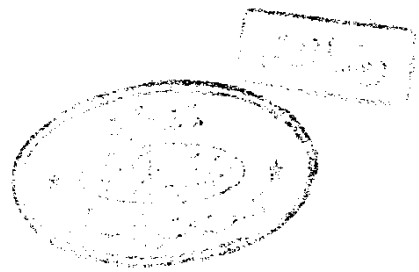
A STUDY OF THE DIAGNOSTIC SYSTEMS (CRITERIA) FOR SCHIZOPHRENIA IN EGYPT

A Thesis Submitted For Partial Fulfillment of M.D. Degree in PSYCHIATRY



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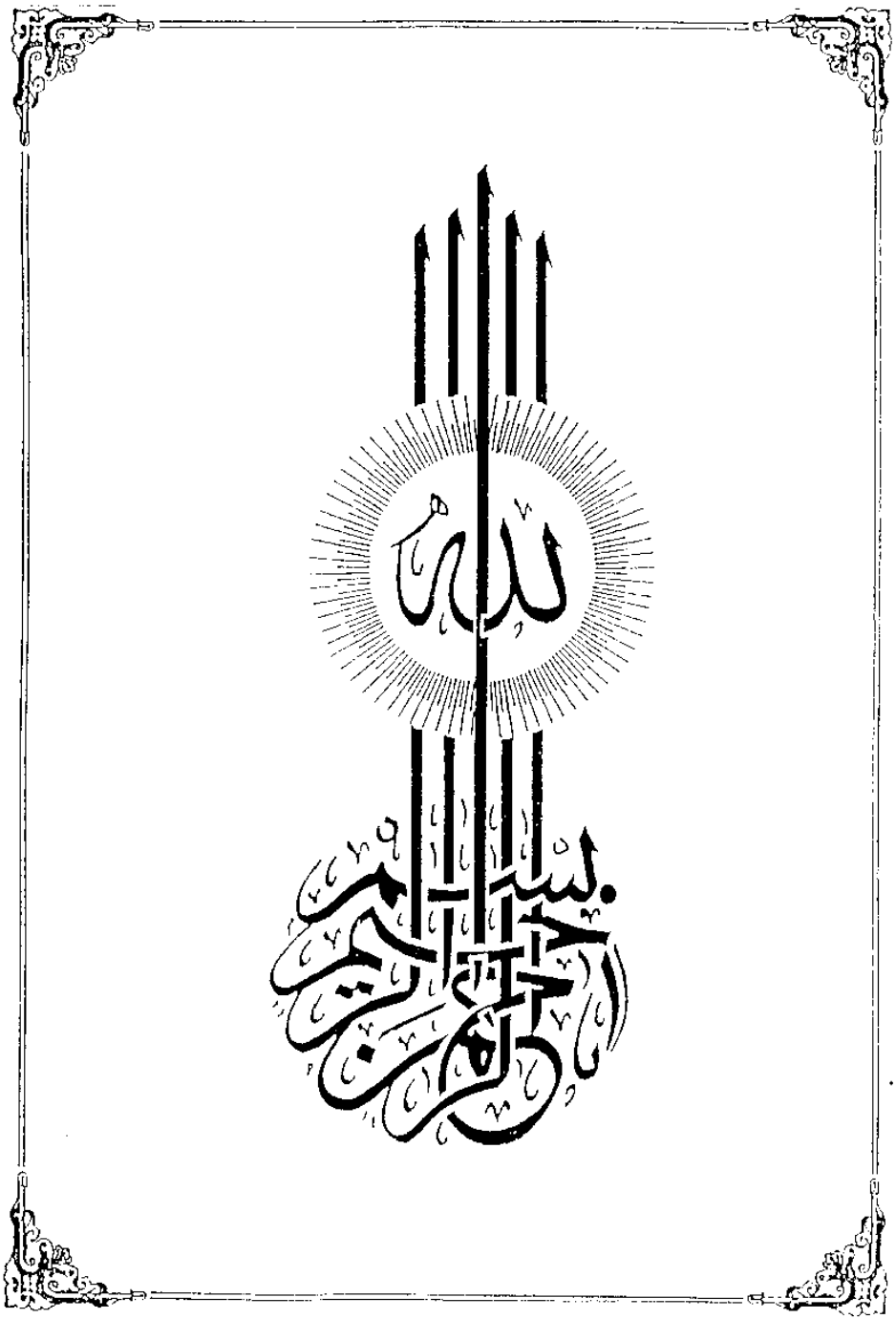
This work is dedicated to the soul of

my mother - my first teacher.



"All I know is, he said rising and looking angrily at the doctor, "that God created me of warm blood and nerves. Yes, Sir ! And organic matter, if it has any vital capacity, must react to irritation. And I do react ! I react to pain with tears and cries, to baseness with indignation, to vileness with disgust. And that, in my opinion, is life ! The lower the organism, the less sensitive it is, and the feebler its reaction to irritation; and the higher it is, the more sensitive and energetic its reaction to reality. How is it you don't know that? A doctor not to know such elementary things! For a man to be able to despise suffering, always to be content, and wonder at nothing, he must have reached this stage; or else have become so hardened by suffering, as to have lost his sensitiveness to it, in other words, to have ceased to live."

Ivan Dimitrich in a discussion with his doctor-
"The ward number six",

A.P. Chekhov.

ACKNOWLEDGEMENT

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No words can encompass my feelings towards ***my husband and daughters*** *for backing and supporting me especially during the hard moments.*

Lastly, I must beg the excuse of the 200 patients of this study for exposing their frustrated painful existence to research study.

CONTENTS

AIM OF THE WORK

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The functional psychoses continue to be classed as illnesses of unknown origin. In this context, diagnostic concepts can only be considered as hypotheses, the validity of which depends on extrinsic criteria such as course and outcome, genetic data, response to treatment, and results of biological investigation. Such validation requires that the procedure for diagnostic attribution in question be as unequivocally and as reproducibly set up as possible. The operational diagnostc criteria, which have been developed primarily within the last decade issue from this concern. Such formulations when considered as hypotheses accessible to scientific evaluation, the one sidedness of their contents or their ideological bias become less important (Berner et al., 1983).

It has proved possible to examine one and the same patient population employing various diangostic formulations for a given illness concept, for example, schizophrenia, utilizing "the poly diagnostic approach in psychiatric research". The polydiagnostic approach concerns the analysis of specific diagnostic formulations as to their contents and logic. The approach could become a kind of "comparative psychiatric nosology" facilitating mutual understanding among psychiatrists in different countries and cultures. Thus, it could be possible to gradually diminish on a worldwide scale,

the differences in psychiatric diagnostics (Katschnig and Berner, 1985).

Results to date have shown that, when the basic requirements of a comprehensive data gathering "core instrument" and a computer program have been satisfied, the polydiagnostic approach works. During the last few years many publications applying the same principle have appeared in England, U.S.A. and Denmark (Berner et al., 1983).

Our study, is an Egyptian trial to apply the "poly diagnostic approach" as a tool of research to an Egyptian psychotic patient population for the following aims:

1. Comparison of many several diagnostic formulations for schizophrenia as to their rates of diagnosing schizophrenia in a sample of pscyhotic patients (comphrehensiveness).

2. Measuring their agreements and analyzing their differences.

3. Testing the validity of five of these diagnostic formulations through:

   a. Concordance with established clinical use (face validity).

   b. Sensitivity and specificity (descriptive validity).

4. Detecting underlying constructs of the various variables and schizophrenic symptoms that can be considered as hypotheses concerning the structure of these variables.

THEORETICAL INTRODUCTION

CHAPTER I

GENERATING AND VALIDATING NOSOLOGICAL CLASSES

HISTORICAL PERSPECTIVE

Although descriptions of various syndromes and disease classes appear in the ancient Greek medical texts, particularly those codified by Hippocrates, the modern concepts of disease and nosology did not emerge in Western Europe until the late 18th Century. The concept of multiple discrete illnesses, each with its own signs, symptoms and natural course, outcome and prognosis, was most clearly enunciated by Thomas Sydenham in England, who has been called the Father of Modern Medical Nosology. These concepts were applied to psychiatric disorders in the later part of the 19th Century. The generation of Kraepelin and Bleuler were vigorous in the application of these general medical ideas to psychiatric disorders (Klerman, 1985).

Jaspers (1959, 1963), characterizes Kraepelins' work as follows: "Kraepelin has taken Kalbaum's idea of disease entities and defended it with uncommon vigor, and for a time has achieved general recognition for it. One of the most fruitful research approaches, namely the study of the entire life history of psychiatric patients, was founded by him.. Kraepelin's basic orientation remained somatic which together with the majority of physicians he held to be the only one appropriate to medicine; not only the preferred one but absolutely the only one".

The application of these medical concepts to the field of psychiatry was further supported by discoveries as the relationship of general paresis to prior infection with syphilis at the end of the 19th Century, then its confirmation in 1905 by the development of Wasserman test and in 1911 by the isolation of the spirochete in the brain by Noguchi. Soon afterwards, Goldberger and his associates in the U.S. Public Health Service demonstrated the relationship between Pellagra and nutritional vitamin deficiency and established both a nutritional etiology and the preventive intervention of this disorder resulting in its eradication (Klerman, 1985).

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CRITICISM OF THE DISEASE-CONCEPT IN PSYCHIATRY:

After World War I, many critics, both within and outside psychiatry, came to question the validity and utility of the classic medical approach - a state of affairs more prevalent in the United States than in Europe. Klerman (1979), explained this state on the basis of the plateau in new biological knowledge regarding the functional psychoses and the neuroses, and because of the domination of the American psychiatric thinking by the ideas of Adolf Meyer and and his school of Psychopathology. So, the classical concepts of multiple mental disorders was discarded in favour of a unitary concept or continuum from mental health through severe mental illness. Along with this rejection of the concept of multiple mental disorders with separate etiologies and the classical 19th Century views of Kraepelin and Bleuler, emerged another view in favour of a search for social and interpersonal factors such as stress, social class, marital disruption, and early childhood experiences.

Klerman (1985), has summarized 5 types of criticism that have been expressed:-

1. The most fundamental criticism challenged whether or not psychiatric phenomena and mental state such as psychoses and neuroses, are valid within the province of medical illness. The foremost proponent of this radical critical view was Szasz (1961), who reported that, until a biological cause has been established, it is inappropriate to use the concept of illness. He will not accept an illness without a biological basis, and regards personality disorders and developmental problems as outside of the realm of medicine and therefore outside of the realm of psychiatry. He rejects the concept of schizophrenia as a disorder, because he is not satisfied that the available evidence from pharmacologic and genetic sources is of sufficient level to establish a biological basis for schizophrenia. Klerman (1985), commented "in part, his criticism involves a very narrow, conservative definition of the province of medicine"

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2- A second line of criticism focused on the low reliability of psychiatric diagnosis made by clinicians and researchers. This was a major issue in the 1950s and 1960s.

Weissman and Klerman (1978), declared that the low reliability of psychiatric diagnosis, along with other factors, contributed to the decision by many social epidemiologists after World War II, to avoid discrete diagnoses and to rely on a unidimensional measure of mental illness-mental health.

3- The third line of criticism is a humanistic one emphasizing the adverse social and psychological consequences of diagnosis. This criticism was expressed forcefully by Karl Menninger (1963) in his influential book "The Vital Balance" which drew attention to the dehumanizing and depersonalizing manner in which psychiatric diagnoses are often used. This view was tested experimentally by Rosenhan (1973) in his paper "On Being Sane In Insane Places" which generated considerable controversial exchange.

4- The fourth type of criticism involves the research community, mainly psychologists, who are experienced in multivariate statistical techniques. They questioned the reliance on categorical methods and advocate emphasizing dimensional rather than typological criteria for diagnosis. They do not attempt to collapse all mental illness into a single dimension but rather challenge the reliance on categorical judgements. This point of view has also been expressed by Strauss (1973) and has been influential in generating the multiaxial approaches embodied in DSM-III.

5- Psychiatrists in developing countries and students of cross-cultural psychiatry have criticized most diagnostic schema as being derived from Western Culture. They argued caution in interpreting psychopathology as described in Western-text-books as universal and invariable, arguing for cultural determinants of symptoms, illness, behaviour and help-seeking.

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