W12.02
THE NOSOLOGICAL DIFFERENTIATION OF CATATONIA

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In a family study we tested Leonhard's postulate of a clinical dichotomy into systematic catatonia and periodic catatonia regarding cross-sectional symptomatology and long-term course, and whether these clinical entities arise from different genetic backgrounds. Involving 139 probands with DSM III-R catatonic schizophrenia, we analyzed the reliability and stability of diagnoses and investigated the age specific morbidity risk among 543 first-degree relatives. Diagnostic reliability was Kappa statistic 0.93 and diagnostic stability during catamnesis reached 97%. Life-table analysis revealed that the age-corrected morbidity risks were significantly different in periodic catatonia and systematic catatonia. In systematic catatonia first-degree relatives had a risk of 4.6%. In periodic catatonia an excess of homologous psychoses was apparent: there was a risk of 26.9% for first degree relatives. In periodic catatonia, 59% of the families were multiple-afflicted with pronounced vertical transmission. Periodic catatonia and systematic catatonia proofed to be valid subgroups of DSM III-R schizophrenia. In systematic catatonia heritability is very low, whereas periodic catatonia is a familial disorder with unilineal vertical transmission indicating a major gene effect.

W12.03
NOSOLOGIC DIFFERENTIATION OF POSTPARTUM PSYCHOSES AND THE ROLE OF REPRODUCTIVE FUNCTIONS FOR THE MANIFESTATION OF ENDOGENOUS PSYCHOSES IN WOMEN

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We investigated whether there exist differences with regard to diagnostic entities considering the role of reproductive functions for the manifestation of endogenous psychoses in women. In a first study, we classified polydiagnostically 34 systematically recruited women with an endogenous psychosis with postpartal onset. Applying ICD-10 criteria, unipolar depressive disorders (32%) and acute polymorphous psychotic disorders (28%) were the most frequent diagnoses, whereas schizophrenias were rarely found (15%). According to Leonhard's nosology, cycloid psychoses accounted for 62% of all patients with the subform of motility psychosis predominating clearly (38% of all patients). Unsystematic schizophrenias were rare (12%), systematic schizophrenias were not found. In a second study, we examined whether a correlation exists between menstrual cycle phase on the day of an acute psychiatric admission and diagnosis. In 122 female patients, the menstrual cycle phase was assessed and independently a diagnosis according to Leonhard and to ICD-10 was established. We found patients with cycloid psychoses significantly more frequently admitted to hospital during the luteal-/menstrual phase than schizophrenic patients (χ^2-test, $p = 0.02$). Using ICD 10-criteria revealed no significant differences between diagnostic entities.

We found neither evidence for a nosological independence of postpartum psychoses nor for a specificity of a premenstrual exacerbation of symptoms for schizophrenic psychoses. Our findings rather suggest that female reproductive function especially influences the manifestation of cycloid psychoses. Postpartum psychoses in the majority of cases could be classified as cycloid psychoses which were also significantly more frequently associated with a premenstrual exacerbation of symptoms than schizophrenic psychoses.

W12.04
MOTILITY PSYCHOSIS: A FUNCTIONAL DISEASE OF THE PSYCHOMOTOR SPHERE

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Motility psychosis is a functional disease of the psychomotor sphere which is bipolar in nature and characterized by hyperkinetic or akinetic episodes. The course is phasic with complete remissions after each episode. The hyperkinesia and akinesia of motility psychosis is of a purely psychomotor nature representing a quantitative excess or reduction of expressive and reactive movements independent of disorders of thought or emotion. Expressive movements appear in connection with certain mental states; reactive movements are immediate psychomotor reactions to sensory impressions. Voluntary movements are only in so far affected as they contain the psychomotor elements. In contrast to catatonia, movements retain their natural character and become quantitatively exaggerated or decreased compared to the qualitatively distorted movements like parakinesias, grimacing or stereotypes in catatonic psychoses. In hyperkinetic episodes often disconnected words are blurted out and a severe distractibility by environmental conditions occurs. In akinetic episodes a lack of spontaneous speech and in severe cases an akinetic stupor is present.

Severe depressive mood alterations are lacking, as are typically manic features like marked elevation of mood with simultaneous irritability, inflated self-esteem or flight of ideas. Motility psychosis is a subform of the cycloid psychoses which represent a nosologically independent group of prognostically favourable bipolar phasic psychoses with an acute onset and a polymorphous but nevertheless characteristic symptomatology.

W12.05
THE NOSOLOGICAL DIFFERENTIATION OF PARANOID SCHIZOPHRENIA

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According to the differentiated nosology of the Wernicke-Kleist-Leonhard school paranoid schizophrenic psychoses diagnosed along the lines of DSM-IV and ICD 10 have to be divided into clinically and etiologically different subforms, anxiety-happiness psychosis, affectful paraphrenia and systematic paraphrenias. The allocation to one of these distinct diagnoses provides important therapeutic implications. There are no research data that patients suffering from an episodic anxiety-happiness psychoses profit by neuroleptic long-term treatment. In contrary, maintenance of neuroleptic treatment after recovery here often results in "secondary negativ symptoms". With respect to patients suffering from affectful paraphrenia neuroleptic long-term treatment is strongly recommended. Systematic paraphrenia, however, is completely treatment resistant and paranoid-halluzinatory states remain stable over many years despite (high-dose) neuroleptic treatment. Guidelines for correct allocation to one of these diagnostic entities and new research data are presented.

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