point of view is that the acute and transient psychotic disorders demonstrate the importance of differential diagnosis and of exact final diagnosis in creating a homogeneous group for research. Diagnosis remains a central task in psychiatry – clinically, determining the approach to treatment and to the prognosis, and in research, identifying the population of interest. Clinical and paraclinical features, course and outcome of acute and transient psychotic disorders oblige us to exclude this kind of psychotic disorder

from other psychotic groups such as schizophrenia, and from affective or schizoaffective disorders.

Patients can also develop affective, schizoaffective and schizophrenic episodes during the long-term course of acute and transient psychotic disorders, perhaps providing a strong argument in favour of a psychotic continuum or a set of bridges to classical mental disorders such as schizophrenia and melancholic depression. An exotic group of mental disorders such as acute and transient psychotic disorders should be separately defined in the hope that the Delphic oracle of their nature – and that of all other psychotic disorders – will one day be solved. Perhaps Emil Kraepelin had such cases in mind when arguing against the Kraepelinian dichotomy.

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