Simple Schizophrenia: Past, Present, and Future

Donald W. Black, M.D., and Todd J. Boffeli, M.D.

The diagnostic category called simple schizophrenia has disappeared from official American nosology but has been retained in ICD-9. The diagnosis has a long history, was one of the traditional schizophrenic subtypes identified by Bleuler, and was later accepted by Kraepelin. The authors provide a historical overview of the concept, review its modern successors, and provide recommendations for its inclusion in DSM-IV as a proposed diagnostic category needing further study. (Am J Psychiatry 1989; 146:1267–1273)

In use for nearly 70 years, the diagnostic category of simple schizophrenia was ceremoniously deleted from DSM-III. Concomitantly, a new diagnosis—schizotypal personality—was created and, together with a redefined schizoid personality category, was believed to provide an adequate substitute for simple schizophrenia. In this article we trace the origins of simple schizophrenia, review its history, and consider the reasons for its demise. Further, we address whether its demise was justified, what its modern successors are, and whether it should have some role in the future.

ORIGINS OF SIMPLE SCHIZOPHRENIA

The concept of simple schizophrenia dates to the turn of the century, during a time when the concept of schizophrenia was in great ferment. In 1896, in the fifth edition of his Textbook of Psychiatry, Emil Kraepelin brought together the formerly disparate concepts of hebephrenia, catatonia, and paranoia into a single entity that he called “dementia praecox.” The name of this new disorder reflected his belief that its pathognomonic feature was mental deterioration, usually occurring in young persons. Eugen Bleuler, however, felt that the process in the disorders described by Kraepelin represented a splitting of psychic functions, and in 1908 he renamed the disorder “schizophrenia,” which he thought was a more appropriate term than “dementia praecox” (1). He expanded Kraepelin’s narrow concept of dementia praecox on the grounds that the condition of patients did not always deteriorate, nor did the disorder always appear in adolescence. Furthermore, Bleuler felt that a group of schizophrenias, rather than one disease process, existed. He acknowledged Kraepelin’s three subtypes (hebephrenia, catatonia, and paranoia) but included two new ones. These subtypes were schizophrenia simplex, a simple type of schizophrenia characterized by social withdrawal and affective flattening but not by prominent catatonic, hebephrenic, or paranoid features, and latent schizophrenia, which was even more vaguely defined. Bleuler believed that latent schizophrenia was probably very common and implied that the diagnosis should be used for odd or eccentric persons who arouse “the suspicion of schizophrenia” (1, p. 239). Simple schizophrenia was later accepted by Kraepelin and included in the eighth edition of his Textbook of Psychiatry (2).

Credit for initially describing simple schizophrenia is usually accorded to Bleuler in 1911. However, the essential features of the disorder were described much earlier. Bleuler himself (1) traced the syndrome to Karl Kahlbaum (3) who in 1890 separated heboidohebephrenia from hebephrenia, which Ewald Hecker (4) had delimited in 1871. Heboidohebephrenia, wrote Bleuler (1), was “no more than a milder form of hebephrenia manifesting itself chiefly by changes in character” (p. 6), including only disturbances of social feeling, tact, and behavior.

Bleuler also identified simple primary dementia as a forerunner of simple schizophrenia and credited Arnold Pick (in 1891) and Robert Sommer (in 1894) with its description (1, p. 6). However, the condition was identified earlier by Thomas Clouston as “primary dementia.” Bleuler cited an 1888 address by Clouston: “The patients became less acute in emotion and judgement, less powerful in volition, less able to do their work or take care of themselves, and less social and more ‘silly,’ these symptoms gradually going on to marked dementia” (5, p. 335).

It was Otto Diem (6), however, who in 1903 published the monograph “Die einfach demente Form der Dementia Praecox (Dementia simplex)” [“The Simple Dementing Form of Dementia Praecox”] and probably

Presented in part at the 141st annual meeting of the American Psychiatric Association, Montreal, May 7–12, 1988. Received Aug. 9, 1988; revision received Jan. 24, 1989; accepted March 3, 1989. From the Department of Psychiatry, University of Iowa College of Medicine, Iowa City, and the Department of Psychiatry, Washington University School of Medicine, St. Louis, Mo. Address reprint requests to Dr. Black, Psychiatric Hospital, 500 Newton Rd., Iowa City, IA 52242.

The authors thank George Winokur, M.D., for his suggestions.

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Am J Psychiatry 146:10, October 1989 1267
deserves credit for the earliest formulation of simple schizophrenia. The syndrome described by Diem was similar to the later and better known description by Bleuler. Diem wrote:

We can summarize thus: In addition to the clinical pictures of hebephrenia, catatonia, dementia paranoïdes and the paranoid form, which all terminate in the particular dementia of dementia praecox (after Kraepelin), there is a further type of clinical course leading to the same terminal state—to the same disturbance of intelligence and affect. But here the onset is regularly simple, indolent, without special prodrome, and the sickness develops without acute episodes and remissions, without marked manic or melancholic dejectedness, without illusions or hallucinations, and without the other particularities of the above mentioned forms characteristic of dementia praecox: catatony, tics, affectations, mannerisms, stereotypies, negativism, mutism, etc. (6, pp. 185–186)

As Diem had divided the symptoms of schizophrenia, Bleuler, too, described both the essential and the accessory symptoms of the disorder. The essential symptoms consisted of those now known as Bleuler’s four A’s: autism, ambivalence, associative loosening, and affective disturbances. He suggested that these elements were fundamental and universal in schizophrenia. This formulation led him to divide the phenomena that these patients experience into essential and accessory symptoms. According to Bleuler (1), schizophrenia could be identified by the presence of essential symptoms alone, while the accessory symptoms were felt to be less important and were not found in either the simple or the latent subtypes. These accessory symptoms consisted of psychotic features, such as hallucinations and delusions, catatonia, somatization, changes in speech and writing, and certain mnestic disturbances. According to Bleuler, the course of simple schizophrenia showed weakening of affect and intellect and a decreasing capacity for self-care and work. Further, the disorder led, he believed, to the mental deterioration seen in other subtypes of schizophrenia. Bleuler (1) wrote:

This group is rarely found in hospitals, but outside it is as common as any of the other forms of schizophrenia. In private practice we often see it, indeed as frequently in the relatives who bring the patients as in the patients themselves. On the lower levels of society, the simple schizophrenics vegetate as day laborers, peddlers, even as servants. They are also vagabonds and hoboes as are other types of schizophrenics of mild grade. On the higher levels of society, the most common type is the wife (in a very unhappy role, we can say) who is unbearable, constantly scolding, nagging, always making demands but never recognizing duties . . . . Furthermore, there are many simple schizophrenics among eccentric people of every sort who stand out as world saviors and reformers, philosophers, writers and artists, beside the “degenerated” and deteriorated. (p. 236)

Kraepelin (2) later embraced the concept of simple schizophrenia. He wrote:

Dementia simplex consists of an impoverishment and devastation of the whole psychic life which is accomplished quite imperceptibly . . . . The former good, perhaps distinguished, scholar fails always more conscientiously in tasks which till then he could carry out quite easily, and he is more and more outstripped by his companions. He appears absentminded, thoughtless, makes incomprehensible mistakes . . . . Others become idle and indifferent, stare for hours at their book without reading, give themselves no trouble with their tasks, and are not incited either by kindness or severity. (pp 90–91)

Kraepelin (2) also described certain affective changes in simple schizophrenia:

The patients become timid, lachrymose, or impertinent, irritable, malicious . . . . Their circle of interests becomes narrower; their relations to their companions become cold; they show neither attachment nor sympathy . . . . Ambition and pleasure in the usual occupation become extinct, work and plans for the future are silent; inclination and ability for useful occupations disappear . . . . A considerable number in the end fall into the crowd of beggars and vagabonds, and oscillate hither and thither in a half-witted state from year’s end to year’s end between public highway and workhouse, wherever anew the hopeless attempt is made to turn them around. (pp 91–92)

Kraepelin (2) also believed, along with Bleuler, that the disorder led to mental deterioration—hence dementia, although he stated clearly that the dementia was not profound (p. 93).

SIMPLE SCHIZOPHRENIA AFTER BLEULER

As a result of the contributions of Diem, Bleuler, and Kraepelin, simple schizophrenia became established as a psychiatric entity and was incorporated widely into textbooks and classification systems. The rapid acceptance of simple schizophrenia is illustrated by its inclusion in influential textbooks of psychiatry that were published after the ensuing decades. Representative of textbook descriptions are those by White (7), Henderson and Gillespie (8), Noyes (9), Sadler (10), Mayergross et al. (11), Lehmann (12), and day and Semrad (13). These descriptions uniformly included simple schizophrenia among the traditional subtypes of schizophrenia. Although their accounts borrowed heavily from Bleuler and Kraepelin, they provided little new information about the syndrome and often reported contradictory data.

A review of the definitions in these seven textbooks, spanning almost 60 years, shows that of eight symptom complexes, only two—avolition and deteriorating course—were accepted in all the texts as part of the simple schizophrenia syndrome. Two sources (8, 10) suggested that thought disorder may occur, but the others did not. White (7) and Sadler (10) included motor signs (bizarre mannerisms and negativism), which were not accepted by Bleuler or Kraepelin. White (7), Henderson and Gillespie (8), Noyes (9), and Sadler
These either hallucinations. 

Bleuler and Kraepelin believed that the disorder led to mental deterioration, yet only Sadler (10) agreed; Henderson and Gillespie (8) did not (i.e., "memory is retained"), and the other authors made no comment. These varied descriptions of simple schizophrenia also included other symptoms. White (7) and Sadler (10) noted listlessness, inattention, poor concentration, and lack of insight; Lehmann (12) and Day and Semrad (13) listed sleep/wake cycle disturbances. All authors noted insidious onset, usually in adolescence, and shallow or blunted affect. Clearly, the multiple competing definitions offered in the textbooks contributed to the ever-widening boundaries encompassed by simple schizophrenia.

Simple schizophrenia eventually found its way into the sixth revision of the International Classification of Diseases (ICD-6) in 1948, DSM-I in 1952, and DSM-II in 1968. In DSM-I, simple schizophrenia was described as a type of reaction characterized by a "reduction in external attachments and interests and by impoverishment of human relationships." It was felt to involve an adjustment on a "lower psychobiological level of functioning, usually accompanied by apathy and indifference but rarely by conspicuous delusions or hallucinations." The concept of mental deterioration was included, but not dementia. In DSM-II, the definition of simple schizophrenia was relatively unchanged from that in DSM-I, although the deterioration process was emphasized. The syndrome was described as a psychosis "characterized chiefly by a slow and insidious reduction of external attachments and interests and by apathy and indifference leading to impoverishment of interpersonal relations, mental deterioration, and adjustment on a lower level of functioning." The condition was described as "less dramatically psychotic" than the other subtypes of schizophrenia. The definition in the ninth and most recent edition of ICD is similar and includes the notions of deterioration, social impoverishment, and avolition but not mental decline. Further, ICD-9 cautions that the diagnosis should be made "sparingly, if at all."

Simple schizophrenia continued to expand, with the official definitions later including the possibility of hallucinations and delusions. These official definitions, along with the textbook descriptions, described a disorder with indistinct boundaries, unclear symptoms, and, as a result, doubtful validity.

CRITICISM OF THE SYNDROME

Despite its wide acceptance and its inclusion in diagnostic systems, simple schizophrenia came under early criticism. In a 1936 bibliography Lewis (14) noted:

In many clinics using the classification of Kraepelin...the group known as "simple praecox" is a very heterogeneous affair. It serves the praecox group as a sort of diagnostic waste basket into which every undifferentiated problem is neglected, serving as the term "neurasthenia" did in the days before Freud gave us some leads for differentiation. Therefore, in the "simple praecox" group one finds borderline cases of feeblemindedness, deteriorated hebephrenia, psychopathic personalities, peculiar character fixation, etc., classed together. (p. 32)

Lewis took a dim view of research on this syndrome, noting that any such research would "mean nothing" because of its heterogeneity.

In a more thorough and highly critical review, Stone et al. (15) noted that 1) between 1930 and 1968 only one significant clinical paper (16) was produced; 2) the diagnosis was rarely used (0.04–0.24% of a state hospital population were given the diagnosis, although these patients probably would not be found in great numbers in state hospitals); 3) the existing criteria were vague or contradictory and failed to distinguish between the essential and accessory symptoms described by Bleuler; and 4) there was no agreement among authors on whether thought disorder was present. Stone et al. criticized the wholesale acceptance of simple schizophrenia despite the paucity of supporting clinical evidence and the acknowledgement by experts such as Lewis (14) that it was an ill-defined concept. On the basis of a review of eight cases of persons diagnosed as having simple schizophrenia, these authors reported that other existing diagnostic categories, such as severe personality disorders or chronic schizophrenia, were probably more appropriate. Stone et al. observed that even Kant's (16) findings were at variance with the classical descriptions of simple schizophrenia, and although Kant did not interpret them that way, the findings failed to support the existence of the syndrome. Kant (16) surveyed a state hospital population and found that 81, or 5.1%, of the schizophrenic population had simple schizophrenia. When he examined 64 of the 81 patients with simple schizophrenia, only two had no evidence of hallucinations or delusions, either historically or on current mental status examination. In 43% of the subjects, psychotic symptoms were pronounced. Stone et al. (15) believed, and Kant's (16) data would indicate, that in many cases of simple schizophrenia, the presumed lack of delusions or hallucinations is based on inadequate information. White (17) stated the situation this way:

"The more carefully the history is taken, the less great are the chances that the case will be classified under the simple form. This is because the patient may have experienced delusions and hallucinations, and may have engaged in queer behavior when by himself, without revealing these facts to anyone." On the basis of the information they reviewed, Stone et al. (15) recommended that the diagnosis be discarded.

The descriptive validity of the syndrome also came under fire. Data collected in the International Pilot Study of Schizophrenia (18) failed to substantiate the usefulness of the classic subtypes of schizophrenia, including the simple subtype. It was noted that patients...
with simple schizophrenia had quite low ratings of psychotic symptoms, but this trend would be expected. Strauss and Carpenter (19), who assisted in the project, observed that the traditional subtypes were of limited usefulness, and distinctions were less apparent among patients than among textbook descriptions. They concluded that the simple and latent subtypes, in the absence of psychotic features, should be considered as outside the realm of schizophrenia. They cautioned, however, that "this does not deny the possibility of a subsyndromal or even subclinical schizophrenia, but we cannot presently identify such cases reliably" (p.38).

Other data also cast doubt on the validity of the simple schizophrenia diagnosis. Helmchen (20) compared the phenomenology of all 10 ICD-8 schizophrenic subtypes. No symptom appeared with any special frequency in simple schizophrenia, suggesting that the diagnosis was used for persons whose symptoms were indistinct or uncertain. Helmchen observed that the "differential diagnosis between simple schizophrenia and schizoid personality is often impossible, unless the course is considered."

**DSM-III**

**DSM-III**, published in 1980, represented a major advance in psychiatric classification, at once both praised and condemned for introducing operational criteria to help standardize psychiatric diagnosis. The American Psychiatric Association’s Task Force on Nomenclature and Statistics, responsible for developing **DSM-III**, felt that one of the first problems for the new manual was to set the boundaries of schizophrenia (21, 22). The committee members noted that the concept of schizophrenia was very broad and explicitly included two nonpsychotic forms, simple and latent schizophrenia. In order to narrow the concept of schizophrenia, it was decided to restrict the disorder to an illness in which at some time there had been characteristic delusions, hallucinations, or marked formal thought disorder.

The new conceptualization of schizophrenia had resulted from a climate of change begun years earlier. The broad, Bleulerian concept of schizophrenia, which emphasized psychological aspects of the syndrome, was predominant in the United States through the late 1960s and into the early 1970s. The narrower, Kraepelinian approach, stressing phenomenology and course, was prominent among British and Continental psychiatrists, however. This situation led to great differences in the prevalence of diagnosed schizophrenia and manic-depressive illness here and abroad. In New York hospitalized psychiatric patients were more likely to be diagnosed as schizophrenic than manic-depressive, whereas the reverse was true in London. These differences were uncovered in the United States/United Kingdom diagnostic project (23) and confirmed in the International Pilot Study of Schizophrenia (18). In the latter study, schizophrenia in nine countries was compared. The major finding was that similar criteria were used in seven countries, but broader criteria were used in the United States and the Soviet Union. In the context of these studies, an interest in reliable diagnosis emerged. Bleulerian symptoms, with their breadth and imprecision, did not lend themselves to close agreement among clinicians. On the other hand, hallucinations and delusions as defining features are clearly discordant with normality and are easier to identify reliably. These forces led to the reshaping of the American concept of schizophrenia into that of a relatively severe psychotic disorder, bringing it closer to the original ideas of Kraepelin and more in line with European practice. Along with the changing conceptualization of schizophrenia and growing criticisms specific to simple schizophrenia, the formerly wide diagnostic net of schizophrenia was narrowed, and the simple and latent subtypes were deleted from **DSM-III**.

The new definition adopted for schizophrenia was derived from both the St. Louis criteria (24) and the Catego system developed by Wing for the International Pilot Study of Schizophrenia (18); it emphasized a long duration of illness and the presence of florid psychosis. Specifically, the new criteria required 1) a period of active psychotic symptoms such as hallucinations, delusions, or certain disturbances in form of thought and 2) a duration of disturbance or impairment of at least 6 months. The rationale for restricting the diagnosis was to identify a more homogeneous population with regard to early onset, greater prevalence in family members, severe impairment, and differential response to somatic treatment. Because simple and latent schizophrenia, by definition, were not accompanied by these abnormalities, they could not be considered forms of schizophrenia within the narrow limits established in **DSM-III** (25). Thus, these categories were eliminated because of the difficulty in differentiating them from severe personality disorders and the lack of evidence that patients with simple or latent schizophrenia share important features with the other traditional subtypes. The task force members felt that patients who had not been frankly psychotic and who were formerly diagnosed as having latent or simple schizophrenia would probably fit into a newly created category—either schizotypal or borderline personality—or the redefined category of schizoid personality (25).

Although simple schizophrenia is no longer included in American classification schemes, the diagnosis is still included as a schizophrenic subtype in **ICD-9** and is used in other countries.

**SUCCESSORS TO SIMPLE SCHIZOPHRENIA**

Among the newly created diagnoses was schizotypal personality. The definition of this disorder was developed largely on the basis of data from the Danish adoption study of Kety et al. (26), which suggested that relatives of schizophrenic patients had mild forms
of the disorder. The criteria used by the task force members (27) to define schizotypal personality were based on the experience of Kety et al. These criteria included magical thinking, ideas of reference, odd speech, unusual perceptual experiences, eccentric behavior, inadequate rapport, suspiciousness or paranoid ideation, and undue social anxiety. In their study, Kety et al. derived these criteria from case records of adopted offspring of schizophrenic patients and control subjects who were considered to have characteristics related to schizophrenia. These characteristics were more frequent in the biologic relatives of the schizophrenic probands than in their adopted relatives or the biologic relatives of the control subjects. The term “schizotypal,” however, was derived from Rado's (28) “schizotype,” a term which he applied to patients who may or may not have been overtly psychotic but who manifested “schizotypal organization,” his term for a collection of psychodynamic traits. Meehl (29) refined and elaborated a similar formulation and, like Rado, advocated the term “schizotype” for the personality organization observed in persons with a genetic predisposition to schizophrenia.

Whereas the schizotypal personality category had been created to identify the eccentric character of genetic relatedness to schizophrenia, other “borderline” conditions, long of interest to psychoanalysts, were placed in another new category, borderline personality. This new category represented an attempt to identify persons with enduring personality features characterized by instability in sense of identity, interpersonal relationships, impulse control, and mood. Thus, formulation incorporated the ideas of Zilboorg (30), Hoch and Polatin (31), Frosch (32), Kernberg (33), and others and was supported by a factor analytic study (27) of the symptoms of a group of more than 800 patients diagnosed as borderline. Thus, the delimitation of these two new personality disorders arose from an attempt to differentiate, within the context of DSM-III, the chronic instability of borderline personality, in which regression was said to be accompanied by loss of reality testing, from borderline schizophrenia, in which psychotic-like symptoms were presumed to be due to a genetic relationship to schizophrenia.

While the schizotypal and borderline personality categories were created by task force members to fill theoretical vacuums, schizoid personality was merely redefined. The term “schizoid” had originally been used to describe the isolation and emotional distancing that occurred in patients with schizophrenia before its onset and during remissions, as well as in schizophrenic patients’ relatives. Kraepelin (2) had noted that in retrospect, children who became schizophrenic were particularly “quiet, shy, reserved.” Bleuler had conceived of the schizoid element as a dimension of all personalities, with schizophrenia as its extreme prototype. For him, the line between the normal person with a schizoid component and the schizoid nature of schizophrenia was not clear. He also referred to the schizoid characters in families of schizophrenic patients as “people who are shut-in, suspicious, incapable of discussion, people who are comfortably dull” (34, p. 441). Thus, the term “schizoid” evolved in the context of an attempt to understand the nature and genetic basis of schizophrenia.

Eventually, the concept of schizoid personality was embraced by dynamically oriented clinicians who broadened the concept to encompass those persons who had difficulty with intimacy and, later, to describe a wide range of behavioral peculiarities (35). In DSM-I the disorder was defined as an inherent trait characterized by avoidance of close relations with others, inability to express hostility or even ordinary aggressive feelings directly, and autistic thinking. Persons with these qualities were described as aloof, emotionally detached, fearful, avoiding competition, and often eccentric. In DSM-II the description was relatively unchanged. Although the descriptions in DSM-I and DSM-II of both simple schizophrenia and schizoid personality appeared to dovetail, these manuals took care to note that schizoid personality is not accompanied by deterioration of functioning, unlike simple schizophrenia.

In the process of developing DSM-III, the committee members noted that the schizoid personality disorder category would be best served by restoring the original intent of the diagnosis; in doing so they divided the DSM-II schizoid personality category into three separate clusters corresponding to three personality disorders: schizotypal, schizoid, and avoidant (25). Persons with eccentricities were felt to be best described by DSM-III schizotypal personality disorder. The distinction between schizoid and avoidant personalitiess was based on whether there was a defect in the motivation and capacity for emotional involvement (schizoid) or avoidance of desired close relationships because of fear of rejection (avoidant). These descriptive distinctions, as yet unproven, were believed to have therapeutic and prognostic significance.

It was assumed that all persons with DSM-II simple schizophrenia would fit into one of the newly created or redefined DSM-III categories. There was some debate, however, during the revision of DSM-III (R. Spitzer, personal communication, May 1988) about whether a diagnosis for a simple deteriorated state should be reintroduced to describe nonschizotypic persons with avolition, apathy, and a markedly deteriorating course. These negative or defect symptoms had been incorporated into early definitions of simple schizophrenia, but they were not traditionally included as core features of personality disorder. Thus, although a person with Bleulerian simple schizophrenia might satisfy the DSM-III-R criteria for schizotypal personality disorder, the diagnosis fails to capture the accompanying amotivation or the downward trajectory expected in simple schizophrenia. The concept of simple deterioration was rejected, but the debate about how to properly classify such persons continues.
FUTURE DIRECTIONS

A task force has now been formed to revise DSM-III-R diagnostic categories in preparation for DSM-IV, tentatively scheduled for release in 1992. Although the concept of simple schizophrenia was rejected in revising DSM-III, the Schizophrenia Work Group formed to review schizophrenia spectrum disorders is interested in reconsidering it (N. Andreasen, personal communication, October 1988). The original formulation of simple schizophrenia—that of a nonpsychotic illness with a deteriorating course and accompanied by features suggesting unusual affect, speech, or thinking—is not encompassed by any DSM-III-R diagnosis. The closest equivalents in DSM-III-R appear to be chronic schizophrenia, residual type, and schizotypal personality. These categories do not include the nonpsychotic, deteriorated state, however. In fact, a patient with residual schizophrenia has, by definition, experienced an “active phase” of schizophrenia characterized by the psychotic symptoms outlined in criterion A. Schizotypal personality disorder, on the other hand, captures the sense of oddity in affect, speech, or thought and impairment of social or occupational functioning, but not the deterioration. Traditionally, personality disorders have been conceptualized as stable, enduring, and maladaptive but not leading to marked deterioration of functioning in areas such as work, social relations, and self-care—the symptoms required in criterion B for the diagnosis of schizophrenia.

Apart from its delimitation from other disorders, several reasons exist for restoration of the simple schizophrenia diagnosis: 1) there are historic precedents for the disorder, 2) there is evidence for its genetic relatedness to core schizophrenia, 3) simple and core schizophrenia are similar descriptively and clinically, and 4) research emphasizing the schizophrenia spectrum would benefit from an operational definition of simple schizophrenia. Clearly, criteria need to be developed, and research assessing the reliability and validity of the syndrome needs to be conducted. Without compelling data, however, simple schizophrenia should not be included in a diagnostic manual.

We now propose criteria for simple schizophrenia (see appendix 1). The criteria are a modification of those currently used to define schizophrenia. We have simply omitted criterion A, which requires psychotic phenomena, and have modified criterion D (our criterion A) to require four of nine prodromal or residual symptoms rather than two symptoms. The reason for the latter change is to make the diagnostic category more restrictive than it is when only two symptoms are required. We have added schizotypal personality as an exclusion criterion (criterion F); mood disorders, autism, and organic disorders remain as exclusion criteria. The criteria are consistent with the original definitions of simple schizophrenia that Diem, Bleuler, and Kraepelin described. Each had emphasized the fundamental and not the accessory symptoms of schizophrenia. In modern parlance, simple schizophrenia is a syndrome of negative or defect symptoms but not positive or psychotic symptoms (36).

CONCLUSIONS

We have traced the origins of the concept of simple schizophrenia to the late nineteenth century, when European descriptive psychiatrists initially identified the syndrome of simple primary dementia. Simple schizophrenia was later elaborated by Diem and Bleuler and accepted by Kraepelin.

Use of the category flourished over the next half-century, and the syndrome was incorporated into widely used textbooks of psychiatry, although no new information had been learned since its early description. Rumblings of discontent arose, but not until the development of DSM-III was the disorder dropped from official American classification. Criticism had focused on its unclear and changing definition, its infrequent use, its poor reliability, and its doubtful descriptive validity. However, the original definition is still of heuristic interest. As the concept is not fully captured by any current DSM-III-R category, we propose operational criteria for simple schizophrenia and recommend that they be used to amass data to determine the validity of its inclusion as a category in DSM-IV.

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APPENDIX 1. Proposed Criteria for Simple Schizophrenia (Simple Deteriorated State)

A. Presence of four or more of the following symptoms:
1. Marked 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, hoarding food)
4. Marked impairment in personal hygiene and grooming
5. Blunted or inappropriate affect
6. Digestive, vague, overly elaborate, or circumstantial speech, or poverty of speech, or poverty of content of speech
7. Odd beliefs or magical thinking, influencing behavior and inconsistent with cultural norms (e.g., superstitiousness, belief in 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)
9. Marked lack of initiative, interest, or energy
B. Continuous signs of the disturbance for at least 6 months
C. During the course of the disturbance, functioning in areas such as work, social relations, and self-care is markedly below the highest level achieved before the onset of the disturbance (or, when the onset is in childhood or adolescence, failure to achieve expected level of social development)
D. Has never met criterion A for schizophrenia during the course of the disturbance
E. Schizoaffective disorder and mood disorder have been ruled out (i.e., if a major depressive or manic symptom has ever been present, the total duration of all episodes of a mood symptom has been brief relative to the total duration of the disturbance)
F. Schizotypal personality disorder has been ruled out (e.g., there is clear evidence of marked deterioration in functioning from the highest achieved in areas such as work, social relations, and self-care)
G. It cannot be established that an organic factor initiated and maintained the disturbance
H. There is no history of autistic disorder