Without a proper definition, you do not see the phenomenon

The history of a missing diagnosis

Revision of a paper originally presented at the AAPP conference
Consciousness and its pathologies
San Diego, California, May 17-18, 1997

Helge Malmgren
PhD, MD, Associate Professor,Dept. of Philosophy, Göteborg University
e-mail: helge.malmgren@filosofi.gu.se

List of contents:

Introduction

The theme of this conference is *Consciousness and its pathologies.* In my lecture, I will talk about a psychiatric disorder, which is usually not classified as a "disturbance of consciousness". However, it involves disturbances of subconscious cognitive functions, and so can help us understand the ways in which consciousness depends on such functions. I will also try to show that the disorder is worthy of the philosopher’s attention for several other reasons.

The disturbance in question will here be referred to as ***astheno-emotional disorder*** (or AED). The term was introduced by my Swedish collegue Göran Lindqvist and myself in two relatively recent publications (Lindqvist & Malmgren 1990, 1993a), so if you are not familiar with the term, you are excused. To explain its meaning, I have chosen to start by presenting a number of cases. Hopefully, this also ensures that my lecture is in gear with the experiences and concepts of those of you who are familiar with organic psychiatry (or neuropsychiatry). All of the cases are from Göran Lindqvist's clinical practice, and most of them have already been published. It should be noted that the cases are not unique. On the contrary, each of these patients represents a common kind of patients in organic psychiatry.

(Note: The repetitions in the case descriptions derive from the fact that both the pictures shown and the spoken text is reproduced here.)

Four cases

Here, then, are the first four cases.

Case 1

Male, 20, who after a traffic accident with *head trauma* suffers from **concentration difficulties, forgetfulness, irritability and occasional emotional lability.** The symptoms only allow him to work half-time. Complete recovery after six months.
DSM-IV diagnosis: ***294.9 Cognitive Disorder NOS (Tentatively: Postconcussional Disorder)***
ICD-10 (psychiatric) diagnosis: ***F07.2 Postconcussional syndrome***

The first patient is a 20 year old man, who after a traffic accident with head trauma suffers from concentration difficulties, forgetfulness, irritability and occasional emotional lability. The symptoms only allow him to work half-time. He has recovered completely after six months.

I will try to state DSM-IV and ICD-10 diagnoses for all the patients. However, my general argument does not depend on these diagnoses being the most adequate ones. The proper DSM-IV diagnosis in Case 1 is clearly *Cognitive Disorder Not Otherwise Specified*, with the possible additional specification

Postconcussional Disorder. In ICD-10, the psychiatric diagnosis will be *Postconcussional syndrome*.

Case 2 *(= Case 3; Lindqvist & Malmgren 1990)*

Female, 59, who develops neurological symptoms and an **emotional lability, irritability and sense of fatigue.** Subjectively no memory difficulties or other mental symptoms; objectively, also considerable **concentration difficulties.** A *parieto-sagittal meningeoma* is removed.
DSM-IV diagnosis: ***310.1 Personality Change Due to Brain Tumor, Labile Type***
ICD-10 diagnosis: ***F06.6 Organic emotionally labile (asthenic) disorder***

The second case is a woman of 59, who develops localizing neurological symptoms but also emotional lability, irritability and a sense of fatigue. Subjectively she has no memory difficulties or other mental symptoms, but objectively, one also finds clear concentration difficulties. Her symptoms are relieved soon after a parieto-sagittal meningeoma has been removed. Because of the dominating emotional component in the clinical picture, the proper DSM-IV diagnosis here is *Personality Change Due to Brain Tumor, Labile Type*, while following ICD-10, we would call the condition *Organic emotionally labile (asthenic) disorder*. This case was published in the 1990 book by Professor Lindqvist and myself, **Organic Psychiatry.**

Case 3

Female, 25, who gradually develops **concentration difficulties, mental fatiguability and occasional memory failure.** The condition is first judged as psychogenic, especially when after some time she shows mild **depressive symptoms.**However, she finally develops physical signs of *Cushing's disease*, and when proper treatment of this condition is installed her mental symptoms soon disappear.
(Retrospective) DSM-IV diagnosis: ***294.9 Cognitive Disorder NOS (Tentatively: Mild Neurocognitive Disorder)***

***ICD-10 diagnosis:*F06.7 Mild cognitive disorder**

Our third case is a 25 year old woman, who gradually develops concentration difficulties, mental fatiguability and occasional memory failure. The condition is first judged as psychogenic, especially when after some time she shows mild depressive symptoms. However, she finally develops physical signs of Cushing's disease, and when proper treatment of this condition is installed her mental symptoms soon disappear. The correct retrospective DSM-IV diagnosis for this patient is, I think, *Cognitive Disorder Not Otherwise Specified*, just like Case 1. However, the subtype should now be*Mild Neurocognitive Disorder.* In ICD-10, the diagnosis will be *Mild cognitive disorder.*

Case 4 *(= Case 2; Lindqvist & Malmgren 1990)*

Female, 57, with severe femoro-inguinal pain and chronically disturbed sleep after appendectomy. In daytime she **cannot concentrate properly, is easily fatigued, emotionally labile, irritable and depressed.** After two years both the pain and the mental symptoms diminish somewhat.
***DSM-IV diagnosis:*300.4 Dysthymic Disorder**
***ICD-10 diagnosis:*F48.0 Neurasthenia**

Case 4, which is also in our book, figures a female of 57 with severe neuralgic pain and chronically disturbed sleep after appendectomy. In daytime she cannot concentrate properly, is easily fatigued, emotionally labile, irritable and depressed. After two years both the pain and the mental symptoms diminish somewhat. The best DSM-IV diagnosis is, I think, *Dysthymic Disorder* and the proper ICD-10 diagnosis is *Neurasthenia.*

Now, if you inspect these four cases first with respect to their phenomenology, and then with respect to their classification, you will probably note that the patients have quite similar symptoms but receive many different diagnostic labels. This splitting up of diagnoses is most obvious if you choose ICD-10, but it is marked also with the DSM-III. The diagnostic splitting is partly due to the fact that etiological considerations count. However, it also makes a difference for the diagnosis whether cognitive or emotional problems dominate the clinical picture, as you can see from comparing Cases 2 and 3.

Characteristic symptoms of AED

As you may have guessed already, we want to eliminate the diagnostic splitting by subsuming all four cases under the same category. Each of these patients manifests a substantial subset of the cardinal symptoms of a mild astheno-emotional disorder, as we define it. These cardinal symptoms are: **concentration difficulties, mental fatiguability, memory disturbances, emotional lability** and **irritability.**

Typical manifestations of AED

Mild to moderate forms:

- **Concentration difficulties (specifically: problems with upholding sustained attention)**
- **Mental fatiguability**
- **Secondary memory disturbances (affecting STM as well as storing to, and retrieval from, LTM)**
- **Emotional lability**
- **Irritability**

In severe forms also:

- **Slowed and impoverished associations**
- **Reduced ability to apprehend complex facts**
- **Destruction of stored LTM traces?**

Common psychogenic complications:

- **Anxiety**

• Tension

• Other "neurasthenic" symptoms

• Depressive mood

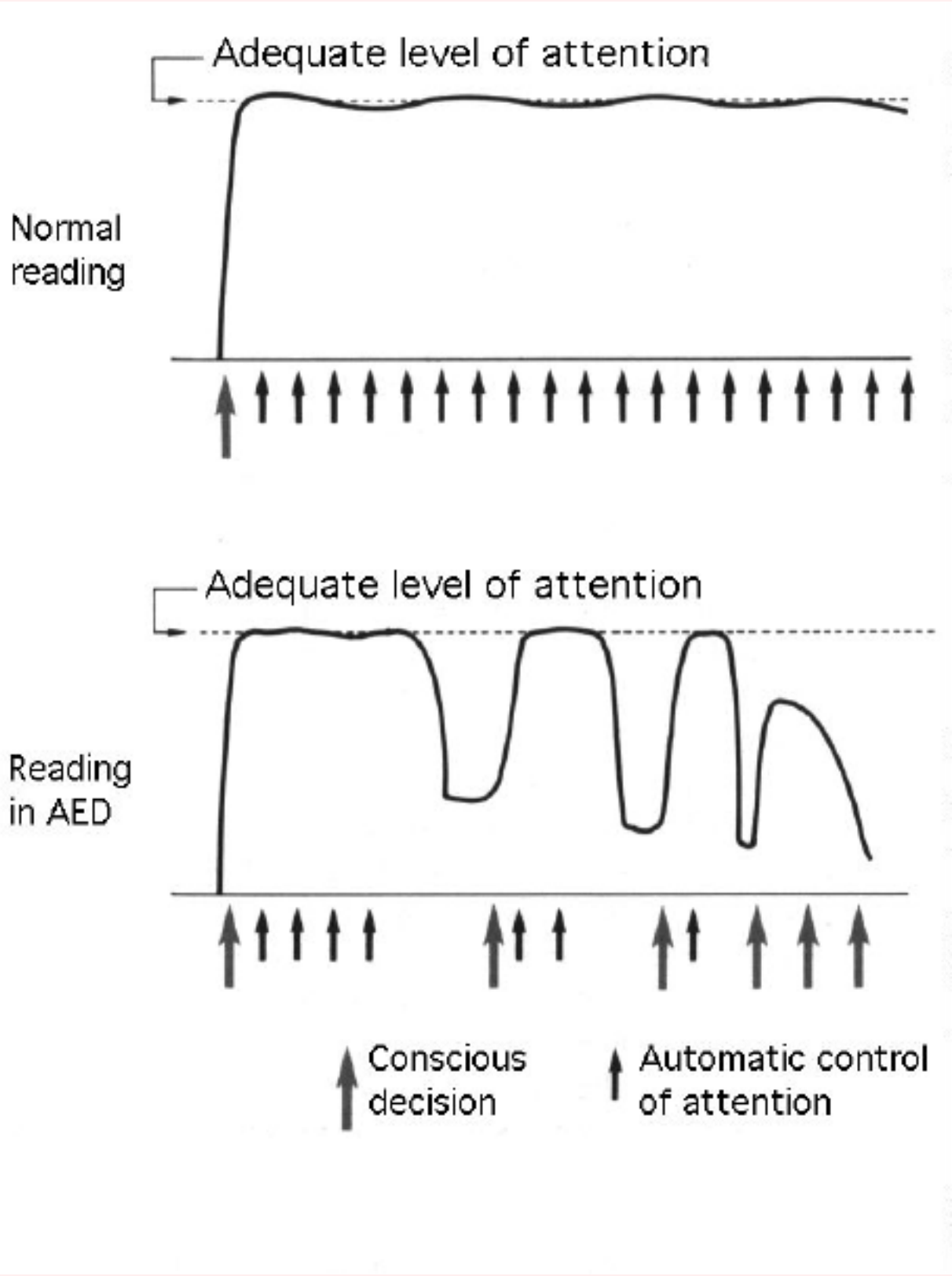
Important masking mechanisms

• If a patient with AED develops a motivational and emotional flattening, his emotional lability, fatiguability and irritability often seem to disappear (e.g., when a fronto-limbic lesion progresses).

• If a patient with AED also has Korsakoff's amnestic disorder, it is difficult to discern those memory deficits which are due to his AED (cf. the period of convalescence after a subarachnoidal bleeding).

As you can see there are additional symtoms in severe forms of AED; I will refer to them later. Now I want to direct your attention to five important matters of detail.

• First. The concentration difficulties in AED can also be characterized as an attention deficit, and more specifically, as a difficulty to maintain sustained attention. This deficit can be tested with psychometric or everyday tasks which require protracted mental work. Here is a picture which contrasts what happens when a healthy person undertakes an interesting reading task with the sequence of events which typically ensues when a patient with mild AED tries to do the same.



Both initiate the reading by a conscious act of will. The difference is that the patient's automatic attention-keeping mechanisms soon fail, and he has to make a conscious effort to continue. The same happens over and over again, until he finally gives up.

• Secondly. It is well-known that attention deficits of different kinds can have a considerable negative influence on learning and remembering. In line with this, we think that the memory disturbances in mild AED are all secondary to the

patient's concentration difficulties. They are quite different in nature from the primary memory deficits seen in Amnestic Disorder, and it is usually not at all difficult to distinguish between them clinically and psychometrically.

• Third, the emotional change in AED is a lability, not a flattening. *The term "emotional disturbance" should never be used without further specification* since it includes not only emotional lability but also the emotional flattening which, for example, is seen in advanced fronto-limbic lesions.

• Four. We believe that the cognitive and the emotional disturbances in mild AED stem from a common source, namely, a defect in the subconscious filtering-out of irrelevant associations and stimuli. Hence we regard both the cognitive and the emotional symptoms as nuclear symptoms of AED, and it does not matter to this diagnosis if the one or the other component dominates.

• Five. AED is an etiologically completely neutral diagnosis, so it can even be applied to psychogenic cases (compare Case 4).

L-M diagnoses of the four cases

Now, let me briefly repeat the four cases and state our diagnostic decisions. All four patients are judged as having mild astheno-emotional disorder. Two of them also recieves the additional diagnosis of a mild depression. "L&M" below stands for *Lindqvist and Malmgren*, as you may have guessed.

Case 1

Male, 20, who after a traffic accident with *head trauma* suffers from **concentration difficulties, forgetfulness, irritability and occasional emotional lability.** The symptoms only allow him to work half-time. Complete recovery after six months.
DSM-IV diagnosis: ***294.9 Cognitive Disorder NOS (Tentatively: Postconcussional Disorder)***
ICD-10 (psychiatric) diagnosis: ***F07.2 Postconcussional syndrome***
L&M diagnosis: ***Mild astheno-emotional disorder***

Case 2 *(= Case 3; Lindqvist & Malmgren 1990)*

Female, 59, who develops neurological symptoms and an **emotional lability, irritability and sense of fatigue.** Subjectively no memory difficulties or other mental symptoms; objectively, also considerable **concentration difficulties.** A *parieto-sagittal meningeoma* is removed.
DSM-IV diagnosis: ***310.1 Personality Change Due to Brain Tumor, Labile Type***
ICD-10 diagnosis: ***F06.6 Organic emotionally labile (asthenic) disorder***
L&M diagnosis: ***Mild astheno-emotional disorder***

Case 3

Female, 25, who gradually develops **concentration difficulties, mental fatiguability and occasional memory failure.** The condition is first judged as psychogenic, especially when after some time she shows mild **depressive symptoms.**However, she finally develops physical signs of *Cushing's disease*, and when proper treatment of this condition is installed her mental symptoms soon disappear.
(Retrospective) DSM-IV diagnosis: ***294.9 Cognitive Disorder NOS (Tentatively: Mild Neurocognitive Disorder)***
ICD-10 diagnosis: ***F06.7 Mild cognitive disorder***
L&M diagnosis: ***Mild astheno-emotional disorder***

Case 4 *(= Case 2; Lindqvist & Malmgren 1990)*

Female, 57, with severe femoro-inguinal pain and chronically disturbed sleep after appendectomy. In daytime she **cannot concentrate properly, is easily fatigued, emotionally labile, irritable and depressed.** After two years both the pain and the mental symptoms diminish somewhat.
DSM-IV diagnosis: ***300.4 Dysthymic Disorder***
ICD-10 diagnosis: ***F48.0 Neurasthenias***
L&M diagnosis: ***Mild astheno-emotional disorder***

Three more cases

I have brought three more cases, demonstrating how we use the AED construct in cases with moderate and severe pathology. As we use the term astheno-emotional disorder, it allows for many degrees. In the definition of its severe forms (cf above), symptoms such as slowing and impoverishment of associations are included.

Case 5 *(= Case 1; Lindqvist & Malmgren 1990)*

Male, 37, who gradually develops a **distressing mental fatiguability, concentration difficulties, a marked emotional lability and and a serious weakness of memory.** It has become more and more difficult for him to work. Six months after removal of a *frontal convexity meningeoma* he has recovered completely.
DSM-IV: ***293.9 Mental Disorder NOS Due to Brain Tumor***
ICD-10: ***F07.8 (Other organic personality and behavioural disorders due to brain disease, damage and dysfunction)***
L&M: ***Moderate astheno-emotional disorder***

Case 5, also in our book, is a man of 37 who gradually develops a *marked* mental fatiguability, concentration difficulties, emotional lability and a *serious* weakness of memory which makes him quite incapable of working. Six months after removal of a frontal convexity meningeoma he has recovered completely and is working full-time. The severity of this patient's symptoms should make on hesitate to use the diagnosis of **mild** cognitive (or neurocognitive) disorder (as in Case 3), and I suggest the DSM-IV diagnosis *Mental Disorder Not Otherwise Specified, Due to Brain Tumor.* Similarly, I suggest the ICD-10 category *Other organic personality and behavioural disorders due to brain disease, damage and dysfunction.* Maybe I am wrong about what can be included within the category of "mild cognitive disorder", but that does not matter for my argument.

Case 6 *(= Case 3; Lindqvist et al 1993)*

Female, 74, with ***subarachnoidal haemorrhage,*** who first improves

but then deteriorates with **somnolence, severe memory difficulties and disorientation.** Diagnosis: *normal pressure hydrocephalus.* Shunt operation. Four months after that she is awake and oriented and manages her family's household with some help, but still has **marked concentration difficulties and memory problems.**
Pre-op, DSM-IV: ***294.1 Dementia due to normal pressure hydrocephalus***
Pre-op, ICD-10: ***F02.8 Dementia in normal pressure hydrocephalus***
Retrospective pre-op diagnosis, L&M: ***Moderate to severe astheno-emotional disorder; moderate somnolence-sopor-coma disorder***
Post-op, DSM-IV: ***294.9 Cognitive Disorder NOS***
Post-op, ICD-10: ***F07.8 (Other organic...)***
Post-op, L&M:***Moderate astheno-emotional disorder***

Case 6 is most interesting. The patient, aged 74, had a subarachnoidal haemorrhage. She first improves but then deteriorates with somnolence, severe memory difficulties and disorientation. The diagnosis is normal pressure hydrocephalus, NPH, and a shunt operation is performed. Four months after that she is awake and oriented and manages her family's household with some help. However, she still has marked concentration difficulties and memory problems.

The case was published in a report on a series of NPH patients in a 1993 supplement to *Acta Psychiatrica Scandinavica.* This is a case of so-called "treatable dementia". Pre-operatively, the DSM-IV diagnosis was no doubt *Dementia due to normal pressure hydrocephalus.* The same holds for ICD-10. Post-operatively, the DSM-IV category of Cognitive Disorder NOS seems fitting, and so does the ICD-10 concept of *Other organic personality and behavioural disorders due to brain disease, damage and dysfunction* already referred to in the previous case. In our system, we recognize combinations of AED with other organic mental disorders (cf also Malmgren 1997). In our opinion, moderate or severe astheno-emotional disorder forms an essential part of the explanation of the symptom picture in many Dementia cases, such as for example Case 6.

Case 7*(= Case 4; Lindqvist & Malmgren 1990)*

Male, 61, with *diabetes, vascular disease* and progressive mental

deterioration. Initially some **difficulties finding words, concentration problems, fatiguability, irritability and unrest.** One year later **more marked memory problems, clearly reduced power of apprehension, reduced initiative and a severe irritability.** After one and a half year there is also **some disorientation,** and the patient's **associations are slow and impoverished; memory is generally very poor.**
DSM-IV diagnosis: ***Initially 294.9 Cognitive Disorder NOS; finally 290.40 Uncomplicated Vascular Dementia***
ICD-10 diagnosis: ***Initially F07.8 (Other organic...); finally F01.1 Vascular dementia***
L&M: ***A progression from mild to severe astheno-emotional disorder, finally reaching dementia degree***

Case 7 is a 61 year old man with diabetes, vascular disease and progressive mental deterioration. Initially he has some difficulties finding words, concentration problems, fatiguability, irritability and unrest. One year later he manifests more marked memory problems, clearly reduced power of apprehension, reduced initiative and a severe irritability. After one and a half year there is also some disorientation, and the patient's associations are slow and impoverished; his memory is generally very poor. His initial DSM-IV diagnosis is *Cognitive Disorder NOS;* finally, however, he qualifies for the diagnosis *Uncomplicated Vascular Dementia.* Similarly, the ICD-10 diagnosis goes from *Mild cognitive disorder* to *Vascular dementia.*

The AED diagnosis covers most of the whole clinical picture in certain cases of Dementia, for example the last one. In other words, this patient can be described as progressing from mild to severe astheno-emotional disorder.

This concludes the clinical introduction. In the second half of my lecture, I will address the following three questions:

- Why is AED a clinically important construct?
- If it is clinically important - how does it come that the concept of AED, or some close equivalent, is not generally recognized today?

• In which ways is the AED diagnosis philosophically interesting?

Why is AED important?

First, almost all psychiatrists would agree that cases of AED, as we define it, are very common. I would even go so far as to argue that AED is by far the most common of all disorders or syndromes in organic psychiatry.

Second, in our experience AED is very often the first clinical sign of cerebral disease or dysfunction.

Third, we would argue that most cases of memory disturbances in organic psychiatry are astheno-emotional in nature rather than due to an *Amnestic Syndrome* in the strict sense (in our system, *Korsakoff's Amnestic Disorder;* see Malmgren 1997).

Finally: astheno-emotional syndromes of different etiologies are not only phenomenologically similar, but as a rule develop quite similarly over time and require similar kinds of care. These are two strong reasons for having a common construct instead of splitting up the diagnosis into many.

Let me summarise:

Why is AED clinically important?

• If all degrees of severity and all aetiologies are included, AED is the most common of all organic mental disorders.

• Mild symptoms of AED are very often the first signs of brain disease.

• AED is probably the most common cause of memory disturbances in organic psychiatry.

• Prognosis and principles of care in AED are common over a wide range of aetiologies.

Why is AED not generally recognized today?

First is a summary of the arguments which follow:

Why isn’t the AED concept generally recognised today?

"External" circumstances:

• For historical and linguistic reasons, the connections between the German-speaking pioneers in the field (Kraepelin, Bonhoeffer, Conrad and others) and present-day Anglosachsian psychiatry are tenuous.

• Specialisation tends to lead to over-specialised diagnostic concepts, and few psychiatrists of today have experience of their own from the whole field of organic psychiatry.

Diagnostic difficulties:

• The mildest forms of AED merge invisibly with normal psychological and physiological reactions.

• The symptoms of mild AED may not be obvious if no demands are placed on the patient (cf. the experience leaving the hospital and going to work).

• The symptoms of AED are often masked by other disorders, especially in more severe cases.

• These difficulties entail that it is impossible to give a strict operational definition of AED.

• 'Astheno-emotional disorder' is an HPP (Hypothetical Pathogenetic Process) concept.

A main cause of the present neglect of AED is to be found in the fact that psychiatry always tends to forget its past. Let us look a little into this past, since AED is definitely not a concept without precedents.

Some antecedents of and alternatives to the concept of astheno-emotional disorder

Neurasthenia **(Beard 1865, Bumke 1948, ICD-10)**

Reizbare Schwäche ***(irritable weakness)*** **(Kraepelin 1882, Korsakoff 1890)**

Emotionell-hyperästhetische Schwächezustände **(Bonhoeffer 1912, 1917; Jaspers 1913, 1949; Wimmer 1936, K. Conrad 1960)**

"Amnestisches" oder "psychoorganisches Syndrom im engeren Sinne" **(Bleuler 1969)**

Hirndiffuses Psychosyndrom **(cf Bleuler 1969)**

Chronic brain syndrome **(cf Lishman 1987)**

Mild (neuro-)cognitive disorder **(DSM-IV, ICD-10)**

• First came Beard's *neurasthenia*, which overlaps considerably with mild

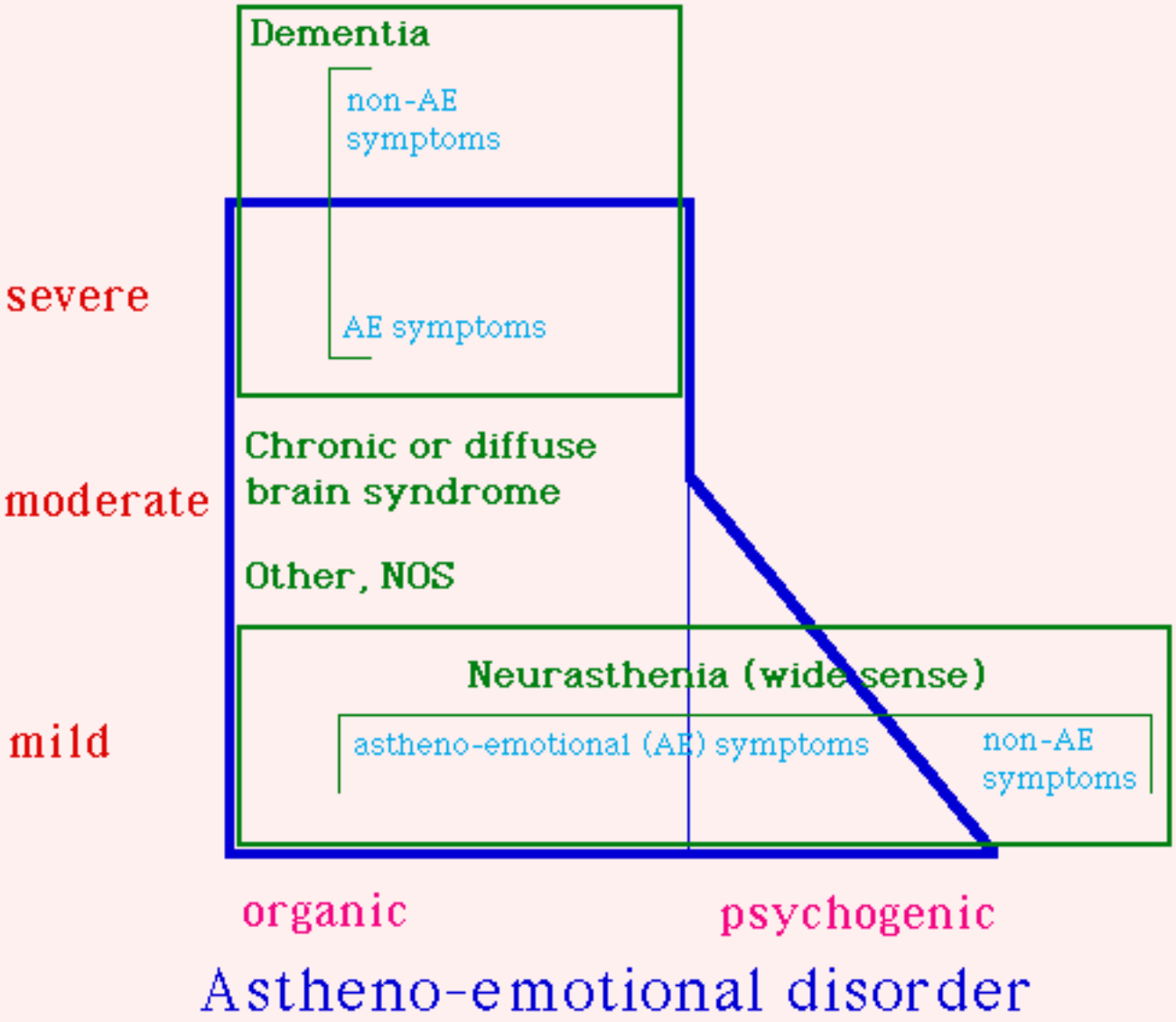
astheno-emotional disorder. Beard recognized organic as well as psychogenic forms of neurasthenia, but not all of his successors do. More about that soon.

• The mild to moderate organic forms of AED were well known to the main figures of late 19th century psychiatry, such as Kraepelin and Korsakoff. For it, they used the name "Reizbare Schwäche", or *irritable weakness.*

• The great pioneer of early 20th century neuropsychiatry, Karl Bonhoeffer, described the syndrome of irritable weakness in detail and named it the ***"emotional-hyperaesthetic weakness state"***. Bonhoeffer's concept was accepted by many leading German-speaking and Scandinavian psychiatrists, such as Jaspers, Conrad and Wimmer. It is still one of the best approximations of the AED spectrum, except the most severe forms. But the connections between modern American psychiatry and the German-speaking classics are weak, to say the least, and one of the concepts which have been lost for historical and linguistic reasons is Bonhoeffer's construct.

• Above, I also mention a number of other constructs which partly cover the same ground as our AED concept, for example the *"Diffuse organic mental syndrome"*, the *"Chronic brain syndrome"* and *"Mild Neurocognitive Disorder"*. I will return to them in a moment.

Let me show you two pictures which illustrate the relations between the concept of AED and the other concepts which I have mentioned so far. The first picture shows that AED covers a wide severity spectrum, ranging from mild conditions usually referred to as *"neurasthenia"* to severe disorders which we know as *"dementia"*.

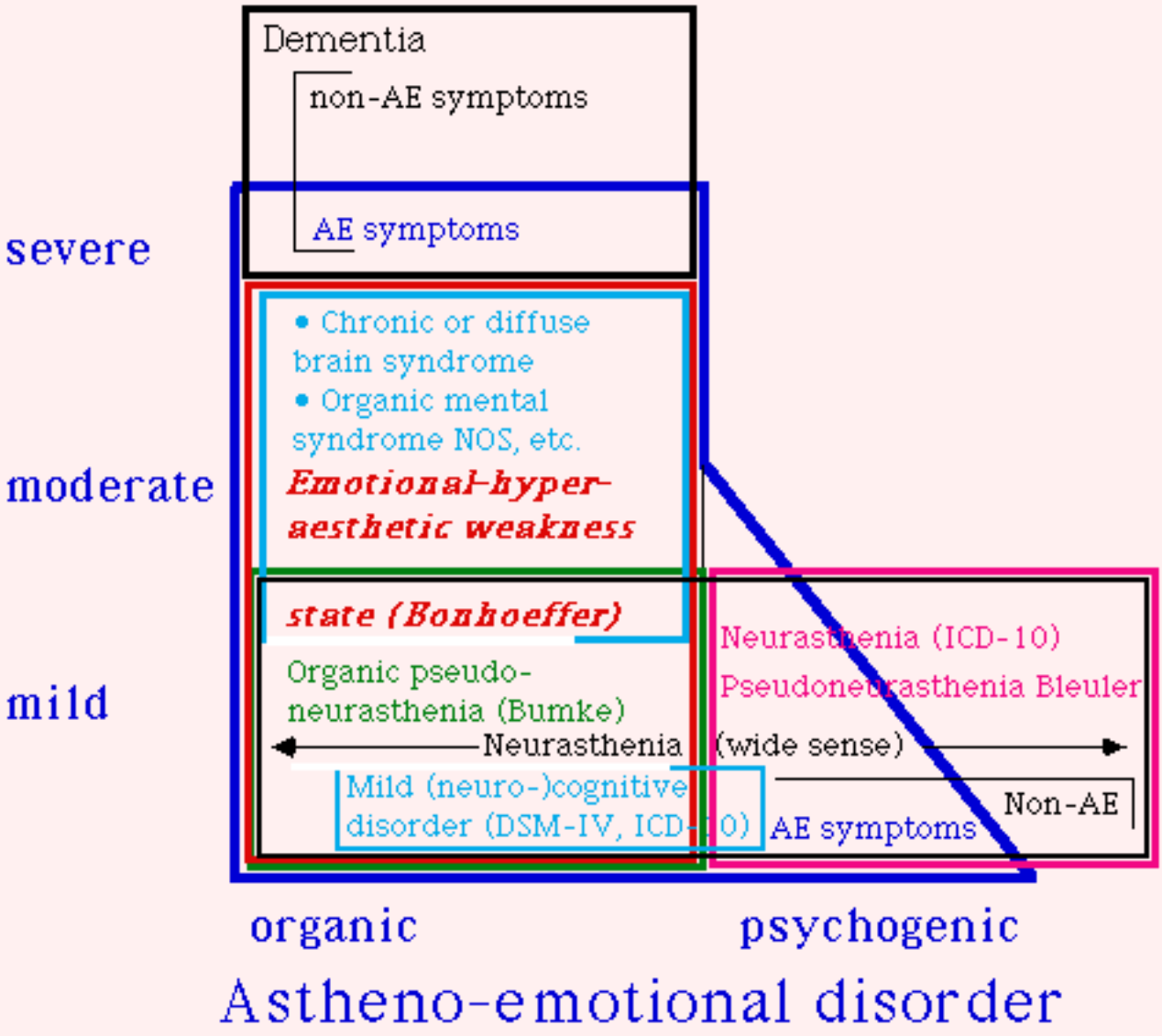


Astheno-emotional disorder

AED is the large irregular polygon. There are two dimensions in the picture, the dimension of severity and the dimension of organicity, if such a simplistic term is allowed for the time being. Dementia is at the top, while the small triangle to the right represents the cases of psychogenic, mild to moderate astheno-emotional disorder.

Note that neurasthenia is not wholly contained in astheno-emotional disorder. This is because the classical concept of neurasthenia encompasses a lot of symptoms which do not belong to the astheno-emotional disorder as such, although they often accompany it. Among these symptoms are: anxiety, headache, tension, and depressed mood. Similarly, dementia is not contained in AED. There is of course much more to dementia than severe AE disorder, although certain cases of dementia, such as my Case 7, mainly have astheno-emotional symptoms.

The second picture contains some more pieces of information.



Within the field of neurasthenia in the wide sense, which is at the bottom of the picture (low on the severity dimension), a distinction has often been made between the organic and the psychogenic cases. This distinction has been designated in many different ways and the terminology is truly confusing. For example, Oswald Bumke names the organic cases "pseudoneurasthenic", while Manfred Bleuler reserves this term for the psychogenic cases! "Neurasthenia" in the ICD-10 is of course psychogenic neurasthenia. The picture also shows that Bonhoeffer's concept, which is marked in red, occupies a considerable part of the whole field of AED, while other concepts such as "Mild neurocognitive disorder" cover a smaller area.

So, it is clear that our concept of astheno-emotional disorder is applicable to a great number of cases drawn from a very large field. Indeed, one could argue here that the simple reason why the AED construct, or some equivalent to it, is not recognized today is that the concept of AED is over-inclusive. I have tried to

show that it is not, by pointing to the common phenomenology in all these cases, the possibly common pathogenetic mechanism, the invariants in the clinical course, and the common principles of care.

So I will instead argue that most current concepts in this field are under-inclusive. I suggest that one main cause of this is that few psychiatrists know the whole field of organic psychiatry. Most psychiatrists who are interested in organic psychiatry draw the main body of their experience from a limited field, such as the care of demented patients, or the treatment and rehabilitation of head trauma cases. This of course encourages the creation of specialised and over-specialised concepts. The predominance of such concepts, in turn, tends to block our vision, so that we do not see the connections and similarities which actually exist.

But the very largeness of the field is not the only source of difficulties here. There are also some intrinsic diagnostic and theoretical problems to be mentioned, which may hinder the recognition of AED as a diagnostic entity.

• First, there is the problem of distinguishing the mildest symptoms of AED from normal physiological and psychological reactions such as ordinary fatigue, distractedness and irritability.

• Second, and this is more interesting from a nosological point of view, the symptoms of AED are dependent on the level of the demand which is put on the patient. For example, it is easy to miss the diagnosis of mild AED in a hospitalised patient, if he is not tested with the proper psychological tests. He may be judged as wholly recovered but when he starts working, he notices clear symptoms and believes he has become worse - which he has not!

• We must also attend to the fact that the symptoms of AED can be masked by other, co-existing disorders. It is self-evident that a confident diagnosis of the degree of AED cannot be made during the course of a Delirium. It is not so well-known that the irritability of a patient with AED can be totally masked if he also develops an emotional flattening. This is for example not seldom the case when a frontal tumour grows larger.

• These diagnostic difficulties together entail that it is strictly impossible to give a strict operational definition of the astheno-emotional disorder. By that I mean that it is impossible to give a list of symptoms such that if and only if a patient manifests a certain subset of them, then he has astheno-emotional disorder. We

must instead regard the astheno-emotional disorder as a process which is often hidden from our view, and concerning which we can therefore often only have a probable opinion. Instead of strictly operational concepts, we need what Göran Lindqvist and I use to call "HPP concepts": *Hypothetical Pathogenetic Processes.* I will however not discuss the general issue of operational definitions versus hypothetical constructs here, since I have done that in other contexts (Lindqvist & Malmgren 1993a, Ch. 3-4).

It now only remains to answer the third question which I put at half-time.

What philosophical interest is there in discussing the astheno-emotional syndrome?

Here are, in short, my answers to this question.

Why is the AED diagnosis philosophically interesting?

• The history of the disorder highlights the possibility that science may tend to forget too much of its past.

• Because of its inherent diagnostic difficulties, AED is a good touchstone for theories about scientific concept formation - especially, for operationalism.

• The terms used to describe AED symptoms are often ambiguous and/or very wide (e.g., "emotional change", "memory disturbance") and stand in need of semantic clarification.

• The extremely varied aetiologies of AED put the issue of brain localisation on the order of the day.

• AED usually involves a subtle interplay of organic and mental causes, which also requires philosophical

clarification.

• The characteristic changes in mild AED illustrate the dependence of conscious life on unconscious control mechanisms.

In other words:

First, the many radical and often unintentional breaks with tradition which have occurred in 20th century psychiatry are of interest to the psychiatrist, the historian of science and the philosopher of science alike. More specifically, the history of the AED concept and its forerunners highlights the possibility that psychiatry, and maybe science in general, ought to become more anxious to keep contact with its past.

Second, the concept of AED illustrates the dangers of strict operationalism.

Third, the ambiguity of the terms used to describe central AED symptoms highlights the need for semantic analysis in psychiatry.

Fourth, AED can occur in lesions of practically any part of the brain, and this warns us not to simplify the discussion about brain localisation.

Five, the subtle interplay between the organic and the mental in AED also demands a philosophical analysis.

Finally, if we are right about the pathogenetic mechanisms, the defective filtering which we take to be a common denominator in AED is a nice example of a subconsciuos control mechanism which is essential for the normal functioning of consciousness.

With the last comment, I hope I have managed to connect my speech with the general theme of this conference. Thank you.

References

Beard, G. (1880), *A Practical Treatise on Nervous Exhaustion (Neurasthenia). Its Symptoms, Nature, Sequences, Treatment.* William Wood, New York.

Bleuler, E. (1969), *Lehrbuch der Psychiatrie*. 11. Aufl., umgearbeitet von M. Bleuler. Springer, Berlin etc.

Bonhoeffer, K. (1912), Die Psychosen im Gefolge von akuten Infektionen, Allgemeinerkrankungen und inneren Erkrankerungen. In: *Handbuch der Psychiatrie. Spezieller Teil, 3:1,* 1-120. Hrsg. G. Aschaffenburg. Franz Deuticke, Leipzig & Wien.

Bonhoeffer, K. (1917), Die exogenen Reaktionstypen. *Archiv für Psychiatrie und Nervenkrankheiten 58*, 50-70.

Conrad, K. (1960), Die symptomatische Psychosen. In: *Psychiatrie der Gegenwart, Bd. II,* 369-435. Hrsg. H.W. Gruhle, R. Jung, W. MayerGross & M. Müller. Springer, Berlin etc.

Jaspers, K. (1913), *Allgemeine Psychopathologie*. 6. Aufl. 1949, Springer, Berlin etc.

Korsakoff, S. (1890), Ueber eine besondere Form psychischer Störung kombiniert mit Neuritis. *Archiv für Psychiatrie 21*, 669-704.

Kraepelin, E. (1881-2) Ueber den Einfluss acuter Krankheiten auf die Entstehung von Geisteskrankheiten. *Archiv für Psychiatrie und Nervenkrankheiten 11*, 137-83, 295-350, 649-77; 12, 65-121, 287-336.

Lindqvist, G. & Malmgren, H. (1990): *Organisk Psykiatri. Teoretiska och kliniska aspekter* (*Organic Psychiatry. Theoretical and clinical aspects.* In Swedish). Almqvist & Wiksell, Stockholm.

Lindqvist, G. & Malmgren, H. (1993a): *Classification and diagnosis of organic mental disorders. Acta Psychiatrica Scandinavica 88, Suppl. 373.* Munksgaard, Copenhagen.

Lindqvist, G., Andersson, H., Bilting, M., Blomstrand, C., Malmgren, H. & Wikkelsø, C. (1993b): Normal Pressure Hydrocephalus: Psychiatric Findings Before and After Shunt Operation Classified in a New Diagnostic System for Organic Psychiatry. In Lindqvist, G. & Malmgren, H. (1993a), pp. 18-32.

Lishman, A. (1987), *Organic Psychiatry*. 2d ed. Blackwell, Oxford.

Malmgren, H., (1997), A longitudinal pilot study of the Rorschach as a neuropsychological instrument. In *Research into Rorschach and Projective Methods*, 117-40. Ed. A.M. Carlsson et al. Swedish Rorschach Society, Stockholm.

Top of page

To Papers and Posters page