CLASSIFICATION OF MENTAL DISORDERS

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In 1929 the Clinical Psychiatry Subcommittee¹ of the Royal Medico-Psychological Association began the revision of the existing official classification. This revision has been completed and accepted by the Royal Medico-Psychological Association as its official classification, and is here presented.

The scheme consists of two parts, intended to be used in conjunction with each other. Part I contains the actual classification and Part II the aetiological factors, or associated factors, as some may care to call them.

The revision of the aetiological factors has enabled the subcommittee to limit Part I as far as possible to a purely clinical classification—that is, one presenting clinical pictures or types of mental disorder with which all psychiatrists are familiar. Except in a very few well-defined instances, referred to later, terms with an aetiological connotation have been excluded from Part I. Further, an attempt has been made to make the classification sufficiently elastic to allow of future developments. For this reason the table consists of a limited number of broad headings, rather than an exhaustive inventory of syndromes and subgroups. Where, however, a patient is found to be suffering from a particular syndrome which is not adequately described under a group heading, it is stipulated that this is to be specified. For instance, a case of Korsakov's syndrome should be returned as "confusional state (Korsakov's syndrome)," and if the condition is deemed to be due to alcohol, the complete classification, expressed in symbols for statistical purposes, would be F (Korsakov's syndrome) 8 A a.

The headings under which such subtypes are likely to occur, or should be specified, have been indicated by an asterisk. Similarly, a number of the headings in Part II have been marked with an asterisk, and in these cases the precise aetiological factor is to be specified, when known. Thus a psychosis due to cerebral tumour should appear as I 10 (cerebral tumour); a case of depression following influenza and associated with a family history of manic-depressive psychosis would appear as E a ii . 8 B c & 1 a (manic-depressive).

CLASSIFICATION OF MENTAL DISORDERS—PART I

*To be Used in Conjunction with Part II
(The Aetiological Factors)*

- A. Oligophrenia (amentia, mental deficiency).
 - (a) Idiocy.
 - (b) Imbecility.
 - (c) Feeble-mindedness (moron).
 - (d) Moral deficiency.
- B. Neuroses and psychoneuroses.
 - (a) Exhaustion states (including neurasthenia).
 - (b) Anxiety states.
 - (c) Compulsions, obsessions, and phobias.
 - (d) Hysteria.
 - * (e) Mixed and other forms.
- C. Schizophrenic psychoses.
 - (a) Dementia praecox.
 - (i) Simple. (ii) Hebephrenic. (iii) Katatonic. (iv) Paranoid.
 - (b) Paraphrenia.
 - * (c) Other forms.
- D. Psychopathic constitution (including paranoia).
- E. Affective psychoses.
 - (a) Manic-depressive psychosis (cyclothymia).
 - (i) Elation. (ii) Depression. (iii) Stupor.
 - (b) Involutional melancholia.
- * F. Confusional states.
- G. Epileptic psychoses.
- H. General paralysis.
- * I. Other psychoses associated with organic brain disease.
- * J. Dementia.
- * K. Undetermined types.

* Specify type when possible—for example, Korsakov's syndrome.

CLASSIFICATION OF MENTAL DISORDERS—PART II

1. Heredity.
 - * (a) Psychotic.
 - (b) Epileptic.
 - * (c) Neurotic.
 - (d) Alcoholic.
 - * (e) Various organic nervous diseases.
 - * (f) Endocrine disease.
 - (g) Tuberculous.
2. Deprivation of special sense.
 - (a) Sight.
 - (b) Hearing.
3. Critical periods.
 - (a) Puberty.
 - (b) Adolescence.
 - (c) Climacteric.
 - (d) Senility.
4. Child-bearing.
 - (a) Pregnancy.
 - (b) Puerperium (not septic).
 - (c) Lactation.
5. Mental factors.
 - (a) Previous attacks of mental disorder.
 - * (b) Sudden stress.
 - * (c) Maladjustments of—
 - (i) Social life.
 - (ii) Sex life.
6. Physiological disturbances.
 - (a) Malnutrition.
 - (b) Privation.
 - * (c) Exhaustion.
7. Trauma.
 - * (a) Injuries.
 - * (b) Operations.
 - (c) Sun- or heat-stroke.
 - (d) Electric shock.
8. Toxic factors.
 - A. Chemical.
 - (a) Alcohol.
 - * (b) Narcotic drugs.
 - * (c) Mineral poisons.
 - * (d) Other poisons.
 - B. Infective.
 - (a) Syphilis.
 - (i) Congenital.
 - (ii) Acquired.
 - (b) Puerperal fever.
 - (c) Influenza.
 - * (d) The specific fevers.
 - (e) Tuberculosis.
 - * (f) Focal sepsis.
 - * (g) Other infections.
 - * C. Metabolic.
- * 9. Deficiency diseases (pellagra, beri-beri, etc.).
- * 10. Diseases of the nervous system.
11. Diseases of other systems.
 - * (a) Haemopoietic system.
 - * (b) Cardiovascular system.
 - * (c) Respiratory system.
 - * (d) Gastro-intestinal system.
 - * (e) Genito-urinary system.
 - * (f) Endocrine system.
12. No factor ascertained.
13. No history obtained.

Additional Notes

The following definitions and explanatory notes have also been adopted for the guidance of those using the classification.

A. *Oligophrenia (Mental Deficiency)*.—A condition of arrested or incomplete development of mind, whether arising from inherent causes or induced by disease or injury.

B. *Neuroses and Psychoneuroses*.—No differentiation is here made between the two conditions.

* To be specified.

(a) This should designate abnormal mental states characterized essentially by mental or motor fatigability and irritability.

(b) This includes the symptoms commonly exhibited by generalized fear.

(c) In this group should be included phobias, where the anxiety is attached to some definite object or situation.

(d) Is a faulty reaction to environment characterized by a variety of (1) motor symptoms, (2) sensory symptoms, (3) mental symptoms.

c. *Schizophrenic Psychoses*.—This syndrome includes cases which show remissions, and even recoveries, in addition to cases which show progressive deterioration.

(a) *Dementia praecox*.

(i) Simple: Cases characterized by defects of interest, gradual development of an apathetic state, often with peculiar behaviour, but without expression of delusions or hallucinations.

(ii) Hebefrenic: Cases showing prominently a tendency to silly laughter, grimacing, mannerisms, together with grotesque ideas and erratic behaviour.

(iii) Katatonic: Cases in which there is a prominence of negativistic reaction or peculiarity of conduct, with phases of stupor or excitement, sometimes characterized by impulsive or stereotyped behaviour, and usually hallucinations.

(iv) Paranoid: Cases characterized by unsystematized delusions, usually of persecution or grandeur, hallucinations in various fields, and a tendency to early dementia.

(b) *Paraphrenia*: Cases in which emotional and volitional disorder is slight. Delusions and hallucinations generally grandiose and fantastic, but with little effect on ordinary conduct.

d. *Psychopathic Constitution*.—This group includes a large group of pathological personalities such as are found among criminals, tramps, sex perverts, drug addicts, mattoids, agitators, etc. The true prison psychoses should be included in this group. *Paranoia*: A delusional syndrome of insidious development. Hallucinations are absent, and there is no deterioration.

e. *Affective Psychoses*.—Involitional melancholia comprises the slowly developing depressions of middle life and later years characterized by worry, insomnia, uneasiness, and agitation. States of depression in arteriosclerosis should be excluded.

g. *Epileptic Psychoses*.—This group includes only what is known as essential epilepsy. Cases of organic brain disease, with seizures of any kind, are not to be included.

h. *General Paralysis*.—Cases of cerebral syphilis are excluded.

j. *Dementia*.—This group does not include the dementias where the original condition is known. The arteriosclerotic and presenile dementias are to be included in Group i.

Commentary

Some of the items dealt with above call for further comment.

a. *Oligophrenia*: The term "amentia" is open to very grave objections. In the first place, few of the cases included present an "absence of mind," so that it is an inaccurate term. The word was first introduced by Meynert as a name for a condition which we to-day call "confusional insanity." It is used in this sense in the Norwegian and Dutch classifications. The Italians use "amenza" as one of their subdivisions of "tossinfessioni ed autointossicazioni," and divide it into "allucinatoria, apatica, lieve (pazzia sistematizzata acuta), gravissima (delirio acuto)." The clinics of Pilcz and Wagner-Jauregg in Vienna both used the word in the confusional sense. Shaw-Bolton used the word to correspond with "dementia" (meaning "out of the mind"), his amentia being defined as "the mental condition of patients suffering from deficient neuronic development." The Greek word "oligophrenia," meaning "small mind," was adopted by Bleuler, and is also in the Dutch classification. This term is certainly not used in any other sense than for all classes of mental defectives. It is hoped that medical men will encourage the use of the word, and that the inaccurate and ambiguous "amentia" will be dropped.

"Amentia" is retained in brackets simply as a guide in the meantime.

b. The terms "neuroses" and "psychoneuroses" were preferred to the expression "minor psychoses."

(a) The word "neurasthenia," for which many confess a liking, was rejected, as it was so very loosely used during the war as a dumping-ground for all sorts and conditions of mental disorders. Freud also uses the word in a restricted sense in connexion with masturbation. The expression "exhaustion states" was thought to convey a very definite meaning, and to indicate a fairly clear-cut clinical condition.

(c) Phobias have been separated from the anxiety states on the grounds of a fundamental difference between the vaguer, more indefinite and generalized fears of the latter and the definite attachment of fear to an object in the former.

(b) and (d) call for no special comment.

c. The word "schizophrenia" has come to occupy a permanent place in our vocabulary. The paraphrenic conditions, it was thought, ought to be separated from what we are used to calling dementia praecox. The time-honoured division into simple, hebephrenic, katatonic, and paranoid types was adhered to.

d. The paranoiac conditions which do not end in intellectual impairment should, it was thought, be sharply separated from the schizophrenic psychoses.

e. This section does not call for much comment. It was thought that the involitional states were more closely allied to manic-depressive insanity than to the schizophrenic conditions.

Section g is an unsatisfactory group, and will undoubtedly be subdivided as knowledge advances, but in the meantime it is retained to correspond to what is called "essential" epilepsy with psychosis. Obviously, however, an epileptic may remain sane, or may develop some other form of insanity, such as manic-depressive psychosis.

Section h (general paralysis) is a recognized clinical group, although purists may not agree with the diagnosis as sometimes made. Here again our knowledge is not sufficiently advanced to permit of any alteration.

i. The expression "the psychoses associated with organic brain disease" was intended to correspond with the present "insanity with gross brain lesion." It was felt that there was no need to separate off more than the syphilitic conditions.

k. The last division was left for conditions which could not be classified under any of the divisions a to j.

I cannot close these notes on the work of the subcommittee without expressing indebtedness to the late Dr. J. R. Lord. No one who has not had the pleasure of working with him can appreciate the extraordinary amount of work he did, or the help and encouragement he gave to the younger men. Although he did not live to see the completion of this classification, his was the moving spirit in the last two years' work.

REFERENCE

¹ This subcommittee at the time the classification was finally adopted consisted of the following members: Sir Hubert Bond (Emeritus Lecturer on Psychiatry, Middlesex Hospital), J. Brander, L. C. F. Chevens, K. K. Drury, W. Norwood East (Prison Commissioner), F. L. Golla, W. McCartan, Professor D. K. Henderson (Professor of Psychiatry, Edinburgh University), P. K. McCowan (Lecturer in Mental Diseases, Welsh National School of Medicine), D. McRae, W. F. Menzies, J. E. Nicole, W. D. Nicol (Lecturer on Psychiatry, London School of Medicine for Women), A. A. W. Petrie (Lecturer on Mental Diseases, Charing Cross Hospital and West London Post-Graduate College), M. Hamblin Smith, W. H. B. Stoddart, W. S. J. Shaw, B. H. Shaw, A. Walk, H. Yellowlees (Lecturer on Psychological Medicine, St. Thomas's Hospital), and the Honorary Secretary.

F. Bamatter (*Arch. f. Kinderheilk.*, March 31st, 1934) states that, whereas up to September, 1932, isolated cases of facial paralysis were rare, and actual bulbar paralysis was unknown, during the subsequent twelve months six sporadic cases of the bulbo-pontine form of infantile paralysis were observed in the University Children's Clinic at Zürich. There was, moreover, a simultaneous increase in sporadic cases of encephalitis and aseptic meningitis. In two very acute cases of bulbar paralysis the diagnosis was confirmed by inoculation of monkeys.