

A historical account of schizophrenia proneness categories from DSM-I to DSM-5 (1952-2013)

Uma revisão histórica das categorias de propensão à esquizofrenia do DSM-I ao DSM-5 (1952-2013)

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The history of diagnostic classifications in psychiatry has been recognized as a privileged means of access to the vicissitudes inherent to the configuration of a scientific and professional field, also bringing significant contributions to conceptual history. We have taken as primary sources the five editions of the DSM (1952-2013) to examine the construction of diagnostic categories related to schizophrenia proneness, indicating the scientific and social contexts related to the development of DSM and psychiatry itself. Along this process we highlight the conditions of possibility for the emergence of the Attenuated Psychosis Syndrome, a highly controversial diagnostic proposal, in the elaboration of DSM-5. This proposal ended up being rejected not only on scientific grounds, but also because of feared unintended consequences.

Key words: History of Diagnostic and Statistical Manual of Mental Disorders (DSM); schizophrenia; attenuated psychosis syndrome; values in psychiatry

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Introduction

In the last three decades, the history of diagnostic classifications in psychiatry has been recognized as a privileged means of access to the vicissitudes, tensions, conflicts and negotiations inherent to the configuration of a scientific and professional field, also bringing significant contributions to conceptual history (Berrios, 1999; Berrios & Porter, 1995; Engstrom & Weber, 2007; McNally, 2012, 2013; Venancio, 2010).¹ In this paper, we begin by briefly describing the history of the concept of schizophrenia, especially in the US. After, we explore the evolution of the diverse kinds of schizophrenia proneness categories in the five editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; 1952-2013) of the American Psychiatric Association (APA) indicating whenever possible the changes in the scientific and social contexts linked to the development of the manual. Finally, we discuss the historical conditions of possibility for the emergence and rejection of the Attenuated Psychosis Syndrome (APS), a highly controversial diagnostic proposal, in the making of DSM-5.

Schizophrenia was described in the last century as a heterogeneous clinical syndrome which occurs in diverse populations at comparable rates, but whose precise clinical nature remains undefined (Fusar-Poli et al., 2014; Tandon, Nasrallah, & Keshavan, 2009). It is supposed to have a complex etiology, involving a still not fully understood interplay between genetic and environmental factors (Jablensky, 2010). Due to its devastating impacts on quality of life, schizophrenia is considered one of the most severe psychiatric disorders, its treatment still is seen as “palliative” (McGlashan, 1996, p. 201), and the diagnosis frequently

¹ We understand that the historical development of psychiatric classifications, in their cognitive dimensions, is always articulated to the history of strategies and professional cultures and to the history of specific socially contextualized scientific practices. For a broad revision about the methods and objects of psychiatric historiography see Huertas (2017).

evokes a “corrosive pessimism” (McGorry, 1998, p. 22) among psychiatrists. Although patients may present different symptoms, time of disorder onset, course, and outcome, researchers in the field have reported that most cases of schizophrenia are preceded by a prodrome (Fusar-Poli et al., 2013; McGorry, 1998). The signs and symptoms specific to a pre-psychotic state (prodromal phase) have been documented for decades, with validating evidence from researches (Fusar-Poli et al., 2014).

In mid 1990s the interest in schizophrenia prevention led to the development of the psychosis high-risk mental state concept, which broadened the notion of prodrome to encompass states of significant probability to (but not certainty of) conversion to full-blown psychosis (Yung & McGorry, 1996). Early in the preparation of the fifth edition of the DSM, the Psychotic Disorders Work Group proposed a new diagnosis to serve as a placeholder for the high-risk mental state concept (Fusar-Poli et al., 2014). The debate on including or not this new category in the manual was heated and full of conflicting values (Gonçalves, Dantas, & Banzato, 2016) and the APS ended up not being listed as an official diagnosis (APA, 2013). Although APS was the first category proposal related to the high-risk mental states concept, previous diagnostic categories in earlier DSMs were already linked to prodromal and other kinds of schizophrenia proneness states.

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The birth of schizophrenia

The schizophrenia concept is relatively new when compared with other diagnosis such as mania, melancholia, or the more general term “insanity”, all three described since ancient times (Jablensky, 2010). The French alienist Bénédict Morel (1809-1873) used the term “*démence précoce*” referring to a mental disorder with unknown causes affecting young people and rapidly progressing to mental deterioration (Morel, 1852, 1860). The German psychiatrist Ewald Hecker (1843-1909) published a paper on “hebephrenia” (Hecker, 1871), and his mentor Karl Ludwig Kahlbaum (1828-1899) described a patient suffering from “catatonia” (Kahlbaum, 1874). These conditions, although different, all described states of mental deterioration (*dementia*) with onset in youth (Tandon et al., 2009). In the late nineteenth century, Emil Kraepelin (1856-1926) observed the similarities among these clinical pictures and he proposed to integrate them into a single nosological entity under the name of “*dementia praecox*” (Kraepelin, 1893, 1896, 1899).

Kraepelin (1899) distinguished it from “manic-depressive insanity” (*manisch-depressives Irresein*), a new name he gave to a description that Jean-Pierre Falret (1794-1870) made of “*folie circulaire*”, a disorder characterized by periodicity and absence of deterioration (Falret, 1854).²

In 1908 the Swiss psychiatrist Eugen Bleuler (1857-1939) presented a lecture at a meeting of the German Psychiatric Association in Berlin disagreeing with Kraepelin’s *dementia praecox* in respect to its precocious onset and inevitable fate of deterioration (Fusar-Poli & Politi, 2008). Bleuler introduced the term “schizophrenias” to refer to a group of diseases with variable course and outcome, which had basic and accessory symptoms (Tandon et al., 2009). He believed that the schizophrenias core was not delusions and hallucinations, considered by him as accessory symptoms, but the dissociative pathology present in all cases, which lead to the basic symptoms of loosening of association, flat or inappropriate affect, ambivalence and autism (Bleuler, 1950; Moskowitz & Heim, 2011). Bleuler’s new term, quickly adopted by many European psychiatrists and even mentioned by Kraepelin in his later works, took time to be broadly accepted in US (Noll, 2011).³

The emergence and rise of schizophrenia in the US

The history of the diagnosis of schizophrenia in the US reveals a history of diverse and competing definitions (McNally, 2012). In 1911, when Bleuler described the schizophrenia concept in his influential book *Dementia Praecox or the Group of Schizophrenias*, the US psychiatry was under heavy influence of Adolf Meyer’s (1866-1950) works (Andreasen, 1989). Meyer was a Swiss neurologist and neuropathologist who moved to Chicago in 1892 seeking better job opportunities (Tueth, 1995). He worked as a general pathologist from 1893 to 1895 at a psychiatric hospital with 3,000 patients and,

² Although Kraepelin later on changed his opinion on the fundamental distinction between *dementia praecox* and manic-depressive insanity as separate disease entities, his initial view have been dominant until current times as argued by Eric J. Engstrom and Matthias M. Weber (2007) and Assen Jablensky (2007).

³ For a discussion on the appropriation of the concepts of *dementia praecox* and schizophrenia see McNally (2013). Venancio (2010) discusses the same in the Brazilian context.

disappointed by the low quality of the services provided by the hospital staff to patients, started teaching his colleagues neuroanatomy, neuropathology, and neurology. After realizing how distant these subjects were from the problems of the patients, he included lectures on psychoses, based on the teachings he received from his Swiss mentor Auguste Forel (1848-1931) and on his reading of Kraepelin's textbook (Gelder, 2003). Due to the prestige Meyer developed along his career and to his broad influence in training almost all North-American psychiatrists at his time, he had an important role in introducing and disseminating the diagnosis of *dementia praecox* in US.⁴ However, as he continued to work with psychiatric patients, he became increasingly dissatisfied with Kraepelin's approach and began to focus on environmental influences on mental illnesses (ibid.). Influenced by Freud's psychoanalysis, but also departing from it, Meyer gradually developed his "psychobiological" approach, emphasizing that disorders were in fact "reactions" of the individual to its environment, deserving thus "dynamic formulations" (Meyer, 1922, p. 356).

As long as the diagnosis of *dementia praecox* was gaining popularity in the US, Bleuler's ideas started to be studied by a small circle of psychiatrists in North-America (Noll, 2011). In 1912, the also Swiss neuropathologist August Hoch (1868-1919), then the director of the New York Psychiatric Institute, presented a summary of his careful review of Bleuler's 1911 book at a meeting of the New York Psychiatric Society (Martin, 2007). Years earlier Hoch had been to the Burghölzli mental hospital in Zurich to train with Carl Jung (1875-1961) and Bleuler, and since then had been following their work with admiration (Noll, 2011). Hoch, and also Meyer, were interested in Bleuler's ideas, especially due to the fact that schizophrenia did not imply an inevitable poor outcome for diagnosed cases (Tueth, 1995). Both psychiatrists sustained an optimistic view on patients and their treatment, believing in psychotherapeutic interventions for psychosis. Meyer even took this optimism (and a diagnosis potentially compatible with it) to the Henry Phipps Psychiatric Clinic, a section of the Johns Hopkins Hospital he headed from

⁴ Although the sixth and seventh editions of Kraepelin's *Lehrbuch der Psychiatrie* were "abstracted and adapted" into English by Diefendorf in *Clinical Psychiatry – A Textbook for Students and Physicians* (1902, 1912), a full and precise translation of Kraepelin's work was unavailable at the time. Only a small circle of psychiatrists in the US (including Meyer) followed Kraepelin's original work along his career, as argued by Noll (2011). As we will see, the same happened with Bleuler's schizophrenia in the US.

1909 until his retirement in 1940. The clinic opened to the public in 1913 and at that year it received its first patient diagnosed with schizophrenia, probably the first institutionally identified case in the US (Noll, 2011).

However, it took more than a decade to schizophrenia receive wide adoption in the country. The delay was partially attributed to the late translation of Bleuler's works into English. The first translation was of the fourth edition of his *Textbook of Psychiatry* (1916) in 1924 and the second was of his already mentioned book on the group of schizophrenias (1911) only in 1950. Another possible reason was due to Bleuler himself, who frequently wrote about schizophrenia relating it to *dementia praecox*, as in "*Dementia Praecox or the Group of Schizophrenias*" (Bleuler, 1950) and "[Chapter] IX. Schizophrenias (*Dementia praecox*)" (Bleuler, 1924), opening space to the hasty reader to believe the diagnoses meant exactly the same.

Both terms were used interchangeably in the US until the late 1920s, when Bleuler's started to supplant Kraepelin's. One condition that possibly initiated this trend was the widespread adoption by 1921 of the *Statistical Manual for the Use of Institutions for the Insane* (The National Committee for Mental Hygiene, 1918). Created in 1918 by the American Medico-Psychological Association (now APA) and The National Committee for Mental Hygiene, it was the first recommended national classification for use in asylums to solve the lack of uniformity in psychiatric diagnosis in the US. Although it did not give to schizophrenia a proper chapter, it presented both terms as synonyms⁵ and for the first time schizophrenia could officially be used for statistical, clinical and research purposes. Another probable reason for terminology change was the fact that after the World War I Kraepelin publicly expressed his impassioned German nationalism and his disregard of psychoanalysis, generating a certain antipathy among his colleagues in the US (Noll, 2011; Shepherd, 1995). On the contrary, as the psychologist and historian of medicine Richard Noll acknowledged, Bleuler had for US psychiatrists "the right nationality (Swiss), the right temperament (noncombative), and the right ideas (a dissociative model of schizophrenia that held out the promise of therapy and recovery)" (Noll, 2011, p. 263). Following Kraepelin's death in 1926 and the decline of *dementia praecox* in titles of medical publications by 1927, schizophrenia rose in importance in the US psychiatry (ibid.).

⁵ "The term 'schizophrenia' is now used by many writers instead of *dementia praecox*" (The National Committee for Mental Hygiene, 1918, p. 24).

The broadening of the schizophrenia concept in the US

The interest in Bleulerian teachings was paralleled by the gradual rise of psychoanalysis and psychodynamic thinking in US psychiatry, especially after the 1930s and 1940s (Moskowitz & Heim, 2011). As a consequence of this transformation, psychiatry's scope broadened, as psychiatrists began to increasingly treat outpatients with relatively milder conditions seen as problematic reactions to life events (Andreasen, 1989). Psychodynamic thinking was applied to psychosis as well, and the optimism regarding its treatment with some form of psychotherapy was gradually increasing. Moreover, many US psychiatrists made their own interpretation of Bleuler's basic symptoms as a continuum with normality and were prone to see "a touch of schizophrenia" (ibid., p. 520) in many of their patients.

Compared to *dementia praecox*, schizophrenia already represented a much larger group of diseases, under which Bleuler included "many atypical melancholias and manias ... most hallucinatory confusions, much that is elsewhere called amentia ... most of the paranoias of the other schools ... nearly all incurable "hypochondriacs", some "nervous people" and compulsive and impulsive patients" (Bleuler, 1924, p. 436). Interpreted with psychodynamic and psychoanalytic lenses, as Meyer's notion of reactions to life events and Freud's defense mechanisms, the schizophrenia concept broadened even more in the US than its original author would intend. Schizophrenia became just a more severe psychological maladjustment than other personality or neurotic manifestations (Rzesnitzek, 2013).

Psychosis, prodrome and the "pre-psychotic"

Another clinical picture encompassed by Bleuler's schizophrenia was the "latent" presentation, an attenuated form of the basic symptoms, manifesting as abnormal personality traits (Jablensky, 2010). It was considered by Bleuler a very widespread and underdiagnosed kind of schizophrenia with blurred boundaries especially to schizophrenia *simplex*, a form that presented only basic symptoms in their full intensity, but not accessory ones as hallucinations, delusions, and dementia. Although both latent and *simplex* schizophrenias could cast doubt about where was the beginning of schizophrenia course, for Bleuler both forms were already considered psychotic clinical pictures on their own, and not prodromes (Rzesnitzek, 2013). Regarding the latter, he acknowledged:

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In acquired psychoses one frequently speaks of *prodromal stages*, but here as in most cases they represent nothing but such mild morbid symptoms, that a diagnosis is impossible. [The attitude in prodrome] may resemble the character of many healthy people, and ... does not necessarily seem morbid. To be sure, all the real signs of mental diseases in a less marked form may also have the significance of prodromes. (Bleuler, 1924, p. 167, emphasis in original)

Thus, for Bleuler the schizophrenia prodrome was conceptualized as the presence of symptoms (morbid or not, specific or not) with attenuated intensity that appear as new to the affected person. Differently from latent schizophrenia, the prodrome would evolve to some form of schizophrenia, even if the *simplex* one, and it was of impossible diagnosis. However, due to the flourishing optimism in US psychiatry some clinicians started looking at early diagnosis of schizophrenia as an achievable task. The North-American psychiatrist and psychoanalyst Harry Stack Sullivan (1892-1949) presented a vigorous example of such view in his 1926 lecture *The onset of schizophrenia*:

The great number of our patients have shown for years before the break, clear signs of coming trouble ... The psychiatrist sees too many end states and deals professionally with too few of the pre-psychotic ... With this in mind, it would seem as if we should lay great stress on the prompt investigation of failing adjustment, rather than ... wait and see what happens. (Sullivan, 1926/1994, p. 106)

Other psychiatrists in the US took a similar approach, devoting time to study the early manifestations of schizophrenia. The introduction of terms like “ambulatory schizophrenia”, “pseudoneurotic schizophrenia”, and “borderline states” reflected the psychodynamic view on early psychosis (Rzesnitzek, 2013).

DSM-I (1952)

The *Statistical Manual for the Use of Institutions for the Insane* was reprinted until its 10th edition in 1942, but did not reflect the important shift in US psychiatric nosology of the time that took place especially as a result of World War II. Even APA's collaboration with the New York Academy of Medicine to develop another nationally acceptable psychiatric classification that would be incorporated within the first edition of the American Medical Association's *Standard Classified Nomenclature of Disease* still focused primarily on diagnosing inpatients with severe psychiatric and neurological disorders (APA, 2009).

Along with the optimism of Meyer, Hoch, Sullivan and others, psychiatrists serving in the military also found that the early identification and treatment of mental illness in outpatient settings could help alleviate and prevent worsening of clinical symptoms (Sanders, 2011). So the army made extensive revisions to the *Standard Nomenclature*, which was finally adopted by all US armed forces. The Veterans Administration (VA) also developed a similar system (APA, 2009). With many classifications in use, APA considered that US psychiatric terminology in the early 1950s was in a chaotic state and decided to publish in 1952 the *Diagnostic and Statistical Manual: Mental Disorders* (later known as DSM-I).⁶ It contained selected categories from the *Statistical Manual*, the *Standard Nomenclature*, the US Armed Forces and VA classifications and even from the sixth edition of the *International Statistical Classification of Diseases* (ICD-6) of the World Health Organization (WHO, 1948). The DSM-I contained 132 pages and 128 categories of “Disorders of the Psychobiologic Unit” (APA, 1952, p. 1). Psychotic disorders were included in the chapter “Disorders of psychogenic origin or without clearly defined physical cause or structural change in the brain” (ibid., p. 24) and were differentiated into “Affective Reactions”, “Schizophrenic Reactions”, “Paranoid Reactions” and other psychotic reactions (see Figure 1).

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Not much effort was needed to notice in this classification the influence of the intellectual “eclecticism” of the time (Cooper & Blashfield, 2016; Gelder, 2003; Martin, 2007; Sadowsky, 2006). The broad division of psychoses into organic and functional dated back to a pre-Kraepelin era (Beer, 1996). The distinction between manic-depressive insanity (Affective Reactions), paranoia and schizophrenia, and also the subdivision of the later into hebephrenic, catatonic and paranoid types, were a clear influence of Kraepelin nosology, adapted with Bleuler’s term for *dementia praecox*. From an etiological perspective the categories were seen through the lens of Meyer’s psychobiology in the sense of reactions of the individual to its societal relations and life events. Psychoanalysis, although did not underpin the structure of the DSM-I as a whole (Cooper & Blashfield, 2016) as is commonly assumed, also exerted influence on the description of the schizophrenic reactions as seen by the US psychoanalytical terminology: “tendency to retreat from reality [and] regressive behavior” (APA, 1952, p. 26).

⁶ For a critical discussion on the DSMs see Cooper (2004, 2017).

DSM-I	DSM-II	DSM-III	DSM-III-R	DSM-IV	DSM-IV-TR	DSM-5
Psychotic Disorders	Psychoses not Attributed to Physical Conditions	Affective Disorders	Mood Disorders	Mood Disorders	Mood Disorders	Bipolar and Related Disorders Depressive Disorders
Affective Reactions	Major Affective Disorders	Schizophrenic disorders	Schizophrenia	Schizophrenia and Other Psychotic Disorders	Schizophrenia and Other Psychotic Disorders	Schizophrenia Spectrum and Other Psychotic Disorders
Schizophrenic reactions hebephrenic type catatonic type paranoid type residual type childhood type acute undifferentiated type chronic undifferentiated type schizo-affective type latent type other types	Schizophrenia hebephrenic type catatonic type paranoid type residual type childhood type acute schizophrenic episode chronic undifferentiated type schizo-affective type latent type other types	Schizophrenia disorganized type catatonic type paranoid type residual type undifferentiated type prodromal symptoms	Schizophrenia disorganized type catatonic type paranoid type residual type undifferentiated type prodromal symptoms	Schizophrenia disorganized type catatonic type paranoid type residual type undifferentiated type	Schizophrenia disorganized type catatonic type paranoid type residual type undifferentiated type	Schizophrenia
Paranoid Reactions	Paranoid States	Paranoid Disorders	Delusional (Paranoid) Disorder	Delusional Disorder	Delusional Disorder	Delusional Disorder
		Psychotic Disorders, Not Elsewhere Classified	Psychotic Disorders, Not Elsewhere Classified	Psychotic Disorders, Not Elsewhere Classified	Psychotic Disorders, Not Elsewhere Classified	Brief Psychotic Disorder
		Brief Reactive Disorder	Brief Reactive Disorder	Brief Psychotic Disorder	Brief Psychotic Disorder	Brief Psychotic Disorder
		Schizophreniform Disorder	Schizophreniform Disorder	Schizophreniform Disorder	Schizophreniform Disorder	Schizophreniform Disorder
		Schizo-affective Disorder	Schizo-affective Disorder	Schizo-affective Disorder	Schizo-affective Disorder	Schizo-affective Disorder
		Psychotic Disorder, Not Otherwise Specified	Psychotic Disorder, Not Otherwise Specified	Psychotic Disorder, Not Otherwise Specified	Psychotic Disorder, Not Otherwise Specified	Substance/Medication Induced Psychotic Disorder Psychotic Disorder Due to Another Medical Condition
Psychotic reaction without clearly defined structural change, other than above	Other Psychoses	Induced Psychotic Disorder	Induced Psychotic Disorder	Shared Psychotic Disorder (Folie à Deux)	Shared Psychotic Disorder (Folie à Deux)	Other Specified Schizophrenia Spectrum Disorder <i>E.g. there have been discussions, deliberations with significant development, mood changes, and other symptoms in a partner of individual with delusional disorder</i> Unspecified Schizophrenia Spectrum Disorder
Personality Disorders	Personality Disorders	Personality Disorders	Personality Disorders	Personality Disorders	Personality Disorders	Schizotypal (Personality) Disorder
Schizoid Personality Disorder Paranoid Personality Disorder	Schizoid Personality Disorder Paranoid Personality Disorder	Schizotypal Personality Disorder Schizoid Personality Disorder Paranoid Personality Disorder	Schizotypal Personality Disorder Schizoid Personality Disorder Paranoid Personality Disorder	Schizotypal Personality Disorder Schizoid Personality Disorder Paranoid Personality Disorder	Schizotypal Personality Disorder Schizoid Personality Disorder Paranoid Personality Disorder	Schizotypal Personality Disorder Schizoid Personality Disorder Paranoid Personality Disorder

Figure 1 – Evolution of psychotic and psychotic-like disorders along the DSMs.

American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (1952, 1968, 1980, 1987, 1994a, 2000, 2013). In bold, categories linked at least temporarily with schizophrenia proneness states, in italics, categories removed in subsequent printings. Psychotic-like personality disorders were included for context clarification.

With regard to prodromal or pre-psychotic states, DSM-I included two related categories. The first, “Schizophrenic reaction, acute undifferentiated type”, diagnosed

cases exhibiting a wide variety of schizophrenic symptomatology ... [which] appear acutely, often without apparent precipitating stress, but exhibiting historical evidence of prodromal symptoms ... The symptoms often clear in a matter of weeks, although there is a tendency for them to recur ... If the reaction subsequently progresses, it ordinarily crystallizes into one of the other definable reaction types. (ibid., p. 27)

The category encompassed cases of usually brief, limited and potentially recurrent psychosis, possibly progressing to other persistent and defined clinical pictures. “Prodromal symptoms” were characterized only as retrospectively identifiable (i.e. “historical evidence”) and this explicit reference to them was unique in the manual. Another related category was the “Schizophrenic reaction, chronic undifferentiated type”:

When the reaction cannot be classified in any of the more clearly defined types, it will be placed in this group. Patients presenting definite schizophrenic thought, affect and behavior beyond that of the schizoid personality, but not classifiable as any other type of schizophrenic reaction, will also be placed in this group. *This includes the so-called “latent”, “incipient”, and “pre-psychotic” schizophrenic reactions.* (ibid., emphasis added)

This diagnosis included the schizophrenia proneness cases, but did not refer to them as prodrome. The referred “Schizoid Personality” was characterized by “avoidance of close relations with others, inability to express directly hostility or even ordinary aggressive feelings, and autistic thinking” (ibid., p. 35). It was related at puberty with “introversion, namely, quietness, seclusiveness, ‘shut-in-ness’, and unsociability, often with eccentricity” (ibid.). Both acute and chronic undifferentiated types seem to be the first reference to prodromal or pre-psychotic categories in US psychiatric classification.

DSM-II (1968)

Although the DSM-I had much more useful categories for outpatient services than previous North-American classifications, in 1955 almost 60% of psychiatric patients in the US were still treated in asylums (Cooper

& Blashfield, 2016). The somatic treatments provided in hospitals and developed mainly in the 1930s and 1940s (prolonged narcosis, insulin coma, seizure induction with camphor oil/metrazol, and frontal leukotomy) had been gradually replaced in the 1950s by the use of pharmacotherapy (Sadowsky, 2006; Tueth, 1995). But in the late 1950s and early 1960s the anti-psychiatric movement rose in the US, criticizing psychiatric nosology for the development of “the myth of mental illness” (Szasz, 1960). According to proponents of this movement, the function of mental illness was “to disguise and ... render more palatable the bitter pill of moral conflicts in human relations” (ibid., p. 118). Mental illnesses were thus considered an inappropriate way to label and deal with “problems in living” (ibid.). Notwithstanding, the conception of mental illness as common problems in the adjustment of the individual to society and environment (i.e. “problems in living”) was not first brought into life by Thomas Szasz (1920-2012) and other anti-psychiatry authors. As previously seen, Meyer, Sullivan and other psychiatrists inspired by psychodynamic and psychoanalytic thinking popularized this idea (and the terminology adopted by DSM-I) in the US in the first half of the twentieth century. Although to our knowledge there is no historical evidence of a direct relation between anti-psychiatric movement and the making of DSM-II, published in 1968, interestingly the new manual abandoned the term “reactions”, as seen by the change from “schizophrenic reaction” to “schizophrenia” (APA, 1968, p. ix).

The DSM-II contained 119 pages with 193 diagnostic categories divided into 11 sections, and the psychoses section, renamed to “Psychoses not attributed to physical conditions” (APA, 1968, p. 32), was slightly expanded (Figure 1). The definition of schizophrenia and the description of its types also did not change much from DSM-I. Of notice, “latent” schizophrenia included in DSM-I “Schizophrenic reaction, chronic undifferentiated type” became a proper type, and the “Schizophrenic reaction, acute undifferentiated type” was renamed to “Acute schizophrenic episode” (ibid., p. 34). In respect to prodromal or pre-psychotic phases, the new “Schizophrenia, latent type” still encompassed “disorders sometimes designated as incipient, pre-psychotic, pseudoneurotic, pseudopsychopathic, or borderline” (ibid.). The “Acute schizophrenic episode” also still encompassed schizophrenic symptoms with spontaneous recovery within weeks and possible recurrence. The terms “prodrome” and “prodromal”, however, disappeared from the classification without explanation.

DSM-III (1980)

The development and widespread use of anti-psychotic medications in the 1950s and 1960s not only reduced the use of other somatic treatments, but allowed state hospital administrators and psychiatrists to consider the option of discharging to the community inpatients who may have been hospitalized for decades (Decker, 2007; Rochefort, 1984; Tueth, 1995). Community mental health centers opened all around the US to provide outpatient biopsychosocial management and resocialization services. However, the idealized plan never came fully to practice and many discharged patients could not access adequate mental health services. With time some patients started living in the streets or went to jails, while the availability of beds in psychiatric hospitals plummeted (Tueth, 1995). With the continuous rise of anti-psychiatric movement, the public image of US psychiatry was more and more criticized, while the US society was rapidly changing (Sanford, 1970). In contrast to a social scenario which gradually stressed “efficiency and rationality” (ibid., p. 215), the US psychiatry faced many important scientific, political and economic problems in the 1970s (Mayes & Horwitz, 2005; Rosenhan, 1973; Spitzer, 1973).

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In face of an embarrassing public image and the threat of losing professional space, US psychiatry urged a change to solve its crisis and DSM-III was a proposed answer to it (Wilson, 1993). Interestingly the history of the third edition begins before the publication of the DSM-I. In the early 1950s, at Washington University in St. Louis, a group of psychiatric researchers headed by Eli Robins (1921-1994), Samuel Guze (1924-2000) and George Winokur (1925-1996) started developing structured interviews, examining mental illness prognosis, and performing family studies (Fischer, 2012). In the following decades they developed research on biological psychiatry, exploring pathophysiological data of mental disorders. They were dissatisfied with the state of US psychiatry at their time, especially by its disregard of a medical model of mental disease which presupposed specific diagnosis. They believed that biologically-focused empirical psychiatric research could be useful for the treatment and improvement of the mentally ill (Decker, 2007). The group trained medical residents and one of them, John Feighner, worked refining diagnostic criteria capable of providing much greater reliability than DSM-II categories. Feighner, the St. Louis trio and other colleagues published their *Diagnostic Criteria for Use in Psychiatric Research* in 1972 with a clear intention: to present a synthesis “based on

data rather than opinion or tradition” (Feighner et al., 1972, p. 62). Due to this strong pursuit of more specific disease categories and a shift from a psychosocial model to a medical one, the Washington Group of St. Louis was called (and some of its members self-proclaimed themselves) the “neo-Kraepelinians” (Decker, 2007, p. 345).

In 1974 the psychiatrist Robert Spitzer was appointed as the chairman of the DSM-III task-force. He, in collaboration with the Washington University group, extended Feighner criteria, creating the *Research Diagnostic Criteria* (RDC) to solve “a crucial problem in psychiatry ... the generally low reliability of current psychiatric diagnostic procedures” (Spitzer, Endicott, & Robins, 1978, p. 773). His pragmatism and political skills, in accordance with the mindset of the time, made him achieve the complex task of changing the underlying model in the APA classification of mental disorders (Decker, 2007). DSM-III grew up to 494 pages, with 163 of its 228 categories described with specific diagnostic criteria (APA, 1980). For each diagnosis there was a general explanation of the category, the presentation of typical demographic profile, comments on differential diagnosis and, if known, on the onset and course of the disorder. For the first time, the DSM presented a definition of mental disorder:

a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability) ... and the disturbance is not only in the relationship between the individual and society. (ibid., p. 6)

DSM-III concepts were quickly adopted in psychiatric practice, teaching, and research. In the first half of the 1980s most US textbooks of psychology and psychiatry adopted DSM-III as their organizing structure, and residency programs prepared their examinations based on its criteria. Scientific journal editors began to expect papers written in DSM-III language, and it started to be assumed that proposals in psychiatric research would conform to conventions presented by the manual (Kawa & Giordano, 2012). Moreover, while DSM-III did not explicitly suggest treatment options, it was compatible with biological therapies customized to symptom-based discretely constructed disease entities (ibid.). The 1980s witnessed the allocation of billions of dollars by the government and pharmaceutical companies for psychopharmacological research, with a subsequent increase in prescriptions. Insurance providers also welcomed DSM-III as a better reference for reimbursement (Mayes & Horwitz, 2005; Wilson, 1993). The manual categories became so ubiquitous

in US psychiatry that by the end of the 1980s, as Noll put it, “biological psychiatry had purged the profession of its eclecticism” (Noll, 2011, p. 279).

The schizophrenia description changed significantly (Figure 1). First, it appeared in a chapter entitled “Schizophrenic disorders” and comprised a group of disorders whose essential features were “the presence of certain psychotic features during the active phase of the illness, characteristic symptoms involving multiple psychological processes, deterioration from a previous level of functioning, onset before age 45, and a duration of at least six months” (APA, 1980, p. 181). With the minimal 6-month duration, the category DSM-II “Acute schizophrenic episode” was split into “Brief Reactive Psychosis” (preceded by a psychosocial stressor with a maximum duration of 2 weeks) and “Schizophreniform Disorder” (same as schizophrenia, but during from 2 weeks to 6 months), both described in another chapter entitled “Psychotic Disorders Not Elsewhere Classified” (ibid., p. 199). Second, “illnesses without overt psychotic features, which have been referred to as Latent, Borderline, or Simple Schizophrenia” (ibid., p. 181) should be diagnosed as “Schizotypal Personality Disorder”. The new personality category included individuals with various eccentricities of communication or behavior “not severe enough to meet the criteria for Schizophrenia” (ibid., p. 312). With this inclusion there was a change in “Schizoid Personality Disorder”, which became a category for diagnosing individuals with “defects in the capacity to form social relationships but without eccentricities of communication or behavior” (ibid., p. 310). All this rearrangement was in line with an intention to narrow the schizophrenia concept (Andreasen, 1989).

Third, the schizophrenia prodromal phase was not only brought back to life, but also presented with a list of symptoms: “(1) social isolation or withdrawal; (2) marked impairment in role functioning as wage-earner, student, or homemaker; (3) markedly peculiar behavior (e.g., collecting garbage, talking to self in public, or hoarding food); (4) marked impairment in personal hygiene and grooming; (5) blunted, flat, or inappropriate affect; (6) digressive, vague, overelaborate, circumstantial, or metaphorical speech; (7) odd or bizarre ideation, or magical thinking, e.g., superstitiousness, clairvoyance, telepathy, “sixth sense,” “others can feel my feelings,” overvalued ideas, ideas of reference; (8) unusual perceptual experiences, e.g., recurrent illusions, sensing the presence of a force or person not actually present” (APA, 1980, p. 189). In the new glossary of terms, “prodromal” was defined generally as “early signs or symptoms of a disorder” (ibid., p. 367).

DSM-III-R (1987)

Research on DSM-III criteria appeared soon after the manual was published, generating data that motivated the task-force for an update entitled DSM-III-R (APA, 1987). Although its structure remained the same, the revision had 567 pages, with 174 of its 253 categories defined using diagnostic criteria (compared to 163 of 228 in DSM-III). The chapter “Schizophrenic Disorders” was renamed to “Schizophrenia”. The diagnosis gained a minimal duration limit of one week and abandoned the maximum age limit of 45 years (*ibid.*, p. 419). To move towards more “descriptive” terms, “Affective Disorders” were renamed to “Mood Disorders”, and “Paranoid Disorders” were renamed to “Delusional Disorders” (*ibid.*, p. 213, 420). The prodrome continued with the same definition from DSM-III in the glossary of terms and the list of prodromal symptoms increased by one item, “(9) marked lack of initiative, interests, or energy” (*ibid.*, p. 195).

DSM-IV (1994)

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The time between the editions of DSM was gradually decreasing, generating complaints about the rate of change (Fischer, 2012). However, the DSM-IV task-force did not fully address these complaints and proceeded with the revision that would generate, “more than any other nomenclature of mental disorders, [a manual] grounded in empirical evidence” (APA, 1994a, p. xvi). Although DSM-III and DSM-III-R relied on data from the RDC and Feighner criteria for some categories, most of them were the result of expert opinion. The DSM-IV task force intended to change that by “finding, extracting, aggregating, and interpreting data in a comprehensive and objective fashion” (*ibid.*, p. xviii). US psychiatry started to parallel the rise of an evidence-based approach in general medicine during the 1990s (Claridge & Fabian, 2005).

To accomplish this task, the APA chose a new leader for the DSM-IV, Allen Frances, who created the 13 work groups responsible for the various subsections of the DSM-IV. Their initial task was to perform careful literature reviews of the various diagnostic categories, which generated a three-volume series of source books with more than 3,000 pages (APA, 1994b, 1995, 1997). The DSM-IV grew to 886 pages and had 201 of its 383 categories defined using diagnostic criteria (APA, 1994a).

The chapter on schizophrenia was renamed to “Schizophrenia and Other Psychotic Disorders”. (Figure 1). The DSM-III-R “Brief Reactive Psychosis” was renamed to “Brief Psychotic Disorder” in DSM-IV, eliminating the requirement for a severe psychosocial stressor (although this could be indicated by the specifier “With Marked Stressor”). The resulting category included all psychotic disturbances lasting less than 1 month that were not attributable to a mood disorder and were not due to the direct physiological effects of substance use or a general medical condition. The minimum duration of the psychotic symptoms increased from a few hours to 1 day (APA, 1994a, p. 779). The definition of “Schizophrenia” changed in duration (a minimum of 1 month duration, opposed to 1 week in DSM-III-R) and it categorized symptoms as “positive” (excess or distortion of normal functions) and “negative” (a diminution or loss of normal functions).

The lack of proven validity of prodromal symptoms was responsible for removing the DSM-III-R list (Yung & McGorry, 1996). However, in the supportive text of Schizophrenia the description of prodrome gained more details. The prodromal phase could appear as negative symptoms, which “are often the first sign to the family that something is wrong”, and as “positivelike symptoms”, which were “relatively mild or subthreshold forms of the positive symptoms” (APA, 1994a, p. 278). The term “prodrome” also was redefined as an “early or premonitory sign or symptom of a disorder” (ibid., p. 770).

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DSM-IV-TR (2000)

In order to keep DSM-IV up-to-date, the APA reviewed the manual and published the DSM-IV-TR (APA, 2000). It had 943 pages, with no substantive changes made to the DSM-IV criteria nor the number of disorders. The update occurred in the supportive text describing associated features of disorders, which included laboratory findings, culture, age, and gender features, prevalence, course, and familial pattern (Blashfield et al., 2014). With regard to whether these modifications demanded the publication of a new DSM, or whether they could have been released as bulletins, or even just be presented as updates in DSM-IV subsequent printings, Fischer (2012) remembered that “DSM-III was a best-seller, and, by the early 1980s, the APA had shifted its organization so that most of its funds came from publications” (ibid., p. 1029).

DSM-5 (2013)

In 1999, the APA began an evaluation of the “strengths and weaknesses of DSM” (APA, 2013, p. 6). It published in 2002 *A Research Agenda for DSM-V* (Kupfer, First, & Regier, 2002), which described many aims, as the intention to incorporate findings from studies in behavioral genetics, neuroimaging, modern molecular biology, cognitive and affective neuroscience, and psychometrics in the disorder classifications in the DSM-5 (Blashfield et al., 2014; Kawa & Giordano, 2012). DSM-5 drafts were posted on a website dedicated to the new manual. The first draft was posted in 2010 and the second in 2011, and APA received more than 10,000 online comments. Although the online form allowed posting of comments, no feedback was given to commentators. After the publication of DSM-5 in 2013, the rationales and reviews posted on the manual website were taken down and could not be retrieved. Unlike the DSM-IV, no source books were published to document the processes used by the work groups, so no public and permanent record of the making of DSM-5 lasted. These facts rendered to DSM-5 the criticism of being “secretive” (Wakefield, 2015, p. 189).

The manual grew to 947 pages, with 151 of 541 categories using diagnostic criteria (compared with 201 of 383 in DSM-IV-TR). Although DSM-5 stated that “a diagnosis does not carry any necessary implications regarding the etiology or causes of the individual’s mental disorder” (ibid., p. 25), the manual moved further into a “revised chapter structure ... informed by recent research in neuroscience and by emerging genetic linkages between diagnostic groups” (ibid., p. xlii). Even “some *putative* diagnostic markers” (ibid., emphasis added) were highlighted in the text. Genetic and physiological risk factors, together with prognostic indicators indicated a deeper integration of the notion of risk into US psychiatry,⁷ paralleling with some delay the same trend in medicine in general (Aronowitz, 2009). According to the task-force, the new structure “should improve clinicians’ ability to identify diagnoses in a disorder spectrum based on common

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⁷ It is interesting to note the increase in occurrence of the word “risk” along the DSMs editions – DSM-I and II: 0; DSM-III: 6; DSM-III-R: 25; DSM-IV: 152; DSM-IV-TR: 181; DSM-5: 485 (already discounted 317 occurrences of “Risk and Prognostic Factors” and “Suicide Risk,” which were new sections added to categories supportive text).

neurocircuitry, genetic vulnerability, and environmental exposures” (APA, 2013, p. xlii).

Some chapters were renamed to inform a more dimensional approach, such as the “Autism Spectrum Disorders” and the “Schizophrenia Spectrum and Other Psychotic Disorders”. About the later (see Figure 1), it included “schizophrenia, other psychotic disorders, and schizotypal (personality) disorder”, all characterized by “abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms” (APA, 2013, p. 87). The DSM-IV subtypes of schizophrenia were eliminated due to their limited diagnostic stability, low reliability, and poor validity. Instead, a dimensional approach to rating severity for the core symptoms of schizophrenia was included in DSM-5 Section III (ibid.). The term prodrome was described the same way it appeared in DSM-IV-TR.

Attenuated Psychosis Syndrome

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DSM-5 Section III also included a chapter entitled “Conditions for Further Study” that harbored proposals for which “the Task Force determined that there was insufficient evidence to warrant inclusion ... as official mental disorder diagnoses in Section II” (ibid., p. 783). Among the proposals was the “Attenuated Psychosis Syndrome” (APS), a clinical picture that differed from full-blown psychosis due to the sub-threshold (attenuated) intensity or frequency of presented symptoms. APS was named according to one subgroup of patients identified by high-risk mental state research criteria (Yung et al., 2005). The high-risk mental state concept had been initially developed in mid 1990s in order to prospectively identify individuals at risk for psychosis, broadening the notion of prodrome to states of significant probability to (but not certainty of) conversion to full-blown psychosis (Yung & McGorry, 1996). It pioneered in Australia, but was quickly adopted and further developed in many research centers around the world (Carpenter, 2014). Research on the subject led to the development of different conceptualizations, criteria and instruments for assessing at-risk mental states, among which is the Ultra-High-Risk (UHR) criteria (Fusar-Poli et al., 2014). The UHR criteria comprises three distinct risk groups: (a) the Attenuated Psychosis Group (which inspired the APS proposal), characterized by sub-threshold attenuated (in intensity and frequency) psychotic symptoms that endure for at least 1 week; (b) the Brief Limited Intermittent

Psychotic Symptoms (BLIPS), characterized by frank psychotic symptoms during less than 1 week that spontaneously remit; and (c) the Vulnerability group, comprised of patients with family history of psychosis in first degree relative or schizotypal personality disorder in identified patient, and impairment in the level of functioning for at least 1 month (Yung et al., 2005).

Although inspired by one of the most important and used research criteria for prospective identification of individuals at high-risk for psychosis, APS ended up in DSM-5 Section III as a condition for further study, unavailable for diagnostic purposes in clinical settings. APA justification for rejecting APS from DSM-5 main text was the failure of field trials to recruit a large enough sample of patients to measure APS diagnostic reliability (Regier et al., 2013). Even though APA stated that “the results of the DSM-5 Field Trials were intended to help to inform the DSM-5 decision-making process (along with many other factors unrelated to field trials)” (Clarke et al., 2013, p. 56), no other reasons for APS rejection were reported.

Conditions of possibility for the emergence and rejection of APS

Although a linear account cannot be traced between the UHR criteria and past DSMs categories, it is interesting to note that, if ignored duration constraints, the Attenuated Psychosis Group (and also DSM-5 APS) resembles the DSM-I “Schizophrenic reaction, chronic undifferentiated type” (“latent”, “incipient” and “pre-psychotic” cases, with schizophrenic symptoms beyond that of the schizoid personality but not classifiable as any other specific category). Accordingly, the BLIPS group shares a similar clinical description with the DSM-I “Schizophrenic reaction, acute undifferentiated type” (schizophrenic symptoms that appear acutely and spontaneously clear with tendency to recur). These similarities with old DSM-I (and also DSM-II) clinical descriptions point out that schizophrenia proneness cases, although still not systematically researched, were already in the gaze of US psychiatrists of the time. However, UHR and APS itself could not emerge without the many changes that occurred in the US psychiatry over decades. The move towards more specific disease entities and the emphasis given to research in DSM-III were of most importance to the development of specific and agreeable research criteria on high-risk mental states. Interesting to note, the first studies on the subject used DSM-III prodromal symptoms (Yung & McGorry, 1996). The focus of empirical data initiated by the Washington

University trio in the 1950s, fostered by the evidence-based approach in the development of DSM-IV and improved in DSM-5, also provided the means for the scientific validation of APS. Likewise, the integration of the notion of risk into psychiatry paved the way to the construction of a category based on probability of conversion to frank psychosis. By integrating the best contemporary scientific concepts with the potential benefits of schizophrenia prevention (or at least of its onset delay), the inclusion of APS in DSM-5 could potentially “bring psychiatry in line with other fields of medicine that identify risk factors for the purposes of instituting preventative interventions” (Corcoran, First, & Cornblatt, 2010, p. 18), a goal recurrently aimed by the profession for at last half a century.

818 However, some historical changes in the US psychiatry also seemed to be responsible for the rejection of APS from DSM-5. As Wilson (1993) noticed, in its struggle to survive as a legitimate professional practice, the US psychiatry officially adopted with DSM-III “a model of psychopathology that stressed what was publicly visible over what was privately inferred” (ibid., p. 408). It moved from a psychosocial model of disease to a medical one, disfavoring psychodynamic and psychoanalytical thinking. Nonetheless, although not necessarily intentionally, the underlying medical model of disease gradually moved further into a biomedical one. Psychiatric syndromes gained status of diseases with implicit putative neurobiological causes, and treatment gradually equated the prescription of medication, even when scientific evidence did not recommend it (Nelson, 2014). The public debate on the possible inclusion of APS in DSM-5 counted with many stakeholders, whose majority stressed the risk of stigmatization and inappropriate prescription of anti-psychotics to identified patients. McGorry, pioneer in high-risk mental states research in Australia, withdrawn his initial support to the category inclusion, highlighting the need to break “the nexus in the U.S. that drug treatment is the main or only form of intervention for patients — a nexus reinforced by the hard neurobiological reductionism that took over [North-]American psychiatry from the 1980s” (McGorry, 2012, p. 1).

Conclusions

Identification and treatment of schizophrenia as early as possible has been a pursued goal by some psychiatrists since before the DSMs. The interest in categorizing patients prone to this condition varied over time in

each edition of the manual, along with changes in DSM aims and structure. Shifts in the US psychiatry, which simultaneously received influence of and exerted influence on broader changes in US society, provided conditions for the scientific evolution of initial schizophrenia proneness categories to finally culminate as the APS proposal for DSM-5. However, even with important scientific advances that could enable the inclusion of a promising category for psychosis prevention in the DSM, the most feared downside of this deed was stigmatization and the potential inadequate prescription of anti-psychotic medication to identified patients (Nelson, 2014). This fact, more than anything, challenges the view that science is constituted by pure scientific interests and is isolated from historical and social particularities of professional practice (Bourdieu, 1976).

If during the making of the first DSMs the psychiatric eclecticism in US lacked empirical methods to assert the validity, reliability and clinical utility of its diagnostic categories, DSM-III and further editions had changed the balance and provided the means to do so. However, the abandonment of a multi-theoretical instance in favor of an “atheoretical” one (as if it were really possible) opened space for the influence of many kinds of biases that are harming more and more psychiatry’s reputation (Pilecki, Clegg, & McKay, 2011). In the case of APS, it is certainly very important to answer if the category is ready for DSM-5.1 or 5.2 (Carpenter, 2014; Fusar-Poli et al., 2014). But its rejection from the DSM-5 main section uncovers the utmost question of whether psychiatry itself is ready for the individuals it classifies. As Sir Aubrey Lewis stated, “philosophical influences, social influences, religious influences, ideological influences, all play their part in moulding the mental outlook of psychiatrists [and] we need to acknowledge and reckon with this when we are trying to establish a truly sound scientific discipline of psychiatry” (Lewis, 1991, p. 585).

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References

- Andreasen, N. C. (1989). The American concept of Schizophrenia. *Schizophrenia Bulletin*, 15(4), 519-531.
- APA (1952). *Diagnostic and Statistical Manual of Mental Disorders* (1st ed.). Washington, DC: American Psychiatric Association.
- APA (1968). *Diagnostic and Statistical Manual of Mental Disorders* (2nd ed.). Washington, DC: American Psychiatric Association.

- APA (1980). *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.). Washington, DC: American Psychiatric Association.
- APA (1987). *Diagnostic and Statistical Manual of Mental Disorders* (3–R ed.). Washington, DC: American Psychiatric Association.
- APA (1994a). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington, DC: American Psychiatric Association.
- APA (1994b). *DSM-IV Sourcebook* (Vol. 1). Washington, DC: American Psychiatric Publishing, Inc.
- APA (1995). *DSM-IV Sourcebook* (Vol. 2). Washington, DC: American Psychiatric Publishing, Inc.
- APA (1997). *DSM-IV Sourcebook* (Vol. 3). Washington, DC: American Psychiatric Publishing, Inc.
- APA (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4–TR ed.). Washington, DC: American Psychiatric Association.
- APA (2009). DSM History. Retrieved October 12, 2018 from: <<http://www.psychiatry.org/practice/dsm/dsm-history-of-the-manual>>.
- APA (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Aronowitz, R. A. (2009). The converged experience of risk and disease. *The Milbank Quarterly*, 87(2), 417-442.
- Beer, M. D. (1996). Psychosis: A History of the Concept. *Comprehensive Psychiatry*, 37(4), 273-291.
- Berrios, G. E. (1999). Classifications in psychiatry: a conceptual history. *Australian and New Zealand Journal of Psychiatry*, 33(2), 145-160.
- Berrios, G., & Porter, R. (1995). *A History of Clinical Psychiatry: The Origins and History of Psychiatric Disorders*. London, UK: Athlone.
- Blashfield, R. K., Keeley, J. W., Flanagan, E. H., & Miles, S. R. (2014). The cycle of classification: DSM-I through DSM-5. *Annual Review of Clinical Psychology*, 10, 25-51. <https://doi.org/10.1146/annurev-clinpsy-032813-153639>.
- Bleuler, E. P. (1924). *Textbook of Psychiatry*. New York, NY: The Macmillan Company.
- Bleuler, E. P. (1950). *Dementia Praecox or the Group of Schizophrenias*. New York, NY: International Universities Press.
- Bourdieu, P. (1976). Le champ scientifique. *Actes de la Recherche en Sciences Sociales*, 2(2), 88-104.
- Carpenter, W. T. (2014). Attenuated psychosis syndrome: Need for debate on a new disorder. *Psychopathology*, 47(5), 287-291. <https://doi.org/10.1159/000365221>.
- Claridge, J. A., & Fabian, T. C. (2005). History and development of evidence-based

- medicine. *World Journal of Surgery*, 29(5), 547-553. <https://doi.org/10.1007/s00268-005-7910-1>.
- Clarke, D. E., Narrow, W. E., Regier, D. A., Kuramoto, S. J., Kupfer, D. J., Kuhl, E. A., ... Kraemer, H. C. (2013). DSM-5 field trials in the United States and Canada, part I: Study design, sampling strategy, implementation and analytic Approaches. *American Journal of Psychiatry*, 170, 44-58.
- Cooper, R. (2004). What is wrong with the DSM? *History of Psychiatry*, 15(1), 5-25.
- Cooper, R. (2017). Understanding the DSM-5: stasis and change. *History of Psychiatry*, 29(1), 49-65.
- Cooper, R., & Blashfield, R. K. (2016). Re-evaluating DSM-I. *Psychological Medicine*, 46(03), 449-456. <https://doi.org/10.1017/S0033291715002093>.
- Corcoran, C. M., First, M. B., & Cornblatt, B. (2010). The psychosis risk syndrome and its proposed inclusion in the DSM-V: A risk-benefit analysis. *Schizophrenia Research*, 120, 16-22. <https://doi.org/10.1016/j.schres.2010.03.018>
- Decker, H. S. (2007). How Kraepelinian was Kraepelin? How Kraepelinian are the neo-Kraepelinians? – from Emil Kraepelin to DSM-III. *History of Psychiatry*, 18(3), 337-360. <https://doi.org/10.1177/0957154X07078976>
- Diefendorf, A. R. (1902). *Clinical Psychiatry – A Textbook for Students and Physicians*. New York, NY: The Macmillan Company.
- Diefendorf, A. R. (1912). *Clinical Psychiatry – A Textbook for Students and Physicians*. New York, NY: The Macmillan Company.
- Engstrom, E. J., & Weber, M. M. (2007). Making Kraepelin history: a great instauration? *History of Psychiatry*, 18(3), 267-273. <https://doi.org/10.1177/0957154X07080819>.
- Falret, J. P. (1854). Mémoire sur la folie circulaire. *Bulletin de l'Académie Nationale de Médecine*, 19, 382-400.
- Feighner, J. P., Robins, E., Guze, S. B., Woodruff, R. A., Winokur, G., & Munoz, R. (1972). Diagnostic criteria for use in psychiatric research. *Archives of General Psychiatry*, 26(1), 57-63.
- Fischer, B. A. (2012). A review of American psychiatry through its diagnoses: The history and development of the diagnostic and statistical manual of mental disorders. *Journal of Nervous and Mental Disease*, 200(12), 1022-1030. <https://doi.org/10.1097/Nmd.0b013e318275cf19>.
- Fusar-Poli, P., Borgwardt, S., Bechdolf, A., Addington, J., Riecher-Rössler, A., Schultze-Lutter, F., ... Yung, A. (2013). The psychosis high-risk state: a comprehensive state-of-the-art review. *JAMA Psychiatry*, 70(1), 107-120. <https://doi.org/10.1001/jamapsychiatry.2013.269>.
- Fusar-Poli, P., Carpenter, W. T., Woods, S. W., & McGlashan, T. H. (2014).

- Attenuated psychosis syndrome: ready for DSM-5.1? *Annual Review of Clinical Psychology*, 10, 155-192. <https://doi.org/10.1146/annurev-clinpsy-032813-153645>
- Fusar-Poli, P., & Politi, P. (2008). Paul Eugen Bleuler and the birth of schizophrenia (1908). *American Journal of Psychiatry*, 165(11), 1407. <https://doi.org/10.1176/appi.ajp.2008.08050714>.
- Gelder, M. (2003). Introduction: Adolf Meyer and his influence on British psychiatry. *History of Psychiatry*, 14(4), 475-508.
- Gonçalves, A. M. N., Dantas, C. R., & Banzato, C. E. M. (2016). Values and DSM-5: looking at the debate on attenuated psychosis syndrome. *BMC Medical Ethics*, 17(7), 8. <https://doi.org/10.1186/s12910-016-0090-8>.
- Hecker, E. (1871). Die Hebephrenie – Ein Beitrag zur klinischen Psychiatrie. *Archiv Für Pathologische Anatomie Und Physiologie Und Für Klinische Medicine*, 52(3), 394-429. <https://doi.org/10.1007/BF02329963>.
- Huertas, R. (2017). Actualizando discursos. In *Otra historia para otra psiquiatría* (pp. 251-269). Barcelona, Espanha: Xoroi Edicions.
- Jablensky, A. (2007). Living in a Kraepelinian world: Kraepelin's impact on modern psychiatry. *History of Psychiatry*, 18(3), 381-388. <https://doi.org/10.1177/0957154X07079690>.
- Jablensky, A. (2010). The diagnostic concept of schizophrenia: its history, evolution, and future prospects. *Dialogues in Clinical Neuroscience*, 12(3), 271-287.
- Kahlbaum, K. (1874). *Die Katatonie – oder das Spannungsirresein, Eine klinische Form psychischer Krankheit*. Berlin, Germany: August Hirschwald.
- Kawa, S., & Giordano, J. (2012). A brief historicity of the Diagnostic and Statistical Manual of Mental Disorders: Issues and implications for the future of psychiatric canon and practice. *Philosophy, Ethics, and Humanities in Medicine*, 7(1), 1-9. <https://doi.org/10.1186/1747-5341-7-2>.
- Kraepelin, E. (1893). *Psychiatrie: Ein Lehrbuch Für Studierende Und Aerzte* (4th ed.). Leipzig, Germany: Ambr. Abel.
- Kraepelin, E. (1896). *Psychiatrie: Ein Lehrbuch Für Studierende Und Aerzte* (5th ed.). Leipzig, Germany: Johann Ambrosius Barth.
- Kraepelin, E. (1899). *Psychiatrie: ein Lehrbuch für Studierende und Aerzte* (6th ed.). Leipzig, Germany: Johann Ambrosius Barth.
- Kupfer, D. J., First, M. B., & Regier, D. A. (2002). *A Research Agenda for DSM-V*. Washington, DC: American Psychiatric Association.
- Lewis, A. (1991). Dilemmas in psychiatry. *Psychological Medicine*, 21, 581-585. <https://doi.org/10.1017/S0033291700022212>.
- Martin, S. A. (2007). Between Kraepelin and Freud: the integrative psychiatry

- of August Hoch. *History of Psychiatry*, 18(3), 275-299. <https://doi.org/10.1177/0957154X06065266>.
- Mayes, R., & Horwitz, A. V. (2005). DSM-III and the revolution in the classification of mental illness. *Journal of the History of the Behavioral Sciences*, 41(3), 249-267.
- McGlashan, T. H. (1996). Early Detection and Intervention in Schizophrenia: Research. *Schizophrenia Bulletin*, 22(2), 327-345.
- McGorry, P. D. (1998). “A stitch in time”...the scope for preventive strategies in early psychosis. *European Archives of Psychiatry and Clinical Neuroscience*, 248, 22–31. <https://doi.org/10.1007/s004060050014>
- McGorry, P. D. (2012). News brief: Attenuated psychosis syndrome left out of DSM-5 Main Text – Comment by: Patrick McGorry (SRF Advisor). Retrieved October 12, 2018, from: <<https://ia601509.us.archive.org/30/items/chizophreniaResearchForumNewsBriefAttenuatedPsychosisSyndromeLeftOutOfDSM5MainText/SchizophreniaResearchForumNewsBriefAttenuatedPsychosisSyndromeLeftOutofDsm-5MainText.html>>.
- McNally, K. (2012). Definitions of schizophrenia, 1908-1987: The failed essentialism. *Theory & Psychology*, 22(1), 91-113.
- McNally, K. (2013). Dementia praecox revisited. *History of Psychiatry*, 24(4), 507-509.
- Meyer, A. (1922). Constructive Formulation of Schizophrenia. *The American Journal of Psychiatry*, 78(3), 355-364.
- Morel, B. A. (1852). *Études cliniques - Traité théorique et pratique des maladies mentales*. Nancy: Grimblot et Veuve Raybois.
- Morel, B. A. (1860). *Traité des maladies mentales*. Paris: Librairie Victor Masson.
- Moskowitz, A., & Heim, G. (2011). Eugen Bleuler’s Dementia Praecox or the Group of Schizophrenias (1911): A Centenary Appreciation and Reconsideration. *Schizophrenia Bulletin*, 37(3), 471-479. <https://doi.org/10.1093/schbul/sbr016>
- Nelson, B. (2014). Attenuated Psychosis Syndrome: Don’t Jump the Gun. *Psychopathology*, 47(5), 292-296. <https://doi.org/10.1159/000365291>
- Noll, R. (2011). *American Madness – The rise and fall of Dementia Praecox*. Cambridge, Massachusetts: Harvard University Press.
- Pilecki, B. C., Clegg, J. W., & McKay, D. (2011). The influence of corporate and political interests on models of illness in the evolution of the DSM. *European Psychiatry*, 26(3), 194-200. <https://doi.org/10.1016/j.eurpsy.2011.01.005>
- Regier, D. A., Narrow, W. E., Clarke, D. E., Kraemer, H. C., Kuramoto, S. J., Kuhl, E. A., & Kupfer, D. J. (2013). DSM-5 field trials in the United States and Canada, part II: Test-retest reliability of selected categorical diagnoses. *American Journal of Psychiatry*, 170, 59-70. <https://doi.org/10.1176/appi.ajp.2012.12070999>

- Rochefort, D. A. (1984). Origins of the “Third Psychiatric Revolution”: the Community Mental Health Centers Act of 1963. *Journal of Health Politics, Policy and Law*, 9(1), 1-30. <https://doi.org/10.1215/03616878-9-1-1>
- Rosenhan, D. L. (1973). On Being Sane in Insane Places. *Science*, 179(4070), 250-258.
- Rzesnitzek, L. (2013). “Early psychosis” as a mirror of biologist controversies in post-war German, Anglo-Saxon, and Soviet Psychiatry. *Frontiers in Psychology*, 4, 1-9. <https://doi.org/10.3389/fpsyg.2013.00481>
- Sadowsky, J. (2006). Beyond the Metaphor of the Pendulum: Electroconvulsive Therapy, Psychoanalysis, and the Styles of American Psychiatry. *Journal of the History of Medicine and Allied Sciences*, 61(1), 1-25. <https://doi.org/10.1093/jhmas/jrj001>
- Sanders, J. L. (2011). A Distinct Language and a Historic Pendulum: The Evolution of the Diagnostic and Statistical Manual of Mental Disorders. *Archives of Psychiatric Nursing*, 25(6), 394-403.
- Sanford, N. (1970). The Decline of Individualism. *Public Health Reports*, 85(3), 213-219.
- Shepherd, M. (1995). Two Faces of Emil Kraepelin. *British Journal of Psychiatry*, 167, 174-183.
- Spitzer, R. L. (1973). *A proposal About Homosexuality and the APA Nomenclature: Homosexuality as One Form of Sexual Behavior and Sexual Orientation Disturbance as a Psychiatric Disorder*. Arlington, VA.
- Spitzer, R. L., Endicott, J., & Robins, E. (1978). Research Diagnostic Criteria: Rationale and Reliability. *Archives of General Psychiatry*, 35, 773-782.
- Sullivan, H. S. (1994). The Onset of Schizophrenia. *The American Journal of Psychiatry*, 151(6 Suppl), 105-134.
- Szasz, T. S. (1960). The Myth of Mental Illness. *The American Psychologist*, 5(2), 113-118.
- Tandon, R., Nasrallah, H. A., & Keshavan, M. S. (2009). Schizophrenia, “just the facts” 4. Clinical features and conceptualization. *Schizophrenia Research*, 110, 1-23. <https://doi.org/10.1016/j.schres.2009.03.005>
- The National Committee for Mental Hygiene. (1918). *Statistical Manual for the Use of Institutions for the Insane*. New York: University of Michigan Library.
- Tueth, M. J. (1995). Schizophrenia: Emil Kraepelin, Adolph Meyer, and beyond. *The Journal of Emergency Medicine*, 13(6), 805-809. <https://doi.org/10.1126/science.87.2251.167>
- Venancio, A. T. A. (2010). Classifying differences: the dementia praecox and schizophrenia categories used by Brazilian psychiatrists in the 1920s. *Hist. Cienc.*

Saude-Manguinhos, 17(2), 327-343.

Wakefield, J. C. (2015). DSM-5, psychiatric epidemiology and the false positives problem. *Epidemiology and Psychiatric Sciences*, 24(3), 188-196. <https://doi.org/10.1017/S2045796015000116>

WHO. (1948). International Classification of Diseases, Revision 6.

Wilson, M. (1993). DSM-III and the Transformation of America Psychiatry: A History. *American Journal of Psychiatry*, 150(3), 399-410.

Yung, A. R., & McGorry, P. D. (1996). The Prodromal Phase of First-Episode Psychosis: Past and Current Conceptualizations. *Schizophrenia Bulletin*, 22(2), 353-370.

Yung, A. R., Yuen, H. P., McGorry, P. D., Phillips, L. J., Kelly, D., Dell'olio, M., ... Buckby, J. (2005). Mapping the onset of psychosis: The Comprehensive Assessment of At-Risk Mental States. *The Australian and New Zealand Journal of Psychiatry*, 39(1), 964-971. <https://doi.org/10.1080/j.1440-1614.2005.01714.x>

Abstracts

(Uma revisão histórica das categorias de propensão à esquizofrenia do DSM-I ao DSM-5 [1952-2013])

A história das classificações diagnósticas na psiquiatria tem sido reconhecida como meio privilegiado de acesso às vicissitudes inerentes à configuração do campo científico e profissional, além de trazer aportes significativos para a história conceitual. Tomamos como principais fontes primárias as cinco edições do DSM (1952-2013) para examinar a construção de categorias diagnósticas relacionadas à propensão para a esquizofrenia, indicando os contextos sociais e científicos relacionados ao desenvolvimento do DSM e da própria psiquiatria. Nesse processo, destacamos as condições de possibilidade para a emergência da Síndrome Psicótica Atenuada, uma proposta diagnóstica altamente controversa, na preparação do DSM-5. Essa proposta foi rejeitada não somente no plano científico, mas também em razão de temidas consequências indesejadas.

Palavras-chave: História do Manual Diagnóstico e Estatístico de Transtornos Mentais (DSM), esquizofrenia, síndrome psicótica atenuada, valores em psiquiatria

(Un rappel historique des catégories de prédisposition à la schizophrénie du DSM-I au DSM-5 [1952-2013])

L'histoire des classifications diagnostiques en psychiatrie a été reconnue comme un moyen privilégié d'accès aux vicissitudes inhérentes à la configuration du champ

scientifique et professionnel, apportant également des contributions importantes à l'histoire conceptuelle. Comme sources primaires principales, nous avons utilisé les cinq éditions du DSM (1952-2013) pour examiner la construction des catégories diagnostiques liées à la prédisposition à la schizophrénie, en indiquant les contextes scientifiques et sociaux du développement du DSM et de la psychiatrie elle-même. Au cours de ce processus, nous mettons en évidence les conditions de possibilité d'émergence du Syndrome Psychotique Atténué, une proposition diagnostique fortement controversée, dans l'élaboration du DSM-5. Cette proposition a fini par être rejetée, non seulement pour des raisons scientifiques, mais aussi par crainte des conséquences non désirées.

Mots clés: Histoire du Manuel Diagnostique et Statistique des Troubles Mentaux

(DSM); schizophrénie; syndrome psychotique atténué; valeurs en psychiatrie

(Una revisión histórica de las categorías de propensión a la esquizofrenia del DSM-I al DSM-5 [1952-2013])

La historia de las clasificaciones diagnósticas en psiquiatría, ha sido reconocida como un medio privilegiado de acceso a las vicisitudes inherentes a la configuración de un campo científico y profesional, además de traer aportes significativos a la historia conceptual. Como recursos primarios, hemos utilizado las cinco ediciones del DSM (1952-2013), para examinar la construcción de categorías de diagnóstico relacionadas a la propensión a la esquizofrenia, indicando los contextos sociales y científicos relacionados al desarrollo del DSM y de la propia psiquiatría. A lo largo del proceso, destacamos las condiciones de posibilidad para el surgimiento del Síndrome de Psicosis Atenuada, una propuesta de diagnóstico altamente controvertida, durante la elaboración del DSM-5. Esta propuesta fue rechazada, no solo por motivos científicos, sino también por las temidas consecuencias indeseadas.

Palabras clave: Historia del Manual Diagnóstico y Estadístico de los Trastornos Mentales (DSM), esquizofrenia, síndrome de psicosis atenuada, valores en psiquiatría

(Historischer Überblick der Schizophrenie-Kategorien von DSM-I bis DSM-5 [1952-2013])

Die Geschichte der diagnostischen Klassifizierungen in der Psychiatrie wird als privilegiertes Mittel des Zuganges zu dem Wandel im Rahmen der Gestaltung eines wissenschaftlichen, beruflichen Gebietes anerkannt und trägt wesentlich zur Begriffsgeschichte bei. Als primäre Quellen wurden die fünf Auflagen des DSM (1952-2013) berücksichtigt, um den Aufbau der diagnostischen Kategorien mit Neigung zur Schizophrenie und den sozialen und wissenschaftlichen Zusammenhang der Entwicklung des DSM und der Psychiatrie zu untersuchen. Dabei heben wir die Möglichkeiten der Notbehandlung für „Attenuated Psychosis Syndrome“, eines sehr

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umstrittenen diagnostischen Vorschläges bei der Vorbereitung des DSM-5, hervor. Dieser Vorschlag wurde nicht nur aus wissenschaftlichen Gründen, sondern auch aufgrund befürchteter, unerwünschter Folgen abgelehnt.

Schlüsselwörter: Geschichte des DSM, Schizophrenie, „Attenuated Psychosis Syndrome“ (schwache Psychose), Werte in der Psychiatrie

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