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The *Journal* regularly highlights the nosology of the schizophrenias from various perspectives (1, 2). Notably, the extension of the schizophrenic spectrum depends on classification (1). We wish to elaborate on the Wernicke-Kleist-Leonhard school within the traditional and current context.

Originally, Kraepelin's dementia praecox and Bleuler's schizophrenias described heterogeneous psychoses with no *restitutio in integrum*. They were unbiased against deficit symptoms. The Wernicke-Kleist-Leonhard school sustained this heuristic notion of the schizophrenias. It rejected nosological hybridism, empirically separating developmentally more conspicuous systematic schizophrenias of insidious onset or course from genetically higher loaded unsystematic schizophrenias inclined to some bipolarity (i.e., periodic catatonia, affective paraphrenia, and cataphasia). Thus, periodic catatonia is but one of three unsystematic schizophrenias that were previously omitted from mention (2). Some well-described conditions dominated by specific deficits were grouped into hebephrenias, which exist only in systematic forms. In fact, various cases of heboidophrenia (Kahlbaum), dementia simplex (Weygandt and Diem), schizoidia (Bleuler and Kretschmer), schizotypes (Rado), latent schizophrenia (Bleuler), and pseudoneurotic schizophrenia (Hoch and Polatin) corresponded clinically to Kleist and Leonhard's hebephrenias. Moreover, Leonhard passionately differentiated early childhood catatonias from mental retardation. Dementia infantilis (Heller) and early infantile autism (Kanner) overlapped to some extent with Leonhard's systematic childhood catatonias, whereas autistic psychopathy of childhood (Asperger) denoted a nonschizophrenic condition.

Currently, DSM and ICD criteria strive for atheoretical consentaneity but impose several inconsistencies. Productive manifestations are appointed as primary gatekeepers for psychoses and schizophrenias that are subtyped but essentially treated as a single entity. Positive symptoms dominate the "A" criteria for DSM-IV schizophrenia. In anamnestic pervasive developmental disorders, DSM-IV defines comorbid schizophrenia as contingent on delusions or hallucinations. Similarly, the inclusion criteria for ICD-10-schizophrenia are largely neo-Schneiderian. Mere duration segregates schizophrenia from schizophreniform disorder. For both, ICD-10 refers to active duration but DSM-IV to total duration as well. Schizotypes are conceptualized either as personality disorders (DSM-IV) or as tightly related to schizophrenia (ICD-10). However, ICD-10 disfavors schizotypes as hardly demarcated from simple schizophrenia and schizoid and paranoid personality disorders. According to DSM and ICD consensus, the schizoaffective disorders are essentially hybrids. Schizoaffective (Kasanin) and schizophreniform (Langfeldt) psychoses preferentially describe cases of Leonhard's unsystematic schizophrenias or fast-cycling cycloid psychoses. Representing neither schizophrenic nor affective psychoses, cycloid psychoses recur frequently in phases—unlike brief psychotic disorders (DSM-IV)—and without progressing to residua.

According to the Wernicke-Kleist-Leonhard school, the DSM and ICD criteria exclude some cases of schizophrenic psychoses (namely hebephrenias and catatonias) from research on schizophrenias. In other nonschizophrenic (particularly cycloid) psychoses, "schizophrenia" may be misasserted. Supported by genetic evidence (3), Leonhard's classification has just been retranslated (4). For technological sophistication to eventually alleviate a centurial enigma (1), psychopathological

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disputes (e.g., of primary negative symptoms and alternative dimensional descriptors) must consider the history of the schizophrenias.

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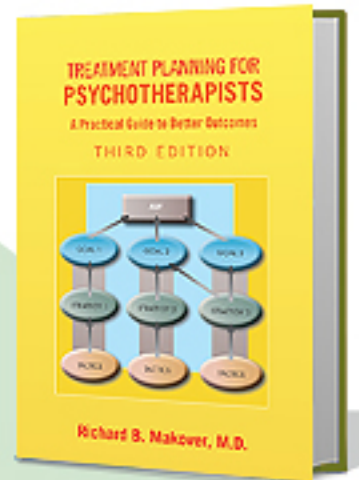
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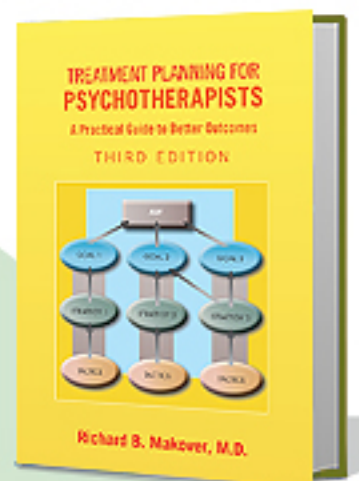


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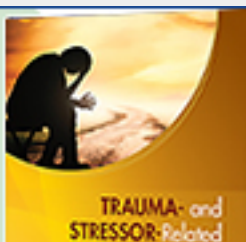
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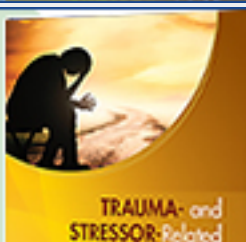


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