Classification and the British Glossary of Mental Disorders: 
Some Experience of Its Use

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A Glossary of Mental Disorders was published in 1968, prepared by the Registrar-General’s Advisory Committee on Medical Nomenclature and Statistics. The document used as a basis the Eighth Edition of the World Health Organization’s International Classification of Diseases (I.C.D.), Section V, which deals with mental disorders and mental subnormality. For the first time in this country the meaning of the categories listed in the I.D.C. are described, and the new Glossary stands beside the Second Edition of the American Diagnostic and Statistical Manual (D.S.M. II) which was also published in 1968. The psychiatrists working on the United States–United Kingdom Diagnostic Project* at the Institute of Psychiatry, Maudsley Hospital, London, and the Psychiatric Institute, New York, made diagnoses according the new Glossary descriptions on 820 hospital in-patients drawn from both sides of the Atlantic and interviewed using a standardized interview. The comments contained in this article are based on their experience.

Some clinicians still express the opinion that psychiatric diagnosis is either useless or impossible. Historically, medical classification is associated with an attempt to separate illnesses into discrete entities after the manner of botanical specimens. Many psychiatrists no longer hold this view of mental illness. Some have wished to retain certain categories or entities but not others, some have preferred to regard types of mental illness as distributed along a continuum either phenomenological or aetiological. Others have questioned the usefulness of a classification derived by dividing up a continuum, but they still find it helpful to divide psychiatry along the continuum of age into paediatric and geriatric sections.

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Sometimes classification is seen as irrelevant because attitudes to treatment are blinkered by theory.

Still other psychiatrists would prefer to retain classification, but have considered its reliability between different psychiatrists and for the same psychiatrists on different occasions to be decidedly poor (Beck et al., 1962). Stengel, however, has many times affirmed the importance of classification as a means of communication between psychiatrists with different interests or cultural background. Baldwin (1968) lists three main purposes of classification and applies them to psychiatry: (1) control of disease through aetiological and prognostic correlates of the classes, (2) communication between clinical staff, and (3) counting for research and administration uses.

It is not infrequently found that such words as nomenclature, classification, glossary and definition are used indiscriminately as synonyms. Nomenclature is simply a list of approved names used to describe items worth distinguishing from one another; classification is an attempt to group these names in a purposeful manner. A glossary is an explanatory list of difficult or technical terms, and the descriptions in it are not definitions nor in any way complete. In this instance they merely call to attention important points to assist in distinguishing one group in the classification from others.

The U.S.–U.K. Project did not set out with the purpose of examining the British Glossary, and no separate study was directed to that end. The comments, therefore, are mainly matters of opinion. However, it is hoped that they will serve as a minor contribution to the discussions from which the next edition of the Glossary must arise. They may also be of some help to other psychiatrists currently using the Glossary.
Two studies were undertaken, one without and one with the use of the Glossary. The procedures were quite different, and it is not possible to compare the one with the other.

The first study illustrates that British psychiatrists can arrive at some measure of agreement on diagnosis by using a classification but without the use of a glossary. Two hundred psychiatrists from seven different training centres in the British Isles were asked to make a diagnosis according to their own criteria and to rate their level of confidence in that diagnosis on three different patients given an unstructured interview on video-tape. Tape 1 had been specifically chosen because it was considered likely to give rise to diagnostic uncertainty; nevertheless 70 per cent of the psychiatrists agreed that the patient had schizophrenia, though they disagreed about the subcategory. The second tape was expected to produce more agreement, and here 83 per cent of the raters agreed that the diagnosis was schizophrenia and 78 per cent that it was paranoid in type. The third tape was chosen because it was considered that American psychiatrists would diagnose the patient as having schizophrenia but that British psychiatrists might disagree. Of the British psychiatrists 67 per cent made a diagnosis of either hysterical personality or hysterical neurosis; the overall agreement amongst the U.S. psychiatrists was quite different: 63 per cent diagnosed the patient as having schizophrenia. Over 83 per cent of the psychiatrists who made a diagnosis on each tape rated their choice as either 'quite confident' or 'reasonably confident', the two top ratings of a five point scale of certainty. These results show that for the videotapes used the British psychiatrists reached a measure of agreement on diagnosis without consulting the Glossary, but that in some instances their choice of diagnosis differed markedly from those of their fellows in other countries (Kendell et al).

For the second study, the members of the U.S.-U.K. Project themselves examined 820 hospital in-patients using standardized techniques, the Present State Examination (Wing et al., 1967) and a standardized history schedule (Cooper et al., 1969), after which they allotted each patient to a diagnostic category using the British Glossary as a guide. If they were uncertain of the diagnosis they were allowed to record an alternative choice. Subsequently a group discussion was held among the Project members on each diagnosis, and a change was made if it was considered by the group as a whole that the criteria of the Glossary had not been accurately applied. Results showed that in 70 per cent of the cases examined the members of the Project had sufficient confidence in their choice of diagnostic subcategories to render an alternative diagnosis unnecessary. As a result of the subsequent discussion it was agreed that 75 per cent of the diagnosis should stand; of the remaining 25 per cent, 8 per cent concerned minor changes, i.e. within a category and 17 per cent major changes from one category to another. No category or subcategory stood out more than another as giving rise to subsequent changes. The differences between the actual and expected values for both major and minor changes were not significant.

In the Glossary itself most categories were considered by members of the U.S.-U.K. Project to be clear and helpful but in some, especially the functional disorders, the instructions or descriptions were sometimes thought ambiguous or obscure. For example, under the heading 'Schizophrenia and Paranoid States' in the Introduction, paraphrenia and other paranoid states are discussed... 'The International Classification does not take sides in this controversy. It still allows those who adhere to the broader disease concept to view these paranoid conditions as subgroups of schizophrenia, while enabling others to classify according to their nosological theory.' The Glossary instructions say nothing about the use of alternatives under these categories. The Introduction could be interpreted to suggest that a diagnosis according to one's nosological theory is to be allowed, but this would make nonsense of statistical data. The Project has assumed that 'it still allows those who adhere to the broader disease concept... etc., means 'for their own personal use'; that each subcategory of the Glossary must be used if it is appropriate unless an alternative choice is specifically permitted.
The category of schizophrenia as a whole works well, but involutional paralysis has a separate entry elsewhere, and schizo-affective type has a different meaning to the one sometimes used by clinicians, i.e. to indicate that the diagnosis between affective or schizophrenic illness is in doubt. In the I.C.D. it is a subcategory of schizophrenia in which, according to the Glossary, "both the affective and schizophrenic symptoms are pronounced".

By far the least satisfactory categories are those dealing with the affective group. There are four subcategories of depression, three psychotic: involutional melancholia 296.0, manic depressive psychosis, depressed type 296.2, reactive depressive psychosis 298.0; and one neurotic, depressive neurosis 300.4. Here there are a number of problems, of which one is the disputed division between psychotic and neurotic depressions. This distinction the Project psychiatrists found particularly difficult to make according to the Glossary descriptions. The hard-pressed clinician probably tends to make a rapid diagnosis on clinical impression, enquiring for a number of prominent key symptoms. In the Glossary diagnosis of neurotic depression is to be made largely by exclusion. Part of the description reads: 'Here are to be included states of depression which follow some psychic trauma, and in which excessive preoccupation with the traumatic experience is prominent.' The Project psychiatrists found patients with no convincing traumatic experience but with predominantly neurotic type symptoms and relative absence of somatic features. They therefore interpreted 'Here are to be included . . . ' to mean only what it said, and not to imply that other types, i.e. without preceding psychic trauma, were to be excluded.

It has been claimed that such features as feeling worse in the morning, or evening, are important for distinguishing between psychotic and neurotic depression. Although the Glossary makes reference to this distinction in the description of manic depressive psychosis, depressed type, it nevertheless ignores it in the description of depressive neurosis. It seems to regard all forms of diurnal variation as indicating psychotic depression. Here the Glossary pays only lip service to the separationists and the I.C.D. It should have the courage either to amend the I.C.D. to its own liking—as the American Psychiatric Association has done for parts of their glossary D.S.M. II (which would be highly undesirable)—or make an attempt to give fuller descriptions of these subcategories.

The original U.S.–U.K. sample of affective disorders diagnosed according to the Glossary descriptions was submitted to discriminant function analysis (Kendell and Gourlay, 1970) and there appeared a 14 per cent overlap in diagnosis between neurotic and psychotic depression when the patients' diagnostic index scores were placed on a continuum. The present author (1970), using his own descriptions based on symptoms culled from the literature (e.g. psychotic depression: retardation, self-blame, early morning waking, feeling worse in the morning, somatic features, etc.; neurotic depression: anxiety, blaming others, difficulty getting off to sleep, feeling worse in the evening, none or only slight somatic features, etc.), found, after discriminant function analysis on a consecutive series of 94 depressed in-patients, only a 3 per cent overlap. Although more precise description of the categories is probably largely responsible for this reduction in overlap, the use of a single observer is also likely to have contributed. Nevertheless it is suggested that if these categories are retained in the next edition of the I.C.D., aetiological descriptions of depressive neurosis should be avoided in the Glossary, which should here concentrate on the phenomenology.

The other main cause of confusion arises from the new subcategory of reactive depressive psychosis, 298.0. This is to be clearly distinguished from 'reactive depression' interpreted by many writers in the past as more or less synonymous with depressive neurosis. Reactive depressive psychosis, principally a Scandinavian term, is described as having the symptomatology of manic depressive psychosis, depressed type, but supposed to be precipitated by psychological trauma 'other than childbirth or surgery'. In some centres observed by the Project, a clinical diagnosis of reactive depression (i.e. almost synonymous with neurotic depression) is being coded as reactive depressive psychosis.
The description of manic depressive psychosis, manic type, is all-embracing, and the inclusion of phrases which hardly suggest abnormality, such as 'ranging from a quiet, sunny good humour to boisterous elation', etc., can only lend weight to those who claim that the British tend to overdiagnose this condition (Spitzer et al., 1969). The description of manic depressive psychosis, circular type, seems unnecessarily obscurely worded and difficult to apply. It would have been sufficient to indicate a disorder in which both mania and depression occur at different times in the same patient.

The neurosis section on the whole appears to work satisfactorily. Here there seems to be a reluctance to extend the logic of including the syndrome depression among the neuroses to including the symptom depression in other neurotic conditions, e.g., anxiety neurosis. Often it is a haphazard choice by the clinician, or one determined by his orientation, which decides under which label the many patients with mixed symptoms of anxiety and depression are included; some guidance here would have been welcome.

The sub-categories of personality disorder are fairly described, and it is not the fault of the Glossary if many patients still have to be included under the sub-category 'Other'. It is difficult to see how at this stage they could be more precise, but certain sub-categories tend to overlap with sub-categories elsewhere, i.e., schizoid personality is not clearly distinguished from simple schizophrenia. Perhaps this is the fault of the Classification for including so dubious and confusing a sub-division of schizophrenia, which is not helped by the description 'clear-cut schizophrenic symptoms are often not evident, and the diagnosis, often arrived at by exclusion, seldom definite'. Paranoid personalities are to be distinguished from paranoia by the often slender distinction between an over-valued idea and a delusion. This means that the morbidly jealous, if the belief is not delusional, are included under the personality disorders; if the belief is delusional they are provided for under paranoia 297-o, unless the condition is considered due to alcoholism when it appears under alcoholic paranoia 291-3. However, it is easier to criticize than to suggest solutions in the category of personality disorders.

One or two terms still need clarifying, e.g., how transient is a 'transient situational disturbance' (307)? The description starts: 'Acute symptoms of a varied kind appearing as a transient response, etc.' It might be helpful to remind the diagnostician that, as this category is to be found in the non-psychotic section, 'acute symptoms of a varied kind' presumably do not include delusions, hallucinations or confusion. The last has a special sub-category of its own—reactive confusion 298-2 in the psychotic section. Category 307 should not be used as a ragbag for any kind of acute undiagnosable condition thought to be precipitated by stress.

Apart from observations on individual categories there are a number of comments which may be made on the Glossary as a whole. For example, there is an unhappy occurrence of words like 'supposed', which by their pejorative undertones may reflect the views of the compilers and influence adversely the use of certain categories. Since these categories have been included in the Glossary they should be provided with clear and if possible unbiased descriptions.

The Glossary provides some disputed categories with an escape clause. For example, those who cannot force themselves to recognize the sub-category reactive depressive psychosis may use instead manic depressive psychosis, depressed type. A superficial impression of flexibility and reasonableness is conveyed by the compilers' willingness to allow an alternative choice. The Project psychiatrists regarded it as an unsatisfactory solution, reducing the value of the statistical data. There are many similar categories in the I.C.D. to which such an alternative could apply, 'reactive excitation' for example.

Finally there are two important points, one regarding the approach to the diagnostic process, and the second advice on the coding of more than one diagnosis, which although they did not fall within the terms of reference of the Glossary Committee need to be urgently considered if the Glossary is to be applied to its best advantage. The American D.S.M. II
contains an introduction which goes some way toward solving these difficulties, and it would seem sensible for the General Register Office to arrange for a similar introduction to precede the British Glossary.

The Diagnostic Project attempted to overcome these problems for its own purpose. For example, when making a diagnosis according to the Glossary descriptions the U.S.–U.K. Project members abandoned any attempt to translate their personal diagnoses into Glossary terms. Instead they attempted to set aside their own diagnostic prejudices, and bearing in mind the symptoms and in some instances the history of the condition made the first diagnosis in accordance with the Glossary descriptions, and only subsequently made their own diagnosis if they so wished. Unfortunately, in routine clinical practice the Glossary diagnosis is often made in retrospect, sometimes after the patient has been discharged, and not always by the doctor who made the clinical diagnosis. A more satisfactory solution would be for the clinician to diagnose in a manner similar to the project by first making the Glossary diagnosis, and then his own, at the time of the first clinical review, modifying it later if necessary. Thus the clinician would be encouraged to examine critically his own personal diagnosis if it varied from the I.C.D. and Glossary. Only by such a disciplined, self-critical approach to diagnosis can psychiatrists hope to agree in their use of parts of the classification and Glossary, while having at the same time more knowledge to pool on other parts, where they may agree between themselves but disagree with the Glossary.

Guidance is needed about coding more than one diagnosis, or deciding to which of a number of diagnoses to give priority. This point can hardly be sufficiently stressed. At present official statistics, which form the basis of much Ministerial planning, are lamentably inaccurate and subject to diagnostic fashion. The Glossary descriptions will go some way towards improving diagnostic reliability, but so long as no guidance is forthcoming on what is to be coded, spurious differences will appear between different hospitals and between the same hospital at different times. For example, a homosexual is admitted with an anxiety neurosis. Gradually the latter condition resolves and the patient then impresses the doctor with his underlying problem. Whether he is coded primarily under Neurosis or Sexual Deviation is left to the whim of the doctor. Recently, in a study of depressed patients, the author found that 13 per cent of patients admitted with a diagnosis of depressive neurosis and subsequently treated with antidepressants, on discharge received a primary diagnosis of personality disorder. The American D.S.M. II instructs its readers to list first ‘the condition which most urgently requires treatment’ and if ‘there is no issue of disposition or treatment priority, the more serious condition should be listed first’. The members of the U.S.–U.K. Project required a uniform system, and for their own purpose drew up a simple hierarchy of terms whereby any psychosis preceded a neurosis and any neurosis a personality disorder. The system in this country has usually been to give the diagnosis that was the reason for treatment, but until official guidance is given no uniform method will be used. It is hoped that official instruction will be forthcoming in the case of returns to the Department of Health and Social Security. If the I.C.D. and Glossary are used for research or for comparing different areas it will be necessary for the investigators to state clearly which system they are using.

In the Introduction to the Glossary there is a short apologia pointing out that not all psychiatrists will agree with the choice of categories but that this feeling of dissatisfaction is unavoidable in 'a classification which is the result of compromises between many schools of thought, none of which can claim superiority over the rest'. Although criticisms of the Glossary will be inevitable, they should not be allowed to obscure the basic success of the compilers in producing a document which attempts description of these compromise categories and is so generally acceptable. Some psychiatrists may feel unhappy about the use made of prognosis in the descriptions, e.g. involuntional paraphrenia, bearing in mind that the diagnosis may have to be made before the prognosis is known. Some, no doubt, would have preferred the Glossary to have introduced a
fifth digit like the D.S.M. II so that important items like Huntington's chorea, Down's syndrome, anorexia nervosa and others could have been recorded separately. But on the whole the Glossary is not difficult to use, and its appearance should be welcomed as a significant event by those who consider that diagnosis is an essential part of clinical psychiatry.

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References


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