Disturbance of Perception in Depressive Disorders in the Different Diagnostical Systems

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Introduction: Disturbances of perception play a considerable role in depressed patients' symptoms. These symptoms are mostly secondary in the daily practice, however, the disturbances of perception of a mild degree lead to cognitive distortions, and they make the recognition of the depression significantly more difficult. **Purpose:** To review several systems of diagnostic criteria, five developed in Europe, ten in the area of the United Kingdom, five in the United States and five other diagnostic systems with respect to the kind of significance they ascribe to the disturbances of perception in the presence of the depression. **Results:** The author establishes that the diagnostic systems examined in case of the patients suffering from depression ascribe different significances to the disturbances of perception despite the fact that all depressed patients suffer from these symptoms. In case of the 23 examined disturbances of perception, out of the 25 systems 20 ascribe significance to fewer than ten symptoms, 11 systems ascribe significance to five or fewer symptoms. In the process of the simplification of the diagnostic systems these symptoms do not obtain emphasis, which makes the establishment of the accurate diagnosis difficult. The author emphasizes that in the background of disturbances of perception the detection of the misshapen reality hides, from which the patients suffer the most. Out of the examined diagnostic systems the European and the complex diagnostic systems ascribe a more considerable emphasis to the disturbances of perception. In Kielholz's system there are 14, while in the CODE system there are 19 kinds of disturbances of perception. **Conclusion:** The author establishes that the disturbances of perception and the symptoms developed by the consequences of the disturbances of perception have a greater significance in patients suffering from depressive disorders than it is known in the common knowledge. In fact most of the psychiatric signs and symptoms may be attributable to some kind of disturbance of perception. Out of the examined diagnostic systems Paul Kielholz's and Thomas Ban's complex diagnostic system, the CODE-DD takes the significance of the disturbances of perception into consideration in the largest degree. It is necessary to keep in mind that patients suffering from depression with disturbances of perception also present have difficulty in recovery. In the process of the simplification of the diagnostic systems these symptoms may evade the doctors' attention making the recognition of the illness more difficult and weaken the efficiency of the therapy. It would be justified to indicate the disturbances of perception as a diagnostic criterion in the ICD-11 and in the DSM-V among the illnesses related to depression. Paying attention to the disturbances of perception may transform the system of psychiatric classifications and the research of psychiatric illnesses not only in case of affective disorders but also in case of psychoses. Especially the genetic research concerning the disturbances of perception may support the objective judgement of the psychiatric disorders, its biological tenability could stabilize the situation of psychiatry among medical sciences.

Keywords: disturbance of perception, symptoms, signs, depressive disorders, diagnostic systems.

Despite huge improvements in the research of the central nervous system, psychiatry has not yet been able to define a lot of criteria necessary to accurately define psychiatric illnesses. (1) The crisis in psychiatry has employed psychiatrists all over the world, as was seen in the Fourteenth World Congress in Prague in 2008. With plenty of research discrepancies between traditional psychiatry and new trends, it is often difficult to accurately assess, diagnose, and address psychiatric symptoms. This particularly raises the significance of psychiatric signs and symptoms in the establishment of the.

In latter years, the scientific research has focused primarily on the different algorithms and classification systems, nearly not dealing with the accurate definition of different symptoms and signs. This has made the validity of the diagnostic systems uncertain. The newer and newer diagnostic systems show this uncertainty, that is why it is even more important to improve the psychiatric definition, the elimination of the mistakes of the subjectivity and finding the correct nozological system. Similarly, at the creation of the diagnosis of depressive disorders there is a lot of subjectiveness involved, which makes the success of the basic principles of the evidence-based medicine difficult or even impossible in the psychiatric diagnostics. Patients suffering from depression clinically form an inhomogeneous group. The pathology, aethiology, genetics, symptomatology, process, outcome, result and treatment of the illness is exceptionally diverse. Although there is evidence linking depression to biochemical alterations, receptor modifications within the central nervous system, somatic processes etc., specific illness markers have not been identified so far.

Some parts of our central nervous system are suitable for the intake and comprehension of the events occurring in the world around us. However, if the environmental events are outside the scope of the sensory channels, (e.g. spirituality), one may no longer be able to directly detect these events. In accordance with the reality that the intake of the mental nourishment happens through the senses, it may follow that these "mental nutrients" have their own metabolism - thus "organs" can be found, which carry out the processing of these sensations. As the normal intake of food is possible according to the needs of the digestive system; reduced intake (malnutrition), desire for more input, (overdose), and the harmful intake of material (poisoning) also exist in perception. Deficiency, damage caused by overdose, perception pollution, and damage caused by the intake of harmful information are all possible within the senses. As the metabolism keeps the bodily life alive, the vital of the psychic activity is the continuous contact with the environment. Our remarks adjust to our memories well, our recognitions are suitable for our expectations, we build our cognitions into our world productively. If this process is interrupted, misperceptions come into existence. (2)

Every person inhabits the same world, but his or her perceptional world is different and changes continuously. For instance, growing older and older some people become unable to hear the chirring of a cricket, this way it is excludes from their world, although they are aware of the fact that the crickets have not disappeared from the world. Likewise, the colour blinds also see the world differently. (3)

It would be worth focusing on the duality of the psychiatric disorders, which are partly biological (i.e. objective and can be examined with scientific methods) and partly based on culture (which is subjective, spiritual, mythological, subject to social changes, and can only be examined with scientific methods indirectly).

A person's culture is decisive, it is deeply rooted in the human central nervous system, and also defines how we observe the world. The largest part of our culture is hidden, falls out of the sphere of the conscious act. A human being is only able to act sensibly and to form relationship with each other through the medium of the culture. Communication is the essence of both culture and life. Here perception, culture and society are connected with psychiatry as with one of the branches of medical science. (4)

This recognition may not only lay the foundations for creating a new diagnostic system, but may put an end to the contradiction between biologically oriented psychiatrists and psychiatrists applying a psychological approach, creating the biological-psychological-sociological continuity. It is about the same phenomenon from different aspects and both halves are right from their own aspects. The two can complete each other.

Following this analogy the diet of the nervous system is provided by the stimuli from the outside world. If the stimuli flow is lost, the perception is distorted, and the internal world of the nervous system starts to live an "independent life", causing the manifestation of various psychiatric signs and symptom. For instance, the serious reduction of vision results in visual hallucinations, the reduction of hearing often results in auditory hallucinations and the formation of delusions. Certain phantom pains appearing in cases following the loss of a limb is the result of the game of

the central nervous system. The experiential experience is intrinsically connected to the functioning, or perhaps malfunctioning of the central nervous system. These facts may well be the basis of the material explanation for many psychiatric signs and symptoms. The experiential experience is therefore a lot more vast than merely the five (or more) senses. It consists of mental and physical (electrical), biological, and biochemical activities, and these activities cannot be separated from the functioning of the nervous system. Our experiences have physical realities that constantly interact with each other and change within space, time and culture. Therefore one may not deduce higher-order operations directly from physical realities, just as one cannot know the complete properties of water by just knowing the characteristics of the oxygen and hydrogen. (5) *www.internetandpsychiatry.com*

A person's picture about the world changes if the perception becomes deformed and the most diverse psychiatric symptoms may come into existence. Even the perception disturbances with a mild degree lead to cognitive distortions and the recognition of psychiatric illnesses may significantly be made more difficult. The disturbance of perception plays a considerable role in the symptoms of patients suffering from depression. It is justified by a great number of old recognitions and everyday routine. Pápai Páriz Ferenc wrote about hypochondriac melancholy in his book of 1687 titled Pax Corporis. Pinel (1745-1826) considered melancholy as wrong judgement, nothing else but a "fixa idea". As Koronkai wrote in 1995, in involutious depression 40% of patients, while in endogenous depression 22% of patients, and in psychogenic depression 19% of patients showed hypochondriac symptoms. Anxiety, which can be found behind the hypochondriac fear concerns not only the patients' own health but also their existential existence, their own future as well as their family's, and also their efficiency, as for the prerequisites of their social safety feeling. Ensuring existence is the most important endeavour of personality and with the safety endeavour (which is the opposite of anxiety according to Sullivan), as well as with Ericksonian basic trust they together create the possibility for social coexistence. (6)

It is also important to note that the relationship between the disturbance of perception and suicide has a particularly huge significance in depressive patients. There is a significant association between delusions and suicide: a delusionally depressed patient is five times more likely to commit suicide than a nondelusional one. A retrospective analysis of all suicide victims suffering from unipolar endogenuous depression, at New York State Psychiatric Institute over a 25-year period (1955-1980) was carried out by Roose et al. The most important finding of this study was that among hospitalized unipolar depressives who committed suicide, the rate of delusions was very high. They concluded that a patient with delusional depression was significantly more likely to commit suicide than his nondelusional counterpart. The relative risk (odds ratio) was 5.3 so a delusionally depressed patient was 5.3 times more likely to commit suicide than a nondelusional one. (7)

In recent decades in Hungary the following diagnoses including disturbances of perception were used in practice: Paranoid Depression, Melancholia, Suspicious Depression, Hypochondriacal Depression, Self-torturing Depression, Major Depression with Mood-Congruent Psychotic Symptoms, Neurotic Depression, Suspicious Depressive State/Illness, Hypochondrical Depressive State/Illness, Self-torturing Depressive State/Illness etc.

The symptoms of depression in the same patient are differently judged by psychiatrists living in different sociocultures and belonging to different psychiatric schools. We may claim that the symptom list of depressive disorders is uncertain and not unified, the accurate definition and nosological definition of some symptoms even today depend on age, culture, subculture, psychiatrist, and psychiatric school to a considerable extent (2), however, all signs and symptoms may be attributable to some kind of disturbance of perception. The endeavours of WHO and the APA is to synchronize the systems of ICD and DSM by 2011. It is a praiseworthy pursuit, however, it involves the danger of simplification and the elimination of individual differences, which may mean a relief in diagnostics, yet, it eliminates the differences between some patients, and thus makes the patients' treatment more difficult.

PURPOSE

To review diagnostic criteria system, five of which was developed in Europe, ten in the area of the United Kingdom, five in the United States, and five other diagnostic systems from the point of view of what kind of significance they ascribe to the disturbances of perception in the presence of depression. Today disturbances of perception are generally not diagnostical criteria in Depressive Disorders except in depressions with a psychotic level. Of the 25 diagnostic systems five were based on European classifica-

Table 1. Disturbances of perception in the examined 25 Diagnostical Systems

	12	13	20	21	25	26	27	28	29	32	36	38	41	43	45	46	47	50	51	56	65	80	81	Sum
A	X	X	X	X					X	X									X				X	8
B								X			X	X	X		X	X	X	X		X		X		10
C		X	X	X		X	X	X	X	X			X	X	X	X		X	X	X				15
D													X	X										2
E	X							X				X			X	X	X	X			X		X	9
F	X			X		X	X			X		X				X			X					8
G								X		X		X				X								4
H								X							X									3
I			X					X	X						X	X		X						6
J								X						X		X			X		X			5
K								X		X		X			X			X		X				7
L								X	X			X		X										4
M							X	X		X		X				X								6
N			X						X							X	X	X						5
O	X			X								X			X	X								6
P																			X					1
Q										X						X			X					3
R										X						X			X					3

S	X			X	X			X		X				X	X	X	X	X	X					**11**
T	X			X	X										X	X		X					X	**7**
U										X					X	X		X						**4**
V										X			X	X		X		X	X					**6**
W				X																				**1**
X			X	X				X	X	X		X	X		X	X	X	X	X		X		X	**14**
Y	X		X	X		X	X	X	X	X	X	X	X	X	X	X		X	X	X		X	X	**19**
	12	**13**	**20**	**21**	**25**	**26**	**27**	**28**	**29**	**32**	**36**	**38**	**41**	**43**	**45**	**46**	**47**	**50**	**51**	**56**	**65**	**80**	**81**	**sum**
Sum	**7**	**3**	**6**	**9**	**2**	**3**	**4**	**13**	**7**	**13**	**2**	**10**	**6**	**7**	**13**	**18**	**5**	**12**	**11**	**4**	**4**	**2**	**7**	**23**

Horizontal: Disturbances of perception. According to the "Glossary of Variables in Depressive Disorders". (8)
12. Hallucinations 13. Bodily misperceptions 20. Ideas of references 21. Delusions 25. Other feelings of alien influence 26. Derealization 27. Depersonalization 28. Hypochondriasis 29. Suspiciousness 32. Anxious mood 36. Depressive evaluation 38. Anxiety 41. Constricted affect (hypesthesia) 43. Apathetic indifference 45. Feeling of inadequacy 46. Feelings of guilt 47. Feelings of impoverishment 50. Hopelessness 51. Self-incrimination 56. Corporization 65. Histrionics (hyperesthesia) 80. Time still 81. Mood congruent psychotic symptoms (delusions and/or hallucination with depressive content)
Vertical: Classification. 25 Diagnostical Systems. (8)
A. Emil Kraepelin Criteria of Depressive States and Depressive Excitement (1896, 1921) B. Kurt Schneider's Criteria of Vital Depression, Reactive Depression and Depressive Psychopathy (1920, 1958, 1959) C. Karl Leonhard's Criteria of Pure Melanchola and Pure Depressions (1957) D. Vienna Research Criteria (VRC) of Endogenomorphic-Depressive Axial Syndrome and Endogenomorphic-Dysphoric Axial Syndrome (Berner 1965, 1969, 1983) E. ICD-10 (1989 Draft) Criteria of Depressive Disorders F. Aubrey Lewis' Criteria of Melancholia (1934) G. Hamilton and White's Criteria of Retarded Depression (1959) H. Kiloh and Garside's Criteria of Endogenous Depression and Neurotic Depression (1963) I. Pilowsky, Levine and Boulton's Criteria of Class A or Neurotic Depression and Class B or Endogenous Depression (1969) J. Mendels and Cochrane's Criteria of Endogenous Depression (1968) K. Graham Foulds' Criteria of Dysthymic Depression, Neurotic Depression and Psychotic Depression (1973, 1976) L. Overall, Hollister, Johnson and Peennington's Criteria of Type A or Anxious Depression, Type B or Hostile Depression and Type C or Retarded Depression (1966) M. Eugene Paykel's Criteria of Group 4A or Psychotic Depression, Group 4B or Anxious Depression and Group 4C or Hostile Depression (1971) N. Raskin and Crook's Criteria of Type 1 or Agitated Depression, Type 2 or Neurotic Depression, Type 3 or Endogenous Depression and Type 4 or Poor Premorbid Personality Depression (1976) O. CATEGO Criteria of Depressive Disorders (Wing, Cooper, Sartorius, 1974.) P. Robins and Guze's Criteria of Primary Affective (Depressive) Disorder and Secondary Affective (Depressive) Disorder (1972) Q. St. Louis Criteria of Primary Depression and Secondary Depression (Feighner et al, 1972) R. George Winokur's Criteria of Pure Depression, Depressive Spectrum Disease and Sporadic Depression (1974, 1975, 1979) S. Research Diagnostic Criteria (RDC) of Major Depressive Disorder and Minor Depressive Disorder (1983) T. DSM-III-R Criteria of Depressive Disorders (1987) U. Taylor and Abrams' Criteria of Endogenous Depression and Taylor's Criteria of Minor Depression (1986) V. Donald Klein's Criteria of Endogenomorphic Depression, Acute Dysphoria and Chronic Neurotic Dysphoria (1974) W. John Pollitt's Criteria of Psychological Type J Depresssion and Physiological Type S Depression. (1965) X. Paul Kielholz's Nosological Classification of Depressive States (1968, 1972) Y. Composite Diagnostic Classification (CDC) of Depressive Disorders (1987, 1989)

tions, primarily in German speaking countries; ten based on the classification in the United Kingdom and other English speaking countries; five based on the North American classification, primarily from the United States; four provide important links among the different classifications; and one is a composite classification (Composite Diagnostic Evaluation of Depressive Disorders). (8, 9, 10)

METHODS

The examination of the disturbances of perception among the twenty-five diagnostic systems regarding how much significance is ascribed to these symptoms.

RESULTS

a.) Disturbances of perception in the examined 25 Diagnostical Systems according to the "Glossary of Variables in Depressive Disorders" (8): 12. Hallucinations 13. Bodily misperceptions 20. Ideas of references 21. Delusions 25. Other feelings of alien influence 26. Derealization 27. Depersonalization 28. Hypochondriasis 29. Suspiciousness 32. Anxious mood 36. Depressive evaluation 38. Anxiety 41. Constricted affect (hypesthesia) 43. Apathetic indifference 45. Feeling of inadequacy 46. Feelings of guilt 47. Feelings of impoverishment 50. Hopelessness 51. Self-incrimination 56. Corporization 65. Histrionics (hyperesthesia) 80. Time still 81. Mood congruent psychotic symptoms (delusions and/or hallucinations with depressive content).

In patients suffering from depression more disturbances of perception may be seen with a more careful examination of disturbance of perception than we reckon in practice.

Kaplan and Sadock list the following symptoms as disturbances of perception (11): Disturbances of perception: hallucination, (synesthesia) illusion. Disturbances associated with organic mental disorder: agnosia, anosognosia, autotopagnosia, visual agnosia, astereognosia, prosopagnosia, apraxia. Disturbances associated with conversion and dissociative phenomena: hysterical anesthesia, macropsia, micropsia, depresonalization, derealization, fugue, multiple personality.

b.) Examined 25 Diagnostical Systems.

European classifications, primarily in German speaking countries (five): A. Emil Kraepelin Criteria of Depressive States and Depressive Excitement (1896, 1921) B. Kurt Schneider's Criteria of Vital Depression, Reactive Depression and Depressive Psychopathy (1920, 1958, 1959) C. Karl Leonhard's Criteria of Pure Melanchola and Pure Depressions (1957) D. Vienna Research Criteria (VRC) of Endogenomorphic-Depressive Axial Syndrome and Endogenomorphic-Dysphoric Axial Syndrome (Berner 1965, 1969, 1983) E. ICD-10 (1989, Draft) Criteria of Depressive Disorders.

Classification in the United Kingdom and other English speaking countries (ten): F. Aubrey Lewis' Criteria of Melancholia (1934) G. Hamilton and White's Criteria of Retarded Depression (1959) H. Kiloh and Garside's Criteria of Endogenous Depression and Neurotic Depression (1963) I. Pilowsky, Levine and Boulton's Criteria of Class A or Neurotic Depression and Class B or Endogenous Depression (1969) J. Mendels and Cochrane's Criteria of Endogenous Depression (1968) K. Graham Foulds' Criteria of Dysthymic Depression, Neurotic Depression and Psychotic Depression (1973, 1976) L. Overall, Hollister, Johnson and Peennington's Criteria of Type A or Anxious Depression, Type B or Hostile Depression and Type C or Retarded Depression (1966) M. Eugene Paykel's Criteria of Group 4A or Psychotic Depression, Group 4B or Anxious Depression and Group 4C or Hostile Depression (1971) N. Raskin and Crook's Criteria of Type 1 or Agitated Depression, Type 2 or Neurotic Depression, Type 3 or Endogenous Depression and Type 4 or Poor Premorbid Personality Depression (1976) O. CATEGO Criteria of Depressive Disorders (Wing, Cooper, Sartorius, 1974).

North American classifications, primarily from the United States (five): P. Robins and Guze's Criteria of Primary Affective (Depressive) Disorder and Secondary Affective (Depressive) Disorder (1972) Q. St. Louis Criteria of Primary Depression and Secondary Depression (Feighner et al, 1972) R. George Winokur's Criteria of Pure Depression, Depressive Spectrum Disease and Sporadic Depression (1974, 1975, 1979) S. Research Diagnostic Criteria (RDC) of Major Depressive Disorder and Minor Depressive Disorder (1983) T. DSM-III-R Criteria of Depressive Disorders (1987).

Important links in different classifications (four): U. Taylor and Abrams' Criteria of Endogenous Depression and Taylor's Criteria of Minor Depression (1986) V. Donald Klein's Criteria of Endogenomorphic Depression, Acute Dysphoria and Chronic Neurotic Dysphoria (1974) W. John Pollitt's Criteria of Psychological Type J Depression and Physiological Type S Depression (1965) X. Paul Kielholz's Nosological Classification of Depressive States (1968, 1972).

Composite classification (one): Composite Diagnostic Classification (CDC) of Depressive Disorders (1987, 1989). (8)

c.) Disturbances of perception in the examined 25 Diagnostical Systems. (Table 1.)

DISCUSSION

The examined 25 diagnostic systems ascribe different significance to the disturbances of perception. In six diagnostic systems three or less types, in five diagnostic systems four or five types, in ten diagnostic systems from six to ten types, and in one diagnostic system 19 types of disturbances of perception occur. As for the disturbances of perception the greatest significance is ascribed to the disturbances of perception from among the European classification by Karl Leonhard and Kurt Schneider, from among the Classification in the United Kingdom by Aubrey Lewis' system, from among the North American classifications, primarily from the United States the RDC, from among the important links among the different classifications by Paul Kielholz's system (13) and by Thomas Ban's Composite classification. Paul Kielholz's diagnostic system belongs to the European classification indeed. Paul Kielholz uses 14 symptoms, while Thomas Ban uses 19 symptoms in his diagnostics. In the European diagnostic systems on average 8,8 disturbances of perception occur, in the Classification in the United Kingdom 5,4 disturbances of perception appear, in the North American classifications, primarily from the United States there are 5,0; in the systems insuring the connection there are 6,25 disturbances of perception. Symptoms appearing in most cases: feelings of guilt (occurring in 18 systems), hypochondriasis (in 13 systems), hopelessness (in 12 systems), self-incrimination (in 11 systems), feeling of inadequacy (in 11 systems). It is interesting to note that depressive evaluation appearing frequently in practice and the time experience disturbance occur only in two diagnostic systems each.

The symptoms of the disturbances of perception and the ones that develop as the consequences of the disturbances of perception have a greater significance in people suffering from depression-related diseases than it is known by the public, especially, in the judgement of the danger of suicide.

In psychiatry there is no originally given symptom catalogue independent from people, cultures, ages, but most of the psychiatric symptoms may be attributable to some kind of disturbance of perception. In all depressed states/ disturbances/diseases some kind of disturbance of perception can be found, that is why it would be expedient to incorporate perception disturbance in ICD-11 and in DSM-V as a diagnostic criterion in the diagnosis of depression. Paying attention to the disturbances of perception may transform the system of psychiatric thinking and the classifications, the research of psychiatric illnesses, not only in depression-related diseases but in psychoses as well.

CONCLUSIONS

The ultimate cause of all psychiatric diseases and disturbances, as well as depression is the disturbance of perception. Earlier the disturbance of perception was considered as a consequence of affective illnesses, however, it has already been proved by today that affective illnesses are cronobiological diseases, of which the final reason is the desynchronization between different kinds of times (physical-biological-time vs. cultural, -geographical, -social, -historical, -mythological, -spiritual time). The disturbances of time perception, the desynchronization of different times may lead to psychic disturbances. The desynchronization is also the basis of the development of psychiatric signs and symptoms. Different times direct living beings with a hierarchical regulation and they also have an effect on each other. It is likely that the disturbances of cultural-time, social-time etc. significantly influence psychic and biological time. (12) Particularly, the genetic research of the disturbances of perception may promote the objective judgement and the biological tenability of psychiatric disturbances/illnesses, and the stabilization of the situation of psychiatry among medical sciences. In diagnostic systems aiming for simplification, these symptoms may evade the doctors' attention, making the recognition of the illness and the efficiency of the therapy more difficult.

Nyilatkozat. A szerző nem jelölt meg támogatási forrást a közleményben ismertetett kutatáshoz és nem számolt be érdekkonfliktusról.

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A depresszióra jellemző percepciózavarok a különböző diagnosztikai rendszerekben

Bevezetés: A depressziós betegek élménytünetei és magatartástünetei között jelentős szerepe van a percepciózavaroknak. Ezek a tünetek a mindennapi gyakorlatban többnyire háttérbe szorulnak, pedig már az enyhe fokú percepciózavarok is kognitív torzulásokhoz vezetnek, és jelentősen nehezíthetik a depresszió felismerését. **Célkitűzés és módszerek:** Áttekinteni öt európai, öt amerikai, tíz egyesült királyságbeli és öt egyéb diagnosztikai rendszer kritériumait abból a szempontból, hogy ezek milyen jelentőséget tulajdonítanak a depresszió jelenlétében a percepciózavaroknak. **Eredmények:** A szerző megállapítja, hogy a depressziós betegeknél a vizsgált diagnosztikai rendszerek különböző jelentőséget tulajdonítanak a percepciózavaroknak, annak ellenére, hogy a depressziós betegek valamennyien szenvednek ezektől a tünetektől. A vizsgált 23 percepciózavarból 25 rendszerből húsz, tíznél kevesebb tünetnek; 11 rendszer öt vagy annál kevesebb tünetnek tulajdonít jelentőséget. Az egyszerűsítésre törekvő diagnosztikai rendszerekben ezek a tünetek nem kapják meg a jelentőségüknek megfelelő hangsúlyt, ami a pontos diagnózisalkotást megnehezítheti. A szerző hangsúlyozza, hogy a percepciózavarok hátterében a valóság torz érzékelése húzódik meg, amitől leginkább szenvednek a betegek. A vizsgált diagnosztikai rendszerek közül az európai és a komplex diagnosztikai rendszerek tulajdonítanak nagyobb jelentőséget a percepciózavaroknak. Kielholz rendszerében 14, a CODE-rendszerben 19 féle percepciózavar szerepel. **Következtetés:** A szerző megállapítja, hogy a percepciózavaroknak és a következményükként kialakuló tüneteknek nagyobb a jelentőségük a depressziós megbetegedésben szenvedőknél, mint az a köztudatban ismert. Valójában a legtöbb pszichiátriai élménytünet visszavezethető valamilyen percepciózavarra. A vizsgált diagnosztikai rendszerek közül Paul Kielholz, és Thomas Ban komplex diagnosztikai rendszere, a CODE-DD veszi legnagyobb mértékben figyelembe a percepciózavarokat. (vagy: szentel legtöbb figyelmet a percepciózavaroknak) Nehezen gyógyuló depressziós betegeknél mindig gondolni kell a percepciózavarok jelenlétére is. Az egyszerűsítésre törekvő diagnosztikai rendszerekben ezek a tünetek elkerülhetik az alkalmazók figyelmét, ami megnehezíti a betegség felismerését, és csökkenti a terápia hatékonyságát. Indokolt lenne a BNO-11 és a DSM-V-ben a percepciózavarokat diagnosztikai kritériumként feltüntetni a depressziós megbetegedésekben. A percepciózavarokra való odafigyelés átalakíthatja a pszichiátriai klasszifikációk rendszerét és a pszichiátriai betegségek kutatását, nemcsak a depressziós megbetegedések esetében, de a pszichózisokban is. Különösen a percepciózavarok genetikai kutatása segítheti elő a pszichiátriai zavarok/betegségek objektív megítélését, biológiai megalapozottságát és a pszichiátria helyzetének stabilizálását az orvostudományok között.

Kulcsszavak: percepciózavar, élménytünetek, depressziós zavarok, diagnosztikai rendszerek