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CLASSIFICATION AND NOMENCLATURE OF PSYCHIATRIC CONDITIONS

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Table of Contents

CLASSIFICATION AND NOMENCLATURE OF PSYCHIATRIC CONDITIONS

Introduction

Definition of Terms

Dialectic and Debate

The American Psychiatric Association's Diagnostic and Statistical Manual and ICD-8, The International Classification of Diseases

Comment on the Classification

Code Numbers

Nosology of This Handbook

Conclusion

Bibliography

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Introduction

It is traditional to complain about the short-comings and the illogical nature of the various systems of nomenclature and classification; yet this writer knows of no psychiatry that can get along without them. Great psychiatrists at least from the time of Pinel onward have expressed such dissatisfactions, and today the complaints and the suggested solutions are at least as numerous and more sophisticated than ever before. Some authorities advocate an abandonment of all labeling on the grounds that there is no such thing as mental disorder, while others insist that there is only one type of mental disorder whose variations are individual, infinite, and not to be further classified. Still others would replace all existing systems with new synthetic ones based on completely novel approaches, many of which rely on computer-based analyses of quantitative data.

Nevertheless, it is fair to say that for all practical purposes clinical psychiatry continues to place its reliance on regular periodic revisions of

existing classifications. Such revisions seek to incorporate advances in psychiatry and to accommodate to changing views, as well as to develop technical improvement in the methods of classification. Another aim of recent years has been to work toward a convergence among all existing psychiatric systems, and much progress has been made in this direction through the World Health Organization's eighth edition of the *International Classification of Diseases* (ICD-8), and further progress is expected in the next edition, which is now in preparation (ICD-9). The problem is far less difficult than might be expected because, in spite of the great divergencies on specifics that Stengel outlined, the major classifications that are now in active use all derive from a common psychiatric history and share a common scientific literature, and thus they are very similar in basic structure.

Psychiatric classification and nomenclature is often portrayed as a long series of arbitrary inventions that have been created and destroyed in endless succession. This is distinctly not true. It is a matter of common knowledge that such terms as mania, melancholia, and paranoia were already in common use in classic Greek and Roman times. Other terms such as neurosis and neurasthenia were added in the course of time, and although much was tried and abandoned, what has survived the centuries has a vigor that speaks of some real usefulness in what is perhaps the most pragmatic and empirical of all medical undertakings, the treatment of the mentally ill.

The arrangement of individual disorders into major classes, namely, the psychoses, neuroses, character disorders, and the mental deficiencies, is likewise of long development as is the clear distinction between the organic and the functional disorders. Most of this has been accomplished during the last 150 years, and all of this is common to the major classifications worldwide.

Another factor that tends to bring the various systems into alignment is that they must all meet the test of practicability in actual operation. Six essential requirements may be listed for a clinical classification to become generally acceptable:

1. It should be as simple as possible and practical for application under field conditions; highly complex terminology or overelaborate recording procedures are a serious bar to widespread use.

2. It should lend itself to the various operations necessary for public health statistics. It must, therefore, be constructed to comply with technical statistical requirements—a reminder that diagnosis is more than a personal matter between a patient and his physician.

3. A glossary defining each term in the classification is essential. In arriving at such definitions, it is well to note Stengel's position that it is futile to indulge in "last ditch battles" about an exact definition of a type of neurosis or a subgroup of

schizophrenia. In the present state of our knowledge such definitions must be taken more as conventions than as absolute truths, although they do have operational significance and, if generally accepted, provide a valuable medium of communication. ICD-8 has not hitherto had such a glossary, but the World Health Organization is now preparing one.

4. The system should allow maximum comparability between its terms and those of the major psychiatric classifications.

5. The psychiatric classification should be gathered into one list and not scattered through a general manual of medical diagnoses.

6. A good index of all psychiatric terms such as is found in ICD-8 is a valuable part of any classification.

Let us now examine some of the definitions of important terms that are used in describing classifications generally because these can be a source of difficulty. We can then turn to an examination of some of the general and theoretical objections and criticisms that have been raised with respect to current psychiatric classifications, including DSM-II and ICD-8.

Definition of Terms

It might be expected that the field of classification would have a well-standardized terminology, but as Crowson points out this is not the case.

Even at the most expert level one finds considerable variation in usage of such basic terms as classification, systematics, nosology, and taxonomy. The word “classification” may, for example, refer to the process of classifying or to its product. “Systematics” is used by some writers as a synonym for classification, while others reserve the term to describe the general science and theory of classification.

For purposes of this chapter the following definitions have been adopted:

1. Nomenclature: This is a system of the names in a scientific classification. Ideally the terms of a nomenclature are rigorously defined and specific and do not overlap in meaning. Thus a nomenclature can be distinguished from a terminology, which is a general collection of all terms used in a technical field.

The aim of a nomenclature is to promote stability and uniformity in scientific naming. It should be noted that these are names, not of things, but of concepts; thus schizophrenia is, strictly speaking, the name of a concept of a disorder, not of the disorder itself. The APA nomenclature,” in general, recognizes only one primary term for each condition, although some synonyms are mentioned. In ICD-8 there is also only one primary term for each classified condition; but a large number of synonyms are listed as

inclusion terms, and to further assist in defining the various entities ICD-8 also lists for them a series of exclusion terms, names of conditions that are similar but different enough to be excluded from the rubric. The nomenclature also includes names of groups of conditions such as the neuroses and psychoses, as well as subdivisions of various conditions such as "schizophrenia catatonic excited" and "schizophrenia catatonic withdrawn."

2. Classification: This is an orderly arrangement of names into a hierarchical system with successively higher orders of generalization. In psychiatry the basic elements are such names as hysteria and catatonic schizophrenia. The next higher level consists of names of groups of disorders such as schizophrenia and manic- depressive psychoses. The next level is made up of more generalized groupings such as psychoses, neuroses, character disorders, and the like.

3. Natural and Artificial Classifications: A classification may be either natural or artificial. If it reflects some deeper underlying pattern or reality, it is called "natural" or Aristotelian. An example is the current classification of animals and plants that reflects the principles of Darwinian evolution. In psychiatry the classification of organic brain syndromes of known etiology is generally recognized as a "natural" system.

An artificial classification, as the term implies, is purely arbitrary and

synthetic and is developed for utilitarian purposes. An example in psychiatry is the classification of patients by pattern of behavior. A natural classification must be discovered; an artificial one is invented. As a result the members of the first group will share points of resemblance and characteristics other than those required to assign them to the group, but this is not true of members grouped in an artificial system. One of the most difficult questions in modem psychiatry is whether the classification of the so-called functional psychoses should be treated as natural or artificial, and opinion is strongly divided on this point. The current classification of personality and behavior disorders is generally considered to be an artificial one. It is important to note that artificial systems can serve and have served important scientific purposes and that some systems that began as artificial conventions were subsequently found to reflect underlying natural laws. The classification of plants and animals by Linnaeus himself had no theoretical basis until it was later provided by Darwin, and Metchnikoff's periodic table also began as a purely "artificial" arrangement of elements by atomic weight. In psychiatry the identification of psychosis with pellagra and general paresis preceded any knowledge of underlying causes.

4. Diagnosis: This term has many connotations, but essentially it refers to nosology and classification of medical disorders. Some require that a diagnosis must include a knowledge of etiology, or at the very least a well-defined somatic demonstrable pathology. But these statements are really

objections to the principle of artificial classification, and they are based on the assumption that if a classification cannot be proved to be a natural one it must be considered artificial and therefore it is not a diagnosis in any medical or scientific sense. Such a limitation has not been customary in medicine or psychiatry, and it is a matter of medical history that the present level of medical diagnosis was achieved through a series of successively better approximations that began as purely artificial designations and only much later emerged as such entities as vitamin deficiencies, endocrine disorders, and the various specific infections. It is noteworthy that the term "diagnosis" was used for these disease names long before their nature was understood.

5. Nosology, Taxonomy, Systemics, Classification: Specialists make various distinctions among these terms, but they are often interchanged in a confusing manner. For our purposes they can be considered essentially interchangeable, although nosology is usually applied in medical fields, taxonomy to biology, and systemics is a term of broad connotations that include the more abstract aspects of the science and philosophy of classification.

Dialectic and Debate

All of the concepts in classification and nomenclature are continually tested in the debate that has become traditional in this field.

One of the simplest and most recent criticisms is that psychiatric classification and nomenclature is mere pejorative labeling. This criticism indicates that such labeling is in itself an improper procedure, but yet it seems to use the very technique that it condemns by attaching a label of "mere labeling" to the practice of psychiatric diagnosis and classification. If one examines matters more closely, however, he finds that this statement is often linked to an attack on the validity of current categories of mental disorder. This, in turn, is based on a variety of arguments; one of the most common is well stated by Lorr, Klett, and McNair as follows: The psychiatric syndrome is "not a class concept . . . but should represent instead a continuous quantitative variable measurable in terms of degree." The assumption seems to be that where a continuity can be traced from one condition to another the two cannot be really different, or briefly stated, that continuity among things signifies identity. This position seems to ignore the possibility that the continuity can be due to an overlapping of normal and abnormal states as in the case of body weight, blood pressure, hemoglobin measurements, physical stature, and basal metabolic rates.

An even more challenging application of the argument based on continuity is the statement that mental illness does not exist altogether because one can find all possible transitional states between mental health and mental illness. The argument is that this situation is peculiar to psychiatry, and, therefore, the medical model that applies in other specialties

is not appropriate for psychiatry. The fallacy in this logic is the mistaken assumption that there is no continuity between physical health and physical illness. As a British health publication states, ". . . in strictly scientific or technological terms there is no sharp distinction between a healthy and a diseased state in an individual. For a vast range of biochemical and physical observations . . . there is a continuous distribution curve for the population as a whole . . . there is no sharp discontinuity." Thus what was was introduced as the distinctive and therefore disqualifying characteristic of psychiatric classification is, in fact, not distinctive, but is shared by fields in medicine where the medical model is not questioned.

Nor are these problems in classification limited to the medical field, because they are, in fact, found in the biological sciences generally, and it is worth noting that the theory of classification and nomenclature has perhaps had its most intensive development in relation to botany and zoology. In this connection it is most instructive to read such works as that of Crowson who says, "The species is no exception to the rule that the concepts and categories employed in natural history are never susceptible to precise rigorous or final definition; any scientist who is not content to operate with more or less vague and inexact basic principles and ideas is temperamentally unsuited to the study of natural history." Reading further in this and similar works on biological classification we find that other problems that have been discussed as if they were specific to psychiatry are generally encountered in

classification of other biological data, and finally that psychiatry shares a number of other controversies about classification with botany and zoology. Crowson, speaking about biology, objects to "a classification which is limited in its basis to characters which can be counted or measured," and the reasons that he presents will be familiar to any psychiatrist who has been concerned with classification in that field. He also calls attention to an "academic trend over the last fifty years ... of a progressive deprecation of the importance of systematics [the general name of the science of classification], and it has produced the effect that young (recently graduated) botanists and zoologists (have) less real systematic knowledge than at any time in the last hundred years. A projection . . . would suggest the virtual disappearance of systematic content from academic botany and zoology courses." All of which is quite familiar in the field of psychiatry as are the reasons he gives for thinking that the trend will be halted, and this includes the indispensability of classification for practical purposes.

His chapter on "numerical taxonomy" will also be familiar to those interested in psychiatric classification. This chapter is a vigorous attack on the principle (which he traces to American sources) that only a mechanized, computer-produced classification is valid, and his chapter on the noncongruence principle restates the fact that different classificatory characters are rarely coincident in their distributions. His comment on the "splitters" who would create endless subcategories and the "lumpers" who

would go to the opposite extreme is also directly applicable to psychiatry. In brief then it would seem that we must be careful in discussing the problems of psychiatric nomenclature and classification to distinguish between those that are specific to psychiatry, and may reasonably be expected to find a remedy within that discipline, and those that are or seem to be inherent in the classification of all biological data, and are far less likely to do so.

Other issues that are regularly raised with respect to psychiatric nomenclature and classification are displacements from social and political controversies and do not really relate to psychiatric systematics as such. Here one may class the arguments that psychiatric classification can be misused to hospitalize the rejected, to label them in such a way as to express the bias of society, and to stigmatize them and that it can be used as a punishment for behavior unacceptable to the dominant society. Still other arguments and objections appear to represent sheer dialectic, and here one may classify the statement that classification is traditional and should on that account be discarded. This statement ignores the historical fact that attacks on classification are also highly traditional in psychiatry and date back at least to the time of Pinel. Whether one wishes to condemn a practice merely on the grounds that it is traditional is, of course, a political and not a scientific question.

Finally we come to those criticisms that arise out of actual experience in

the application of psychiatric classification. These are quite specific, and we shall see the important role that they play in the development of such systems when we examine the classification of the American Psychiatric Association (DSM II) and of the World Health Organization (ICD-8).

The American Psychiatric Association's Diagnostic and Statistical Manual and ICD-8, The International Classification of Diseases

The 1968 classification of the American Psychiatric Association will now be reviewed in some detail and will be compared with Section V, the psychiatric section of ICD-8, the World Health Organization's classification. The APA classifications began as a national system, but if we include the earlier versions it has probably had more extensive actual use than any other system in the history of psychiatry, having been generally applied in the United States and also used in a number of other countries in North and South America. Stengel pointed this out in his masterly review of national systems.

Among the advantages of DSM II are its glossary[1] and its convertibility to the World Health Organization's system since it uses the same code numbers and, for the most part, uses the same or similar terms. This has become steadily more important as the WHO system has been more widely adopted in Europe and elsewhere.

The changes in DSM II as compared with DSM I are quite extensive and

in many cases represent a return to previous terminology. These changes resulted in part from a serious bilateral effort to develop convergence between the APA classification and that of the WHO. The changes were also responsive to a series of general criticisms in this country that DSM I had moved too far from previously established classification systems. The next decennial revision of the International Classification is now getting under way, but current indications are that this revision will not be extensive and that the alignment with DSM II will not be disturbed. Nevertheless, some changes are to be expected because some problems have become apparent during use; new conditions and new requirements have developed and new data of classificatory significance have emerged, as will be shown further on in this chapter.

As already noted the terms in DSM II are generally the same as those in ICD-8, but differences remain, and these have been identified by marking with an asterisk DSM II items not found in ICD-8 and closing between squared brackets ICD-8 items listed in DSM II but "to be avoided" in actual use. A second significant difference between the two systems is the order of listing of some of the items or groups of items. For example, DSM II lists the forms of mental retardation first, while ICD-8 lists the organic brain syndromes first. The Arabic numerals that comprise the numbering system of ICD-8 have been retained in DSM II, but their sequence has been broken by the rearrangements of the items of classification. Thus the APA list begins with

the 310-315 series (the mental retardations), followed by the 290-294 series (the psychoses associated with organic brain syndromes). Then comes the series number 309 (nonpsychotic organic brain syndromes), followed, in turn, by series 295-298 (psychoses not attributed to physical conditions listed previously).

In ICD-8 the terms are listed in numerical order starting with item 290 (senile and presenile dementia) and ending with item 315 (unspecified mental retardation). Several unused numbers left at the end of the ICD-8 psychiatric series have been used for additional terms in the APA Manual, namely 316-318 (conditions without manifest psychiatric disorder and nonspecific conditions) and 319 (nondiagnostic terms).

To create an overall numerical sequence that corresponds to the order of its own presentation, DSM II has identified eleven main groups of items with Roman numerals, thus it opens with item I (mental retardation and closes with XI (nondiagnostic terms for administrative use).

All of these changes were adopted in order to make the APA system (DSM II) compatible with that of the WHO (ICD-8) and interconvertible with it, and at the same time have it be acceptable in American practice. The history of the collaborative efforts between the APA committee and the WHO representatives that preceded the publication of DSM II is fully described in

the opening pages of that publication.

Following is a brief and modified version of the current APA classification as listed in DSM II under the general title of "The Diagnostic Nomenclature."

I. Mental retardation (310-315)

The primary categories listed are borderline (310), mild (311), moderate (312), severe (313) profound (314), and unspecified (315), and each of these is to be followed by an additional phrase identified by a decimal digit specifying one of ten broad categories of associated conditions of etiological or pathogenic nature, as follows:

.0 infection or intoxication

.1 trauma or physical agent

.2 disorders of metabolism, growth, or nutrition

.3 gross brain disease (postnatal)

.4 disease and conditions due to (unknown) prenatal influence

.5 chromosomal abnormality

.6 prematurity

.7 following major psychiatric disorder

.8 psychosocial (environmental) deprivation

.9 other conditions

When known the specific associated physical condition is specified as an additional diagnosis. The fourth digit is also used to identify subdivisions of various major rubrics as in the case of the alcoholic psychoses 291.1, 291.2, etc. DSM II adds a second decimal place to this basic four-digit system of ICD-8, and this creates additional categories by subdividing a rubric as in the case of 309.13 and 309.14.

II. Organic brain syndromes

(disorders caused by or associated with impairment of brain tissue function)

II-A. Psychoses associated with organic brain syndromes (290-294)

290 Senile and presenile dementia

291 Alcoholic psychosis

.0 delirium tremens

.1 Korsakov's psychosis (alcoholic)

.2 other alcoholic hallucinosis

.3 alcohol paranoid state (alcoholic paranoia)

.4 acute alcohol intoxication

.5 alcoholic deterioration

.6 pathological intoxication

.9 other alcoholic psychosis

292 Psychosis associated with intracranial infection

.0 general paralysis

.1 other syphilis of central nervous system

.2 epidemic encephalitis

.3 other and unspecified encephalitis

.9 psychosis with other intracranial infection

293 Psychosis associated with other cerebral condition

.0 cerebral arteriosclerosis

.1 other cerebrovascular disturbance

.2 epilepsy

.3 intracranial neoplasm

.4 degenerative disease of the central nervous system

.5 brain trauma

.9 other cerebral condition

294 Psychosis associated with other physical condition

.0 endocrine disorder

.1 metabolic or nutritional disorder

.2 systemic infection

.3 drug or poison intoxication (other than alcohol)

.4 childbirth

.8 other undiagnosed physical condition and unspecified

.9 [psychosis with unspecified physical condition]

II-B. Nonpsiichotic organic brain syndromes (OBS) (309)

309 Non-psychotic organic brain syndromes associated with physical conditions

.0 nonpsychotic OBS with intracranial infection

.1 [nonpsychotic OBS with drug, poison, or systemic intoxication]

.13 alcohol (simple drunkenness)

.14 other drug, poison, or systemic intoxication

.2 brain trauma

.3 circulatory disturbance

.4 epilepsy

.5 disturbance of metabolism, growth, or nutrition

.6 senile or presenile brain disease

.7 intracranial neoplasm

.8 degenerative disease of central nervous system

.9 with other physical condition

III. Psychosis not attributed to physical conditions listed previously (295-298)

295 Schizophrenia

.0 simple

.1 hebephrenic

.2 catatonic

.3 paranoid

.4 acute episode

.5 latent

.6 residual

.8 schizo-affective

.8* childhood,

.90 chronic undifferentiated

.99 other

296 Major affective disorders

.0 involutional melancholia

.1 manic-depressive illness, manic

.2 depressed

.3 circular

.8 other

297 Paranoid states

.0 paranoia

.1 involutional paranoid state

.9 other paranoid state

298 Other psychoses

.0 psychotic depressive reaction

.1 [reactive excitation]

.2 [reactive confusion]

.3 [acute paranoid reaction]

.9 [reactive psychosis unspecified]

IV. Neuroses (300)

300 Neuroses

.0 anxiety

.1 hysterical neurosis

[.13 conversion type, .14 dissociative type]

.2 phobic

.3 obsessive-compulsive

.4 depressive

.5 neurasthenic

.6 depersonalization

.7 hypochondriacal

.8 other

V. Personality disorders and certain other nonpsychotic mental disorders (301-304)

301 Personality disorders

.0 paranoid

.1 cyclothymic

.2 schizoid

.3 explosive

.4 obsessive-compulsive

.5 hysterical

.6 asthenic

.7 antisocial

.81 Passive-aggressive

.82 inadequate

.89 other of specified types

.9 [unspecified personality disorder]

302 Sexual deviations

.0 homosexuality

.1 fetishism

.2 pedophilia

.3 transvestitism

.4 exhibitionism

.5 voyeurism

.6 sadism

.7 masochism

.8 other sexual deviation

303 Alcoholism

.0 episodic excessive drinking

.1 habitual excessive drinking

.2 alcohol addiction

.9 other alcoholism

304 Drug dependence

Drug dependence of several distinct types are listed, namely, those due to natural and synthetic drugs of morphinelike action; the barbiturate group; other hypnotics, sedatives, or tranquilizers, cocaine, cannabis; other psychostimulants; and hallucinogens.

VI. Psychophysiological disorders (305)

Ten main topographical subtypes are listed. They include skin, musculo-skeletal, respiratory, etc.

VII. Special symptoms (306)

This is a list of symptoms most often found in child psychiatry, although most of the terms are not limited to any age group (speech disturbance, specific learning disturbance, tic, enuresis, encopresis, etc.).

VIII. Transient situational disturbances (307)

DSM II lists five types under this heading— those of infancy, childhood, adolescence, adult life, and late life. ICD-8 differs in that it lists only the last three types at this point and places the first two under behavior disorders of childhood.

IX. Behavior disorders of childhood and adolescence (308)

The hyperkinetic, withdrawing, overanxious, runaway, unsocialized, and group delinquent reactions of childhood or adolescence are individually listed under this category, which in DSM II differs from the parallel category of ICD-8 (behavior disorders of childhood) since the latter also includes the adjustment reactions of infancy and childhood.

X. Conditions without manifest psychiatric disorder and nonspecific conditions (316-318)

This is a heterogeneous series of terms that include marital maladjustment, social and occupational maladjustment, and dyssocial behavior. The ICD-8 calls this category "social maladjustment without manifest psychiatric disorder."

XI. Nondiagnostic terms for administrative use (319*)

This is a series of terms such as "diagnosis deferred, boarder, experiment only." In ICD-8 such terms are listed under a section "special conditions and examinations without

sickness."

Comment on the Classification

The main strong points and the chief criticisms of the specific categories of DSM II may be listed as follows.

Organic brain syndromes. All the so-called organic mental disorders are listed here according to etiology in an order that is largely standard for somatic disorders generally (genetic and prenatal influence, infections, intoxication, trauma, circulatory disturbance, and so forth).

This is the least controversial division of the classification. Here one finds the classical association of etiology, pathology, and pathological physiology or illness. On the psychic level an organic syndrome has been identified, and this includes defects of sensorium, lability of emotion, and disorders of judgment, volition, and conduct. The method of classification is logical, flexible, and comprehensible.

The APA terminology has now returned to a more complete alignment with the older literature. DSM I's distinction between "acute" and "chronic" has been dropped or very much subordinated, and the organic disorders have been condensed into a single etiological list. In addition, the names of the disorders have been shortened and simplified; "chronic brain syndrome

associated with central nervous system syphilis, meningo encephalitic type" has been replaced by the older term "psychosis with general paralysis," and "acute brain syndrome associated with alcohol intoxication" has now been replaced by such terms as "delirium tremens," "acute alcohol intoxication," and so forth. The general term "organic brain syndrome" still is retained in the overall designation of psychoses associated with cerebral pathology, but it has been almost eliminated from the designations of the individual forms appearing only as the abbreviation OBS in the nonpsychotic group (number 309). It will be noted that this category has been moved up to follow immediately after 294, psychoses with other physical condition, instead of coming immediately before mental retardation as it does in ICD-8.

As stated above, this group is the least controversial one in the classification, but this is based on the relative ease with which the syndromes can be defined and not on a real understanding of pathogenesis. For example, the mechanism of hallucinations and delusions in the senile or the paretic are still no better understood than are those of a schizophrenic, and while the delusions and hallucinations of organic eases are usually of a different pattern than those of functional cases, yet they may be quite indistinguishable as often occurs in the amphetamine psychoses. This observation has led some to feel that the psychic phenomena of all types of psychosis are identical and of a different order than the somatic ones, and this opinion brings to mind the Cartesian philosophy that mind and body operate on different planes. This

dualism may reflect also a deep religious feeling that equates the mind with the soul and views the soul as incorruptible. Such dualism is not usually enunciated in explicit form, but it is often implicit in discussions about the organic syndromes. Organic defect states, for example, are intuitively accepted as due to brain damage or loss of brain function, as in the case of senile dementia, but such states are often seen as different in nature from the organic psychoses with secondary systems even if the behavior problems are identical in both instances. This has lead to endless futile rhetoric about the real meaning of the word "psychosis," a discussion that is founded on the fallacy that this term has some intrinsic and inherent meaning other than the arbitrary significance assigned by usage, custom, and the definitions of professional bodies. Insofar as such discussions distract attention from the real needs of the patient and center everything on the meaning of a word, they are worse than futile because the word "psychosis" does not have a clear and rigorous definition, a characteristic that it shares with other essential words such as "illness" and "health."

A question has recently been raised with respect to the separation of the psychotic and the nonpsychotic forms of OBS on the ground that one should not make such a basic distinction between cases of lesser and greater severity where the basic illness is the same. Other questions have also been raised, but it now seems that changes in the OBS groups are likely to be limited to those based on new discoveries such as that which may move Jakob-Creuzfelt

Disease into the category of infectious disorders from the presenile dementias.

Mental deficiency. The very brief listing previously allocated to mental deficiency has been replaced by a condensed version of a special classification of these disorders that gathers them all in one series that includes those of known and of unknown etiology. In DSM II this is the first major division, while it is the last in ICD-8. This part of the classification now appears to be one of the most satisfactory sections, whereas it was previously one of the least acceptable.

Psychoses (functional). This group now consists of schizophrenia, the affective disorders, and the paranoid states. Also listed and marked as "not for American use" are the reactive psychoses, which play an important role in ICD-8 and are widely recognized in European psychiatry. Whether these last represent a nosological entity remains a fundamental issue in classification and one that future research will have to solve; at this time opinion remains firm on both sides of the question.

For a long time critics have claimed that the classifications listed too many varieties of schizophrenia, but in spite of much discussion it was not possible to abbreviate the list and the number of divisions remains at ten or more.

The five main subgroups, namely, the catatonic, hebephrenic, paranoid, simple, and childhood types are generally accepted, and the main differential diagnosis is between the affective disorders and schizophrenia; the differential response to somatic therapies continues to provide indications that the distinction is significant.

During the preparation of DSM II criticism against this part of the APA classification centered particularly on the acute undifferentiated, chronic undifferentiated, schizo-affective, and residual types, and these are again the focus of considerable discussion, but for the moment they remain either in DSM II or ICD-8 or in both. Another criticism had to do with the use of the term “reaction” as applied to schizophrenia in DSM I. This was interpreted by many as implying a knowledge that we do not have of etiology, and it was even looked upon as propaganda in favor of a hypothesis about the mode of origin of the symptoms. As a result the term “reaction” that was also widely used elsewhere in DSM I has been replaced almost everywhere in DSM II by terms such as “disorder” or “illness,” and this change does not appear likely to be reversed. Europeans in particular tend to believe that many schizophrenic cases are of endogenous origin and felt that “reaction” implied that all cases are exogenous; hence they considered the term insufficiently neutral for a classification.

It is interesting to note that although much of the discussion with

respect to this issue was carried on in terms of exogenous causes of functional disorders contrasted with endogenous origins, Lewis-" has pointed out in a very incisive paper that this distinction is itself vague and does not really clarify the theoretical question.

Major affective disorders. These continue to be a problem in nosology. Recent experience with treatment seems to indicate there is a significant difference between cases that suffer only depressive or manic attacks and those who have both types of syndromes in the course of time. A distinction is thus being made between monopolar and bipolar affective disorders, and this may find its way into the next revision.

In addition, the long-standing debate about the validity of the entity of involutional melancholia still continues, and it seems no nearer to solution than it was in Kraepelin's time. The paranoid forms are now classed with the paranoid states and no longer grouped with the affective disorders, but so many depressed cases show paranoid elements that issues about their proper classification continue to be raised from time to time. Finally one cannot but continue to be concerned about the great disparity in the proportion of cases classified as schizophrenic in the United States as compared with Britain and Scandinavia. Not all of this is due to differences in classification standards, but important differences do exist and efforts continue toward eliminating them through improved nosology.

Neuroses. Called the psychoneurotic disorders in DSM I, this category has taken on increasing importance with the growth of outpatient psychiatry. Long the foundation of psychoanalytic practice and theory, these illnesses as a group have been as well recognized as other major psychiatric divisions, but the subdivisions have remained somewhat vague and subject to shifts from time to time that do not show any clear line of evolution in any specific direction. The "psychasthenia" of Janet, for example, once included the phobias and the obsessive-compulsive reactions, and in the *American Handbook of Psychiatry,* Volume 3, neurasthenia is combined with hypochondriasis.

Virtually all psychiatrists who treat neurotics readily acknowledge that in this class mixed syndromes predominate, that there is a considerable tendency for symptoms to shift from one category to another, and that lack of fundamental knowledge obviously restricts our efforts at classification. This uncertainty goes so far as to leave considerable doubt about the demarcation between the neuroses and other functional disorders, including the psychophysiological disorders, the psychoses, and certain personality disorders, since many cases of personality disorder have neurotic elements and some cases seem to show a transition from neurosis to psychosis. Finally the hysterical psychosis, long rejected in American nosology, is now again being seriously reconsidered.

Among the subdivisions of the neuroses, the obsessive-compulsive syndrome and the phobias (anxiety hysteria in the Manual) are all relatively stable in the various classifications. As a group the neuroses are distinguished from psychoses by absence of change of the basic personality and by lack of delusions or hallucinations and, more recently, by differential response to therapy, since as a class they do not respond strikingly to somatic treatments as do many psychoses, while some forms are far more suitable for psychotherapy than are the psychoses. Curiously enough, limited psychosurgery remains the treatment of last resort for intractable cases of obsessive- compulsive neurosis that do not respond well to psychotherapy.

In DSM II the hysterical neurasthenic and hypochondriacal neuroses reappear after having been dropped in DSM I, and this reflects the general state of uncertainty about the subdivisions of this highly prevalent form of disorder. The other major change is the introduction of the new term "depersonalization neurosis" (or syndrome).

Personality disorders and certain other non- psychotic mental disorders. This major group has long been a source of active controversy and confusion. DSM II has abandoned the attempt of DSM I to separate the so-called personality pattern disturbances from personality trait disturbances; it now groups them together as personality disorders and adds to the title the very significant words "and certain other nonpsychotic mental disorders." This

broader term must, however, be seen as a temporary expedient because new restrictions on the term “mental disorder” are emerging in social psychiatry, where such problems play an important role. There is, for instance, much doubt whether homosexuality necessarily constitutes a form of mental disorder, and the nature of the problem in some of the other forms of sexual deviation is also under debate.

Questions have been raised also about the appropriateness of listing alcoholism or drug dependence per se as a mental disorder since some feel that these may occur in the absence of mental disorder unless one includes alcohol or drug-seeking behavior as mental disorder by definition. No one, of course, can deny that mental disorder is often a cause or effect of dependence.

Omission of the rubric “sociopathic personality disturbance” in DSM II has been the expression of a similar trend to purge the classification of items that label deviant behavior in and of itself as a form of mental disorder. ICD-8 contains essentially the same categories under “other nonpsychotic mental disorders” and faces the same problems.

There is much less question about personality disturbances that are lifelong, fixed, relatively mild, and have some of the qualities of a major psychiatric syndrome without actually being a manifestation of such illness. Among these types DSM II lists the schizoid, cyclothymic, and paranoid

personality types, as well as the compulsive and the passive-aggressive varieties. However, the way in which these conditions have been grouped, and the terms used for such grouping, are still open to controversy. Although the manifest content of these controversies relates to principles of nosology, there can be no doubt that the issue of stigma injects heat into the discussion, and it is with respect to those who are seen as socially deviant in behavior that the controversy is sharpest. In these cases medico-legal issues are involved, and some of the forms of personality disorder are seen quite as frequently in correctional facilities as in psychiatric installations. In many such cases the controversy has to do with which of two unwilling types of facilities, namely, jails or mental hospitals, will have to deal with a given case.

Among the suggestions for improvement of this category are (l) a simplification of the list, (2) removing sexual deviations, drug dependence, and perhaps antisocial personality to more neutral positions in the classification. As noted above, progress was made in this direction when "sociopathic personality disturbance" was eliminated as the name of a group of entities whose only common denominator was conflict with established codes of behavior and with various legal sanctions, and further developments of this type may be expected.

The Psychophysiological autonomic and visceral disorders. Also known as the psychosomatic disorders, this category is now firmly entrenched in

European as well as American medicine, and in both DSM II and ICD-8 the subdivisions are listed in the standard anatomical sequence of the general medical nosology. These disorders have some resemblance to the neuroses but are distinguishable. They are characterized by disorders of function of various organs that are considered to have important emotional elements. In DSM I they were designated "psychophysiological autonomic visceral disorders," but this was considered to be ponderous and contaminated by etiological assumptions. Therefore, the more neutral term "psychophysiological disorder" was substituted in DSM II. ICD-8 has adopted the concept under the name "physical disorders of presumably psychogenic origin."

Special symptoms. In DSM I this was a subgroup listed under "personality disorders." It has now been giving a more independent status and remains a necessary listing, but it will undoubtedly undergo further change and rearrangement together with the two groups that we shall discuss next, since all three are used extensively in child psychiatry where efforts at restructuring of the nosology are already well advanced.

Transient situational personality disturbances. Under this head are grouped a rather heterogeneous collection of terms, many of which are also used in child and adolescent psychiatry. The reactive element is stressed, and the effect has been heightened by removing the term "reaction" from most of

the other parts of the Manual. As the title indicates, one essential characteristic of the transient group is its good prognosis; another is the absence of specific symptoms belonging to other types of psychiatric disorder. It has been argued that many of these syndromes may last for years, leaving the term "transient" open to debate. Furthermore, this category fails to satisfy child psychiatrists, although no generally accepted replacement has yet been developed.

Behavior disorders of childhood and adolescence. This is a new group in DSM II characterized partly by the fact that the duration of the disturbance lies between that of the transient situational disturbances and the psychoses, neuroses, and personality disorders. The patterns of behavior are also fairly well defined, and the rubric is represented in ICD- 8 but in considerably abbreviated form. This category, together with the two preceding ones, appears likely to be much affected by the previously mentioned nosological work now being done in child psychiatry.

Conditions without manifest psychiatric disorder and nondiagnostic terms for administrative use. These two major groups include various conditions likely to be encountered in psychiatric practice and provide a means for indicating that although the cases were seen in a psychiatric setting they were not considered to manifest psychiatric pathology. Included in the first group are various forms of maladjustment and dyssocial behavior, while various

housekeeping entries such as “examination only” or observation are found in the second. This category is not found in Section V of ICD-8, which uses no code numbers above 315, while DSM II uses numbers 316, 317, 318, and 319 for this purpose. These categories are considered useful even though their validity has been questioned on the ground that their inclusion in a psychiatric classification implies psychiatric pathology, but its purpose is altogether the reverse: namely, to indicate affirmatively that no psychiatric pathology was diagnosed.

Code Numbers

Like other modern classification systems, DSM II identifies each entity by a name and also by a corresponding code number. With certain relatively minor exceptions the names and their code numbers in this list are the same as the ones in ICD-8. If one examines the list it will, however, be noted that the DSM II series is not presented in numerical order. Thus the list is headed by the 310-315 series (the mental retardations), and these are followed by the 290-294 series (the psychoses associated with organic brain syndromes), and these are followed by Section 309, the nonpsychotic organic brain syndromes, after which comes a section containing items numbered 295-298. The Arabic numerals represent the order of items as they are listed in Chapter V, the Psychiatric Section of ICD-8. The irregularities found in the sequence of code numbers in DSM II resulted from rearrangements that were made in an

attempt to conform the system to American practices without losing the interconvertibility of the two systems. The sequence of presentation of major categories in DSM II is identified by the Roman numerals I-XI inclusive superimposed on the Arabic numerals that identify each name in the list.

The addition of such serial numbers to names for purposes of better identification is almost universal in our society and is exemplified by Social Security numbers, credit card numbers, and hospital identification numbers. Such numbers render identification more accurate and facilitate statistical and control operations, especially with computer technology. When applied to a classification system such serial numbers have additional advantages in that they can be used to reflect the hierarchical structure of the classification; decimal places of decreasing magnitude are attached to subdivisions of decreasing importance, while the higher values are attached to the major subdivisions. The use of decimal values to introduce subcategories is illustrated in the way DSM II has added the subcategories 302.5 (voyeurism), 302.6 (sadism), and 302.7 (masochism) under the major ICD-8 heading of 302 (sexual deviations), which lists specifically only four forms, ending with 302.4 (exhibitionism). Just as it is possible to add items by expanding the numerical listing, it is possible to drop items that are not locally acceptable without breaking the overall classification pattern, and this has been done with respect to 298.1 (reactive excitation), 298.2 (reactive confusion), 298.3 (acute paranoid reaction), and 298.9 (reactive psychoses unspecified), all of

which are marked “to be avoided in the U.S.” This was done because of a fundamental difference of opinion about the so-called reactive psychoses, which are not widely recognized in the United States, but are fully accepted as valid in Europe, especially in France and the Scandinavian countries.

Another use of the code number system in DSM II is to identify modifying phrases. These are designated by a fourth digit that can be used to specify additional characteristics of a syndrome such as acute or chronic (.x1 or .x2), or mild, moderate, or severe (.x6, .x7, .x8). Thus acute psychosis with brain trauma in DSM II would be identified by the code number 293.51, and the chronic form would have the code 293.52.

Finally it may be noted that the ICD classification system allots three digits for designation of major disease categories and a fourth digit, a decimal digit, for specification of additional details within each category. DSM II adds a fifth digit (in the next decimal place) to provide for qualifying phrases and for other purposes.

In spite of this flexibility both systems provide for only one disorder or disability in each coding, while in clinical practice psychiatric disorders often occur not separately but in interacting combinations with each other. Alcoholism may, for example, occur in combination with schizophrenia, manic-depressive illness, or mental deficiency; similarly schizophrenia may

be combined with epilepsy. A very few combined disorders such as propf-schizophrenia have been given specific names, but these have not achieved general recognition, and for practical purposes the practice of the past has been to select one diagnosis on the ground that it is the underlying, the presenting, or the most serious one. This was felt to be necessary because there are no names for most of the possible permutations of such disorders, and if they were created it would not be feasible or useful to deal statistically with such a large number of entities. The use of multiple diagnoses would solve this problem, but this was long impractical for similar reasons. Computer technology has now removed many of these limitations, and DSM II states that multiple diagnoses should be used where indicated, and this Manual for the first time "encourages the recording of such diagnosis as alcoholism or mental retardation separately," with the caution that no more conditions should be diagnosed than are needed to account for the clinical picture.

In summary, one may say of the code numbers that they may be completely ignored by the clinician, but a fuller understanding of the nature of psychiatric classification as a system may be gained by mastering the relatively simple principles on which it is based.

Nosology of This Handbook

This *Handbook* is based essentially on the current classification, but it shows many variations and such variations occur regularly in textbooks and at virtually all levels of psychiatric communication. In part they are required in order to maintain a continuity with the psychiatric literature of the past; in part they simply illustrate what has been clearly enunciated by Jaspers, namely, that no classification is equally suitable for all purposes, and thus for different situations different classifications may be quite appropriate. For example, the literature on psychiatric states precipitated by the stress of war, or toxic, exhaustive, infectious conditions tends to emphasize the stressing factors. In so doing it often departs from the formal classification systems under which one might assign many of these cases to such categories as schizophrenia, depression, or neurosis. The difference from ordinary classification is further intensified by the use of specific terms such as "war neurosis" that are not found in the currently accepted nomenclature. Such variations, however, will only rarely cause any problems, and for practical purposes the context will enable one to translate the terms into those of the standard classification with no difficulty. The feasibility of such a procedure can be seen from the fact that it is still the practice in some countries for each psychiatrist to enter the diagnoses of his cases in the classification of his choice. These terms are then gathered in a central statistical bureau and translated into the standard system by technical personnel. This is considered by no means ideal, but it is said to be quite practical and even gives

reasonably satisfactory results.

For a textbook the alternative to such flexibility of presentation would be to resurvey all that had been done in the past and attempt to recast the entire literature with every significant change of nomenclature and classification, even though revisions of the formal classification now occur quite regularly at ten-year intervals. Even more difficult is the problem of new categories that have not yet been formally placed in the classification, as is the case with the monopolar affective disorders. Such new developments obviously must be given recognition long before the official classification can incorporate them. All of this means that deviations from the formal classification and nomenclature must be acknowledged as frequent and, for many purposes, necessary. Such deviations do not, however, constitute a repudiation of the accepted system, nor do they diminish the need for such a system to be used for normal clinical records from which public health data must be developed.

Conclusion

While they are vigorously challenged on academic and even political grounds, current systems of classification remain virtually unchallenged in clinical usage, and in one or another form are utilized throughout the world. They all derive from the same evolutionary process and stem from a common

psychiatric literature; this is clearly reflected in their structure. The main categories of psychosis, neurosis, character or conduct disorder, and mental deficiency are everywhere to be found; the leading entities such as schizophrenia, manic- depressive disorder, and so forth are also easily recognized. The division of etiology into functional and organic appears unchallenged, and with the passage of time the list of organic causes grows steadily. We have no certain knowledge of how many of these categories were merely invented, and are thus artificial, and how many are natural like paresis, which was discovered. Many difficulties of a scientific nature remain to be overcome before this question can be answered for the functional disorders; even in the case of the so-called organic cases the age-old body-mind dilemma appears to block any real understanding of how a given physical pathology is transmuted into the corresponding psychic disorder. This issue has been raised most recently with respect to the role of drug abuse in psychiatric disorder; however, it remains without answer even in the case of the amphetamine psychoses, where the cause- effect relation appears quite clear-cut. The irregularity of response pattern, the lack of anatomical or biochemical specificity, and the incomplete correlation between the extent of somatic insult and the psychic response is not different here than it is in relation to cerebral arteriosclerosis or senility, but it shows that our clearest concepts of etiology are severely limited when they are closely examined and that the identification of a somatic agent is but one step toward the

understanding of psychiatric disorder.

In spite of these and other limitations, progress has been made within the framework of the existing systems. Criticism of psychiatric classification has always been active; it is one of the most traditional parts of psychiatry and has been a safeguard against dogmatism, but one doubts that even the most vigorous current critics would wish to sweep away all classification and all "naming" or "labeling." At least I do not know of any active psychiatric service that operates without such "labels." Doubts about the validity of the medical model are frequently expressed and have had considerable recent attention, but they are by no means new, as will be seen from such little known older literature as that of the philosopher Kant on psychiatric classification and that of Jerome Gaub, who preceded him by many years. On the other hand, it is probably correct to say that a large number of mental health professionals expect that sooner or later the computer or the laboratory will open up great new vistas in this field; this view is shared by some who reject the medical model and expect that it will be replaced by a social model of mental disorder. For some this expectation is so strong that there is a real danger that it could lead them into seeing the event before it occurs; such premature acceptance of a pseudoadvance could, if it involved influential individuals, create considerable confusion in psychiatry. At this time, however, it seems that the great preponderance of the professional world is still inclined to wait for firm evidence that any proposed replacement

of the current psychiatric classification will be superior in actual performance to what we now have, and that conviction will come from performance rather than from debate. Indications are that progress will be relatively slow and will be built on the foundations of previous work rather than on revolutionary new principles. Everyone, of course, hopes for a spectacular breakthrough, but at the moment none seems to be in prospect. It also seems clear that the various systems of classification and nomenclature that now are used in various parts of the world will continue to converge toward a common form, providing a better international language for psychiatry, a better basis for public health studies, and, last but not least, a better basis for treatment.

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Notes

[1] The World Health Organization is now preparing a glossary for ICD-8, which will go far toward making this document more effective. The glossary should be available by 1974.