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Classification of Mental Disorders*

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One of the fundamental difficulties in devising a classification of mental disorders is the lack of agreement among psychiatrists regarding the concepts upon which it should be based: diagnoses can rarely be verified objectively and the same or similar conditions are described under a confusing variety of names. This situation militates against the ready exchange of ideas and experiences and hampers progress. As a first step towards remedying this state of affairs, the author of the article below has undertaken a critical survey of existing classifications. He shows how some of the difficulties created by lack of knowledge regarding pathology and etiology may be overcome by the use of "operational definitions" and outlines the basic principles on which he believes a generally acceptable international classification might be constructed. If this can be done it should lead to a greater measure of agreement regarding the value of specific treatments for mental disorders and greatly facilitate a broad epidemiological approach to psychiatric research.

INTRODUCTION

Psychiatry has made considerable strides during the past three decades. There has been great therapeutic activity and an enormous intensification of research work. Medical men, public authorities, and the community at large have become alive to the magnitude of the problems of mental disorders. Conditions for a concerted attack on mental ill health ought, therefore, to be highly propitious at the present time. Yet, in many respects, psychiatrists find themselves ill-prepared to meet the challenge. This is partly due to the incomplete integration of the various approaches to the study of mental illness, though there are signs that this process has been gaining momentum of late. A more serious obstacle to progress in psychiatry is difficulty of communication. Everybody who has followed the literature and listened to discussions concerning mental illness soon discovers that psychiatrists, even those apparently sharing the same basic orientation, often do not speak the same language. They either use different terms for the same concepts, or the same term for different concepts, usually without being aware of it. It is sometimes argued that this is inevitable in the present state of psychiatric knowledge, but it is doubtful whether this is a valid excuse.

The lack of a common classification of mental disorders has defeated attempts at comparing psychiatric observations and the results of treatments undertaken in various countries or even in various centres of the same country. Possibly, if greater attention had been paid to these difficulties, there might be a greater measure of agreement about the value of specific treatments than exists today. Another field in which the lack of a common language threatens to defeat the purpose of much valuable effort is that of experimental psychiatry where research has been very active of late. In recent years the epidemiological approach has been used in the study of mental disorders to an increasing degree. To be fruitfully employed on a broad front it requires a common basic terminology and classification. There is a real danger that the lack of such a vehicle of communication will lead to confusion and to a waste of precious resources.

These are only some of the reasons why a thorough review, on an international level, of the

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present state of the classification of mental disorders has become an urgent necessity. It is submitted that the present chaotic state of the classifications in current use for clinical and statistical purposes is not wholly warranted by the incomplete knowledge of mental disorders and that the situation is capable of improvement. As the first step in this direction, a survey and critical examination of the classifications used in psychiatry today have been carried out. The results of this study are presented here.

SOME HISTORICAL NOTES

A history of psychiatric classification would be almost tantamount to a history of psychiatry. Zilboorg (1941) devoted a large chapter of his *History of medical psychology* to the subject of classification. Other historical studies, though more limited in scope than Zilboorg's, are those of Birnbaum (1928), Gruhle (1932), Ey (1954) and Menninger et al. (1958). No such presentation is intended here. However, the present state of the problem cannot be understood, nor can possible remedies be contemplated, without some historical considerations.

Long before the " era of systems " during which the basis of most present-day classifications was laid, there were physicians who tried to bring order into the variety of manifestations of mental illness, and others who warned against rash systematization. Zilboorg (1941) quoted Nasse as having observed in 1818 that in his day practically every worker dealing with mental diseases felt he had to offer a classification of his own, while Pinel in 1809 had insisted that medical science was not sufficiently advanced to allow of any change in the simple classification which he himself had proposed. In the latter part of the nineteenth century, to produce a well-ordered classification seemed to have become the unspoken ambition of almost every psychiatrist of industry and promise (Zilboorg).

The centrepiece of the classifications in use at present is the part concerning the so-called endogenous psychoses. It owes its existence primarily to the work of Falret (1854), Baillarger (quoted by Zilboorg, 1941), Kahlbaum (1874), Hecker (1877), and Kraepelin (1920) " whose nosology presented the culmination of efforts in both France and Germany " (Zilboorg, 1941). His " empirical dualism " (de Boor, 1954), which combined cerebral pathology with psycho-pathology, was the strength of his system. It was based on clinical observations and took account of the lack of knowledge of etiology. The same could not be said of other contemporary attempts at classification, some of which, though more consistent regarding the underlying criteria, were almost wholly speculative, such as those of Meynert (1890) and Wernicke (1900). Kraepelin's classification is closely associated with the concept of disease entities which he believed he had established. Criticism has been directed against this concept rather than against the clinical foundations of the Kraepelinian system, the core of which has survived many changes of psychiatric orientation. It represented a clinical nosology based on the methods of descriptive psychiatry, including long-term observation and follow-up. Its intrinsic value, as far as the psychoses were concerned, was borne out by its usefulness in genetic research. However, its failure to establish, to the clinician's satisfaction, disease entities similar to that of general paralysis, and the artificiality of any attempt at classifying the almost infinite variety of abnormal behaviour, have led to a decline in the prestige of psychiatric classification. Recently, the attitude of many psychiatrists towards the conventional type of classification has become one of ambivalence, if not of cynicism. This attitude derives partly from a low estimation of diagnosis, which in large areas of psychiatry has remained imprecise and has proved a poor guide to prognosis and therapy. Also, the concept of mental disorder, which in Kraepelin's view closely approximated that of physical disease, has changed in such a way that a conventional medical diagnosis no longer seems applicable. In many schools, especially in America, mental disorders are viewed as reactions of the personality to known or unknown pathogenic factors. The first who tried to replace Kraepelin's system by a scheme of this type was perhaps Hoche (1912) with his theory of syndromes, and his arguments were impressive enough to make even Kraepelin himself revise his earlier conceptions. Later developments were due partly to psychoanalysis, partly

to the concept of psychobiology introduced by Adolf Meyer (1916), both of which stress the uniqueness of the individual. Such an approach has tended to discourage the categorization of mental disorders.

Throughout the ages, there has existed a concept of mental disorders diametrically opposed to the Kraepelinian idea of disease entities. It is the unitary concept which holds that there is only one basic mental illness taking various forms. This concept was most clearly defined by Neumann (1859) a century ago. It has found a modern supporter in Karl Menninger, who views the various types of mental disorders as different only in their quantitative aspects, i.e., in the degree of disintegration of the personality. He discerns a strong trend towards this concept in modern psychiatry. However, opposition to the Kraepelinian classification did not come from the "psychodynamic" schools only. The work of Kretschmer (1919) revealed the importance of the personality type for symptom formation and prognosis in the psychoses, while Kleist (1953), following in Wernicke's (1900) footsteps, rejected the basic principles of the Kraepelinian system. He has remained the chief protagonist of the purely somatic orientation introduced into clinical psychiatry by Griesinger (1861).

Descriptive psychiatry, which reached its peak with Kraepelin, was for a long time mainly concerned with the psychoses ; it was chiefly institutional psychiatry in which a small number of doctors were dealing with large numbers of patients. The systematic study of the neuroses and personality disorders, which, from the beginning, were the most controversial areas of classification, is a more recent development. Many doctors who concerned themselves with these conditions did not enter psychiatry through the mental hospital, but via the out-patient clinic and consulting room, where psychoses were comparatively rare. They were investigating and treating small numbers of patients, in marked contrast to their colleagues working in mental hospitals and reception wards. The differences in the types of observational material from which psychiatrists drew their experience and developed their theoretical orientation now became an important source of ideological divergencies. It created an apparent antithesis between a psychiatry mainly concerned with individuals and one mainly concerned with mental disorders. This cleavage was bound to add to the disagreements on classification. During the last two decades the divisions in psychiatry have been considerably reduced through the gradual merging of the different areas of psychiatric work. A great number of workers of various orientations have come to favour a multidimensional approach, and the need for classifying the variety of mental disorders is again generally recognized.[1]

In spite of doubts and opposition, classifications based on the Kraepelinian system have continued to be used in some form or other all over the world. Many psychiatrists have done so under protest and expressing their disbelief in the working hypotheses underlying that system. If an essential tool is used grudgingly by workers who have a poor opinion of it, it is unlikely to prove useful and may even do more harm than good. This can be said of psychiatric classification today.

AN INQUIRY INTO THE PRESENT STATE OF PSYCHIATRIC CLASSIFICATION

The World Health Organization has collected information about the psychiatric classifications in use in a number of countries. No attempt was made to carry out a complete survey. The aim was to obtain samples which would illustrate present trends in psychiatric classification used for clinical, statistical and research purposes. Inquiries were sent to the statistical departments of national health authorities as well as to a number of leading psychiatrists. The information received showed that the interest in and the provisions for statistical classification varied greatly. In some countries no registration of psychiatric morbidity had, at the time of the inquiry, been carried out at all, while in others it was done very thoroughly. One of the questions to be investigated was that

[1] Some workers, especially in the English-speaking countries, have recently used the term "taxonomy" in preference to "classification". Taxonomy means "classification, especially in relation to its general laws or principles" (*Shorter Oxford English Dictionary*). It is therefore not quite correct to use this term as co-terminous with classification. There may be psychological advantages in using a new term for an old one, especially if the latter has fallen into some disrepute, but they are likely to be offset by the misunderstandings arising from duplication of terms for the same concept.

of the use and usefulness of the existing *International Statistical Classification of Diseases, Injuries, and Causes of Death* (World Health Organization, 1957), as far as it concerned psychiatry. This classification had been adopted in a small number of countries only. In several countries special committees concerned with classification and aiming at establishing uniformity within their national boundaries, were at work at the time of the inquiry. There was almost general dissatisfaction with the state of psychiatric classification, national and international.

The classifications which were received in the course of the inquiry are listed in the annexes at the end of this article. At first glance, they may not seem to differ greatly from each other, but on closer examination they show considerable divergencies. These might be due to differences in the functions various classifications were meant to serve, as well as to differences in the underlying theoretical orientation. Factors of a more technical nature, such as the medical manpower and the administrative apparatus available, are also likely to have played a part. Many classifications, especially those serving large geographical areas, show features indicative of compromises between different orientations and purposes. The history of the problem in a particular locality or country must also have played an important part. There exists a strong conservatism in matters of classification. In some countries, a certain type of classification may have become part of the medical tradition, while in others, where no such heritage existed, it may have fallen to a committee to choose or to work out a system of classification. All this must be taken into consideration in trying to understand differences between classifications in use in various countries.

There are several criteria according to which classifications can be grouped, all of them arbitrary. For the purpose of this study it would seem appropriate to divide them first of all into two groups:

(1) those which have been used or recommended by public health authorities or learned societies (i.e., official, semi-official, or national classifications);

(2) those which have not been used for this purpose, either because they have not yet been adopted, or because they were not meant to serve this function.

However, the majority of those in the second group were proposed with the aim of meeting some of the dissatisfaction felt about the classifications in use. In comparing these classifications it has to be kept in mind that some are very recent, while others, having been in use for many years, are recognized in their countries as obsolete and are due to be replaced before long.

1. OFFICIAL, SEMI-OFFICIAL OR NATIONAL CLASSIFICATIONS (ANNEX 1)

International Statistical Classification of Diseases, Injuries and Causes of Death (ICD) (Annex 1, page 622)

Although all Member States of the World Health Organization had recommended this classification for use, it has been adopted in only a small number of countries. However, in some of them it is used only by the bureaux of statistics, while the hospitals use one or more different systems of classification which, for statistical purposes, have to be converted into the ICD, often at the price of some loss of identity between the concepts. The ICD is in use in Finland, New Zealand, Peru, Thailand and the United Kingdom. In addition, there are several countries where only List B of the ICD (Abbreviated list of 50 causes for tabulation of mortality) is used in psychiatry. The above list of countries which have adopted the ICD is probably incomplete, as inquiries were not sent to all Member States. There can be no doubt, however, about the failure of the ICD to find general acceptance as far as psychiatry is concerned. The causes of this failure require to be carefully studied by all those concerned with a classification which could serve as an international tool of communication. In view of the special importance of the ICD it will be fully discussed in a separate chapter (page 606).

The ICD differs from all other classifications referred to in this report in that it does not group all mental disorders together. Section V is the only part of the ICD solely concerned with psychiatric conditions, but it does not contain all of them. A considerable number of mental disorders are listed in the context of other sections. The pros and cons of this arrangement will be discussed later. No general principles for drawing up the various categories are explicitly stated, but wherever applicable reference is made to organic etiological factors. In some categories psychogenic etiology is referred to.

Classification of the American Psychiatric Association (APA) (Annex 1, page 628).

This classification has been in use in the United States, with the exception of the State of New York, since 1952. It is based on a revised psychiatric nomenclature which is part of the *American Standard Nomenclature of Diseases and Operations, 1952*. Unlike Section V of the ICD, it provides the psychiatrist with a comprehensive system covering all psychiatric conditions. The users of this classification are greatly assisted by the *Diagnostic and Statistical Manual for Mental Disorders* issued by the American Psychiatric Association (1952). This manual also contains a glossary of psychiatric terms. The APA classification is the best documented among recent classifications. Its adoption by some other countries of the Western Hemisphere has been under consideration for some time. In view of its special importance, the distinctive features of the APA classification will also be discussed in a special chapter (page 610). Here it will only be mentioned that this classification is based on etiological considerations; psychogenic etiological factors are accorded equal status with organic causes.

The Canadian Classification (Annex 1, page 630)

This is a shortened version of Section V of the ICD. The twenty-five psychiatric categories of the latter have been reduced to twenty-one. This reduction has been achieved by merging the categories for senile and arteriosclerotic psychoses, by dropping one of the miscellaneous categories of psychosis, by making "psychoneuroses with somatization reactions" into a single category instead of three, and by grouping together "pathological and immature personalities", which are separate categories in the ICD. The category "phobic reaction" has been dropped. On the other hand, epilepsy, and psychiatric conditions associated with it, have been given independent status in this system, contrary to Section V of the ICD, which provides for psychosis resulting from epilepsy only in a miscellaneous category. These modifications are of interest because they indicate some points of criticism of the ICD.

The French Standard Classification (Annex 1, page 631)

This was introduced in 1943 and made convertible into the ICD in 1948. It is regarded as unsatisfactory and obsolete by many French psychiatrists. Proposals for a new classification are under active consideration.

The French standard classification is comprehensive. Its main orientation is that of clinical nosology.

The Würzburg Scheme (Annex 1, page 631)

There is no official or standard classification in Germany, but the majority of hospitals are using the diagnostic scheme recommended by the Deutscher Verein für Psychiatrie at Würzburg in 1933. Several modifications of this classification have been proposed recently. Some of them will be referred to later in this survey.

The main criterion employed in this classification is organic etiology, either established or postulated, and consisting in structural disease of the brain or other organs, or in constitutional factors. It differs from the classifications referred to earlier in that the neuroses are not placed in an independent group but are included in the two categories of "psychopathic personalities" and "abnormal reactions".

Classification of the Dutch Association for Psychiatry and Neurology (Annex 1, page 632)

This classification exemplifies the clinical-nosological approach in a simplified form. The principles underlying it are similar to those of the French and German systems listed above. The 14 categories of mental disorder fall into two groups: in the first four categories a constitutional or unknown structural cause is implied; in the rest an organic disease or physiological process is regarded as the etiological factor. Neuroses and personality disorders are not separated.

Classifications in use in the Scandinavian countries

Only the official Danish classification is of recent origin (Annex 1, page 632). The statistical classifications used in Norway and Sweden are regarded as obsolete and are to be replaced before long. Although both are of a rather simple nosological type they show considerable differences which are all the more remarkable as the two countries share a common basic psychiatric orientation. It would appear that medico-legal and administrative considerations played an important part in the drawing up of the Swedish statistical classification. This is suggested by the broad division of the material into insanities and disorders not thus classifiable.

A new Norwegian classification (Annex 2, page

642) which has not been officially introduced, will be listed among proposed classifications. It is appropriate in this context to point out that epidemiological, especially demographic, research has been among the chief interests of the Scandinavian psychiatric schools. It can therefore be assumed that the classifications have been designed with a view to their usefulness for this kind of research.

Classification of the Danish Psychiatric Society, 1952

The orientation of this classification, like that of other classifications of the Scandinavian psychiatric schools, is frankly clinical-behaviouristic. Where the etiology is unknown and controversial, i.e., in the psychoses, neuroses and personality disorders, this classification is not committed to one particular kind of causation. It therefore has special categories for predominantly psychogenic psychoses and personality disorders. Another feature peculiar to this classification is the main category of "isolated abnormal reactions" occurring in people who cannot be fitted into any other main class.

The guiding principle underlying this type of classification appears to be that, in the present state of psychiatry, differentiation and classification should be based mainly on clinical observation, unbiased by theoretical generalizations.

H. Bersot's statistical classification (Annex 1, page 634) used in Portugal and Switzerland

The Instituto Nacional de Estatistica of Portugal and the Swiss Bureau Fédéral de Statistique used, at the time of this inquiry, a classification proposed for international use by Bersot in 1937. It is a shortened version of the French standard classification (page 605 and Annex 1, page 631), the number of main categories having been reduced to eight.

Classifications in use in the USSR

The two relevant classifications reproduced in Annex 1, pages 634 and 635, are taken from current textbooks. The authors of the first are Kerbikov, Ozeretskij, Popov & Snezhnevskij (1958), the author of the second is Giljarovskij (1954). The first textbook was available in the original, while the classification contained in Giljarovskij's textbook was available only in the German translation by Lustig (1957). The two classifications did not differ fundamentally but only in the arrangement of the material, which was divided into nine categories by Kerbikov et al. and into thirteen by Giljarovskij. The are based on classical European nosology to which Pavlovian concepts are applied. Koupernik (1958), commenting on the textbook by Kerbikov et al., pointed out that anxiety neurosis did not figure in the list. He also observed that in the concept of psychogenesis of the Russian authors, traumatism rather than conflict was assumed to be the pathogenic agency. Lustig drew attention to the low importance accorded by Russian psychiatrists to hereditary factors. Their basic approach is neurological and neurophysiological. From this orientation they are aiming at an etiological classification of psychiatric disorders.

Classifications in use in Japan

Professor Tsuneo Muramatsu of the University of Nagoya approached the Mental Health Section of the Ministry of Health for information about the classifications in use in Japan. He was informed that so far "four different systems" had been employed by the Mental Health Section.

1. Classification used in the "Mental Hygiene Law" (1950).

2. Classification used in the national survey in 1954.

3. Classification used in the national survey of hospitalized psychiatric patients in 1956.

4. *International Statistical Classification of Diseases* (World Health Organization, 1957), Section V, but only with three-digit categories.

The classifications 1, 2 and 3 were not reported in detail, but according to Professor Muramatsu they were relatively simple and each of them was adapted to its special purpose.

In the five most popular Japanese textbooks of psychiatry, modifications of the Kraepelinian system are used. According to Professor Muramatsu, the classification reproduced on page 635, Annex 1, represents a composite picture of those systems.

2. INTERNATIONAL CLASSIFICATION OF DISEASES

This classification is a relatively new venture, although demands for such a classification had been expressed as early as the beginning of this century when an international classification of causes of death was first introduced. The present

ICD was introduced by the World Health Organization in 1948 and adopted for use by all Member States. This decision was reaffirmed in 1956 following the 1955 Revision. However, the classification has been implemented only in a small number of states as far as psychiatry is concerned. It is true that there are other areas of morbidity, for instance that of cardiovascular diseases, where the ICD has met with difficulties, but nowhere have they been as serious as in psychiatry.[1] The Seventh Revision Conference (1955) recommending the renewed adoption of the classification was no doubt aware of the controversial character of some sections. In the introduction to the revised list (page xxxi) reference was made to these difficulties:

It is recognized that certain sections of the Classification are not entirely satisfactory. Such shortcomings, however, are the reflexion of a persisting division of opinion on nosological approach and disease etiology, and amendment of the Classification should preferably not be attempted till substantial agreement has been reached among clinicians and pathologists not only at the national level but also internationally. The section, " Mental, psychoneurotic and personality disorders ", represents a typical example of this kind. In view of the variety of clinical classifications in use in various countries, which differ from each other both in terminology and in the concepts of classification, any major change in the Classification at this stage would not necessarily prove more satisfactory internationally than the present provisions. Another example is the large group of degenerative vascular conditions manifesting themselves as hypertension, arteriosclerosis, cardiac and renal affections or lesions of the central nervous system.

This paragraph has been quoted in full because it stated the policy of WHO at the time. The opinion that there would be no advantage in changing unsatisfactory sections of the Classification before substantial additions to knowledge have accrued is reasonable enough for a classification which has been generally adopted with all its imperfections ; it is hardly applicable, however, if those who were expected to use the classification have, with very few exceptions, refused to adopt it. It was incumbent on this review to investigate the reasons for this refusal and also to find out how the ICD has been working where it has been adopted for use.

In the *Diagnostic and Statistical Manual for Mental Disorders* issued by the American Psychiatric Association (1952), the following criticisms are made of the International Classification :

It does not provide for coding Chronic Brain Syndrome associated with any disease or condition with neurotic reaction, behavioural reaction or without qualifying phrase except in title 083.1—postencephalitic, personality and character disorders. Nor does it provide for coding Acute Brain Syndrome within the group of psychotic conditions, except alcoholic delirium (included in 307) and exhaustion delirium (included in 309).

. . . the International Statistical Classification contains some categories which may be too inclusive for adequate tabulation of diagnostic data, especially with respect to diagnostic distribution of patients under treatment in mental hospitals.

The extracts below represent samples of replies to the inquiry concerning the ICD received from psychiatrists who have not adopted it.

Professor Ø. Ødegard, Oslo :

1. There is no room for reactive or psychogenic depressions of psychotic degree, which means that such conditions will have to be classified under manic-depressive psychosis or under neuroses.

2. Reactive or psychogenic psychoses with predominantly confusional (or " hysterical ") symptomatology are in the same way hard to place within the system.

3. The same applies to the frequent and often atypical psychotic reactions in imbeciles or other mental defectives, which, for administrative purposes, should be singled out in a separate group.

4. It seems inconvenient that symptomatic psychoses should be classified only under the basic disorders—general paresis, for instance, under syphilis. The subgroups under schizophrenia as well as under pathological and immature personality are controversial and too numerous.

Professor V. Lunn, Copenhagen :

Regarding our views about the International Classification, I can only state that it is based on diagnostic and nosological considerations different from ours, and that it is, from our point of view, so unmanageable that I do not think it will ever be accepted in this country.

Professor E. Strömgren, Aarhus :

The two main objections to the ICD are that so many psychiatrically significant states are not to be found in the psychiatric part of the list, and that the terminology of the neuroses differs very much from that in use in Scandinavia.

Dr J. Meyer, Munich :

The ICD is too complicated and unwieldy.

[1] Personal communication from Dr M. Cakrtova, Chief, International Classification of Diseases and Development of Health Statistical Services, WHO

Dr Henri Ey, Paris, in an essay on psychiatric classifications (1954), criticized the ICD for its incoherence and inconsistency with regard to basic principles. In his view, most classifications in current use were mere enumerations and nomenclatures.

Section V of the ICD is headed " Mental, Psychoneurotic and Personality Disorder ". The wording is unfortunate as it implies that " mental disorder " means " psychosis ". This use of the adjective " mental " is out of keeping with the orientation of modern psychiatrists who have for many years endeavoured to persuade their medical colleagues and the public at large that in " mental " hospitals all kinds of conditions are treated besides the " psychoses ", which are still generally regarded as identical with the " insanities ". When psychiatrists talk of mental health today they no longer mean simply freedom from insanity. It is surprising that such a blatant terminological anachronism could have survived the recent revision of the ICD.

Unlike the classifications used nationally and regionally, Section V of the ICD does not lay down a definite terminology to the exclusion of any other. However, in its main headings it avoids the term disease and speaks of disorders or reactions instead. As far as possible, it leaves the door open to a considerable variety of terms ancient and modern. It is not self-contained as far as the psychiatrist's requirements are concerned. A number of categories with an organic etiology are located outside Section V. There may have been several reasons for this arrangement, one of them considerations of convenience for general physicians who would not have to go outside their sections when classifying a psychiatric complication of physical illness. It may also have been the deliberate policy not to isolate psychiatry, but to emphasize the unity of medicine. If this was the intention it was not carried out consistently. Although it is stated first that " this section excludes transient delirium and minor mental disturbances accompanying definitely physical illness ", it also excludes such major psychiatric disorders as general paralysis of the insane, puerperal psychosis, and postencephalitic personality disorders. Nor can Section V be regarded as providing only for disorders of psychogenic or of unknown organic origin, as it includes conditions with known organic etiology such as senile, presenile and arteriosclerotic mental disorders. At any rate, the fact that Section V cannot be used as a comprehensive psychiatric classification has been strongly resented by many psychiatrists and has no doubt been one of the main reasons for its rejection.

Another criticism made against Section V is that several categories are too inclusive and lacking in subcategories. An example is *sexual deviation*. It forms one of the subdivisions of " Pathological personality " (320) and all types of perversions are listed as if they were of equal importance or different names for one and the same disorder. The same criticism has been made of categories such as " Senile psychosis " (304), " Alcoholic psychosis " (307), etc. On the other hand, the subdivisions of the categories concerning personality disorders have been criticized for not being mutually exclusive. Child psychiatrists have felt that the ICD served their needs of classification very inadequately.

The ICD in action

In the United Kingdom the ICD has been used unmodified since its adoption in 1948. This circumstance has provided an opportunity to obtain the views of some of those who have worked with this system and also to examine certain aspects of its usefulness to the potential research worker. I am grateful to Dr W. Maclay, Senior Commissioner of the Board of Control, Ministry of Health, and to Miss E. Brooke, General Register Office, London, for valuable information. Data for statistical registration are received only from mental hospitals concerning in-patients. This material, therefore, does not include data from psychiatric departments and observation wards of general hospitals; but they cater for only a very small proportion of the psychiatric patients, many of whom enter mental hospitals after a short stay in the general hospital. The case material of the psychiatric out-patient clinics is not reported for registration by the General Register Office.

In the light of ten years' experience, Dr Maclay and Miss Brooke expressed themselves far from satisfied with the way the ICD had been working. Their chief complaint was that the psychiatrists who supplied the data for classification very frequently used diagnostic terms which could not, or could only with difficulty, be fitted into the categories of the ICD. This was happening although all psychiatrists were provided with instructions concerning the use of the ICD. The Register Office

had to work out special rules for their coding officers to enable them to fit individual diagnostic terms into the categories of the ICD. There was obviously a widespread disregard for the official classification among psychiatrists.

It is not surprising, under these circumstances, that some of the statistical data obtained with the help of this classification were evidently wrong and misleading. Table 13 in the Registrar-General's (1953) *Statistical review of England and Wales for the year 1949* throws some light on the way the ICD was used. There has been no material change in subsequent reports. It was obvious that several of the categories of the ICD were not recognized by the majority of psychiatrists responsible for the diagnoses. This was most striking with regard to categories 315 to 317 (" Psychoneurosis with somatic symptoms "). Patients suffering from the more severe forms of these conditions are not at all rare among those treated in British mental hospitals. It is quite unbelievable, therefore, that of 55 785 patients admitted to the mental hospitals in England and Wales in 1949 only 114 should have fitted into this category. Probably most of the patients who might have qualified for inclusion under this heading were placed in other categories, such as those of hysterical or anxiety reactions. The numbers of patients recorded for several other categories, such as schizoid, inadequate or immature personality, were so small that they indicate an insufficient usefulness of these categories rather than an extreme rarity of those conditions among the admissions to the mental hospitals.

Among the categories 300-309, which include various types of psychoses, there were striking discrepancies in the recorded figures, but these were probably only terminological. This applies, for example, to the categories " Involutional melancholia " (302) and " Paranoia and paranoid states " (303). Thus, it is noteworthy that the diagnosis of a paranoid state was made in the Manchester region only 14 times among 3212 admissions, while in other regions with approximately the same number of admissions it was made 43, 125, 100, 82, 74 times respectively. Similar discrepancies could be found in the case of involutional melancholia. Another category in which there were very marked discrepancies was *puerperal psychosis* (688.1); the unexpectedly small numbers reported suggest that many cases falling into this group were classified under other headings, probably in accordance with the nature of the psychotic symptoms presented. This particular difficulty is no doubt due to the fact that most psychiatric categories are based on symptomatic criteria, while the concept of puerperal psychosis is an etiological one.

The Registrar-General's (1958) *Statistical review of England and Wales for the 2 years 1952-1953* showed the same trends as that for 1949. The total number of admissions had risen from 55 785 to 67 422 and most categories showed an increase (Appendix to the review, Table M5). However, there were some peculiar discrepancies, such as the rise in the number of paranoid states in the Manchester region from 14 to 79. The number of cases classified under the heading " Psychoneurosis with somatic symptoms " (315-317) had decreased to 88 for the whole country. In 1956 it had dropped to 56, according to Miss Brooke.

This rather superficial examination of two statistical reports shows that, in England and Wales at least, as far as mental health is concerned the ICD has largely failed in its purpose of providing reliable information on the various types of disorders. There are apparently two main reasons for this failure: first, the system of classification was only partly accepted by the psychiatrists who supplied the data; and secondly, there was insufficient agreement about the meaning and scope of the categories. The value of the statistical information thus obtained for epidemiological studies is extremely dubious.

It is unfortunate that the recommendation made in 1950 by the WHO Expert Committee on Mental Health for the compilation of a glossary of descriptive definitions of the 3- and 4-digit headings in that part of the ICD relevant to psychiatry has never been implemented. Such a glossary might have reduced the confusion arising from the inconsistent use of terms.

Some of the difficulties arising from lack of direct communication between coding officers and psychiatrists can be overcome where regular personal consultation is practicable, as, for example, in the case of the Institute of Psychiatry of the University of London, and the associated Bethlem Royal Hospital and Maudsley Hospital, which together accommodate 450 patients. These institutions have their own recording office and every doctor working there is provided with a " Records handbook " containing Section V of the ICD and careful instructions for its use. Mrs M. Perkins,

the Transcription Officer, has informed me that, in using the ICD, she has encountered similar difficulties to those described by Miss Brooke, and her complaints concerning Section V were along the same lines as those of other critics. She had had to work out subclassifications of several categories where they were lacking, for instance, in the case of hysterical reactions, drug addictions, and sexual deviation. Not infrequently, the diagnoses have proved uncodable, but on every such occasion the psychiatrist concerned has been consulted and an agreement reached. Mrs Perkins expressed the view that without easy access to the psychiatrists supplying the data for coding she would often be completely at a loss. Diagnoses received from the out-patient department are also coded, but, as a rule, they prove simpler and less controversial than those made in respect of in-patients. Conditions for coding are no doubt exceptionally favourable in this particular hospital group.

Dr B. H. Kirman and Dr L. T. Hilliard of the Fountain Hospital, London, made some interesting comments in their reply to an inquiry concerning their experience with the ICD in the field of mental deficiency. They referred to earlier criticism contained in a report entitled "The mentally subnormal child" (World Health Organization, 1954). In part this criticism had been met in the subsequent edition of the ICD published in 1957, but Dr Kirman and Dr Hilliard are still critical about some of the subclassifications:

> About the clinical classifications, it seems perhaps a little arbitrary to pick out mongolism for a special heading under 325.4 though this can be justified on the score that this is the biggest clinical group. We find that in our series phenylketonuria ranks second after mongolism, though it is a long way behind numerically. There does not seem to be any very good reason for putting Tay Sachs disease under 325.5 whilst Schilder's disease is to be found under 355 as a disorder of the nervous system and tuberous sclerosis appears under 753.1 as a congenital malformation lumped in with microcephaly and some eye lesions.
>
> *Practical suggestions*
>
> It would probably be best to abolish categories 325.3, 325.4 and 325.5, and to insert three notes:
>
> (1) Cases of borderline intelligence who come for advice should be classified according to the presenting problem other than limited intellect, for example under neurosis.
>
> (2) Cases of mental deficiency falling into specific clinical categories such as mongolism, phenylketonuria, or cerebral lipoidosis, should be classified under the appropriate heading.
>
> (3) In the case of children, some appropriate test other than the Stanford-Binet may be used as a standard of reference, such as the Wechsler Intelligence Scale for Children for suitable ages. It should, however, be borne in mind that in the case of children, intelligence tests results, particularly with no chronological or mental ages, are of limited value and liable to change from time to time.

3. THE AMERICAN STANDARD NOMENCLATURE AND CLASSIFICATION ("THE STANDARD") (ANNEX 1, PAGE 628)

This system did not, like many other classifications, develop by accretion. It is the result of careful and lengthy deliberation by a committee of experts. It shows unmistakable signs of the democratic process which tries to offer something to every interest. The initiative for the introduction of the new nomenclature had come chiefly from psychiatrists working in private practice and clinics rather than from those working in public hospitals. Those pressing for a new nomenclature were specially interested in the areas of personality disorders and transient reactions to psychological stress, i.e., the disorders that are not quite so common in institutional work. In Britain, the ICD is used almost exclusively for hospital in-patients. If this should apply to the "Standard" also it would mean that those providing the bulk of the data would be comparatively little interested in what is one of its most characteristic features, i.e., the sections concerning personality disorders and neurotic reactions.

The "Standard" is self-contained, i.e., it provides categories for all psychiatric conditions. The first section includes all psychiatric disorders in which an impairment of brain-tissue function can be assumed, however transient and of whatever origin. Although the involvement of the brain may be trivial and quite accidental to the main physical illness, it qualifies the case for inclusion in the psychiatric section. For this technical reason, the involvement of the brain is invariably given first consideration, and not the main illness which would often be much more important medically than the psychiatric condition. The choice of the common denominator of impaired cerebral function made it possible to present all organic psychiatric conditions in one comprehensive section. The logical advantages of this arrangement

are obvious, though it resulted in the breaking up of traditional clinical groups of mental disorders. There was little left of mental deficiency outside the section of brain disorders, and of the psychoses only the schizophrenic and manic-depressive reaction types remained as a separate group.

The term " brain syndrome " might lend itself to misinterpretation, especially by neurologically orientated psychiatrists. They may be tempted to use it for a variety of cerebral syndromes other than those to which it is meant to apply. However, the glossary is supposed to obviate such mistakes.

The part concerning psychotic disorders shows the tendency to advance or at least to stimulate etiological theories. " Involutional psychotic reaction " was singled out as a disorder due to disturbance of metabolism, growth, nutrition or endocrine function, which may be understood to imply that such etiological factors play no part in other conditions. Otherwise the section concerning psychoses follows on the whole the conventional pattern. Many psychiatrists will welcome a special category for " Psychotic depressive reaction " and possibly also for " Schizophrenic reaction, schizo-affective type ". About the placing of the paranoid psychoses the " Standard " is as ambiguous as the ICD, and the glossary is, in this instance, unhelpful.

The next section is entitled " Psychophysiologic autonomic and visceral disorders ". This title seems to be based on a presumed etiology. Although the glossary explains that this section comprises the psychosomatic disorders it is not clear whether bronchial asthma and peptic ulcer are meant to be included. The glossary is ambiguous about it. It mentions bronchial spasm and peptic-ulcer-like reaction.

The section devoted to psychoneurotic disorders differs from the conventional classification in that the time-honoured term hysteria has been eliminated.

The main difficulty about the section concerning personality disorders seems to be the tendency of the various subclasses to overlap. A personality can at the same time be inadequate, emotionally unstable, and aggressive. The " Standard " shares this difficulty with the ICD and other classifications.

The *Diagnostic and Statistical Manual for Mental Disorders* (American Psychiatric Association, 1952) offers valuable directions about recording and it enables the psychiatrist to indicate the role of external stress, the type of the premorbid personality, and the degree of psychiatric impairment.

The *Standard Nomenclature and Classification* is based on a framework of established or hypothetical etiological causes. The underlying philosophy is that of a single causal factor, or at least a hierarchy of causal factors, one of which, the involvement of the brain, is singled out as the most important. The validity of this approach is debatable, even where the causative factors are known.

Would the *Standard Nomenclature and Classification* be suitable for international use? To answer this question one would have to know first how it has been working in the United States. Has it been used in the way it was intended to be and has its provided meaningful information? No definite answer to these questions could be obtained. They are at present under review by a committee of the American Psychiatric Association.

The " Standard " certainly meets one of the main criticisms levelled against the ICD, that of incompleteness. However, it is doubtful whether the method by which all psychiatric conditions of organic origin were included would be generally acceptable. Other objections to the ICD, especially those concerning neuroses and personality disorders, apply equally to the " Standard ".

PRINCIPLES OF PSYCHIATRIC CLASSIFICATION

1. GENERAL PRINCIPLES

Carl G. Hempel (1959) recently discussed the principles of classification in general and their application to mental disorders. A classification, he pointed out, divides a given set or class of objects into subclasses which should be mutually exclusive and jointly exhaustive. Each class comes to be specified by means of a corresponding concept which represents the characteristics essential for membership in the class. A classification, therefore, is a special type of scientific concept. Description and theoretical systematization are two basic functions of scientific concepts and

therefore of taxonomic systems, i.e., classifications. In medical science there has been a gradual development from a predominantly descriptive, i.e., symptomatological, to a theoretical, i.e., etiological emphasis. Hempel discussed the difficulties of using objectively verifiable concepts in psychiatry. These difficulties are indeed so serious that many psychiatrists have despaired of classification. However, similar difficulties existed, and still exist, in other fields. Hempel pointed out that one of the favourite remedies in such a situation had been to insist on agreed operational definitions the requirements of which should not be too rigid: mere observation must be allowed to count as an operation. To be scientifically useful a concept must lend itself to the formulation of general principles which would provide a basis for explanation, prediction, and, in general, scientific understanding. "A good taxonomic system is based on, and reflects, a more or less comprehensive system of laws... These systems will change with the theoretical advance made in the field. Systems of classes defined in terms of manifest observable characteristics, give way to systems whose defining principles are couched in terms of theoretical concepts... This trend has also been in evidence in the development of taxonomic systems for mental disorders." A further stage to be expected may be "a gradual shift from classificatory concepts and methods to ordering concepts and procedure both of the non-quantitative and quantitative varieties". The latter trend was illustrated by the growing interest in borderline cases, mixtures, transitional forms, etc.

In psychiatry, the application of the principles of classification outlined by Hempel meets with considerable difficulties. Firstly, what do we classify in this field? Are we classifying diseases or people? Psychiatrists could be divided into two groups according to their answers to this question. It may be said that the material the psychiatrist has to classify consists neither of diseases nor of people but of a variety of disorders or reactions, a material which does not readily lend itself to classification. And there is the added complication that these disorders, or reactions, are not mutually exclusive, and that features of two or three reaction types often co-exist. This is why diagnostic formulations, within which all the main constituents of the disorder can be accommodated, have often been found more satisfactory than a single diagnosis. In these formulations, the supposedly most important constituent is to be given precedence over the less important, but this is an arbitrary judgement which often proves mistaken. We have no means of measuring those constituents objectively. Because of these difficulties, psychiatrists are still using simple diagnostic concepts. There is much to be said in favour of operational definitions in psychiatry. In fact, many of the present nosological concepts are operational definitions; this would not be readily admitted by many psychiatrists because the quest for disease entities has created the idea that our diagnostic concepts stand for biological realities with which it would be wrong to tamper. Schizophrenia, then, as an operational concept, would not be an illness, or a specific reaction type, but an agreed operational definition for certain types of abnormal behaviour. It should be less difficult to agree about an operational definition than about a hypothetical illness. The same applies to such concepts as psychopath, etc. The question, therefore, which a person or group of persons trying to reach agreement on a national or international classification ought to answer is not what schizophrenia or psychopathy is, but what interpretation should be placed on these concepts for the purpose of diagnosis and classification, i.e., for the purpose of communication. Those who find it difficult to accept this frankly practical and utilitarian attitude to psychiatric classification should be referred to Kraepelin's comments on the last version of his classification: "Ich möchte nachdrücklich darauf hinweisen, dass manche der abgegrenzten Krankheitsbilder nur Versuche darstellen, einen gewissen Teil des Beobachtungsstoffes wenigstens vorläufig in eine lehrbare Form zu fassen". ("I should like to emphasize that some of the clinical pictures outlined are no more than attempts at presenting part of the material observed in a communicable form.") It is most unlikely that Kraepelin himself would have disagreed with the recent statement by de Boor (1954) that Kraepelin's groups of clinical pictures are no more than conventions; they can be more precisely termed operational definitions. It appears, therefore, that many psychiatrists since have been more Kraepelinian than Kraepelin.

2. PRINCIPLES UNDERLYING THE PSYCHIATRIC CLASSIFICATIONS LISTED IN THIS SURVEY

It is assumed that "the class of objects" to be subclassified in psychiatry is that of mental disorders. This term is less controversial than that

of mental diseases or reactions. One ought to start by defining the concept of mental disorder, but this would first require a definition of mental health. There is no prospect of agreement on these concepts today. This difficulty is not specific to psychiatry, although it is more serious here than in other fields of medicine where operational definitions of health and disease seem easier. Psychiatrists, in designing their classifications, have not as a rule stated their general concepts of mental disease within which the various elements were to be classified, but it is usually possible to discern them from their classifications. The choice of criteria for subdividing the material depends on the underlying general concept of mental disorder. What have been those criteria, or principles, or dimensions, or axes of subdivision in the classifications listed in this survey? [1]

Kraepelin's orientation (Annex 2, page 640) has been described as one of "empirical dualism" (de Boor, 1954), i.e., he combined cerebral pathology with psychopathology. At first, it seems, his approach was dualistic with regard to methods of investigation rather than to his concept of mental disorder. His idea of disease entities was that of general medicine. His system of classification, which at first was mainly *symptomatological*, became more and more *etiological*, a psychogenic origin of neurotic and some psychotic disorders being assumed. This broad division into three groups, i.e., organic, probably organic and/or constitutional, and psychogenic, is still a basic feature of most classifications in use today.

It did not apparently occur to Kraepelin that diseases having a psychogenic etiology would be disqualified from membership of the class of mental disorders. This is the characteristic feature of K. Schneider's (1950) broad division of the material (Annex 2, page 647). This author, who was strongly influenced by Jaspers, contends that the concept of illness applies only where organic changes have been established or can be postulated with confidence. Other mental disorders are only "abnormal varieties of sane mental life". Therefore, "there are no neuroses, but only neurotics". Thus, the neuroses and other psychogenic reactions are placed outside the class of mental illness in the strictly defined sense, and included with the psychopathic personalities. Within this conceptual framework, Schneider's classification is based on *etiology*. The concept of the neurosis as a psychopathic reaction had a profound influence on psychiatric theory and practice, especially in Germany. However, in some recent German classifications the neuroses and psychopathies are again treated as separate categories.

Adolf Meyer's (1916) basic concept of mental disorders as reactions to life situations led even further away from the concept of disease entities, which he recognized only in the case of some conditions of proven organic etiology. Although Meyer would hardly have agreed with Schneider's classification, his group of reaction types (Annex 2, page 641), which includes the so-called endogenous psychoses, is ideologically akin to Schneider's "varieties of sane life". Both systems tend to widen the borderland between normal and abnormal mental life. Meyer's classification, which differentiates mental disorders according to *behavioural* differences, follows logically from his concept of mental disorder which is fundamentally *psychopathological*.

Kleist's (1953) system (Annex 2, page 638) is consistently *etiological*. The assumed pathogenic factors are lesions, degenerations, maldevelopments or defective dispositions of the nervous system, diffuse or localized. The schizophrenias are regarded as manifestations of cerebral degenerative diseases, the manic-depressive group as due to autonomous cerebral dysfunction. Neuroses are supposed to be manifestations of abnormal cerebral disposition, with psychogenic factors playing only a secondary role. Leonhard's (1957) classification of the endogenous psychoses (Annex 3, page 658) follows the same line; his criteria of differentiation are *symptomatological* with a neurological bias and an emphasis on heredity.[2]

Rümke's (1959) division of the material into three main classes (Annex 2, page 646) is based on the role of *genetic-developmental* pathogenic factors. Within this main grouping, *symptomatology* is the chief criterion of differentiation.

Ey's (1954) system of classification (Annex 2, page 637) is fundamentally *psychopathological* with a psychophysiological basis and an existentialist philosophy. Mental disorder is viewed as a manifestation of disturbances of two variables, viz., the

[1] The classifications not included in the "official" group (Annex 1) have been listed in Annexes 2 and 3. Those used here for demonstrating basic principles are presented in Annex 2, the rest in Annex 3.

[2] Fish (1958) has produced an English version of Kleist's and Leonhard's classifications of schizophrenia.

level of awareness [1] (? consciousness) and the functioning of the personality.

In the classification of Bosch & Ciampi (Annex 2, page 637) mental disorders are classified according to the level on which mental activity is functioning. This is judged by the degree of " autonomy ", i.e., freedom of action possible in a particular disorder. This psychophysiological concept is akin to Ey's. Both are in line with a tendency towards a unitary concept of mental disorders, as advocated by Menninger. If one divides psychiatrists into " separatists " and " gradualists " according to their attitudes towards the boundaries between the various mental disorders, Ey, Bosch & Ciampi and Menninger would fall into the second group. A limited " gradualism " can be observed in other classifications too, e.g., in that of Pacheco e Silva (Annex 3, page 661) where neuroses are classed as minor psychoses.

Krapf's classification (Annex 2, page 640) appears to be based on a concept of mental illness as disturbances of *ego-function*. Its main divisions are therefore *psychopathological*; within this broad framework, pathophysiological subdivisions are introduced and a wide variety of pathogenic factors (organic, hereditary, psychodynamic) are distinguished.

Rado's (1953) system (Annex 2, page 646) presents in parts an attempt at a *psychodynamic* classification in the psychoanalytical sense, but its author had to make use of other frameworks too, especially of clinical and social psychiatry. This classification is a highly personal product and does not represent the views of the psychoanalytical school. In fact, no comprehensive and detailed psychoanalytical classification of mental disorders exists.

The above are examples of the concepts and principles underlying classifications. Only a few have been stated explicitly by the authors of the systems, and quite possibly different or additional principles could be discerned by other investigators. The other classifications reproduced in the Annexes are derived from or related to one or more of those basic systems. The Scandinavian classifications, for instance, can be regarded as modifications and elaborations of Kraepelin's system. They aim at the most careful categorization of symptoms and syndromes. Only a minority of the systems are consistent in respect of the principle of classification. The most common combination is that of etiological and symptomatological criteria. It is noteworthy that all the " official " classifications reported here show combinations of various principles.

In many classifications, consistency is maintained by the postulation of a certain type of etiology, e.g., of an organic cause for schizophrenia. The kind of etiology implied in these classifications is that of a single causal factor. This has long been recognized as inapplicable in psychiatry. Therefore, no etiological classification of this kind, however consistent in itself, can do justice to the multifactorial origin of mental disorders. It cannot even be said that in all cases where reference to etiology is made in a classification, the etiological factor stated is the most important, i.e., the one without which the disorders might not have arisen.

Differences of opinion about the relative weight of etiological factors singled out as criteria on which to base definitions are responsible for a number of divergencies between classifications. The question of whether " psychogenic psychoses " should be given the status of an independent category is a case in point. Such a category is likely to be opposed by the " organicist "—who would accord psychogenic factors only a minor role in the etiology of the psychoses—as well as by the psychodynamically oriented psychiatrist. The latter would argue that such a category implies the absence of psychogenic factors in the etiology of the psychoses not so designated. He would also regard a differentiation of psychoses into psychogenic and non-psychogenic solely on information obtained in one or two interviews as unjustified. Similar differences in basic concepts enter into the question of the relationship between neurosis and psychopathies. Here the problem is that of the relative etiological significance of constitutional versus psychogenic factors.

A chiefly symptomatological approach is apt to create other types of dilemma. Such an orientation might have been responsible for the inclusion of anxiety neurosis in the group of affective disorders (Skottowe, 1953, Annex 3, page 662).

In most classifications, descriptive-clinical, i.e., symptomatological or syndromal criteria are used side by side with etiological ones, but this is fre-

[1] The French word " conscience " might in this context be better translated by " awareness " than by " consciousness ". While it is possible to see in manic-depressive illness a restriction of the area of awareness, one can hardly regard it as a disturbance of consciousness, unless one uses an *ad hoc* operational definition of " consciousness ".

quently done by implication rather than explicitly. Essen-Möller and Wohlfahrt (1947) warned against mixing the two principles of classification. They pointed out that, for many psychiatrists, the diagnosis "hysteria", for instance, had etiological implications, although it was usually made on symptomatological grounds. For this reason the two authors recommend that a descriptive (symptomatological, syndromal) as well as an etiological diagnosis, or diagnoses, should be made in every case. They also find it sometimes useful to allocate a case to a broad grouping such as psychosis, abnormal personality, etc. Their lists (Annex 3, page 649) are, of course, capable of extension.

The system of Lecomte et al. (1947, Annex 3, page 657) represents a similar attempt at classifying along two axes, i.e., the clinical and the etiological, at the same time. Langfeldt's (1956) system (Annex 3, page 655) makes provision for classification according to main diagnosis, personality type, and situational background of the mental disorder. The "Standard" classification (Annex 1) makes similar provision. No information is available as to whether any such device of classifying along two axes at the same time has been used extensively.

Many classifications show features that reflect the special research interests of their authors, e.g., the schizophreniform types of schizophrenia (Langfeldt) and the existential neurosis of van der Horst (Annex 3, page 650).

A number of differences between classifications are attributable not so much to disagreement on basic concepts of mental illness in general as to differences of opinion on specific clinical concepts. The following examples show the measure of disagreement in some important areas.

Schizophrenia, paranoid states, paranoid reactions

There is considerable variety in the number of schizophrenic sub-groups in the various classifications. More serious from the point of view of medical statistics is the discrepancy concerning the place of the paranoid psychoses in the system; only a minority of the classifications, including the ICD, has a special category for paranoid psychoses of equal status with and independent of the other major categories of psychoses. Some of these systems distinguish between paranoid schizophrenia and paranoid states, while others do not. A number of classifications distinguish paranoid reactions within the category of abnormal personality reactions. This means that a paranoid condition may have to be considered for inclusion into one or two or three categories, depending on the system of classification.[1]

Another mental disorder about whose status in the statistical classification there is striking disagreement is that of *involutional depression* or melancholia. Only a minority of the classifications presented have a special category of this name. Others include this condition among the presenile psychoses side by side with dementias of that age period, while the rest include it among the depressive psychoses. This lack of agreement would defeat any attempt at a comparative epidemiological study of this disorder.

There is a similar disagreement in respect of the *psychoses related to child-bearing*. Some systems include in this particular category all serious mental disorders (psychoses) related to child-bearing; the ICD refers to puerperal psychosis only. Other classifications obviously include these conditions among a general category of symptomatic psychoses or among one of the main mental disorders as the case may be, i.e., manic-depressive illness, schizophrenia, or organic confusional states. In this instance, nosological considerations apparently caused the originators of most classifications to refrain from establishing or preserving a special category. At any rate, it is impossible at present to study the psychoses related to child-bearing epidemiologically and to compare their incidence in different areas.

The confusion becomes even more serious, as is to be expected, in those parts of the classificatory systems which are not concerned with the so-called psychoses. Some systems differentiate neurosis from psychoneurosis, while others speak of *Erlebnisreaktionen* instead, which may be understood to mean either reactions to experiences or reactions consisting of certain experiences. This category largely overlaps with the neuroses

[1] The difficulties arising for research from a disagreement such as this are illustrated by the recently published book by Hollingshead & Redlich (1958), who studied the epidemiology of schizophrenia in relation to different socio-economic classes. These authors distinguish only one group of schizophrenic conditions, which includes the paranoid states. However, it is far from certain whether this broad category included all cases which some other investigators would have listed among paranoid states and/or abnormal personality reactions. This research cannot therefore be tested by those who have adopted a different statistical classification.

or psychoneuroses as well as with the psychopathic personalities of other classifications. The categories serving the statistical classification of abnormal or psychopathic personalities reflect the profound diversities of views held amongst psychiatrists about the clinical and etiological aspects of those conditions. In some systems they include the neuroses. The number of sub-groups varies greatly and so do the principles on which the subdivisions have been based.

Only six of the classifications listed in this survey provide a category for so-called *psychosomatic conditions;* there are indications that this concept varies from place to place. It partly corresponds to the category "Psychophysiologic autonomic and visceral disorders" of the "Standard" classification which has ben subdivisions according to organ systems. In the ICD the arrangement is different; there are three categories for these conditions under the heading of "Psychoneurosis with somatic symptoms", one for the circulatory system, one for the digestive system, and a third for other systems.

This list of differences between classifications in current use could be further extended, but the examples quoted suffice to illustrate the existing confusion.

Annex 3 lists a number of further classifications not included in Annexes 1 and 2 (see footnote, page 613). It was decided not to omit any classification received so as to enable the reader to form his own opinion about the merits of the various systems and the differences between them. Some can serve as illustrations for the criticism that the difference between the function of a nomenclature and that of a statistical classification has occasionally been overlooked. The difference has been clearly stated in the *Introduction* to volume 1 of the *Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death* (1957); a nomenclature, being "a list or catalogue of approved terms for describing and recording clinical and pathological observations", has to be extensive and unlimited in scope and detail to allow for the recording of the manifold varieties of ill health. A statistical classification, on the other hand, is concerned with groups of conditions whose peculiarities have to be fitted into a limited number of categories chosen for their usefulness in the numerical study of disease phenomena. The functions of a nomenclature and a statistical classification are, therefore, in some respects opposed to each other.

THE PROSPECTS OF AN INTERNATIONAL CLASSIFICATION OF MENTAL DISORDERS AT THE PRESENT TIME

The arguments in favour of an agreed international statistical classification of mental disorders have been stated earlier in this review. The question may well be asked whether, in view of the existing difficulties and the failure of the ICD to find general acceptance, any other classification would have prospects of success at the present time. Is there sufficient agreement about the need for such a classification among those responsible for the mentally ill, and would there be sufficient willingness to adopt it internationally?

It can be stated with confidence that the need for an up-to-date classification of mental disorders is generally recognized, although there is no complete conformity of views about the functions of such a classification. No psychiatrist, whatever his orientation, could possibly have any quarrel with the following statement quoted from the most recent edition of one of the leading American textbooks on psychiatry (Noyes & Kolb, 1958):

> While classifications are necessary for statistical and other purposes, there has perhaps at times been too great a disposition in psychiatry of considering that its objective was obtained when a classificatory diagnosis had been made . . . The principal value of classification is not a categorizing of disease entity, but in quickly eliminating those considerations which will be least useful in understanding the patient and in directing attention to those which are likely to be relevant.

Similar statements affirming the need for classifying the various manifestations of mental disorders can be quoted from any other textbook of psychiatry published in America or elsewhere.

Special reference has been made to American views because it is sometimes assumed that there exists a negative attitude to classification of mental disorders among the United States psychiatrists. This is certainly not the case at present.

The question whether psychiatrists would be willing, even at the price of some inconvenience and concessions, to adopt an international classification of mental disorders at the present time, cannot be answered in the affirmative with equal confidence. It has still to be established that psychiatrists and other workers in the field of mental health believe sufficiently strongly in the importance of epidemiological research on an international level and in the other advantages of a common language, however limited. Their attitude will also depend on the classification recommended for general adoption.

If a drastic revision of the existing ICD relevant to psychiatry should be attempted, the reasons for the almost general rejection of its present version as well as the lessons learned from its use will have to be carefully considered. It will also be advisable not to recommend any such system for adoption without a glossary containing definitions and detailed instructions. Whoever, as an individual expert or as a member of a group, is concerned with devising a psychiatric statistical classification will have to make up his mind on the following questions:

1. Is it essential for an international psychiatric classification to be preceded by, or even to be the outcome of, a generally accepted international psychiatric nomenclature?

2. Is it essential for such a classification to be preceded by an agreement on basic diagnostic concepts?

In considering these questions the possible need for other classifications for regional purposes, research, etc., will have to be kept in mind, as well as the temporary and utilitarian nature of any such system of classification.

Desirable though the adoption of a common nomenclature might appear to most psychiatrists, it does not seem to be essential for such an agreement to precede a practicable and generally acceptable statistical classification. Probably considerations concerning nomenclature have in the past interfered unduly with the requirements of statistical classifications. Their respective functions, which are partly opposed to each other, have been discussed earlier in this review (page 616). It is even conceivable in principle that a statistical classification could dispense with nosological terms altogether and use numerical or other symbols only. However, it is not suggested at this stage that such a solution should be adopted for psychiatry at present. There probably is sufficient basic agreement on terminology for a generally acceptable list of categories to be drawn up. Possibly, such an agreement would help to prepare the ground for a common nomenclature. The latter would be a much more ambitious and complex undertaking than the attempt to establish a statistical classification which would have to be a relatively simple instrument of communication. It may even be argued that a generally adopted detailed psychiatric nomenclature might at the present time have an inhibiting effect on psychiatric thought and thus hamper progress.[1]

The view is often expressed that the lack of agreement about diagnostic concepts is bound to defeat the purpose of any national or international statistical classification. Comparability of data is indeed a serious problem in psychiatry. The reliability of diagnosis in certain areas of psychiatric morbidity, especially in respect of the so-called endogenous psychoses, has sometimes been found to be very low. Some investigators, however, have found a surprisingly high reliability, especially where psychiatrists shared the same orientation. Psychiatrists have for some time paid too little attention to their diagnostic concepts which often differ considerably, even among members of the staff of the same hospital or institute. If, for instance, some psychiatrists regard recovery as incompatible with the diagnosis of schizophrenia and others do not hold this view, and if they have not made it clear to each other that their diagnostic concepts differ fundamentally, how can they be expected to agree? But apart from these difficulties, which could be considerably reduced, the reliability of psychiatric diagnosis will remain limited in those categories where no objective criteria can be employed. Diagnostic judgement

[1] At the recent Work Conference on Problems of Field Studies in the Mental Disorders held at New York, several speakers referred to the role which language had played in psychiatry. Certain symptoms or mental disorders which to psychiatrists using one language appear very important, do not exist for psychiatrists and patients using another language, because there are no words for them. Several examples demonstrating the part language has sometimes played in the creation of psychiatric symptoms were mentioned. These considerations should not militate against a common basic nomenclature, but they illustrate the complexity and limitations of such a task. They also suggest that the adoption of a detailed common international nomenclature may deprive psychiatrists of means of communication with each other and with their patients which only their own language can provide. It would, of course, be important for psychiatrists using the same language to have an agreed detailed nomenclature.

often still depends on clinical symptoms about whose presence and significance in an individual case opinions may differ. But these difficulties can be overstated. The adoption of operational definitions should go some way towards reduction of disagreements on diagnosis. Earlier in this report (page 615) reference has been made to misleading fluctuations in statistical data, probably due to lack of consensus on terminology and basic diagnostic criteria, such as the status of paranoid states in relation to schizophrenia or of involutional depression to the manic-depressive group. Considering the provisional and practical nature of an international classification, questions such as these should not be treated as problems involving scientific truth which allows of no concessions, but as difficulties in the way of communication. The answer, therefore, to the question posed above, whether an international psychiatric classification has to be preceded by agreement on basic diagnostic concepts, is that no such explicit agreement is necessary, provided that the existence of different diagnostic concepts is generally recognized and guarded against, and provided that operational definitions are adopted for the purpose of the classification.

REQUIREMENTS OF AN INTERNATIONAL CLASSIFICATION OF MENTAL DISORDERS

The need for such a classification has been felt for a long time. The urgency of the problem was stressed very recently in the sixth report of the WHO Expert Committee on Health Statistics (1959) which draws attention to the lack of a "generally acceptable classification of mental disorders" and recommends that:

"(1) the World Health Organization keep in close touch with and co-ordinate national efforts aimed at the revision of the section of the International Classification dealing with mental disorders;

(2) the World Health Organization provide in due course for one or more combined sessions of psychiatrists familiar with the principles of classification for statistical purposes and of statisticians working in the mental health field to review developments and to suggest further action in respect of the revision."

In considering the requirements of a generally acceptable psychiatric classification, it may be of interest to recall the last occasion when this problem was fully debated on an international level. It was one of the main subjects at the Second International Congress for Mental Hygiene held in Paris in 1937. Even then, the needs of epidemiological research were in the foreground of the discussion. Hubert Bond expressed the view that the inconsistency of the existing classifications was responsible for the confusion. H. Bersot proposed a classification (Annex 1, page 634) which was subsequently adopted in Switzerland and Portugal. It is a simple framework for all psychiatric conditions, basically different from the provisions made for psychiatry in the ICD in 1948. Since Bersot proposed his classification for international use, psychiatry has advanced and epidemiological research has become more sophisticated. We also have more experience with statistical classifications than the psychiatrists had in 1937. In the light of this experience, and of the lessons learned from the rejection of the ICD by the majority of psychiatrists, what are the requirements of an international statistical classification of mental disorders today?

To be acceptable internationally, a statistical classification of mental disorders will have to avoid the impression that it aims at educating psychiatrists all over the world along certain lines which many of them may not wish to follow. This requirement of neutrality in the controversies between various schools of thought imposes considerable limitations on an international classification. It has to be based on points of established agreement. It must be a servant of international communication rather than its master. This is why it cannot be ahead of its time. It can at present be no more than a tool of communication for a limited range of data such as the incidence and prevalence of certain mental disorders. It should not be the purpose of an international psychiatric classification to oust and to take the place of regional or local classifications, many of which have a valuable function in research and

administration. Such classifications may stimulate the study of new relationships and thus advance knowledge. The only proviso to be made for such classifications would be that they should be readily convertible into the international system. That this is practicable has been proved in several countries. An international classification, therefore, would have to be, in the first instance at least, rather conservative and theoretically unenterprising. This is inevitable for an international instrument to be used by people of various orientations and knowledge. It must not be forgotten that in the majority of countries no recording of psychiatric disorders for statistical purposes exists. A *glossary* with operational definitions of the various categories would have to be available from the beginning in as many languages as possible.

What should be the principles underlying such a classification? It has sometimes been said that a classification has above all to be consistent with regard to the criteria of differentiation. But however well conceived an international classification may be, it is bound to reflect the patchiness of present knowledge and the lack of a consistent and generally accepted nosology of mental disorders. Therefore, the demand for thoroughgoing consistency is unreasonable at the present state of psychiatry. No psychiatric classification can help being partly etiological and partly symptomatological, because these are the criteria by which psychiatrists distinguish mental disorders from each other. It appears that the requirement of consistency has been overstated by some psychiatrists. "The scientific purist who will wait for medical statistics until they are nosologically exact is no wiser than Horace's rustic waiting for the river to flow away." This general observation made by the late Professor Greenwood is particularly relevant to psychiatry.

No classification can meet every criticism, but even the best classification cannot serve its function unless all those participating in its application know it and want to make it work. All too often the only person interested in a classification has been the coding officer. It is essential that the psychiatrists supplying the diagnostic data should be familiar with the statistical classification in use and with its purpose. Many psychiatrists seem unaware that their diagnoses are more than private observations concerning only themselves and their patients.

There is a further reason why an internationally acceptable psychiatric classification will have to be relatively simple. The existing classifications have in most places been used for hospital in-patients only. This is highly unsatisfactory because the hospital population is not representative of those suffering from mental disorders. With the increase of out-patient facilities and day hospitals, and with the growing trend against hospitalization, the bulk of the psychiatric patients will remain in the community. It is essential for epidemiological research to include these patients, who far outnumber those admitted to hospital. Out-patient material lends itself only to relatively simple classification.

One of the recurrent criticisms of the ICD and similar classifications has been the lack of provision for recording diagnostic formulations. The same difficulty exists in other fields of morbidity and it is doubtful whether a statistical classification which could serve this purpose can be designed at present. The ICD provides for related and unrelated additional diagnoses and can also be adapted for multiple diagnoses when two separate psychiatric conditions co-exist. The American Standard Classification makes provision for the reporting of precipitating factors, premorbid personality, and degree of psychiatric impairment. Several of the classifications listed in Annex 3 allow for the recording of two or more dimensions of the clinical conditions. No information about the use of these arrangements has so far been available.

Those concerned with a revision of the ICD will first have to decide whether Section V should be made comprehensive, i.e., whether it should contain all psychiatric categories. The objections to this section in its present form have been so general and emphatic that comprehensiveness has to be regarded as an essential requirement of an internationally acceptable international classification. Theoretical objections against such a change are far outweighed by the practical disadvantages of the present arrangement. In the American Statistical Classification of Diseases and Operations, which contains a comprehensive psychiatric section, this problem has been solved.

It is not proposed to present a specimen classification which would meet the requirements outlined above. It is hoped that this report will serve as a basis for discussion on a revision of the ICD relevant to psychiatry. Recently, J. E. Meyer (1959) has proposed a "diagnostic scheme" as a

prototype for an international classification (Annex 3, page 659). It meets the requirements of comprehensiveness and relative simplicity.

During the last few decades, *child psychiatry* has emerged as an important branch of psychiatry. There has been a growing tendency to specialization in this field which has many problems of its own. Child psychiatrists are generally dissatisfied with the existing classifications. Of those listed in the Appendix to this report, only that of Selbach (Annex 3, page 659) has a special and detailed section for mental disorders in childhood.

This survey has not been specially concerned with child psychiatry. It has been taken for granted that no satisfactory up-to-date classification serving the requirements of this special field exists. A comprehensive psychiatric classification has to provide for those requirements, either in a special subsection, or in the various categories relevant to mental disorders of childhood. Child psychiatry, being a very new area of study, has not yet developed a tradition of classifications like the psychiatry of adult age. In fact, child psychiatrists have only just started ordering their material and designing tentative classifications. It will be necessary to inquire into the present state of these endeavours. The results of such an inquiry would serve as a basis for consideration of the requirements of this field in a revised classification of mental disorders. The need for relative simplicity of the sections of an international classification dealing with mental disorders in childhood is quite obvious, and so is the desirability of experimental classifications of a regional nature.

The question arises how agreement on a drastic revision of the ICD relevant to psychiatry could be reached. It will be necessary for suitable proposals to be submitted in time for the next revision conference of the World Health Organization. It may be advantageous if the results of pilot studies with one or several classifications thought to be suitable for international use are available before final recommendations are made. Proposals concerning the technicalities of actions to be taken in this matter are outside the scope of this report.

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RÉSUMÉ

Etablir une classification des troubles mentaux est une entreprise ardue, car l'avis des psychiatres diffère quant au choix des critères sur lesquels elle doit reposer. En effet, les diagnostics ne peuvent guère être vérifiés objectivement et les mêmes troubles sont décrits sous des noms différents. C'est un obstacle à l'échange rapide d'idées et d'expérience, donc au progrès.

L'auteur de cet article a entrepris une étude critique des classifications existantes, montrant en particulier leurs côtés faibles. Il passe en revue les classifications existantes, internationales et nationales, notamment celles qui sont en vigueur aux Etats-Unis, au Canada, en France, aux Pays-Bas, au Danemark, en URSS, au Japon.

Il montre que les difficultés créées par le défaut des connaissances sur la physiologie et l'étiologie peuvent être surmontées par l'emploi de « définitions opérationnelles ». Il indique quels pourraient être les principes fondamentaux d'une classification satisfaisante. Celle-ci assurerait un accord plus général sur la valeur des traitements des troubles mentaux. Elle permettrait d'aborder sur un large front l'aspect épidémiologique de la recherche psychiatrique.

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Annex 1

OFFICIAL, SEMI-OFFICIAL OR NATIONAL CLASSIFICATIONS

1. INTERNATIONAL CLASSIFICATION OF DISEASES V. MENTAL, PSYCHONEUROTIC AND PERSONALITY DISORDERS *

This section excludes transient delirium and minor mental disturbances accompanying definitely physical disease. Examples of this kind are transient delirium of febrile reaction, transient intoxication with uraemia, transient mental reactions with any systemic infection, or with brain infection, trauma, degenerative disease, or vascular disease.

PSYCHOSES (300-309)

Numbers 300-309 exclude: juvenile neurosyphilis (020.1); general paralysis of insane (025); post-encephalitic psychosis (083.2); and puerperal psychosis (688.1).

300 *Schizophrenic disorders (dementia praecox)*

300.0 Simple type
Dementia:
primary
simplex
Schizophrenia:
primary
simple

300.1 Hebephrenic type
Dementia, paraphrenic
Hebephrenia
Paraphrenia
Schizophrenia:
hebephrenic
paraphrenic

* World Health Organization (1957) *Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death*, 1955 revision, Geneva, p. 115

300.2 Catatonic type
Catatonia
Dementia, catatonic
Schizophrenia, catatonic

300.3 Paranoid type
Dementia, paranoid
Schizophrenia, paranoid

300.4 Acute schizophrenic reaction
Schizophrenic reaction, acute

300.5 Latent schizophrenia
Latent schizophrenic reaction
Schizophrenia, latent
Schizophrenic residual state (Restzustand)

300.6 Schizo-affective psychosis
Mixed schizophrenic and manic-depressive psychosis
Schizo-affective psychosis
Schizothymia

300.7 Other and unspecified
Dementia praecox, Schizophrenia, Schizophrenic reaction } NOS* or any type not classifiable under 300.0-300.6

301 *Manic-depressive reaction*
This title excludes neurotic-depressive reaction (314)

301.0 Manic and circular
Alternating insanity
Circular:
insanity
stupor
Cyclothymia
Hypomania
Insanity or psychosis, manic-depressive:
circular
manic
Mania NOS
Manic-depressive reaction:
agitated
circular
manic

301.1 Depressive
Insanity or psychosis, manic-depressive, depressive
Manic-depressive reaction, depressive
Melancholia NOS

301.2 Other
Affective psychosis
Insanity or psychosis, manic-depressive:
NOS
any type except circular, depressive, or manic
Manic-depressive reaction:
NOS
stuporous

302 *Involutional melancholia*
Insanity, climacteric
Melancholia:
climacteric
involutional
menopausal
Psychosis, involutional (any type)

303 *Paranoia and paranoid states*
Paranoia
Paranoid conditions, other than in dementia and schizophrenia
Paranoid state NOS

304 *Senile psychosis*
Cerebral atrophy or degeneration with psychosis at ages 65 and over
Dementia of old age
Senile:
dementia
imbecility
insanity
melancholia
psychosis (any type)

305 *Presenile psychosis*
Alzheimer's disease
Circumscribed atrophy of brain
Pick's disease of brain
Presenile:
dementia
psychosis
sclerosis

306 *Psychosis with cerebral arteriosclerosis*
Dementia, arteriosclerotic
Psychosis due to arteriosclerosis (cerebral)

This title is not to be used for primary death classification (334).

307 *Alcoholic psychosis*
Delirium tremens
Hallucinosis, alcoholic

* NOS = not otherwise specified; unspecified; unqualified

307 *Alcoholic psychosis (continued)*

Korsakoff's psychosis or syndrome, unless specified as non-alcoholic

Polyneuritic psychosis, alcoholic

Psychosis, alcoholic (any type)

This title excludes alcoholic addiction without psychosis (322).

308 *Psychosis of other demonstrable etiology*

This title is not to be used for primary death classification and will not generally be used for primary morbidity classification if the antecedent condition is present.

308.0 Resulting from brain tumour

Psychosis:
resulting from brain tumour
with intracranial neoplasm

308.1 Resulting from epilepsy and other convulsive disorders

Epileptic deterioration

Psychosis with any condition classifiable under 353

Psychosis with other convulsive disorders

This title excludes epilepsy without psychosis (353).

308.2 Other

Organic brain disease with psychosis

Psychosis, secondary or due to any disease or injury, not classifiable under 308.0-308.1

309 *Other and unspecified psychoses*

Cerebral atrophy or degeneration with psychosis, ages under 65, not specified as presenile dementia

Dementia NOS

Deterioration, mental

Exhaustion delirium

Insanity NOS
confusional
delusional

Psychosis NOS, or any type not classifiable under 020.1, 025, 083.2, 300-038, 688.1

PSYCHONEUROTIC DISORDERS (310-318)

Numbers 310-318 exclude simple adult maladjustment (326.4) and nervousness and debility (790).

310 *Anxiety reaction without mention of somatic symptoms*

Anxiety:
neurosis NOS
reaction NOS
state NOS

Anxiety reaction with any condition in 311 without mention of somatic symptoms

311 *Hysterical reaction without mention of anxiety reaction*

Anorexia nervosa
Compensation neurosis
Dissociative reaction (any)
Hysteria, hysterical:
NOS
amnesia
anaesthesia
anorexia
anosmia
aphonia
blindness
catalepsy
conversion
convulsions
dyskinesia
fugue
mutism
paralysis
postures
somnambulism
tic
tremor
other manifestations
Hystero-epilepsy

} without mention of anxiety reaction

312 *Phobic reaction*

Fear reaction

Phobia NOS

Phobic reaction

313 *Obsessive-compulsive reaction*

Neurosis:
compulsive
impulsive
obsessional
obsessive-compulsive

313 *Obsessive-compulsive reaction (continued)*

Obsessional:
ideas and mental images
impulses
phobias
ruminations
state
Obsessive-compulsive reaction

314 *Neurotic-depressive reaction*

Neurotic-depressive reaction
Psychogenic depression
Reactive depression

This title excludes manic-depressive reaction (301).

315 *Psychoneurosis with somatic symptoms (somatization reaction) affecting circulatory system*

This title excludes functional heart disease (433), unless specified as psychogenic.

315.0 Neurocirculatory asthenia
Cardiac asthenia specified as psychogenic
Da Costa's syndrome
Disordered action of heart, specified as psychogenic
Effort syndrome
Neurocirculatory asthenia
" Soldier's heart "

315.1 Other heart manifestations specified as of psychogenic origin
Functional heart disease, specified as psychogenic
Any condition in 433 specified as psychogenic, but not classifiable under 315.0

315.2 Other circulatory manifestations of psychogenic origin
Disorder of cardiovascular system specified as psychogenic, but not classifiable under 315.0 or 315.1

316 *Psychoneurosis with somatic symptoms (somatization reaction) affecting digestive system*

This title excludes ulcer of stomach (540) and of duodenum (541). It excludes functional disorders of oesophagus (539.0), of stomach (544), and of intestines (573), unless specified as psychogenic.

316.0 Mucous colitis specified as of psychogenic origin
Any condition in 573.1 specified as psychogenic

316.1 Irritability of colon specified as of psychogenic origin
Functional diarrhoea specified as psychogenic
Any condition in 573.2 specified as psychogenic

316.2 Gastric neuroses
Cyclical vomiting
Functional dyspepsia specified as psychogenic
Gastric neurosis
Any condition in 544 specified as psychogenic

316.3 Other digestive manifestations specified as of psychogenic origin
Aerophagy
Disorder of digestive system specified as psychogenic, but not classifiable under 316.0-316.2
Globus

317 *Psychoneurosis with somatic symptoms (somatization reaction) affecting other systems*

317.0 Psychogenic reactions affecting respiratory system
Disorder of respiratory system specified as psychogenic
Psychogenic asthma

317.1 Psychogenic reactions affecting genito-urinary system
Disorder of:
genito-urinary system
micturition
sexual function
} specified as psychogenic

317.2 Pruritus of psychogenic origin
Pruritus specified as psychogenic

317.3 Other cutaneous neuroses
Disorder of skin specified as psychogenic, excluding pruritus

317.4 Psychogenic reactions affecting musculoskeletal system
Disorder of:
articulation (joint)
joint
limb
muscle
musculosketelal system
} specified as psychogenic
Paralysis

317.5 Psychogenic reactions affecting other systems
Disorders of parts of body not classifiable under 315-317.4, specified as psychogenic

318 *Psychoneurotic disorders, other, mixed, and unspecified types*

318.0 Hypochondriacal reaction
Hypochondria
Hypochondriasis

318.1 Depersonalization
Depersonalization

318.2 Occupational neurosis
Craft neurosis
Miners' nystagmus
Occupational neurosis

318.3 Asthenic reaction
Asthenic reaction
Nervous:
debility
exhaustion
prostration
Neurasthenia
Psychogenic:
asthenia
general fatigue

318.4 Mixed
Psychoneurotic disorders, mixed

This title excludes mixed anxiety and hysterical reactions (310).

318.5 Of other and unspecified types
Nervous breakdown
Neurosis NOS
Psychasthenia
Psychoneurosis:
NOS
other specified types not classifiable under 310-318.4

DISORDERS OF CHARACTER, BEHAVIOUR, AND INTELLIGENCE (320-326)

Numbers 320, 321, 325, 326 exclude residuals of acute infectious encephalitis (083)

320 *Pathological personality*

320.0 Schizoid personality
Schizoid personality

320.1 Paranoid personality
Paranoid personality

This title excludes paranoia and paranoid states (303).

320.2 Cyclothymic personality
Cyclothymic personality

320.3 Inadequate personality
Constitutional inferiority
Inadequate personality NOS

320.4 Antisocial personality
Antisocial personality
Constitutional psychopathic state
Psychopathic personality:
NOS
with antisocial trend

320.5 Asocial personality
Asocial personality
Moral deficiency
Pathologic liar
Psychopathic personality with amoral trend

320.6 Sexual deviation
Exhibitionism
Fetishism
Homosexuality
Pathologic sexuality
Sadism
Sexual deviation

320.7 Other and unspecified
Pathological personality NOS

321 *Immature personality*

321.0 Emotional instability
Emotional instability (excessive)

321.1 Passive dependency
Dependency reactions
Passive dependency

321.2 Aggressiveness
Aggressiveness

321.3 Enuresis characterizing immature personality
Enuresis specified as a manifestation of immature personality

321.4 Other symptomatic habits except speech impediments
Symptomatic habits other than enuresis and speech impediments, specified as manifestations of immature personality

321.5 Other and unspecified
Immature personality NOS
Immaturity reaction NOS

322 *Alcoholism*

This title excludes alcoholic psychosis (307) and acute poisoning by alcohol (E880, N961). For primary cause classification, it excludes cirrhosis of liver with alcoholism (581.1).

322.0 Acute
Alcoholism, acute
Ethylism, acute

322.1 Chronic
Alcoholic addiction
Alcoholism, chronic
Ethylism, chronic

322.2 Unspecified
Alcoholism NOS
Ethylism NOS

323 *Other drug addiction*

Addiction to, or chronic poisoning by:
amphetamine
barbituric acid (and compounds)
benzedrine
bromides
Cannabis indica
chloral
cocaine
codeine
demerol
diacetylmorphine
diamorphine
ethylmorphine
hashish
heroin
Indian hemp
morphine
opium
paraldehyde
pethidine
thebaine
other narcotic, analgesic, and soporific drugs
Drug addiction
Morphinism

324 *Primary childhood behaviour disorders*

Behaviour disorder of childhood not identified with psychopathic personality, mental deficiency, or any physical illness:
jealousy
masturbation
tantrum
Juvenile delinquency

This title excludes personality disorders (320-321).

325 *Mental deficiency*

This title excludes: cerebral spastic infantile paraplegia (351); birth injury (760, 761); epiloia, tuberous sclerosis (753.1); gargoylism (289.0); hydrocephalus (344 and 752); hypertelorism (758.2); and juvenile general paralysis of the insane (020.1).

325.0 Idiocy
Idiot, idiocy (congenital) NOS
Severe mental subnormality
Mental deficiency in:
adult with mental age 0-2 years *
child with I.Q. under 20 *

325.1 Imbecility
Imbecile, imbecility NOS
Moderate mental subnormality
Mental deficiency in:
adult with mental age 3-6 years *
child with I.Q. 20-49 *

325.2 Moron
Feeble-mindedness
High-grade defect
Mild mental subnormality
Moron
Mental deficiency in:
adult with mental age 7-9 years *
child with I.Q. 50-65 *

325.3 Borderline intelligence
Backwardness
Borderline intelligence
Deficientia intelligentiae

325.4 Mongolism
Mongolian idiocy
Mongolism

325.5 Other and unspecified types
Amaurotic family idiocy
Cerebromacular degeneration
Mental deficiency NOS
Mental retardation NOS
Oligophrenia
Phenylpyruvic oligophrenia
Tay-Sachs disease

326 *Other and unspecified character, behaviour, and intelligence disorders*

326.0 Specific learning defects

Specific learning defects (reading) (mathematics) (strephosymbolia)
This title includes alexia (word blindness) of unspecified or non-organic origin.

* According to the 1937 Stanford Revision of the Binet Test

326.1 Stammering and stuttering of non-organic origin
Balbutio
Stammering or stuttering
NOS
due to specified non-organic cause

This title includes any condition in 781.5 of unspecified or non-organic origin.

326.2 Other speech impediments of non-organic origin
Any speech impediment, not in 326.1:
NOS
due to specified non-organic cause

This title includes any condition in 781.6 of unspecified or non-organic origin.

326.3 Acute situational maladjustment
Abnormal excitability under minor stress
Acute situational maladjustment
Combat fatigue
Operational fatigue

326.4 Other and unspecified
Simple adult maladjustment
Primary behaviour disorders and psychoneurotic personalities not classifiable under 083, 310-318, 320-326.3

2. THE STANDARD CLASSIFICATION OF MENTAL DISORDERS OF THE AMERICAN PSYCHIATRIC ASSOCIATION*

01-09 *Acute Brain Disorders*

01 Acute Brain Syndrome Associated with Infection
- 01.0 Intracranial infection, except epidemic encephalitis
- 01.1 Epidemic encephalitis
- 01.2 With systemic infection, NEC

02 Acute Brain Syndrome Associated with Intoxication
- 02.1 Alcohol intoxication
- 02.2 Drug or poison intoxication (except alcohol)

03 Acute Brain Syndrome Associated with Trauma

04 Acute Brain Syndrome Associated with Circulatory Disturbance

05 Acute Brain Syndrome Associated with Convulsive Disorder

06 Acute Brain Syndrome Associated with Metabolic Disturbance

07 Acute Brain Syndrome Associated with Intracranial Neoplasm

08 Acute Brain Syndrome with Disease of Unknown or Uncertain Cause

09 Acute Brain Syndrome of Unknown Cause

10-19 *Chronic Brain Disorders* [1]

10 Chronic Brain Syndrome Associated with Diseases and Conditions Due to Prenatal (Constitutional) Influence
- 10.0 With congenital cranial anomaly
- 10.1 With congenital spastic paraplegia
- 10.2 With mongolism
- 10.3 Due to prenatal maternal infectious diseases

11 Chronic Brain Syndrome Associated with Central Nervous System Syphilis
- 11.0 Meningoencephalitic
- 11.1 Meningovascular
- 11.2 Other central nervous system syphilis

12 Chronic Brain Syndrome Associated with Intracranial Infection Other Than Syphilis
- 12.0 Epidemic encephalitis
- 12.1 Other intracranial infections

13 Chronic Brain Syndrome Associated with Intoxication
- 13.0 Alcohol intoxication
- 13.1 Drug or poison intoxication, except alcohol

* American Psychiatric Association (1952) *Diagnostic and statistical manual for mental disorders*, Washington

[1] To each category of " Chronic Brain Disorders " one of the following qualifying phrases can be added:
with psychotic reaction (× 1)
with neurotic reaction (× 2)
with behavioural reaction (× 3).

14 Chronic Brain Syndrome Associated with Trauma
- 14.0 Birth trauma
- 14.1 Brain trauma, gross force
- 14.2 Following brain operation
- 14.3 Following electrical brain trauma
- 14.4 Following irradiational brain trauma
- 14.5 Following other trauma

15 Chronic Brain Syndrome Associated with Circulatory Disturbance
- 15.0 With cerebral arteriosclerosis
- 15.1 With circulatory disturbance other than than cerebral arteriosclerosis

16 Chronic Brain Syndrome Associated with Convulsive Disorder

17 Chronic Brain Syndrome Associated with Disturbance of Metabolism, Growth or Nutrition
- 17.1 With senile brain disease
- 17.2 Presenile brain disease
- 17.3 With other disturbance of metabolism, etc., except presenile brain disease

18 Chronic Brain Syndrome Associated with New Growth
- 18.0 With intracranial neoplasm

19 Chronic Brain Syndrome Associated with Diseases of Unknown or Uncertain Cause ; Chronic Brain Syndrome of Unknown or Unspecified Cause
- 19.0 Multiple sclerosis
- 19.1 Hutington's chorea
- 19.2 Pick's disease
- 19.3 Other diseases of unknown or uncertain cause
- 19.4 Chronic brain syndrome of unknown or unspecified cause

20-24 *Psychotic Disorders*

20 Involutional Psychotic Reaction

21 Affective Reactions
- 21.0 Manic depressive reaction, manic type
- 21.1 Manic depressive reaction, depressed type
- 21.2 Manic depressive reaction, other
- 21.3 Psychotic depressive reaction

22 Schizophrenic Reactions
- 22.0 Schizophrenic reaction, simple type
- 22.1 Schizophrenic reaction, hebephrenic type
- 22.2 Schizophrenic reaction catatonic type

22 Schizophrenic Reactions (*continued*)
- 22.3 Schizophrenic reaction, paranoid type
- 22.4 Schizophrenic reaction, acute undifferentiated type
- 22.5 Schizophrenic reaction, chronic undifferentiated type
- 22.6 Schizophrenic reaction, schizo-affective type
- 22.7 Schizophrenic reaction, childhood type
- 22.8 Schizophrenic reaction, residual type
- 22.9 Other and unspecified

23 Paranoid Reactions
- 23.1 Paranoia
- 23.2 Paranoid state

24 Psychotic Reaction Without Clearly Defined Structural Change Other Than Above

30-39 *Psychophysiologic Autonomic and Visceral Disorders*

30 Psychophysiologic Skin Reaction

31 Psychophysiologic Musculoskeletal Reaction

32 Psychophysiologic Respiratory Reaction

33 Psychophysiologic Cardiovascular Reaction

34 Psychophysiologic Hemic and Lymphatic Reaction

35 Psychophysiologic Gastrointestinal Reaction

36 Psychophysiologic Genito-Urinary Reaction

37 Psychophysiologic Endocrine Reaction

38 Psychophysiologic Nervous System Reaction

39 Psychophysiologic Reaction of Organs of Special Sense

40 *Psychoneurotic Disorders*

40 Psychoneurotic Reactions
- 40.0 Anxiety reaction
- 40.1 Dissociative reaction
- 40.2 Conversion reaction
- 40.3 Phobic reaction
- 40.4 Obsessive compulsive reaction
- 40.5 Depressive reaction
- 40.6 Psychoneurotic reaction, other

50-53 *Personality Disorders*

50 Personality Pattern Disturbance
- 50.0 Inadequate personality
- 50.1 Schizoid personality
- 50.2 Cyclothymic personality
- 50.3 Paranoid personality
- 50.4 Personality pattern disturbance, other

51 Personality Trait Disturbance
- 51.0 Emotionally unstable personality
- 51.1 Passive-aggressive personality
- 51.2 Compulsive personality
- 51.3 Personality trait disturbance, other

52 Sociopathic Personality Disturbance
- 52.0 Antisocial reaction
- 52.1 Dyssocial reaction
- 52.2 Sexual deviation
- 52.3 Alcoholism (addiction)
- 52.4 Drug addiction

53 Special Symptom Reaction
- 53.0 Learning disturbance
- 53.1 Speech disturbance
- 53.2 Enuresis
- 53.3 Somnambulism
- 53.4 Other

54 *Transient Situational Personality Disorders*

54 Transient Situational Personality Disturbance
- 54.0 Gross stress reaction
- 54.1 Adult situational reaction
- 54.2 Adjustment reaction of infancy
- 54.3 Adjustment reaction of childhood
- 54.4 Adjustment reaction of adolescence
- 54.5 Adjustment reaction of late life

54 Transient Situational Personality Disturbance (*continued*)
- 54.6 Other transient situational personality disturbance

60-62 *Mental Deficiencies*

60 Mental Deficiency (Familial or Hereditary)
- 60.0 Mild
- 60.1 Moderate
- 60.2 Severe
- 60.3 Severity not specified

61 Mental Deficiency, Idiopathic
- 61.0 Mild
- 61.1 Moderate
- 61.2 Severe
- 61.3 Severity not specified

The following codes are to be used as the qualifying phrase x4 (cf. footnote page 628) and will be coded as separate diagnoses. They represent mental deficiency by grades of severity, associated with and as the major symptom in impairment of brain tissue function.

62 Mental Deficiency (x4)
- 62.0 Severe
- 62.1 Moderate
- 62.2 Mild
- 62.3 Severity not specified

3. DIAGNOSTIC CLASSIFICATION OF THE DOMINION BUREAU OF STATISTICS, CANADA *

Psychoses

Syphilis of central nervous system
Schizophrenia
Manic depressive
Involutional melancholia
Paranoia and paranoid states
Senile and cerebral arteriosclerosis
Presenile
Alcoholic
Other and unspecified psychoses

Psychoneuroses

Anxiety reaction
Hysterical reaction
Obsessive-compulsive reaction
Neurotic-depressive reaction
Somatization reaction
Other and unspecified psychoneurotic reactions

Disorders of character, behaviour and intelligence

Pathological personality
Alcoholism
Drug addiction
Mental deficiency
Epilepsy
Primary behaviour disorders
Other and unspecified disorders of character, behaviour and intelligence

Non-psychiatric conditions

Syphilis without psychosis
Mental observation without need for further medical care
Other non-psychiatric conditions

* Canada, Dominion Bureau of Statistics (1957) *Mental health statistics 1956*, Ottawa

4. FRENCH STANDARD CLASSIFICATION

States of mental backwardness

idiocy
imbecility
debility
cretinism

States of constitutional imbalance

disorders of personality and behaviour
disorders of emotionality
sexual perversions

Psychoneuroses (neurasthenia, psychasthenia, hysteria, etc.)

Manic-depressive psychoses

manic state
melancholic state
periodic psychosis

Delusional states

acute
chronic

Dementia praecox (schizophrenias, chronic mental deterioration)

Acute confusional states (simple confusion, acute delirium, encephalitic psychoses, symptomatic psychoses, etc.)

Intoxication

alcoholic (acute, chronic, with dementia)
others

Syphilitic mental diseases

general paralysis, cerebral syphilis
mental disorders in diabetics

Organic dementias

with arteriosclerosis
with circumscribed brain lesions
senile dementia

Presenile or involutional psychoses

Secondary dementias

Epilepsy

Mental disorders in epidemic encephalitis

Atypical mental disorders

simulation

5. GERMAN CLASSIFICATION (WÜRZBURG SCHEME), AS RECOMMENDED BY THE DEUTSCHER VEREIN FÜR PSYCHIATRIE*

1. Congenital and early-acquired mental deficiency (idiocy and imbecility):
   (*a*) without manifest cause
   (*b*) subsequent to brain damage
   (*c*) cretinism
2. Mental disorders due to brain injury (cerebral concussion or contusion):
   (*a*) acute traumatic psychosis (commotional psychosis)
   (*b*) traumatic sequelae (epileptic personality changes, etc.)
3. General paralysis of the insane
4. Mental disorders accompanying Lues cerebri and Tabes
5. Epidemic encephalitis
6. Mental disorders of later life :
   (*a*) arteriosclerotic forms (including essential hypertension)
   (*b*) presenile forms (depressive and paranoid pictures)
   (*c*) senile forms
   (*d*) other forms (Alzheimer's disease, Pick's disease, etc.)
7. Huntigton's chorea
8. Mental disorders due to other diseases of the brain (tumour, disseminated sclerosis, etc.)
9. Mental disorders associated with :
   (*a*) infectious diseases (including chorea minor)
   (*b*) diseases of internal organs, general diseases and cachexia (disorders of organs of the circulatory system, intestinal disorders, diabetes, uraemia and eclampsia, anaemia, carcinosis, pellagra, etc.)
   (*c*) Graves-Basedow's disease, myxoedema, tetany and other endocrine disorders
   (*d*) symptomatic psychoses during puerperium and lactation

* Nitsche, P. (1934) *Allg. Z. Psychiat.*, **102**, 377

10. Alcoholism:
    (*a*) drunkenness
    (*b*) chronic alcoholism (jealousy delusions, etc.)
    (*c*) delirium tremens and hallucinoses
    (*d*) Korsakow's psychosis (polioencephalitis haemorrhagica)
11. Addictions (morphinism, cocainism, etc.)
12. Mental disorders due to other intoxications (narcotics, lead, mercury, arsenic, carbon disulfide, carbon monoxide, etc.)
13. Epilepsy:
    (*a*) without manifest cause
    (*b*) symptomatic epilepsy
14. Schizophrenic group
15. Manic-depressive group (cyclothymia)
16. Psychopathic personalities
17. Abnormal reactions:
    (*a*) paranoid reactions and developments (paranoia querulans, etc.)
    (*b*) depressive reactions which do not come under 15.
    (*c*) imprisonment reactions
    (*d*) compensation neuroses
    (*e*) other psychogenic reactions
    (*f*) induced reactions (folie à deux)
18. Psychopathic children and juveniles
19. Undiagnosed cases
20. Nervous, i.e., neurological diseases:
    (*a*) without mental disorders
    (*b*) with mental disorders
21. Free from nervous disease and mental abnormalities.

6. CLASSIFICATION OF THE DUTCH ASSOCIATION FOR PSYCHIATRY AND NEUROLOGY

1. Neuroses and psychopathies
    (*a*) neurasthenic reactions
    (*b*) constitutional nervousness
    (*c*) psychogenic reactions
    (*d*) hysterical reactions
    (*e*) psychopathic personalities
2. Manic-depressive psychoses and other endogenous and reactive mood disorders
3. Paranoia and paranoid states
4. Schizophrenia and paraphrenic states
5. Exogenous reaction types and organic psychoses
    (*a*) symptomatic psychoses and psychoses associated with childbirth
    (*b*) psychoses due to intoxication
    (*c*) psychoses associated with brain diseases, Huntington's chorea, etc.
6. Encephalitic and post-encephalitic states
7. General paralysis of the insane and syphilitic psychoses
8. Psychoses due to alcoholic abuse
9. Climacteric and involutional psychoses
10. Arteriosclerotic psychoses
11. Senile and presenile psychoses
12. Epilepsy and epileptic psychoses
13. Oligophrenias
14. Myxoedema and cretinism
15. Unclear cases

7. CLASSIFICATION OF THE DANISH PSYCHIATRIC SOCIETY, 1952

A. *Psychoses*

01 Intoxications

011 Alcohol
0111 Acute intoxication
0112 Pathological drunkenness (mania a potu)
0113 Chronic alcoholism
0114 Alcoholic psychosis
0115 Alcohol-antabuse reaction
0119 Alcohol abuse of psychotic origin
012 Opium
013 Other addictions

02 Psychotic states in general physical diseases, fever and exhaustion

03 Infectious diseases of the brain and meninges
- 031 Dementia paralytica
- 032 Other syphilitic diseases affecting the CNS
- 033 Encephalitis epidemica — neurotic, psychopathic, oligophrenic, unclassifiable

04 Traumatic brain lesions with mental symptoms
- 041 Acute trauma
- 042 Post-traumatic cerebral syndrome (with neurotic, psychopathic, unclassifiable picture)
- 043 Post-leucotomy states in psychosis, neurosis, psychopathy, unclassifiable
- 044 Other traumatic brain lesions (hanging, etc.)

05 Brain tumours with mental symptoms
06 Psychosis with vascular lesions in the CNS
07 Senile and presenile psychoses
- 071 Senile
- 072 Presenile psychoses
  - 0721 Alzheimer's disease
  - 0722 Pick's disease
  - 0723 Presbyophrenia
  - 0724 Involutional depression
  - 0725 Others

08 Manic-depressive psychoses
09 Schizophrenia
10 Epilepsy
- 101 hereditary
- 102 without known heredity
- 103 acute epileptic mental disorder
- 104 chronic epileptic mental disorder

11 Psychosis in hereditary organic brain disease, malformations, etc.
12 Psychogenic mental disorder
- 121 psychogenic affective syndrome
- 122 psychogenic psychoses with disturbance of consciousness (including twilight states)
- 123 psychogenic paranoid psychoses

13 Other mental diseases. Diseases of uncertain diagnosis

B. *Neuroses*

Neuroses without predominant somatic symptoms

01 Anxiety neurosis
02 Anankastic neurosis
- 021 predominantly phobic
- 022 predominantly obsessive compulsive

03 Depressive neurosis

Neuroses with predominant somatic symptoms

04 Hysterical neuroses
05 Psychosomatic neuroses

Other neuroses

06 Sexual neuroses
07 Asthenic reactions
08 Mixed or unspecified

C. *Non-psychotic personality disorders*

1 Predominantly endogenous (psychopathic)
2 Predominantly exogenous (pseudo-psychopathic)
- 21 predominantly physiogenic
- 22 predominantly psychogenic (character neurosis)

3 Of uncertain origin
4 Habitual non-psychotic personality variations 01-21

(schizoid, cycloid, ixiod, hyperthymic, depressive, sensitive, fanatic, self-assertive, moody, explosive, callous, unstable, infantile, erethic, emotional, dysphoric, emotionally labile, insecure, homosexual, other perversions)

D. *Oligophrenia*

1 Idiocy
2 Imbecility
3 Intellectual debility
4 Subnormal intelligence
5 Unspecified

E. *Other disabilities*

Dyslexia, etc.

F. *Isolated abnormal reactions*

1 Affective reactions
2 Reactions to shock
3 Hysterical reactions
4 Paranoid reactions

G. *Without certain mental abnormality; mental abnormality of uncertain type*

H. *Without mental abnormality*

I. *Under 15 years*

J. *Suicidal attempt or suicide*

1 Suicidal attempt or suicide
2 Pseudo-attempt
3 Recent attempt

K. *Criminals*

L. *Termination of pregnancy*

8. INTERNATIONAL CLASSIFICATION PROPOSED BY H. BERSOT *

Oligophrenias
Psychopathies
Manic-depressive psychoses
Simple psychoses (schizophrenias, paranoid psychoses and psychoses not falling into any other category)
Epilepsy
Organic psychoses
  Luetic
  Presenile and senile
  Other
Intoxications
  Endogenous-symptomatic psychoses
  Exogenous
    Alcoholic
    Other
Psychoneuroses

* Bersot, H. (1937) In: *Comptes Rendus du Deuxième Congrès International d'Hygiène Mentale*, Paris, vol. 2, p. 313

9. USSR CLASSIFICATION BY KERBIKOV ET AL.*

A. *Mental diseases due to infections*

(*a*) acute general infections (typhus, dysentery, influenza, etc.)
(*b*) chronic general infections (tuberculosis, rheumatism, malaria, etc.)
1. Cerebral syphilis
2. General paralysis of the insane
(*c*) encephalitis, meningitis

B. *Mental diseases due to non-infectious physical illness*

(*a*) diseases of the liver, kidneys, tumours, etc.
(*b*) avitaminoses
(*c*) endocrine disorders

C. *Mental diseases due to intoxications*

(*a*) drug addiction
(*b*) industrial poisoning
(*c*) food poisoning
(*d*) other intoxications

D. *Mental diseases due to brain trauma*

(Open or closed wounds, blast injury, electric shock, etc.)

E. *Mental diseases due to cerebral vascular disease in the brain*

(*a*) cerebral arteriosclerosis
(*b*) hypertension
(*c*) thrombosis of cerebral blood vessels

F. *Mental diseases due to other brain lesions*

(*a*) brain tumours
(*b*) Huntington's chorea, Pick's disease, amaurotic idiocy, tuberculosis, etc.

G. *Psychogenic mental diseases*

(*a*) reactive psychoses
(*b*) neurasthenia
(*c*) neuroses with obsessional states
(*d*) hysterical reactions

H. *Mental diseases of unknown etiology*

(*a*) schizophrenia
(*b*) manic-depressive psychoses
(*c*) epilepsy
(*d*) presenile psychoses
(*e*) senile psychoses

I. *Mental diseases associated with pathological mental development*

(*a*) psychopathies
(*b*) oligophrenias

* Kerbikov, O. V., Ozeretzkij, N. I., Popov, A. & Snezhnevskij, A. V. (1958) *Uchebnik psikhiatrii* (*Textbook of psychiatry*), Moscow

10. USSR CLASSIFICATION ACCORDING TO GILJAROVSKIJ*

1. *Psychoses due to infections*
   - (*a*) acute infections
   - (*b*) encephalitis and meningitis due to acute infections
   - (*c*) encephalitis due to subacute infections (including malaria, disseminated sclerosis, etc.)
   - (*d*) chronic infections
   - (*e*) neurosyphilis (lues cerebri, general paralysis)
2. *Psychoses due to intoxications*
   - (*a*) morphine
   - (*b*) food poisoning
   - (*c*) industrial poisoning
   - (*d*) intoxicants (alcohol, morphine, etc.)
3. *Psychoses following cerebral injury*

   (delirium, twilight state, Korsakow's syndrome, encephalitis, dementia, epilepsy, personality disorders, etc.)
4. *Mental disorders due to brain tumours*
5. *Mental disorders in somatic diseases*
6. *Mental disorders in cerebral vascular disease*
   - (*a*) hypertension
   - (*b*) cerebral arteriosclerosis
7. *Presenile and senile mental disorders*
   - (*a*) presenile psychoses, involutional melancholia, etc.
   - (*b*) senile psychoses (simple dementia, other senile psychoses, etc.)
8. *Schizophrenia*
9. *Manic-depressive psychoses*
10. *Epilepsy* (genuine, symptomatic, pyknolepsy)
11. *Psychogenic disorders*
    - (*a*) neuroses (neurasthenia, hysteria, psychasthenia, obsessional neuroses)
    - (*b*) reactive psychoses (traumatic mental reactions including psychogenic stupor; fugues, including psychogenic twilight states; reactive depression: psychogenic paranoid state; atrogenic reactions; paranoia)
12. *Psychopathic personalities*

    (excitable, labile, impulsive, sexually perverse, hysterical, psychasthenic, asthenic, asocial, querulant types)
13. *Mental states due to under-development (oligophrenias)*

    microcephaly and other developmental cerebral disorders
    early traumatic brain lesions
    sequelae of meningitis and encephalitis
    syphilis acquired in utero or in infancy

* Giljarovskij, V. A. (1954) *Uchebnik psikhiatrii* (*Textbook of psychiatry*), Moscow

11. CLASSIFICATION IN USE IN JAPAN*

A. Exogenous (or Symptomatic) Mental Disorders

1. due to or associated with infectious diseases
2. due to endocrine dysfunctions
3. due to diseases of inner organs
4. due to disturbances of metabolism
5. due to brain diseases
6. due to brain injuries
7. due to intoxications
8. due to syphilis of central nervous system
9. due to cerebral arteriosclerosis
10. involutional psychoses
11. senile psychoses

B. Endogenous Psychoses

12. schizophrenia
    - (i) hebephrenia
    - (ii) catatonia
    - (iii) dementia paranoides

    (Some authors add others type, such as dementia simplex, paraphrenia)

* Compiled by Professor T. Muramatsu, Department of Neuropsychiatry, Nagoya National University, Japan, on the basis of the classifications in the five Japanese textbooks most widely used in Japan.

13. manic-depressive psychoses
14. epilepsy

C. Neurosis or Psychoneurosis

(i) neurasthenia
(ii) hysteria
(iii) compulsive-obsessive neurosis
(Some authors classify this group into more types adding those such as anxiety neurosis, traumatic neurosis, etc.)

C. Psychogenic Psychoses (paranoid reaction and paranoia are included in this group)

D. Psychopathic Personalities (Kurt Schneider's typology seems to be most popular)

D. Behaviour Disorders (in children) of different types

E. Mental Deficiency

(i) idiocy
(ii) imbecility
(iii) moronity
(Special types such as mongolism, etc., are also mentioned)

Annex 2

OTHER CLASSIFICATIONS DISCUSSED IN THE TEXT

1. CLASSIFICATION OF GONZALO BOSCH AND LANFRANCO CIAMPI

(*a*) Premorbid mental syndromes
(*b*) Mental syndromes with temporary lowering of mental autonomy
(*c*) Mental syndromes with complete and temporary loss of mental autonomy
(*d*) Mental syndromes with defects in development of mental autonomy
(*e*) Mental syndromes with complete permanent loss of mental autonomy

2. HENRY EY'S SIMPLIFIED SCHEME OF CLASSIFICATION *

Disturbance of Awareness *(? Consciousness)* (Acute psychoses)	*Disturbance of Personality* (Chronic psychoses and neuroses)
Manic-depressive attacks	Mental imbalance. Neuroses
Paranoid and hallucinatory episodes. Oneiric states	Chronic deliria and schizophrenia
Confusional-oneiric psychoses	Dementias

* Ey, H. (1954) *Etudes psychiatriques*, Paris, p. 22

3. KLEIST'S CLASSIFICATION OF NEUROPSYCHIATRIC DISEASES*

I. ALLOGENIC DISEASES (with and without mental disturbance)

A. *Physical Damage*

1. Mechanical
2. Abnormal atmospheric pressure
3. Thermic
4. Electrical
5. Radiation

B. *Chemical Damage—Poisoning*

1. Intoxicants
2. Food
3. Sedatives and narcotics
4. Other drugs
5. Industrial poisons
6. Gases

C. *Infections, Virus and Parasitic Diseases*

1. Neuritis and polyneuritis; herpes
2. Myelitis
3. Chorea
4. Demyelinating diseases
5. Encephalitis epidemica
6. Encephalitis rabies, etc.
7. Symptomatic psychoses in infectious disease
8. Syphilitic diseases (general paralysis of the insane, etc.)
9. Tuberculosis of the nervous system
10. Abscess of the central nervous system, purulent meningitis
11. Epidemic meningitis
12. Echinococcus, aktinomykosis

D. *Deficiency Diseases*

1. Lesions of the nervous system due to hunger and thirst: cachectic psychoses
2. Anoxaemia and high-altitude syndrome
3. Avitaminoses
4. Acquired nervous exhaustion

II. SOMATOGENIC DISEASES

A. *Metabolic*

1. Liver and gall-bladder diseases; cholaemia—comatose, akinetic and related syndromes
2. Wilson's disease
3. Kidney disease with anaemia

A. *Metabolic (Continued)*

4. Gout with depressions
5. Porphyria
6. Paramyloidosis with dementia
7. Disturbance of calcium metabolism

B. *Dysglandular*

1. Thyroid
2. Parathyroid
3. Pancreas
4. Adrenal
5. Pituitary
6. Testicular and ovarian, including menstrual and climacteric disorders

C. *Procreational and Involutional*

1. Eclamptic toxaemia
2. Puerperal toxaemia
3. Agitated involutional depression
4. Involutional paranoia

D. *Blood Diseases*

1. Anaemia
2. Polycythaemia
3. Leukaemias

E. *Diseases of the Heart*

Anxiety states, disturbance of consciousness, focal symptoms

F. *Vascular and Circulatory Disorders*

1. Arteriosclerosis, hypertension (dementia, etc.)
2. Venous and sinus thrombosis
3. Air and fat embolism
4. Carotid lesions with cerebral damage
5. Strangulation with cerebral damage

G. *Postoperative Psychosis*

H. *Skeletal Diseases*

1. Cervical rib, spina bifida, Paget's disease, etc.
2. Hyperostosis frontalis interna, turricephaly with cerebral involvement

J. *Diseases of the Meninges, Choroid Plexus and Ventricles*

1. Subdural and subarachnoid haematomas
2. Arachnoiditis, ependymitis
3. Liquorrhoea

* Kleist, K. (1953) *Mschr. Psychiat. Neurol.*, **125**, 539

K. *Neoplasms*

1. Meningioma, adenoma
2. Neurinoma
3. Spinal tumours
4. Brain tumours
5. Pituitary and epiphyseal tumours

L. *Neoplastic Dysplasias*

1. Syringomylia
2. Tuberous sclerosis
3. Neurofibromatosis

III. NEUROGENIC DISEASES

A. *Progressive Degenerative Diseases*

1. *Systematic degenerations*, including Friedreich's disease, Pick's disease, Huntington's chorea, etc.
2. *Metabolic degenerations* (Tay-Sachs, Schilder's, Alzheimer's disease, senile dementia)
3. *Schizophrenias*

(*a*) systematic forms:
hebephrenias (fatuous, depressive, apathetic, autistic)
katatonias (lacking in speech impulses, talkative, akinetic, parakinetic, negativistic, proskinetic, stereotyped)
paranoid (phantasiophrenia, progressive confabulosis, progressive hallucinosis, progressive somatopsychosis, progressive influence psychosis, inspiration psychosis)
confused (incoherent, paralogical, schizophasia)
combined forms

(*b*) unsystematic forms (iterative-stuporous, catatonic attacks, confused schizophrenic attacks, paraphrenias)

Related: schizoid psychopaths

B. *Transient Disturbances due to Abnormal Vegetative-nervous Disposition*

1. Vegetative dystonia and organ neuroses
2. Raynaud's disease, aeroparaesthesiae, etc.
3. Migraine and migraine psychoses, habitual headache
4. Periodic ophthalmoplegia

C. *Transient Disorders with Autogenic Fluctuations*

1. Attacks and episodic diseases (genuine epilepsy, pyknolepsy, narcolepsy, episodic mood disorders (dipsomania, pariomania, etc.) episodic twilight states and sleep)

   Related: epileptoid psychopathy
2. Pasophrenias

   (*a*) simple (unipolar) forms:
   melancholia, anxiety psychosis, psychosis of reference with anxiety, hypochondriacal depression, depressive stupor, mania, manic ecstasy, hypochondriacal excitement

   (*b*) multiform (bipolar) types
   manic-depressive mood disorder, hyperkinetic-akinetic mobility psychosis, agitated-stuporous confusional psychosis, anxious-ecstatic delusional psychosis

   Related : cycloid and similar psychopathy

D. *Abnormal Dispositions with Psychogenic and Autogenic Fluctuations*

1. Paranoid psychopathy with fluctuations and developments based on overvalued ideas (querulent and sensitive forms)
2. Obsessive-compulsive psychopathies with fluctuations

E. *Abnormal Dispositions with Psychogenic Reactions*

1. Emotional psychopathies with reactive depression and excitation
2. Hysterical psychopathy and corresponding reactions (hysterosomatic disturbances, hysterical twilight states)
3. Psychopathy with pseudologia phantastica and similar reactions
4. Characteropathy and imprisonment psychosis; instability and addiction
5. Sexopathy and sexual neuroses
6. Neuroses related to accidents, war, conflicts and occupation

F. *Abnormal Dispositions with Exogenic Exhaustion States*

Constitutional neurasthenia and psychasthenia

IV. DEFECT STATES

A. *Allogenic Defect States of Prenatal, Natal and Postnatal Origin*

1. Mongolism
2. Defect states due to congenital syphilis, toxoplasmosis and other infections, with infantile paralysis, hydrocephalus and convulsions
3. Brain lesions due to birth injury and deficiency states
4. Deficiencies with kern icterus

B. *Somatogenic Defect States*

1. Phenylketonuric mental deficiency
2. Cretinism and other glandular deficiencies
3. Disorders of vascular origin: bilateral athetosis with status marmoratus

C. *Defect States of Neurogenic (Hereditary) and Obscure Origin*

1. General and circumscribed mental deficiency
2. Hereditary tremor, tic, stammering and other motor disorders

4. KRAEPELIN-LANGE'S CLASSIFICATION *

1. Psychoses due to brain injuries
2. Psychoses due to diseases of the brain
3. Psychoses due to intoxications
4. Psychoses due to infectious diseases
5. Psychoses due to syphilis
6. Dementia praecox
7. Endocrine psychoses
8. Arteriosclerotic psychoses
9. Presenile and senile psychoses
10. Endogenous dementing processes
11. Epilepsy
12. Manic-depressive psychoses
13. Psychogenic disorders (neurasthenia; neurosis of anticipation; fright neurosis; psychogenic depression; induced psychosis (folie à deux); imprisonment psychosis; paranoid reaction; traumatic neurosis; war neurosis
14. Hysteria
15. Paranoia
16. Obsessional neurosis; compulsive psychosis sexual perversions
17. General paralysis of the insane
18. Mental deficiency

* Kraepelin, E. & Lange, J. (1926) *Lehrbuch der Psychiatrie*, Leipzig, Barth, Bd 2

5. EDUARDO KRAPF'S CLASSIFICATION * *

1. *Primary Psychopathic*[1] *Deficiencies*
   - 1.1 *Oligophrenias*
     - (*a*) Idiocy
     - (*b*) Imbecility
     - (*c*) Mental deficiency (moronism)
   - 1.2 *Dysphrenias*
     - (*a*) Primary group
       - (i) Explosivity
       - (ii) Instability
     - (*b*) Antinomic group
       - (i) Psychasthenia
       - (ii) Sensitivity
     - (*c*) Infantile group
       - (i) Hyperemotivity
       - (ii) Histrionism
2. *Psychopathic Reactions*
   - 2.1 *Situational reactions*
     - (*a*) Emotional shock
     - (*b*) Reactive depression
     - (*c*) Anxiety neurosis
     - (*d*) Neurotic depression
     - (*e*) Neurasthenia
   - 2.2 *Historical reactions*
     - (*a*) Hysteria (conversion)
     - (*b*) Phobic neurosis (anxiety hysteria)
     - (*c*) Obsessional neurosis
     - (*d*) Hypochondria
     - (*e*) Paranoia

[1] In the Spanish language, " psychopathic " is a generic term for all types of mental disorder.

* * This classification is at present undergoing revision.

2. *Psychopathic Reactions (continued)*
   - 2.3 *Psychosomatic disturbances*
   - 2.4 *Sexual deviations (perversions)*
   - 2.5 *Abnormal reactions of the deficient*
     - (*a*) Typical reactions of the deficient
       - (i) Impulsive reaction
       - (ii) Evasive reaction
       - (iii) Irritable reaction
       - (iv) Resentment reaction
       - (v) Passion reaction
       - (vi) Ostentatious reaction
     - (*b*) Reactive psychoses of the deficient ("psychoses of the degenerate")
       - (i) Impulsive confusion
       - (ii) Pseudodementia (Ganser's syndrome)
       - (iii) Anxiety confusion
       - (iv) Hyperemotive twilight state
       - (v) Histrionic twilight state ("delusional imagination of the degenerate")

3. *Psychopathic Disorders*
   - 3.1 Episodes
     - (*a*) Autochthonous
       - (i) Dysbiotonias
         - (A) Dysthymic (manic-depressive disease)
         - (B) Dyskinesia (hyper- and akinetic psychosis)
         - (C) Dyseidetic (amentia)
       - (ii) Dysrhythmias
         - (A) Epilepsy
         - (B) Episodic twilight state
     - (*b*) Symptomatic
       - (i) Traumatic psychoses
       - (ii) Exo- and endotoxic psychoses

3. *Psychopathic Disorders (continued)*
   - (iii) Infectious and toxic-infectious psychoses
   - (iv) Vascular and anoxic psychoses
   - (v) Metabolic deficiency psychoses
   - 3.2 *Processes*
     - (*a*) Autochthonous
       - (i) Infantile processes (infantile dementia, etc.)
       - (ii) Processes of maturity
         - (A) Schizophrenia
           - a. Simple dementia
           - b. Hebephrenia
           - c. Catatonia
           - d. Paranoid dementia
           - e. Paraphrenia
         - (B) Huntington's disease
       - (iii) Processes of the elderly
         - (A) Presenile psychoses
         - (B) Presenile dementias
           - a. Alzheimer's disease
           - b. Pick's disease
         - (C) Senile dementia
     - (*b*) Symptomatic
       - (i) By physical agents (tumours etc.)
       - (ii) Bu chemical agents
       - (iii) By infections
         - (A) Neurosyphilis
           - a. General progressive paralysis
           - b. Cerebral syphilis
         - (B) Other infections
       - (iv) By vascular diseases
       - (v) By metabolic deficiencies

4. *Terminal Psychopathic Deficiencies*
   - 4.1 *Dementias*
   - 4.2 *Character disorders*

6. ADOLF MEYER'S CLASSIFICATION *

Merergasia — the psychoneuroses

Thymergasia — the primary affective disorders, divided into hyperergastic or other active manic states and hypoergastic or depressive retarded states

Parergasia — the fantastic, incongruous schizophrenic states

Dysergasia — the toxic delirious states

Anergasia — with defect traits characteristic of the organic group

Oligergasia — the group of constitutionally defective states

* Meyer, A. (1957) *Psychobiology*, Springfield, Ill., Thomas

7. CLASSIFICATION PROPOSED FOR OFFICIAL USE IN NORWAY *

I. PSYCHOSES *(P 01 — P 13)*

P 01 *Psychoses schizophrenicae* (300)

P 01.1 *Schizophrenia sensu strictorii* (300.0 — 300.5, 300.7)
Dementia praecox (300.7)
Schizophrenia
NUD (300.7)
catatonia (300.2)
hebephrenica (300.1)
latens (300.5)
paranoides (300.3)
paraphrenica (300.1)
primaria (300.0)
reactiva acuta (300.4)
residuae (300.5)
sequelae (300.5)
simplex (300.0)

P 01.2 *Psychosis schizo-affectiva* (300. 6)

P 02 *Psychoses reactivae, constitutionales et psychogenicae* (301.1, 303, 309p, 314p)

P 02.1 *Paranoia et psychosis paranoides* (303)
paranoia (303)
Psychosis paranoides (303)
Status paranoicus (303)

P 02.2 *Psychosis reactiva depressiva* (301.1, 314p)

P 02.3 *Excitatio reactiva* (309p)
Reactio excitativa (309p)
Excitatio reactiva (hysteriformis) (309p)

P 02.4 *Confusio reactiva* (309 p)
Confusio reactiva (hysteriformis) (309 p)

P 03 *Psychoses manico-depressivae* (301)

P 03.1 *Psychosis manica et circularis* (301.0)
Cyclothymia (301.0)
Hypomania (301.0)
Mania (NUD) (301.0)
Psychosis:
circularis (301.0)
manica (301.0)

P 03.2 *Melancholia manico-depressiva* (301.1, 301.2)
Melancholia:
NUD (301.1)
Manico depressiva (301.1)
Psychosis:
depressiva (301.1)
manico depressiva (301.1)
Reactio manico-depressiva
NUD (301.2)
Stuporosa (301.2)

P 04 *Melancholiae involutivae* (302)
Melancholia:
climacterica (302)
involutiva (302)

P 05 *Psychoses seniles aut praeseniles* (304, 305)

P 05.1 *Psychosis senilis* (304)
Atrophia cerebri cum psychosi (304)
Degeneratio cerebri cum psychosi (304)
Psychosis senilis (304)

P 05.2 *Psychosis praesenilis* (305)
Atrophia cerebri praesenilis cum psychosi (305)
Degeneratio cerebri praesenilis cum psychosi (305)
Morbus Alzheimer (305)
Morbus Pick (305)
Psychosis praesenilis (305)

P 06 *Psychoses e morbis vasorum cerebri* (306, 308.2 p)

P 06.1 *Psychosis ex arteriosclerose cerebri* (306)

P 06.2 *Psychosis e morbo alio vasorum cerebri* (308.2 p)
Psychosis:
ex embolia cerebri (308.2 p)
e haemorrhagia cerebri (308.2 p)
e thrombose cerebri (308.2 p)

P 07 *Psychoses alcoholicae aut euphomanicae aliae* (307, 308.2 p)

P 07.1 *Psychosis alcoholica* (307)
Delirium tremens (307)
Dementia alcoholica (307)
Hallucinosis alcoholica (307)
Paranoia alcoholica (307)
Psychosis polyneurotica alcoholica (307)
Syndroma Korsakoff (307)

* Only the terms in small capitals or italics form part of the official classification; the others are examples only.
The numbers in brackets in Roman type refer to the ICD. The letter p after a number indicates that the heading corresponding to this number covers only part of the cases.
The letters NUD signify *Non ultro descriptus.*

P 07.2 *Psychosis euphomanica alia* (308.2 p)
Addictio veneni auphorici cum psychosi (308.2 p)
Euphomania cum psychosi (308.2 p)

P 08 *Psychosis ex oligophrenis* (325)

P 09 *Psychoses epileptica* (308.1)

P 10 *Psychoses syphiliticae* (02-.1, 025, 026 p)

P 10.1 *Paralysis generalis* (020.1, 025)
Dementia paralytica (adultorum) (juvenilis) (020.1 p)
Paralysis generalis (tabetica) (025)

P 10.2 *Psychosis syphilitica alia* (026 p)
Syphilis cerebrospinalis cum psychosi (026 p)

P 11 *Psychoses e morbis organicis aliis cerebri* (083.2, 308.0, 308.2 p)

P 11.1 *Psychosis e neoplasmate s. tumore cerebri* (308.0)

P 11.2 *Psychosis ex encephalitide* (083.2)

P 11.3 *Psychosis e morbo hereditario cerebri* (308.2p)

P 11.4 *Psychosis e traumate cerebri* (308.2 p)

P 11.5 *Psychosis e morbo organico alio cerebri* (308.2 p)

P 12 *Psychoses symptomaticae causis aliis definitis* (642.1 p, 648.3 p, 688.1, 308.2 p)

P 12.1 *Psychosis in graviditate et puerperio* (642.1 p, 648.3 p, 688.1)

P 12.2 *Psychosis causa alia definita* (308.2 p)

P 13 *Psychoses aliae aut non definitae* (309)
Delirium acutum NUD (309)
Dementia NUD (309)
Insania NUD (309)
Psychosis:
NUD (309)
e lassitudine (309)
causa ignota, alibi non indicabilis (309)

II. NEUROSES *(P 14-P 20)*

P 14 *Neuroses angoris sine symptomatibus somaticis* (310)
Neurosis angoris (NUD) (sine symptomatibus somaticis) (310)
Reactio angoris (NUD) (sine symptomatibus somaticis) (310)
Status angoris (NUD) (sine symptomatibus somaticis) (310)

P 15 *Neuroses hystericae* (311)
Hysteria
NUD
cum amaurosi
amblyopia
amnesia
anaesthesia
anoreia
anorsmia
aphasia
catalepsia
conversione
convulsione
dyskinesia
cum fuga
ingresu abnormi
mutismo
paralysi
paresi
postura abnormi
reactione dissociativa
somnambulismo
tic
tremore
postraumatica compensativa
Reactio hysterica posttraumatica
compensatione causa

P 16 *Neuroses ananoasticae* (312, 313)

P 16.1 *Phobia* (312)
Phobia (obsessiva) (312)
Reactio phobica (312)

P 16.2 *Neurosis obsessiva-compulsiva* (313)
Neurosis:
compulsiva (313)
impulsiva (313)
obsessiva (313)
Reactio:
compulsiva (313)
impulsiva (313)
obsessiva (313)

P 17 *Neuroses depressivae* (314 p)
Depressio reactiva s. psychogenes (314 p)
Neurosis depressiva (314 p)
Reactio neurotico-depressiva (314 p)

P 18 *Neuroses cum symptomatibus somaticis* (315-318)

P 18.1 *Neurosis cardiovascularis* (315)
Angioneurosis (315.2)
Arrhythmia nervosa (315.1)
Asthenia neuro-circulatoria (315.0)

P. 18.1 *Neurosis cardiovascularis* (315) (*continued*)
Dystonia neuro-circulatoria (315.1)
Cor militis s. militum (soldier's heart)
Effort syndrome (315.0)
Morbus cordis militis (315.0)
Neurosis cordis (315.1)
Tachycardia nervosa (315.1)
Syndroma Da Costa s. lassitudinis (315.0)

P 18.2 *Neurosis respiratorica* (317.0)
Asthma nervosum s. psychogenes (317.0)
Neurosis respiratorica s. cardio-respiratorica (317.0)

P 18.3 *Neurosis gastro-intestinalis* (316)
Aërophagia (316.3)
Diarrhoea nervosa s. psychogenes (316.1)
Dyspepsia nervosa s. psychogenes (316.2)
Colitis mucosa s. spastica nervosa aut psychogenes (316.0)
Globus (316.3)
Neurosis:
gastrica s. gastro-intestinalis (316.2)
intestinalis (316.2)

P 18.4 *Neurosis uro-genitalis* (317.1)
Frigiditas nervosa s. psychogenes (317.1)
Impotentia nervosa s. psychogenes (317.1)
Micturito nervosa s. psychogenes (317.1)

P 18.5 *Neurosis systematis locomotorici* (317.4)
Arthralgia nervosa s. psychogenes (317.4)
Dorsalgia nervosa s. psychogenes (317.4)
Myalgia nervosa s. psychogenes (317.4)
Neuralgia s. neuromyalgia psychogenes (317.4)

P 18.6 *Neurosis professionalis* (318.2)
Graphospasmus professionalis (318.2)
Neuromyalgia professionalis (318.2)
Nystagmus e tenebris (Miners' nystagmus) (318.2)

P 18.7 *Neurosis cum symptomatibus somaticis aliis aut non definitis* (317.2, 317.3, 317.5)
Morbus psychosomaticus NUD (317.5)
Neurosis cutanea (317.3)
Neurosis somatisata s. vegetativa NUD (317.5)
Pruritus neuroticus s. psychogenes (317.2)
Reactio psychosomatica NUD (317.5)
Somato-neurosis NUD (317.5)

P 19 *Neuroses asthenicae* (318.3)
Debilitas nervosa (318.3)
Exhaustio nervosa (318.3)
Defatigatio nervosa (318.3)

P 19 *Neuroses asthenicae* (318.3) (*contiuued*)
Lassitudo nervosa (318.3)
Prostratio nervosa (318.3)
Neurasthenia (318.3)

P 20 *Neuroses aliae et non definitae* (318.0, 318.1, 318.5)

P 20.1 *Hypochondria* (318.0)

P 20.2 *Neuroses alia et non definita* (318.1, 318.5)
Depersonalisatio (318.5)
Collapsus nervosus s. psychogenes (318.5)
Neurosis NUD (318.5)
Psychasthenia (318.5)
Psychoneurosis NUD s. alibi non indicabilis (318.5)

III. ANOMALIAE CHARACTERIS ET PERSONALITATIS *(P 21 - P 24)*

P 21 *Anomalia e characteris s. personalitatis constitutionalis aut habituales (Neuroses characteris s. psychopathiae)* (320, 321, 326.4)

P 21.1 *Anomalia sexualis s. psychopathia sexualis* (320.6)
Exhibitionismus (320.6)
Fetischismus (320.6)
Homosexualismus (320.6)
Lesbianismus (320.6)
Masoschismus (320.6)
Sadismus (320.6)
Sexualitas pathologica (320.6)
Transvestitismus (320.6)

P 21.2 *Anomalia alia habitus characteris s. personalitatis (Neurosis characteris s. psychopathia)* (320.0 — 320.5, 320.7, 321, 326.4)
Anomalia characteris s. personalitatis, se neurosis characteris
Aggresivitas abnormis (321.2)
Constitutio psychopathica NUD (320.7)
Enuresis psychoinfantilica (321.3)
Dependentia passiva s. psychoinfantilica (321.1)
Inferioritas constitutionalis (320.3)
Instabilitas emotionalis (excessiva) (psychoinfantilica) (321.0)
Insanita moralis (320.5)
Maladaptatio socialis adultorum (326.4)
Mendacitas pathologica (320.3)

P 21.2 *Anomalia alia habitus characteris s. personalitatis (continued)*

Neurosis characteris:
NUD (320.7)
asocialis (320.5)
antisocialis (320.4)
cyclothymica (320.2) excentrica (320.7)
parancides (320.6)
schizoides (320.0)
Personae s. personalitas abnormis:
constitutionalis, se neurosis characteris
habitualis, se neurosis characteris
Psychoinfantilitas:
NUD (321.4)
cum aggressivitate (321.4)
dependentia passivae (321.1)
enuresi (321.3)
instabilitate emotionali (excessivi) (321.0)
Psychopathia NUD, se neurosis characteris (320.7)

P 22 *Reactiones maladaptoricae transitoriae* (326.1)

Maladaptatio situationalis acuta (326.3)
Excitatio abnormis (326.3)
Exhaustio s. lassitudo abnormis (326.3)
Reactio maladaptorica transitoria
proeliatoris (326.3)
situationalis (326.3)

P 23 *Euphomaniae. Addictiones venenorum euphoricum* (322, 323)

P 23.1 Alcoholismus (322)

P 23.11 Alcoholismus acutus (322.0)
Alcoholismus, Ebrietas, Ethylismus } acutus, reactio normalis (322.0)

P 23.12 *Alcoholismus, reactio pathologica* (322.0)

P 23.13 *Alcoholismus, reactio ex antabu* (322.1)

P 23.14 *Alcoholismus chronicus* (322.1, 322.2)

Alcoholismus:
NUD (322.2)
chronicus (322.1)
periodicus (322.1)
recurrens (322.1)
Dipsomania (322.1)
Ethylismus, se alcoholismus

P 23.2 *Euphomania alia. Addictio veneni euphorici alius* (323)

Abusus medicamenti, se euphomania
Addictio medicamenti s. veneni euphorici, se euphomania

P 24 *Habitus abnormis infantum* (324)

Delinquentia juvenilis (324)
Enuresis (diurna) (nocturna) (324)
Excitabilitas excessiva (324)

IV. ANOMALIA INTELLIGENTIA ET LOCUTIONIS *(P 25 — P 26)*

P 25 *Oligophreniae* (325)

P 25.1 Idiotia (I.Q. 0-35) (325.0)

P 25.2 Imbecilitas (I.Q. 36-55) (325.1)

P 25.3 Debilitas mentis (I.Q. 56-75) (325.2)

P 25.4 Inferioritas intellectualis (I.Q. 76-90) (325.3)

P 25.5 *Mongolismus* (325.3)

P 25.6 *Defectus alius mentalis* (325.5)
Idiotia amaurotica (325.5)
Defectus mentalis NUD (325.5)
Deficientia mentalis NUD (325.5)
Oligophrenia NUD (325.5)
Oligophrenia phenylpyruvica (325.5)
Retardatio mentalis NUD (325.5)
Syndroma Tay-Sachs (325.5)

P 26 *Anomaliae aliae intelligentiae aut locutionis* (326.0 — 326.2)

P 26.1 *Dysarrythmia et dyslexia primaria* (326.0)
Agraphia (NUD) (primaria) (326.0)
Alexia (NUD) (primaria) (326.0)
Dysarrythmia (NUD) (primaria) (326.0)
Dyslexia (NUD) (primaria) (326.0)
Strephosymbolia (326.0)

P 26.2 *Balbutio primaria* (326.1)
Balbutio (NUD) (primaria) (326.1)
Battarismus (NUD) (primaria) (326.1)

P 26.3 *Impedimentum aliud loquendi primerium* (326.2)
Aphasia (NUD) (primaria) (326.2)
Dysarthria (NUD) (primaria) (326.2)
Dysphasia (primaria) (326.2)
Impedimentum loquendi (primarium) (326.2)
Vitium loquendi (primarium) (326.2)

8. RADO'S CLASSIFICATION *

Class I. Over-reactive disorders. (1) Emergency dyscontrol: the emotional outflow, the riddance through dreams, the phobic, the inhibitory, the repressive, and the hypochondriacal patterns. (2) Descending dyscontrol. (3) Sexual disorders: disorders of the standard pattern. Dependence on reparative patterns: the patterns of pain-dependence; the male-female pattern modified by replacements; the eidolic and reductive patterns. Fire-setting and shoplifting as sexual equivalents. (4) Social over-dependence. (5) Common maladaptation: a combination of sexual disorder with social over-dependence. (6) The expressive pattern: expressive elaboration of common maladaptation: ostentatious self-presentation; dream-like interludes; rudimentary pantomimes; disease-copies and the expressive complication of incidental disease. (7) The obsessive pattern: obsessive elaboration of common maladaptation: broodings, rituals and overt temptations. Tic and stammering as obsessive equivalents; bed-wetting, nail-biting, grinding of teeth in sleep, as precursors of the obsessive pattern. (8) The paranoid pattern. Paranoid elaboration of common maladaptation: the non-disintegrative version of the Magnan sequence.

Class II. Moodcyclic disorders. Cycles of depression; cycles of reparative elation: the pattern of alternate cycles; cycles of minor elation; cycles of depression masked by elation; cycles of preventive elation.

Class III. Schizotypal disorders. (1) Compensated schizo-adaptation. (2) Decompensated schizo-adaptation. (3) Schizotypal disintegration marked by adaptive incomptence.

Class IV. Extractive disorders. The ingratiating (" smile and suck ") and exertive (" hit and grab ") patterns of transgressive conduct.

Class. V. Lesional disorders.

Class VI. Narcotic disorders. Patterns of drug-dependence.

Class VII. Disorders of war adaptation.

* Rado, S. (1953) *Amer. J. Psychiat.*, **110**, 406

9. RÜMKE'S CLASSIFICATION **

I. *Mental disorders in patients with a previously undisturbed development and without signs of an abnormal constitution*

(*a*) *Mental disorders* on the basis of *apparent organic diseases of the brain:*

1. vascular diseases
2. tumours
3. atrophy
4. inflammations
5. trauma capitis
6. anaemia perniciosa
7. heredo-degenerations, Huntington's disease
8. Pick's and Alzheimer's diseases
9. part of the epilepsies
10. hydrocephalus

Most frequent forms of expression: encephalopathic syndrome with variations: frontal, brain stem and diencephalic syndromes, temporal and parietal syndromes, Korsakow's syndrome, syndromes of dementia.

(*b*) *Mental disorders on the basis of extra-cerebral noxious influences*

1. intoxications from outside, auto-intoxications
2. infectious diseases
3. psychotraumata (?)

Forms of expression: the exogenous reaction types (Bonhoeffer)

II. *Mental disorders mainly on the basis of disturbances in the constitution*

(*a*) *Constitutional disorders with phasic course:*

1. manic-depressive psychosis
2. degeneration psychoses
3. part of the epileptic psychoses

** Rümke, H. C. (1959) *Nosology, classification, nomenclature.* In: American Psychopathological Association. *Report of work conference on problems of field studies in mental disorders*, New York (in press)

(*b*) *Constitutional mental disorders with progressive course :*

1. schizophrenia
2. paraphrenia
3. unclear chronic paranoid states, paranoia
4. chronic hypochondria
5. malignant chronic compulsive syndrome
6. part of the epileptic psychoses

(*c*) *Constitutional mental disorders noticeable during the whole life :*

1. nervositas
2. neurasthenia
3. psychasthenia
4. part of the psychopathies
5. dégénérés supérieurs

III. *Mental disorders on the basis of a disturbed course of development*

(*a*) *Mental disorders on the basis of a defective natural disposition*

1. part of the psychopathies
2. part of the oligophrenic diseases
3. part of the perversions

(*b*) *Mental disorders on the basis of disturbances in the processes of growth of the personality (mainly hereditary)*

1. part of the psychopathies
2. infantilism
3. part of the perversions
4. disturbances in the course of the phases of life
5. part of the oligophrenic diseases

(*c*) *Mental disorders on the basis of mainly psychogenetically determined disturbances in the processes of growth of the personality*

1. neuroses in the strict sense
2. character neuroses
3. part of the perversions
4. part of the psychopathies and abnormal reactions of the personality
5. developmental schizophrenia (type Sechehaye) ?

10. SCHNEIDER'S CLASSIFICATION *

1. *Abnormal varieties of sane mental life*

   Abnormal intellectual capacity (Anlagen)
   Abnormal (psychopathic) personalities
   Abnormal reactions to emotional impressions

2. *Results of illness and developmental defects*

Somatological (etiological) grouping	Psychological (symptomatological) grouping
Intoxications Paresis Other infections Other somatic illnessess Abnormal brain development Brain injuries Cerebral arteriosclerosis Senile brain diseases Other brain diseases	Acute: Clouding of consciousness Chronic: Personality deterioration (congenital: arrested personality development) and dementia.
Genuine epilepsy ? ?	Cyclothymia Schizophrenia

* Schneider, K. (1950) *Amer. J. Psychiat.*, **107**, 334

Annex 3

CLASSIFICATIONS NOT INCLUDED IN ANNEX 1 OR ANNEX 2

1. CONRAD'S SCHEME OF PSYCHIATRIC DIAGNOSIS *

Abnormal personalities, including addicts

Abnormal personalities 320[1]
Disturbances of maturation 321
Addictions I: to drugs and intoxicants 323
Addictions II: alcoholism (except complications) 322
Neuropathies and personality disorders of uncertain origin 326

Reactions to inner conflict and other mental stress

Anxiety neurosis 310
Hysterical reactions 311
Phobias 312
Obsessional neurosis and obsessional illness 313
Psychogenic disturbances of the circulatory system 315
Psychogenic disturbances of the digestive system 316
Psychogenic disturbances of the other systems 317
Other psychogenic disorders and disabilities in childhood (including sexual neuroses) 314
Impulsive and primitive reactions 319
Neurasthenic states 790

Paranoid states 303

Endogenous psychoses

Schizophrenias 300

* Conrad, K. (1956) *Fortschr. Neurol.*, **24**, 231

[1] The numbers refer to the corresponding categories of the ICD.

Endogenous psychoses (continued)	
Cyclothymia	301
Involutional depressions	302
Atypical endogenous psychoses	309
Presenile and senile psychoses	
Senile psychoses	304
Presenile psychoses	305
Cerebral arteriosclerosis, with dementia	306
Psychoses due to alcoholism	307
Symptomatic psychoses (acute syndrome)	308
Maldevelopments and isolated disabilities in childhood	324-326
Psychoses related to pregnancy	688
General paralysis of the insane	025

2. ESSEN-MÖLLER'S AND WOHLFAHRT'S CLASSIFICATION *

Reactions

Schizophrenia, schizophreniform reactions, schizoidia
Manic-depressive reactions, dysphoria, hyperthymia
Epilepsy, ixophrenia, ixoidia
Oligophrenia
Asthenia, hydrophrenia, hypochondria

Obsessive-compulsive states, apprehensive or hypersensitive reactions

Hysteria, mythomania
Primitive reaction
Delirium amentia, twilight state
Motor disturbances, catatonia
Paranoiac reaction, fixed idea, querulousness
Hallucinosis
Dementia, impaired judgement, amnesia, aphasia
Emotional instability
Weakness of will, intantilism
Emotional frigity, amorality
Asociality
Suicidal attempt
Sexual abnormality
Narcomania, abuse of intoxicants
Anorexia
Agrypnia, rhythm disorder
Cephalalgia, hemicrania
Vegetative lability
Normal personality variant

Etiology

Cerebral arteriosclerosis
Senile atrophy of the brain

Alzheimer's disease, Pick's disease, Huntington's chorea
Amaurotic idiocy, diffuse sclerosis
Dementia paralytica, cerebral syphilis
Encephalitis of different kinds

Multiple sclerosis

Cerebral trauma
Haemorrhage, malacia
Asphyxia, strangulation
Tumour, abcess, swelling of the brain

Chidhood, puberty
Climacterium, presinility, senility
Pregnancy, abortion, puerperium, lactation

Myxoedema, Basedow's disease, diabetes

Cachexia, uraemia
Undernourishment, deficiency disease

Systemic infection
Blood disease
Cardiac disease, hypertension

Alcoholic intoxication, acute or chronic

Alkaloid intoxication
Barbiturate intoxication
Carbon monoxide intoxication
Mental trauma
Mental stress
Induction, faulty ubpringing
Strain
Hereditary
Cryptogenic

* Essen-Möller, E. & Wohlfahrt, S. (1947) *Acta psychiat. (Kbh.)* Suppl. 47, p. 551

3. CLASSIFICATION SUGGESTED BY HENDERSON AND GILLESPIE *

1. Affective reaction types:
   (*a*) manic-depressive
   (*b*) involutional melancholia
2. Schizophrenic reaction types
3. Paranoiac and paranoid reaction types:
   (*a*) paranoia
   (*b*) paraphrenia
   (*c*) paranoid states, with or without hallucinations
4. Psychopathic states in:
   (*a*) aggressive psychopathic personality
   (*b*) inadequate personality
   (*c*) creative personality
5. Organic reaction types (toxic-infectious; metabolic diseases of internal organs; cerebral degenerative, traumatic, etc.)
   (*a*) acute (delirium)
   (*b*) chronic
6. Epilepsy
7. Mental deficiency
8. Psychoneuroses:
   (*a*) neurasthenia
   (*b*) anxiety states
   (*c*) hysteria
   (*d*) obsessive-compulsive states
9. Unclassified, e.g., some cases of folie à deux

* Henderson, D. K. & Gillespie, R. D. (1956) *A textbook of psychiatry*, 8th ed., London, Oxford University Press

4. VAN DER HORST'S CLASSIFICATION **

1. *Paranoia*
2.
3. *Manic-depressive constitution*
   (*a*) constitutional mood disorder
   (*b*) constitutional exaltation
4. *Manic-depressive psychosis*
   (*a*) melancholia
   (*b*) mania
   (*c*) mixed states
   (*d*) atypical states
   (*e*) circular states
5. *Psychopathic constitution*
   A. I. Hyperthymic psychopaths
      (*a*) explosive
      (*b*) irritable
      (*c*) expansive
      (*d*) tachythymic
   II. Hypothymic or athymic psychopaths
      (*a*) phlegmatic
      (*b*) dull
   A. II. Hypothymic or athymic psychopaths (*continued*)
      (*c*) indolent
   III. Poikilothymic psychopaths
      (*a*) constitutional emotional lability
      (*b*) reactive emotional lability
   IV. Dysthymic psychopath
      (*a*) moody
      (*b*) depressive
      (*c*) timid
   B. (*a*) unstable
      (*b*) schizoid
      (*c*) cold autistic
      (*d*) anankastic
      (*e*) sensitive
      (*f*) hysterical
      (*g*) hypochondriacal
      (*h*) quarrelsome
      (*i*) eccentric
      (*j*) asthenic
      (*k*) paranoid
      (*l*) inadequate
      (*m*) aboulic
   C. Psychopathic reaction types
      I. Criminality (habitual delinquents)

** Personal communication from Professor L. van der Horst, Psychiatric and Neurological Clinic, University of Amsterdam

C. Psychopathic reaction types (*continued*)
- II. Perversions
  - (*a*) excessive masturbation
  - (*b*) homosexuality
  - (*c*) exhibitionism
  - (*d*) fetishism
  - (*e*) sadism
  - (*f*) masochism
  - (*g*) transvestitism
  - (*h*) paedophilia
- III. Kleptomania
- IV. Poriomania
- V. Pseudologia phantastica
- VI. Addictions

D. Psychopathic states
- (*a*) excitement
- (*b*) periodic twilight states
- (*c*) epileptoid psychopathy
- (*d*) diencephalic psychopathy

6. *Innate mental deficiency*
   - (*a*) debility
   - (*b*) imbecility
   - (*c*) idiocy
7. *Neuropathy*
   - (*a*) vegetative
   - (*b*) psychic
8. *Asthenia*
   - (*a*) confusional psychosis
   - (*b*) asthenic psychosis
   - (*c*) psychasthenic psychosis
9. *Intoxication*
   - A. I. Alcoholism
     - (*a*) pathological drunkenness
     - (*b*) acute hallucinosis
     - (*c*) delirium tremens
     - (*d*) paranoia
     - (*e*) Korsakow's syndrome
     - (*f*) chronic alcoholism
     - (*g*) dipsomania
     - (*h*) alcoholic dementia
   - B. Morphinism, cocainism
   - C. I. Other drugs (narcotics, etc.)
     - II. Other intoxications
10.
11.
12.
13. *Symptomatic psychoses*
    - A.
      - (*a*) in infectious diseases
      - (*b*) in exhaustion and chronic diseases
      - (*c*) heart disease
      - (*d*) uraemia
      - (*e*) lues and tabes
      - (*f*) intoxications
      - (*g*) rheumatism
    - B.
      - (*a*) confusional psychosis
      - (*b*) neurasthenic state
      - (*c*) hallucinatory state
      - (*d*) Korsakow's syndrome
      - (*e*) amentia
14. *Psychoses associated with the reproductive functions*
    - (*a*) postpuerperal psychosis
    - (*b*) pregnancy psychosis
    - (*c*) menstrual mood disorders
15. *Endocrine psychoses*
    - (*a*) thyreogenic (Graves' disease: myxoedema)
    - (*b*) others
16. *Auto-intoxications*
17. *General paralysis of the insane*
18. *Presenile psychoses*
    - (*a*) melancholia
    - (*b*) anxiety states
    - (*c*) depressive delusions
    - (*d*) depressive states followed by dementia
    - (*e*) presenile paranoid psychosis
    - (*f*) others, including presenile dementia of unknown origin
19. *Arteriosclerotic psychosis*
    - (*a*) neurasthenic state
    - (*b*) general debility
    - (*c*) dementia
    - (*d*) depressive
    - (*e*) delirious
    - (*f*) apoplectic dementia
20. *Senile dementia*
    - I. (*a*) dementia
      - (*b*) presbyophrenia
      - (*c*) senile paranoia
      - (*d*) senile delirium
    - II. Alzheimer's disease

21. *Heredodegenerative psychoses*
    (*a*) Pick's disease
    (*b*) Huntington's disease
    (*c*) Wilson's disease
    (*d*) amaurotic idiocy
    (*e*) atypical (e.g., Jacob-Creutzfeldt's disease)

22. *Organic psychoses*
    A. Infections (encephalitis, disseminated sclerosis, chorea)
    B. Neoplasms
    C. Trauma
        (*a*) acute
        (*b*) post-traumatic
            (i) dementia
            (ii) psychopathy

23. " *Dementia praecox* " *(schizophrenia)*
    A. I. (*a*) hebephrenia
        (*b*) catatonia
        (*c*) dementia paranoides
        (*d*) dementia simplex
    II. Defect states
        (*a*) hypochondriacal hallucinosis
        (*b*) verbal hallucinosis
        (*c*) hebephrenic flattening of affect
    B. Paraphrenias
        (*a*) systematica
        (*b*) expansiva
        (*c*) confabulatoria
        (*d*) phantastica
    C. Dementia praecocissima

24. *Epileptic psychoses*
    (*a*) dementia
    (*b*) twilight states and fugues
    (*c*) violent rages
    (*d*) delirium

25. I. *Hysterical psychoses*
    II. (*a*) imprisonment psychoses
        (*b*) situational psychoses

26. *Disturbances of development*
    (*a*) behaviour disorders in puberty
    (*b*) psychoses in puberty and prepuberty
    (*c*) psychoses and other disorders of integration
    (*d*) infantile psychoses

27. *Involutional psychoses*

28. *Degeneration psychoses*
    A. Psychoses
        (*a*) autochthonous delusion
        (*b*) acute hallucinosis
        (*c*) mobility psychosis
    B. Degenerative states

29. *Psychogenic psychoses*
    (*a*) psychogenic disorders of affect
    (*b*) psychogenic psychosis in the strict sense
    (*c*) existential neurosis
    (*d*) sensitive delusions of reference
    (*e*) paranoid states in deaf people
    (*f*) folie à deux

30. *Organ psychoses*
    (*a*) essential hypochondria

31. *Psychoses in mental defectives*
    (*a*) pseudo-schizophrenic syndrome
    (*b*) autochthonous lability of affect
    (*c*) simple delusion

32. *Reactive states*
    I. Fright psychosis
        (*a*) stupor
        (*b*) twilight state
    II. Reactive disturbance of affect
        (*a*) depression
        (*b*) mania

33. *Nervous state*

34. *Neurasthenia*

35. *Psychasthenia*
    (*a*) obsessional neurosis

36. *Hysteria*
    (*a*) conversion hysteria
    (*b*) hysterical character
    (*c*) hysterical depression

37. *Unclassifiable neurosis* (e.g., in children)

38. *Traumatic neurosis*

39. *Vegetative neurosis* (*anorexia nervosa*)

40. *Other disturbances of the vegetative nervous system* (Raynaud's disease, sclerodermia, etc.)

41. *Vasomotor-trophic disturbances*
42. *Allergic states*
43. *Migraine*
44. *Ménière's syndrome*
45. *Epilepsy*

This system also includes further categories covering endocrine disease and organic neurological diseases.

5. JUNG'S CLASSIFICATION *

1. *Innate or early acquired mental deficiency*
   - (*a*) of unknown origin
   - (*b*) due to brain lesion
   - (*c*) cretinism
   - (*d*) mongolism
   - (*e*) specific disability
   - (*f*) phenylketonuria mental deficiency
2. *Mental disorders due to brain injuries*
   - (*a*) acute traumatic (contusional) psychoses
   - (*b*) traumatic dementia and personality disorders
3. *General paralysis of the insane*
4. *Mental disorders of later life with brain atrophy*
   - (*a*) presenile
     1. premature deficiency
     2. Pick's disease
     3. Alzheimer's disease
     4. other dementias
   - (*b*) senile
   - (*c*) arteriosclerotic (including hypertension)
   - (*d*) confusional states
5. *Mental disorders due to other cerebral diseases*

   (tumour, encephalitis, disseminated sclerosis, cerebral syphilis, Huntington's chorea and other heredodegenerative syndromes)
6. *Symptomatic psychoses*
   - (*a*) in infectious diseases
   - (*b*) in diseases of the inner organs, cachexia, systemic diseases (including carcinoma, uraemia, eclampsia, pellagra, etc.)
   - (*c*) psychoses of pregnancy, puerperium, lactation, and menstruation
   - (*d*) postoperative psychoses
7. *Alcoholism*
   - (*a*) intoxications
     1. simple
     2. pathological (epileptoid)
   - (*b*) chronic alcoholism (delusions of jealousy)
   - (*c*) delirium tremens and hallucinosis
   - (*d*) Korsakow's psychosis and polioencephalitis haemorrhagica
8. *Addictions (morphinism, cocainism, etc.)*
9. *Mental disorders due to poisoning (drugs, other chemicals, gas, etc.)*
10. *Neurasthenic-depressive states of somatic origin*
    - (*a*) neurasthenic states due to starvation, exhaustion and infections
    - (*b*) chronic pseudo-neurasthenic pictures in metabolic diseases (porphyria, anaemias)
11. *Mental disorders in endocrine diseases (endocrine psycho-syndrome)*
12. *Symptomatic epilepsy*
    - (*a*) residual (including pyknolepsy)
    - (*b*) traumatic
    - (*c*) others
13. (*a*) Epilepsy without ascertainable origin
    (*b*) Epilepsy with established heredity
14. *Group of the schizophrenias*
    - (*a*) simple
    - (*b*) predominantly hebephrenic
    - (*c*) predominantly catatonic
    - (*d*) predominantly paranoid-hallucinatory
    - (*e*) pseudo-neurotic
    - (*f*) paraphrenia
    - (*g*) simple defect state
15. *Manic-depressive group*
    - (*a*) genuine cyclothymia, i.e., with depressive *and* manic phase

* This is a modification of the Würzburg Scheme (see page 631).

15. *Manic-depressive group (continued)*
    (*b*) manic phase
    (*c*) depressive phase
    (*d*) cyclothymic disorders during involution and old age (without cerebral change)
    (*e*) depressive-paranoid disorders during the climacteric and involution
    (*f*) endo-reactive forms (dysthymia, basic and background depressions)
16. *Psychopathic personalities*
    (*a*) hyperthymic
    (*b*) depressive
    (*c*) insecure
    (*d*) fanatic
    (*e*) self-assertive
    (*f*) emotionally labile
    (*g*) explosive
    (*h*) callous
    (*i*) weak-willed
    (*k*) asthenic
    (*l*) others
17. *Obsessive-compulsive disease (including anankastic personalities)*
18. *Abnormal reactions and developments; neuroses*
    (*a*) primitive reactions
    (*b*) paranoid reactions and developments
    (*c*) depressive reactions (not included in group 15)
    (*d*) actual crises (" actual neuroses ")
    (*e*) neurotic developments
    (*f*) phobic symptoms
    (*g*) sexual neuroses and perversions
    (*h*) hysterical syndrome
    (*i*) induced psychosis (folie à deux)
    (*k*) compensation neurosis
    (*l*) imprisonment reaction
    (*m*) suicidal attempt (to be added)
19. *Developmental and behaviour disorders of children and adolescents*
20. *Unclear cases*

6. CLASSIFICATION PROPOSED BY LÓPEZ IBOR *

1. *Congenital and acquired oligophrenias*
    (*a*) without known cause
    (*b*) due to cerebral lesions, or of other known etiology
    (*c*) cretinism
2. *Mental disorders from cerebral traumatisms*
3. *Syphilitic psychosis*
    (*a*) general paralysis of the insane
    (*b*) mental changes in cerebral lues and tabes
4. *Mental changes in old age*
    (*a*) vascular forms
    (*b*) senile forms
    (*c*) special forms (Alzheimer's, Pick's disease, etc.)
5. *Mental disorders with other diseases of the nervous system* (tumours, multiple sclerosis, Huntington's chorea, etc.)
6. *Mental disorders with diseases of the rest of the organism* (state the disease or disorder of origin)
7. *Alcoholism*
    (*a*) pathological drunkenness
    (*b*) chronic alcoholism
    (*c*) delirium tremens and hallucinosis
    (*d*) Korsakow's psychosis
8. *Drug addiction*
9. *Epilepsies*
    (*a*) true or essential
    (*b*) symptomatic
10. *Schizophrenias*
11. *Manic-depressive psychosis*
12. *Psychopathic personalities and development*
13. *Abnormal mental reactions* (neurosis)
14. *Obscure cases*
15. *Cases under observation*

* Personal communication from Professor J. J. López Ibor, Madrid.

7. KLOOS' CLASSIFICATION *

PSYCHOSES

I. *Endogenous (i.e., of unknown, constitutional organic origin)*
- (*a*) schizophrenia
- (*b*) manic-depressive psychosis
- (*c*) psychotic episodes in genuine epilepsy

II. *Exogenous (i.e., caused by known constitutional or acquired physical disease)*
- (*a*) of cerebral origin
- (*b*) symptomatic psychoses, i.e., of non-cerebral origin
- (*c*) toxic psychoses

ABNORMAL PERSONALITIES

I. *Oligophrenia*
- (*a*) general deficiency
- (*b*) special disability

II. *Psychopathy*

III. *Neuropathy (organ neurosis, neurasthenia)*

ABNORMAL REACTIONS

I. *Reactions to external events*
- A. Qualitatively abnormal
  - (*a*) reactive depression
  - (*b*) hypochondriacal reaction
  - (*c*) anxiety reaction
  - (*d*) terror reaction
  - (*e*) reactive states of excitement (joyful or irascible)
- B. Qualitatively abnormal
  - (*a*) purposeful reactions
    - (i) hysterical
    - (ii) simulation
  - (*b*) delusional reactions
    - (i) paranoid (sensitive, expansive)
    - (ii) induced psychosis (folie à deux)
- C. Mixed
  - (*a*) to accidents
  - (*b*) to war
  - (*c*) to imprisonment

II. *Abnormal reactions to inner events (i.e., to internal conflicts), the neuroses*
- (*a*) conflicts of the instinct of self-preservation
- (*b*) conflicts of the instinct of power
- (*c*) conflicts of the social, including the sexual, instinct

* Kloos, G. (1951) *Med. Klin.*, **46**, 1

8. LANGFELDT'S CLASSIFICATION **

I. *Main diagnoses with subdiagnoses*

Group *a* : *Schizophrenic disorders*
1. Hebephrenic form
2. Catatonic form
3. Paranoid form
4. Simple demential form
5. Other forms
6. Schizophreniform forms (schizophrenia-like)

Group *b* : *Manic-depressive disorders*
10. Depressive form
11. Manic form
12. Circular form
13. Involutional melancholia
14. Atypical forms

Group *c* : *Mental disorders following organic brain diseases*
17. Presenile psychoses (in Pick's and Alzheimer's atrophies)
18. Senile psychoses
19. Arteriosclerotic psychoses
20. General paralysis
21. Other luetic forms
22. Epileptic psychoses and epileptic disturbances of conscience
23. Psychoses e tumoral cerebri and cerebral tumour
24. Psychoses e sclerose multiplicae and multiple sclerosis
25. Psychoses e chorea Huntington and Huntington's chorea
26. Psychoses in chronic encephalitis and chronic encephalitis

** Langfeldt, G. (1956) The prognosis in schizophrenia. *Acta psychiat. scand.*, Suppl. 110

Group *c* : *Mental disorders following organic brain diseases (continued)*

27. Psychoses in other brain disorders of non-traumatic nature
28. Other disorders in organic brain diseases.

Group *d* : *Traumatic and post-traumatic disorders*

31. Traumatic neuroses } acute reactions
32. Traumatic psychoses }
33. Post-traumatic neuroses } late reactions
34. Post-traumatic psychoses
35. Post-traumatic dementia
36. Post-traumatic encephalopathy
37. Post-traumatic disorders, others

Group *e* : *States of intoxication*

40. Alcoholic psychoses
41. Chronic alcoholism
42. Other states of exogenic intoxication

Group *f* : *Psychoses in infections and general diseases*

45. Psychoses in infectious diseases
46. Psychoses in endocrine disorders
47. Psychoses in other general diseases

Group *g* : *Constitutional psychoses*

50. Affective reactions
51. Amential reactions
52. Paranoiac and paranoid reactions
53. Ideas of reference
54. Other

Group *h* : *Psychogenic psychoses*

57. Emotional states
58. Amential states
59. Paranoid states
60. Other states

Group *i* : *Other mental disorders*

63. Psychoses of uncertain origin
64. Symptomatic psychoses

Group *k* : *Oligophrenia*

66. Slight moronism (I.Q. 90-75)
67. Pseudodebility (pseudo-moronism)
68. Moronism
69. Imbecility (I.Q. 50-25)
70. Psychotic reaction in oligophrenia

Group *l* : *Psychopathias*

71. Cycloid form } Hereditary
72. Schizoid form }
73. Constitutional forms
74. Post-encephalitic form
75. Post-traumatic form
76. Other forms

Group *m* : *Psychoneuroses*

79. Depressive reactions
80. Anxiety reaction
81. Anancastic reaction
82. Hysterical reaction (conversion)
83. Neurastheniform and hypochondriacal reactions
84. Psychosomatic reactions
85. Other forms

Group *n* : *Neurasthenias*

87. Constitutional forms } secondary forms
88. Post-infectious forms
89. Post-intoxicational forms
90. Due to exhaustion
91. Other secondary forms

Group *o* : *Observation*

93. Judicial observation
94. R.T.V. (medical insurance observations)
95. Other observations

Group *p* : *Temporary diagnoses and incompletely investigated patients*

II. *Diagnoses of personality*

This heading is intended for recording of more dominant traits in the individual, as manifested prior to illness.

The concept of personality is here used less in the meaning of the unique and individual and more in the meaning of personality type.

0. Non-abnormal person
1. Intellectual and socially positive individual
2. Hypophrenic person
3. Infantile person
4. Ambitious person
5. Hypersensitive person
6. Repressed person
7. Person of weak character
8. Schizoid person
9. Constitutional emotional abnormalities:
   (*a*) Depressive
   (*b*) Hypomanic
   (*c*) Cyclothymic
10. Paranoid person
11. Paranoiac person
12. Anancastic person
13. Impulsive person

14. Sexually abnormal person
15. Person having previous brain damage
16. Other forms
17. Combinations
18. Hysteroid person
19. Affective, unstable person
20. Incompletely investigated person
21. Asthenic: (*a*) neurasthenic
    (*b*) psychasthenic

III. *Diagnoses of situation and milieu*

This heading is intended for the recording of situations in the environment of the individual having a stated or supposed relation to the actual state. This relation may be supposed to be of three different types:

1. Predisposing factors
2. Pathoplastic factors
3. Factors directly causing the disease. 36 types of situational factors are listed.

9. CLASSIFICATION OF LECOMTE ET AL.*

	Oligophrenic syndromes			confusional syndrome (chronic)	dementia syndrome	excitement syndrome (chronic)	depressive syndrome (chronic)	discordant syndrome	syndrome of mental unbalance	neurotic syndrome	epileptic syndrome	internment unnecessary or cure	Totals
	Idiocy	Imbecility	Mental Deficiency										
No. of cases													
So-called degenerative stigmata													
Syphilis													
Hereditary syphilis													
Alcoholism													
Hereditary alcoholism													
Personal tuberculosis													
Family tuberculosis													
Epidemic encephalitis													
Various infectious diseases													
Parasitic diseases													
Cerebral tumours													
Cancers													
Endocrine disturbances													
Puerperium													
Cranial traumatism													
Senility													
Arteriosclerosis													
Hypertension													
Somato-sensory disorders													
Emotional and affective factors													
Social factors													

* Lecomte, M., Donney, A., Delage, E. & Marty, F. (1947) *Techn. hosp.*, **2**, 5

10. LEONHARD'S CLASSIFICATION OF ENDOGENOUS PSYCHOSES *

A. *Phasic psychoses*
- I. Manic-depressive group
- II. (*a*) pure melancholia
  (*b*) pure mania
- III. (*a*) pure depression
  1. agitated
  2. hypochondriacal
  3. self-torturing
  4. suspicious
  5. apathetic
  (*b*) pure euphorias
  1. unproductive
  2. hypochondriacal
  3. exalted
  4. confabulatory
  5. indifferent

B. *Cycloid psychoses*
- I. Anxiety-bliss psychosis
- II. Excitation-retardation psychosis with confusion
- III. Hyperkinetic-akinetic psychosis

C. *The unsystemic schizophrenias*
- I. Affective paraphrenia
- II. Schizophasia
- III. Periodic catatonia

D. *The systemic schizophrenias*
- I. Schizophrenia with
  (*a*) simple systemic catatonia
  1. parakinetic
  2. manneristic
  3. proskinetic (i.e., with liability to automatic movements)
  4. negativistic
  5. talkative
  6. untalkative
  (*b*) simple systemic hebephrenia
  1. fatuous
  2. odd
  3. emotionally flat
  4. autistic
  (*c*) simple systemic paraphrenia
  1. hypochondriacal
  2. phonemic (i.e., with verbal hallucinations)
  3. incoherent
  4. phantastic
  5. confusional
  6. expansive
- II. Combined systemic schizophrenias
  (*a*) combined systemic catatonia
  (*b*) combined systemic hebephrenia
  (*c*) combined systemic paraphrenia

* Leonhard, K. (1957) *Aufteilung der endogenen Psychosen*, Berlin, Akademie-Verlag, p. 480

11. MIRA LOPEZ' CLASSIFICATION **

A. *Deficiency disorders*
- (*a*) Congenital, early (oligophrenia)
  1. Idiocy
  2. Imbecility
  3. Mental deficiency
- (*b*) Acquired and incurable (dementia)
  1. Vascular
  2. Infectious
  3. Degenerative

B. *Disorders of personality integration, constitution and psychopathic reactions*
- (*a*) Asthenic
- (*b*) Paranoid
- (*c*) Hysterical
- (*d*) Irritable
- (*e*) Compulsive
- (*f*) Explosive
- (*g*) Cycloid
- (*h*) Schizoid
- (*i*) Perverse

** Bustamante, J. A. (1948) *Las enfermedades mentales en Cuba*, La Habana, Tamayo, p. 87

C. *Mental disorders*

(*a*) Psychoneuroses and organic neuroses

1. Hysterical
2. Neurasthenic
3. Anancastic
4. Anxiety

(*b*) Psychoses

1. Situational or reactive
2. Traumatic
3. Infectious and post-infectious
4. Exotoxic
5. Endotoxic
6. Epileptic
7. Manic-depressive
8. Schizophrenic
9. Paranoiac and paraphrenic

12. J. E. MEYER'S PROPOSED DIAGNOSTIC SCHEME *

1. *Psychoneuroses, psychoneurotic reactions*
2. *Psychopathic personalities*
   (*a*) antisocial and criminal psychopaths
   (*b*) all other types

Some well-defined forms of 1 and 2:

(*a*) neurotic and maladjusted children
(*b*) psychoneuroses with predominant somatic manifestations
(*c*) sexual deviations
(*d*) obsessional and phobic states
(*e*) alcoholism
(*f*) drug addiction
(*g*) depressive reactions

II.

1. *The schizophrenic disorders*
   (*a*) schizophrenia
   (*b*) schizophrenic episodes
   (*c*) paranoid states
2. *Affective disorders*
   (*a*) mania
   (*b*) depression

special forms [1]

(*c*) climacteric depression
(*d*) affective disorders of the aged

3. *Atypical psychotic disorders* if not under 1 (*b*) or 1 (*c*).

III.

1. *Sequelae of brain trauma*
2. *Convulsive disorders*
   (*a*) idiopathic epilepsy
   (*b*) symptomatic forms of epilepsy
3. *Syphilis of the central nervous system*
4. *Presenile, senile and vascular brain disease*
5. *Mental disorders associated with other brain lesions*
6. *Mental disorders in toxic, infectious and other diseases*, as far as not included in No. 7
7. *Mental disorders associated with metabolic and endocrine disturbances and avitaminoses*
8. *Mental deficiency*
   (*a*) with proved somatic cause
   (*b*) of unknown cause

* Meyer, J. E. (1959) *An internationally acceptable diagnostic scheme suitable for comparative psychiatric studies.* In: American Psychopathological Association. *Report of work conference on problems of field studies in mental disorders*, New York (in press)

[1] If there was no attack previous to climacterium or aging.

13. SELBACH'S (BERLIN) CLASSIFICATION **

I. *Mental deficiency*

1. hereditary
2. of unknown etiology
3. acquired in utero
4. due to birth trauma
5. acquired in early childhood

II. *Mental disorders in heredo-degenerative diseases*

1. Pick's disease
2. Huntington's chorea
3. spino-cerebellar ataxia
4. amyotrophic lateral sclerosis
5. paralysis agitans

** Personal communication from Professor H. Selbach, Psychiatric and Neurological Clinic, Free University of Berlin

III. *Mental disorder in and subsequent to systemic diseases*[1]
1. heart and circulation diseases
2. gastro-intestinal diseases
3. liver diseases
4. kidney diseases
5. metabolic diseases
6. deficiency diseases and dystrophies
7. blood diseases
8. endocrine diseases
9. infectious diseases
10. pregnancy and puerperium
11. cachexias due to neoplasm

IV. *Mental disorders in and subsequent to brain diseases*
1. traumatic psychoses
2. post-traumatic personality change
3. acute meningo-encephalitis, etc.

V. *Mental disorders due to syphilis*
1. general paralysis
2. juvenile paralysis
3. taboparalysis

VI. *Mental disorders associated with involution and aging*
1. climacteric psychosis with depression
2. climacteric psychosis with paranoid ideas and hallucinations
3. involutional depression
4. involutional paranoid psychosis with hallucinations
5. senile dementia
6. Alzheimer's disease
7. senile depression
8. senile mania
9. senile paranoia
10. cerebral atrophies

VII. *Manic-depressive group* (cyclophrenia)
1. cyclical type
2. mania
3. depression
4. constitutional dysthymia
5.
6.
7. reactive depression

VIII. *Schizophrenic group*
1. catatonia
2. paranoid-hallucinatory schizophrenia
3. hebephrenia
4. dementia simplex

[1] Addition to No. 1-7 ps = psychoses, delirious states
Addition to No. 1-7 de = organic dementia
Addition to any category = suicidal attempt

IX. *Special psychotic forms* (" mixed psychoses ")
1. with mainly schizophrenic symptoms
2. with mainly manic-depressive symptoms
3. unclear types

X. *Abnormal psychic reactions*
1. primitive reactions
2. reactive excitements
3. depressive reactions
4. conversion reactions
5. hysterical reactions
6. hypochondriacal reactions
7. paranoid reactions
8. imprisonment reactions

XI. *Abnormal psychic developments and neuroses*
1. simple developments
2. paranoid developments
3. conversion neuroses
4. anxiety neuroses
5. obsessional neuroses
6. depressive neuroses
7. character neuroses
8. neuropathy
9. neurasthenia

XII. *Psychopathies and perversions*

XIII. *Addictions*

XIV. *Alcoholism*
1. states of intoxication
2. chronic alcoholism
3. delusional jealousy
4. hallucinosis
5. delirium tremens
6. Korsakow's psychosis

XV. *Intoxications*

XVI. *Mental disorders in children and adolescents*
Mental deficiency
1. simple inherited

Acquired defects
2. partial disabilities
3. other forms of acquired deficiency

Special forms of mental deficiency
4. in hereditary organic nervous diseases
5. in endocrine diseases
6. mongolism

Developmental and sensory defects
7. general disorders of development
8. speech disorders
9. sensory defects

XVI. *Mental disorders in children and adolescents (continued)*

Psychopathies, abnormal reactions (neuroses)

10. irritable psychopath
11. overanxious psychopath
12. oversensitive psychopath
13. overexcitable psychopath
14. affectless psychopath
15. unstable psychopath
16. self-assertive psychopath
17. depressive psychopath
18. obsessional psychopath
19. others

Neuroses

20. neuropathics
21. stammerers
22. enuretics
23. wanderers

Childhood psychoses

24. schizophrenia
25. manic-depressive illness
26. symptomatic psychoses

Asociality

27. asocial, delinquent

14. PACHECO E SILVA'S CLASSIFICATION *

1. Infectious psychoses
2. Autotoxic psychoses
3. Heterotoxic psychoses
4. Dementia praecox
5. Systematic hallucinatory chronic delirium; paraphrenia
6. Paranoia
7. Manic-depressive (periodic) psychosis; predominantly manic forms; predominantly melancholic; mixed
8. Involutional psychosis
9. Psychosis through cerebral lesion and terminal dementia (arteriosclerosis, syphilis, etc)
10. General paralysis
11. Epileptic psychosis
12. Psychoses called neurotic (hysteria, chorea, neurasthenia, psychasthenia)
13. Other constitutional psychopathies (atypical degeneratives states)

* Bustamante, J. A. (1948) *Las enfermedades mentales en Cuba*, La Habana, Tamayo, p. 87

15. SJÖGREN'S CLASSIFICATION **

A. SYMPTOMATOLOGICAL ETIOLOGICAL GROUP

I. *Intoxications*

(*a*) Alcohol
1. hallucinosis syndrome
2. paranoid syndrome
3. delirium syndrome
4. dipsomania syndrome
5. amnesia syndrome
6. chronic alcoholism syndrome
7. others

(*b*) Other chemical substances
1. morphine
2. barbiturates
3. amphetamine
4. coal gas
5. metallic poisons
6. others

II. *Infectious diseases and diseases of the internal organs*

III. *Disorders of the nervous system*

1. encephalitis
2. brain tumour
3. traumatic encephalopathy
4. syphilitic brain disease
5. cerebrovascular disease
6. Alzheimer's and Pick's diseases
7. senile dementia
8. others

IV. *Epilepsy*

1. grand mal syndrome
2. petit mal syndrome
3. psychomotor syndrome
4. others

** Personal communication from Professor H. Sjögren, University of Gothenburg

B. PSYCHOLOGICAL-SYMPTOMATIC GROUP

V. *Psychoneurosis or situational (psychogenic) reactions or syndromes*

1. neurasthenic syndrome
2. anankastic syndrome
3. hysterical syndrome
4. reactive-depressive syndrome
5. paranoid syndrome
6. others

C. OTHER GROUPS

VI. *Schizophrenic reactions or syndromes*

1. dementia simplex syndrome
2. hebephrenic syndrome

VI. *Schizophrenic reactions or syndromes (continued)*

3. catatonic syndrome
4. paranoid syndrome
5. other forms

VII. *Manic-depressive reactions or syndromes*

1. manic syndrome
2. depressive syndrome
3. manic-depressive syndrome
4. melancholic syndrome
5. other forms

VIII. *Psychopathic reactions or syndromes*

IX. *Oligophrenic reactions or syndromes*

16. SKOTTOWE'S CLASSIFICATION *

1. Affective disorders (the manic-depressive psychoses; minor depressive syndromes; anxiety states; involutional depressive syndromes).
2. Schizophrenic disorders (essential schizophrenia; schizophrenoid states).
3. Paranoid disorders (paranoia; paraphrenia; reactive and incidental paranoid syndromes).
4. Organic mental disorders (toxic-exhaustive states [symptomatic psychoses]; minor toxic-exhaustive syndromes [including so-called " neurasthenia "]; malnutrition with psychosis [pellagra, etc.]; exogenous poisons with psychosis [alcohol, etc.]; organic brain disease with psychosis).
5. Obsessive disorders (essential obsessional illness; other obsessional syndromes).
6. Hysterical disorders (the hysterical personality; general hysterical syndromes [fugues; amnesia; mimicry; grande hysterie]; conversion hysteria [paralysis; anaesthesia; aphonia; blindness]).
7. Disorders of development (oligophrenia; special disabilities; backwardness).
8. Psychopathic personalities.
9. Mental disorders in children (the foregoing formal disorders; disorders of behaviour, personality and habits; the maladjusted child).

* Skottowe, I. (1953) *Clinical psychiatry for practitioners and students*, London, The Practitioner

17. PSYCHIATRIC NOMENCLATURE AND CLASSIFICATION OF THE UNITED STATES WAR DEPARTMENT (1945) **

1. *Transient personality reactions to acute or special stress*
   - (*a*) General
   - (*b*) Combat exhaustion
   - (*c*) Acute situational maladjustment

2. *Psychoneurotic disorders*
   - (*a*) General
   - (*b*) Anxiety reaction
   - (*c*) Dissociative reaction
   - (*d*) Phobic reaction
   - (*e*) Conversion reaction
   - (*f*) Somatization reactions
     - (i) General
     - (ii) Psychogenic gastro-intestinal reaction
     - (iii) Psychogenic cardiovascular reaction

** The Standard Veterans Administration Nomenclature (1951) is a modification of this scheme. The most important change is the introduction of a separate main category of disorders headed " Alcoholic intoxication and drug addiction ". In the 1945 classification these were included under " Character and behaviour disorders ".

2. *Psychoneurotic disorders (continued)*
   - (iv) Psychogenic genito-urinary reaction
   - (v) Psychogenic allergic reaction
   - (vi) Psychogenic skin reaction
   - (vii) Psychogenic asthenic reaction
   - (*g*) Obsessive-compulsive reaction
   - (*h*) Hypochondriacal reaction
   - (*i*) Neurotic and depressive reaction
3. *Character and behaviour disorders*
   - (*a*) General
   - (*b*) Pathological personality types
     - (i) General
     - (ii) Schizoid personality
     - (iii) Paranoid personality
     - (iv) Cyclothymic personality
     - (v) Inadequate personality
     - (vi) Antisocial personality
     - (vii) Asocial personality
     - (viii) Sexual deviate
   - (*c*) Addiction
   - (*d*) Immaturity reactions
     - (i) General
     - (ii) Emotional instability reaction
     - (iii) Passive-dependency reaction
     - (iv) Passive-aggressive reaction
     - (v) Aggressive reaction
     - (vi) Immaturity with symptomatic "habit" reaction
4. *Disorders of intelligence*
   - (*a*) Mental deficiency
     - (i) General
     - (ii) Mental deficiency, primary
     - (iii) Mental deficiency, secondary
   - (*b*) Specific learning defects
5. *Psychotic disorders*
   - (*a*) Psychoses without known organic etiology
     - (i) General
     - (ii) Schizophrenic disorders
       - (ii.i) General
       - (ii.ii) Schizophrenic reaction, latent
       - (ii.iii) Schizophrenic reaction, simple type
       - (ii.iv) Schizophrenic reaction, hebephrenic type
       - (ii.v) Schizophrenic reaction, catatonic type
       - (ii.vi) Schizophrenic reaction, paranoid type
       - (ii.vii) Schizophrenic reaction, unclassified
     - (iii) Paranoid disorders
       - (iii.i) Paranoia
       - (iii.ii) Paranoid state
     - (iv) Affective disorders
       - (iv.i) Manic-depressive reaction
       - (iv.ii) Psychotic depressive reaction
       - (iv.iii) Involution melancholia
   - (*b*) Psychoses with demonstrable etiology or associated structural changes in the brain, or both

Manner of recording

Only the lowest sub-classification of the disorder is to be specified. Multiple diagnoses should be recorded, showing where relevant the primary diagnosis. Apart from type of reaction, its severity should be noted, as also type, degree and duration of external stress; predisposition; degree of incapacity.