NOSOLOGY and the OFFICIAL PSYCHIATRIC NOMENCLATURE

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"What's the use of their having names?" the Gnat said, "if they won't answer to them?" "No use to them," said Alice, "but it's useful to the people that name them, I suppose. If not, why do things have names at all?"

Lewis Carroll, *Through the Looking Glass*

Nosology and Principles of Classification

Classification is the process by which man reduces the complexity of phenomena by arranging them into categories according to some established criteria for one or more purposes. Classification is the formal human process analogous to concept formation that occurs in all higher animals as they attempt to master their environment.

A classification of disease entities in medicine is called a nosology, from the Greek words *nosos* (disease) and *logia* (study). The specific terms used to identify the categories are called a nomenclature. It includes the names of the disorders as well as any other technical terms used to describe patients. Whereas the classification system indicates how the various disorders relate to each other, the nomenclature is merely an arbitrary collection of technical terms independent of any underlying characteristics.

Many fevered polemical discussions of psychiatric classification could be mercifully shortened were there a basic understanding that the concept of disease or illness is made by man. It does not reflect any intrinsic property in nature. All of the variations in the human condition which exist in nature such as left handedness, genius, tuberculosis, schizophrenia, atherosclerosis, and dwarfism, are in a sense equally "natural." It is man who in his efforts to improve the quality and length of his life has developed the concept of illness to identify those conditions for which there exists a consensus that they are bad and ideally should be treated. In addition, the concept of illness implies that the medical profession, or one of its specialties, has certain skills which are of aid in treating, or at least in identifying and hopefully understanding such conditions.

A nosology is reliable to the extent that the rules for categorization are clear so that users of the system diagnose patients in the same way. A nosology is valid to the extent that it is useful in accomplishing the three purposes of all classification systems — communication, control, and comprehension. The first purpose of a nosology is to enable users to communicate with each other about the pathological phenomena they deal with in common. In medicine, communication involves using names that function as efficient symbols for summarizing naturally occurring clusters of data that would otherwise require a larger number of descriptive terms. This is the first stage in the development of a classification system whose only purpose is to facilitate communication by identifying the subject.
matter which is to be mastered. The ability to predict the course and outcome of a disorder, even if one is unable to treat it, provides a limited form of control. The ability to modify the disorder by treatment adds additional control. Comprehension means understanding the cause and pathological process of the disorder. In psychiatry, as in the rest of medicine, there are many disorders that can be treated effectively without understanding either the etiology or the pathological process.

Psychiatry and the Medical Model

Although it has become fashionable to denounce the medical model as inappropriate to the problems of psychiatry, most of the arguments rely on straw man assumptions about what the medical model implies. Critics of the medical model for psychiatry often cite 4 presumed criteria for medical disorders that most psychiatric conditions do not meet. They are: (1) specific etiology (2) discontinuity with normality, (3) demonstrable physical change, and (4) an internal process that, once initiated, is not completely modifiable by external environmental influences. However, these critics fail to realize that numerous other diseases do not meet these requirements either.

Even for the infectious diseases that meet Koch's postulates, specific etiological agents or factors are, at most, necessary but not sufficient to account for the presence of disease. Most medical illnesses are the result of a combination of etiological factors, which include host resistance, environmental influences, and severity of exposure to the causative agents.

Most medical conditions manifest themselves as qualitatively different from normal functioning. However, in many medical diseases, such as essential hypertension and the endocrine disorders, there is no sharp demarcation between health and pathology, and the criteria for diagnosis are only arbitrarily specified.

Most medical conditions are accompanied by manifest physical changes in the body. However, many medical conditions—such as idiopathic epilepsy, cardiac arrhythmia, and some of the endocrine disorders—appear to be disturbances in physiological function and have no anatomical correlates demonstrable by current technology.

Most medical conditions are processes that, once initiated, proceed relatively independently of environmental influences. However, vitamin deficiencies and kwashiorkor are both initiated and maintained by environmental factors operating on essentially normal organisms.
Since many medical illnesses, as well as psychiatric conditions, do not meet these requirements, what are the fundamental assumptions of the medical model? In the authors' view they are merely the following: (1) there are more or less distinct human conditions associated with suffering and disability with more or less distinct etiologies and natural courses which respond differently to more or less distinct treatments, and (2) the study and treatment of these conditions is at least partly the responsibility of the medical profession. This conception of the medical model makes no a priori assumptions as to what etiological factors (physical, social, genetic, psychological, developmental) are responsible for the development of these conditions nor what kind of treatment (somatic, psychological, social, behavioral) will be most effective. Consequently, there is no a priori reason not to apply the medical model to psychiatric problems. Its appropriateness cannot be determined on logical grounds but only by examining how well it works in practice in mastering psychiatric phenomena. Even when it works poorly it should not be abandoned unless some other model is shown to work more effectively in mastering the same phenomena. However, since the word "disease" usually does connote manifest physical dysfunction, the appropriate generic term for a psychiatric illness is "mental disorder."

Problems in Defining Mental Disorder

It is remarkable that none of the standard textbooks of psychiatry, nor the first or second edition of the American Psychiatric Association's Diagnostic and Statistical Manual provide a definition of mental disorder. It is true that textbooks in medicine also fail to provide a definition of medical (nonpsychiatric) disorders but the reason for this is simple: no definition is needed. Medical (nonpsychiatric) disorder, are conditions associated with physical pain, disability, or death. Within our society there is a consensus shared by the medical profession, society at large, and those individuals afflicted with conditions associated with physical pain, disability, or death, that they are invariably undesirable and ideally should be treated (even if for some of them no treatment is currently known). Consequently, individuals with migraine headaches or painful, swollen, rheumatoid joints, never insist that these conditions are normal and should not be classified as illnesses. (Members of some religious sects deny the concept of bodily illness but they would agree that the manifestations of these conditions are undesirable.)

On the other hand, mental disorders are manifested by deviations in behavior from some normative concept. (Throughout this discussion, the term "behavior" includes ideation and affect.) The problem in defining mental disorder is that the widespread consensus that exists regarding the unde-
sirability of specific manifestations of nonpsychiatric medical disorder (pain, disability, death), does not always exist for the behavioral manifestations of what have traditionally been regarded as mental disorders.

The lack of consensus regarding the specific manifestations of psychiatric disorder may take three forms: controversy as to whether a given condition should be regarded as undesirable at all; how undesirable a condition should be to warrant its designation as an illness; and finally, whether the condition, even if markedly undesirable, should be regarded as within the domain of psychiatry or some other discipline. An example of the first area is the controversy as to whether or not preferential homosexual behavior should be regarded as undesirable compared to heterosexual behavior. An example of the second area would be whether certain mild personality patterns are sufficiently undesirable to warrant designation as a psychiatric disorder or whether they should be viewed purely as descriptive traits. A further example in this area would be the controversy as to whether preferential homosexuality, even if viewed in some sense as not as desirable as heterosexuality, is sufficiently undesirable to warrant its designation as illness. Finally, an example of the third area is the controversy as to whether certain forms of serious antisocial behavior should be regarded as "sick" (manifestations of psychiatric disorders) or "bad" (the responsibility of the criminal justice system).

Although there is as yet no explicit definition of mental disorder which is universally accepted by our profession, by examining the labeling practices of psychiatrists, it is possible to identify at least two main approaches to the problem. The first, or broad, approach views mental disorder as any significant deviation from an ideal state of positive mental health. Thus, sexual practices, value systems and personality traits which are deemed less than optimal or a result of intrapsychic conflict are viewed as manifestations of mental disorder. The second, or narrow, approach also accepts the notion of a continuum of conditions highly desirable (positive mental health) to highly undesirable (mental illness) but places the cut-off point for mental disorder closer to the highly undesirable end of the continuum so that only conditions clearly associated with suffering and disability are designated as illness or disorder. Although the broad approach is not logically implied by the acceptance of basic psychoanalytic principles, it does seem to have its strongest adherents amongst psychoanalytically oriented psychiatrists. This may explain the widespread prevalence of this approach in the United States. In contrast, the narrow approach seems more characteristic of the approach taken by almost all European psychiatrists and may explain the tendency in epidemiological studies conducted in the United States to report a much higher incidence of mental disorder than is generally reported in European studies.
The narrow and broad approaches can be contrasted with each other by dividing the health-sickness continuum into three groups of conditions and determining how each approach towards defining mental disorder classifies each group of conditions as either illness or not illness (Table 1). Each group is determined by the attitude taken towards experiencing the manifestations of the conditions by (1) individuals who have the conditions, and (2) individuals who do not have the conditions.

The first group consists of conditions whose manifestations no one wants to experience—either those individuals with the conditions or those without them. This criterion is met by all non-psychiatric medical disorders (from mild cold to malignant carcinoma) and almost all of the traditional psychiatric disorders, such as the neuroses, the personality disorders, and the psychoses. It may be argued that some manics or schizophrenics while ill seem, or even claim, to enjoy their symptoms. However, if a period of remission occurs in such individuals, they by and large take a very negative attitude towards the original experience as well as towards reexperiencing the same symptoms. It may also be argued that individuals with personality disorders, such as antisocial personality, often do not take a negative view towards experiencing the manifestations of their condition since they frequently justify their own behavior and blame others for the difficulties that it causes. However, a distinction must be made between justifying a particular behavior and viewing the experience associated with the behavior as inherently desirable. For example, an individual with antisocial personality, with a life long history of job failure, marital difficulty, and arrests for stealing may feel that his behavior which resulted in these difficulties was unavoidable and therefore justified, but he would still agree that if it were possible, he would be better off if he could have avoided these difficulties.

The second group consists of conditions whose manifestations are such that (1) individuals without the conditions do not want to experience them, and (2) some of the individuals with the conditions wish to experience them and some do not. Thus some individuals who are either introverted, racially prejudiced, asexual, or exclusively homosexual, are glad they are that way; others wish they were not. However, no individuals who are extroverted wish they were introverted; no individuals who are not racially prejudiced wish they were; no individuals with sexual feelings wish they were asexual; and no heterosexually oriented individuals wish they were exclusively homosexually oriented.

The third group of conditions is characterized by the following: (1) all of the individuals who have these conditions take a positive attitude towards experiencing their manifestations, and (2) individuals who do not have these conditions are divided as to their attitude towards experiencing the
manifestations; some are positive, and some are negative. Examples of conditions that meet these criteria include: heterosexuality, extroversion and genius. Thus, heterosexuals never ask to become exclusively homosexual, extroverts never wish to be introverted and geniuses never wish to be of duller intelligence, whereas, some exclusive homosexuals wish they were heterosexual, some introverted individuals wish they were extroverted, and many individuals with average intelligence wish they were in the genius range.

Returning to the two main approaches towards defining mental disorder, it is clear that both approaches agree that the first group of conditions represent mental “disorder” or “illness” and that the third group is not illness. It is with the second group that the two approaches differ. By conceptualizing mental disorder as any significant deviation from an ideal state of positive mental health, the broad approach tends to view the second group of conditions as mental disorders. On the other hand, the narrow approach, by conceptualizing mental disorders to include only conditions clearly associated with suffering and disability, does not designate the second group as illness.

A consequence of the broad approach is that frequently individuals who do not feel sick or ill will be designated as having a mental disorder, since many individuals with the second group of conditions are quite satisfied with them and do not wish treatment. This approach has led to the charge that psychiatry in its diagnostic practices is acting as an agent of social control by disguising essentially social values in the language of medical diagnostic concepts.

A consequence of the narrow approach is the dilemma of how to diagnose those individuals with conditions in the second group who wish treatment, since these conditions per se do not according to this approach, warrant designation as illness. Since these individuals are distressed by their condition it can be argued that they are ill and that the labeling dilemma can be solved by labeling the mental disorder with terms that describe the distress caused by the second group of conditions without the necessity of categorizing the condition itself as an illness. For example, as applied to homosexuals who are disturbed by their sexual orientation, the mental disorder of these individuals could be designated as sexual orientation disturbance, since the distress is with the sexual orientation. Similarly, individuals with asexuality who are distressed by this condition, could be given the diagnosis of sexual functioning disturbance, associated with asexuality.

The authors believe that psychiatry can more cogently claim to be a part of medicine if in its diagnostic practices it limits the concept of illness to the first group of conditions and to those
individuals who are distressed by any of the second group of conditions. We also believe that this approach makes it possible to rather clearly define in more operational terms what a mental disorder is.

Definition of a Mental Disorder

The definition of a mental disorder proposed here is an elaboration and expansion of a definition offered by Spitzer in considering the problem of whether homosexuality should be removed from the official nomenclature of the American Psychiatric Association (Spitzer, 1973);

I The manifestations of the condition are primarily psychological and involve alterations in behavior. However, it includes conditions which are manifested by somatic changes (e.g., psychophysiological reactions) if an understanding of the etiology and course of the condition is largely dependent on the use of psychological concepts, such as personality, motivation, and conflict.

II The condition in its full blown state is regularly and intrinsically associated with either:
(a) subjective distress, or
(b) generalized impairment in social effectiveness or functioning, or
(c) voluntary behavior that the subject wishes he could stop because it is regularly associated with physical disability or illness.

III The condition is distinct from other conditions in terms of clinical picture, and ideally, follow-up, family studies and response to treatment.

The first criterion deals with the problem of distinguishing psychiatric from nonpsychiatric medical conditions. However, there are many conditions, such as general paresis and the psychosomatic disorders, which are regarded as psychiatric because the manifestations are behavioral, but also as nonpsychiatric because the actual treatment involves skills that are associated with the training of other specialties. It is understandable that as the treatment of a traditional psychiatric disorder, such as paresis, becomes almost entirely dependent on the skills of other specialties, it ceases for all practical purposes to be regarded as a psychiatric disorder, even though it may remain in the standard nomenclature as a psychiatric disorder.

The phrase in the second criterion, "full blown" acknowledges that some psychiatric conditions in an early stage of development may not be associated with subjective distress or impairment just as many nonpsychiatric medical illnesses may be initially asymptomatic. Similarly, the phrase
"regularly...associated with" recognizes that just as some highly unusual cases of carcinoma may remain totally asymptomatic, so it is possible that some rare individuals with even a psychotic illness may not evidence subjective distress or impairment in social effectiveness. These criteria are for defining conditions that are mental disorders, not for defining individuals who are overtly ill.

The phrase "intrinsically associated with" indicates that the source of the distress or impairment in functioning must be the condition itself and not with the manner in which society reacts to the condition. Transsexualism is a mental disorder because the source of the subjective distress associated with this condition resides in the very nature of the disorder. In contrast, left handedness, and masturbation in adolescents ceased to be considered illnesses when it was recognized many years ago that the source of the distress associated with these conditions was entirely in the negative reaction of society to these conditions.

Generalized impairment in social effectiveness or functioning refers to the inability to function in a large number of social contexts, such as with friends, at work, at school and in marriage. The impairment in functioning, if it is not subjectively distressful, must not be limited to a single area, such as work or heterosexual relations, for otherwise the definition of mental disorder would be an invitation to clinicians to employ their own individual value systems in determining what areas of human functioning are critical. There is no difficulty in reaching a consensus within the profession and society at large that generalized impairment in social effectiveness or functioning is undesirable. It is also a reasonable assumption that when a limited area of impairment in functioning is properly designated as illness, it will be associated with subjective distress (e.g., work inhibition, impotence).

The criterion of "voluntary behavior which the subject wishes he could stop because it is regularly associated with physical disability or illness" is a new concept which makes it possible to identify conditions such as compulsive cigarette smoking and compulsive eating as mental disorders since a consensus is developing within our society and by those individuals with these conditions that they are physically harmful to their well being. This criterion also makes it possible to include as a mental disorder conditions in which a patient has been advised to avoid certain kinds of foods or other voluntary activities in order not to aggravate a medical condition, but finds that he is unable to do so as a consequence of which his health deteriorates.

The third criterion deals with the problem of justifying the appropriateness of the medical model. In doing this, it must be demonstrated that the condition is separate from other conditions, thus
justifying conceiving of it as a distinct diagnostic entity. For example, the presence of worry, anxiety, and lack of self-confidence upon entering college satisfies the first two criteria of a mental disorder. However, since this constellation of symptoms cannot be distinguished from similar symptoms occurring in a variety of other psychiatric conditions and in a host of situations, it makes no sense to regard this constellation of symptoms when it occurs upon entering college as a separate diagnostic entity.

It should be noted that the criteria for a mental disorder proposed here in no way depends on the etiology of the condition. This is because the etiology of a condition, although it may be of great interest for a variety of reasons, does not speak to the issue of whether the condition, once it has developed, is inherently undesirable and therefore potentially classified as a disorder or illness. This is contrary to the widespread notion that if it can be demonstrated that a condition is caused by or associated with a higher than normal incidence of some form of familial disturbance, intrapsychic conflict or irrational fear, this is proof that the condition is somehow inherently pathological. The fallacy of this approach can be demonstrated with a few examples. If it could be shown that psychiatrists come from families with more psychiatric disturbance than do physicians from other medical specialties, this would not be proof that being a psychiatrist is pathological. Similarly, monogamy is maintained in many individuals by irrational fears of disapproval, sexual inadequacies, etc. This does not make monogamy per se a pathological condition.

How well do the criteria for a mental disorder proposed here apply to the psychiatric disorders in the traditional nomenclature? All of the conditions in the traditional nomenclature satisfy the first criterion, although the exact role of psychological factors in the development and course of the psychosomatic disorders remains unclear.

The second criterion would seem to apply to virtually all of the conditions in the traditional nomenclature with the exception of homosexuality and some of the other sexual deviations (when in mild form). Although it could be argued that some of the personality disorders also do not fulfill the second criteria, this is probably only true when a diagnosis of a personality disorder is incorrectly used to describe the presence of certain personality traits. However, as already noted,
the second criterion would include conditions such as compulsive cigarette smoking and compulsive eating, which are not now in the standard nomenclature.

The greatest discrepancy between the three criteria proposed here and the traditional nomenclature is in the third criterion: the demonstration that the disorder is distinct from other disorders in terms of clinical picture, follow-up, family studies and response to treatment. Many of the personality disorders, and some of the subtypes of neurosis in the standard nomenclature have not been demonstrated to be distinct conditions.

The purpose of presenting this definition of a mental disorder is to help clarify some of the issues in the controversy as to what psychological conditions should be regarded as pathological, in need of treatment, and the responsibility of the psychiatric profession, and what are the borders separating psychiatry from other disciplines. The definition proposed here, because it takes the narrow approach to defining a mental disorder, is also helpful in answering the charge that by defining certain conditions as mental disorders psychiatry is merely acting as an agent of social control. On the other hand, it should be recognized that this definition may need to be changed in future years to correspond with a change in the attitude of society and the psychiatric profession towards certain conditions. The tentativeness of the definition is illustrated by the fact that the criterion of "voluntary behavior which the subject wishes he could stop because it is regularly associated with physical disability of illness" was only added very recently as it became clear to society and the medical profession that, for instance, inability to stop chronic cigarette smoking was not a trivial matter but rather could have important consequences for one's physical health.

LEVELS OF PSYCHIATRIC DIAGNOSIS

As is true in the rest of medicine, it is useful in psychiatry to conceptualize various levels of understanding of pathological phenomena. At the simplest level, one speaks of a sign or symptom that represents a specific discernible abnormality. Examples in psychiatry include anxiety, depressed mood, and hallucinations. Signs of symptoms by themselves fulfill the first two criteria of the definition of a mental disorder offered above, but not the third since they do not represent distinct entities. Just as in physical medicine fever is a sign associated with many different physical disorders, anxiety is a symptom associated with many distinct psychiatric disorders.
At the next level, recurring groupings or patterns of symptoms are designated as syndromes. The concept of a syndrome is that many different specific processes may be involved in producing the disturbance. For example, the neurological syndromes, such as Horner's syndrome, result in a pattern of symptoms by virtue of the location of the lesion in a specific portion of the nervous system. The lesion, however, can be caused by a variety of specific pathological processes. Similarly, in psychiatry the organic brain syndrome involves the associated presence of impairment in memory, orientation, and other aspects of intellectual functioning, with diffuse impairment of brain tissue function.

When the best evidence available suggests a distinct pathological process, one then speaks of a disease entity or, in psychiatry, a mental disorder. For example, syphilis is a specific disease entity sometimes associated with Horner's syndrome, and alcoholic deterioration is a specific mental disorder associated with an organic brain syndrome. Recent evidence suggests that bipolar affective illness is a distinct psychiatric disorder whereas the constellation of depressed mood, loss of interest, psychomotor and vegetative disturbance, etc. is merely the depressive syndrome. It is important to realize that whether a condition should be regarded as a syndrome or as a distinct diagnostic entity is a function of our present state of knowledge. Future knowledge may lead to a distinct entity being recategorized as a syndrome as new distinct entities are discovered. An example of this is the discovery of many diagnostic entities based on specific biochemical defects associated with mental retardation.

A common misunderstanding in the discussion of the relationship of medical nosology to psychiatric nosology is the belief that one can speak of a disease entity only when the etiology is known. Actually, the term disease entity is widely used in medicine for conditions in which the cause is unknown but in which a seemingly specific pathological process has been identified. Examples include Hodgkin's disease, multiple sclerosis, and arteriosclerosis.

Robins, Winokur, Guze, and their colleagues (Feighner et al., 1972) have described a process for determining whether a psychiatric condition can be properly conceptualized as a valid diagnostic entity (criterion III in the definition of a mental disorder offered above).
First, the clinical picture must be described. This may consist of a single prominent symptom or a cluster of symptoms or clinical features, including social or demographic characteristics, patient's age at onset, and precipitating factors. Second, the defining characteristics of the group are refined to exclude patients whose characteristics by other criteria, such as course, laboratory studies, or familial characteristics, suggest that they are not members of the core group. Follow-up studies are helpful to determine whether or not all of the individuals in the core group are suffering from the same
classification disorder. If a sizable number at follow-up appear to have a different condition, it suggests that the original criteria need to be modified to make the group more homogeneous. If all the patients in a core group respond similarly to a specific treatment, for example, manic depressives in the manic phase treated with lithium, there is additional evidence that the core group represents a homogeneous entity. It should be noted that the use of course or response to treatment as a defining characteristic of a psychiatric illness is controversial. The illness process may be different from the factors in the patient or in his environment which account for some patients recovering while others do not (Zubin, 1967). However, in the absence of knowledge of a specific illness process, it is wise to be suspicious of the concept that the illness is a single condition if the course or response to a specific treatment is extremely variable.

As Klein (1969) has noted, a classification system based on categories that have been refined by using all of these criteria probably delineates categories based on a common etiology or pathological process. However, until specific pathological processes have been demonstrated, these categories must be considered to have the status of syndromes rather than diagnostic entities.

At this point in history, our standard classification system in psychiatry includes many "diagnostic" categories, such as some of the personality disorders, which at best do not even have much value for the simple purpose of communication. On the other hand, there are other
categories, such as dissociative or conversion neurosis, which, while not at the syndromal level, have been of value to clinicians over the years as a convenient short-hand way of describing one or more prominent features found in some patients. Other categories, such as affective illness and schizophrenia, are probably at the syndromal level. It must be acknowledged that only some of the organic brain syndromes for which the etiology and pathological process are known can be considered fully valid diagnostic entities.

The reader can determine for himself whether the diagnostic categories in the standard nomenclature are at the level of symptom, syndrome or diagnostic entity (disease or disorder) by asking himself the following question as he reads about them in this textbook: What information is conveyed by knowledge of this diagnostic category (other than the defining characteristics of the category) in terms of etiology, familial characteristics, correlates of demographic or social variables, course, prognosis and response to specific treatment modalities?

Alternatives to Nosology in Psychiatry

Szasz. The most radical critique of psychiatric nosology comes from Dr. Thomas S. Szasz, who has summarized his position in the phrase title of one of his books, The Myth of Mental Illness, (1961). His arguments rest on four assumptions: (1) only symptoms with demonstrable physical lesions qualify as manifestations of disease, (2) mental symptoms are subjective in nature and dependent upon socio-
cultural norms whereas physical symptoms are objective and independent of cultural and ethical norms; (3) mental symptoms are expressions of problems of living; and, therefore, (4) "psychiatric" problems are not illnesses but rather conflicts over ways of achieving social values which are disguised by the psychiatric profession through the use of medical terminology. The first assumption has already been examined by the authors in the discussion of the medical model. The other assumptions have been found wanting in excellent critical commentaries on Szasz's position by Akisakal and McKinney (1973), Ausubel (1961) and Reiss (1972). There is no evidence that conceptualizing psychiatric problems as mere interpersonal conflicts, as advocated by Szasz, is more useful in solving or managing these problems than is an approach that uses the medical model.

Menninger. Dr. Karl Menninger, in his book, The Vital Balance, (1963) has set forth the intriguing notion that there is only one mental illness! He argues that all of the so-called mental disorders are merely manifestations of five stages of dyscontrol in the unitary process of mental illness. The first stage is "nervousness," a slight but definite impairment of adaptive control, organization, and coping. The second is, "increased disorganization" and includes the traditional neurotic syndromes. The third is "undisguised aggression." The fourth is "extreme disorganization, regression, and reality repudiation," which includes the traditional psychoses. The fifth is "malignant anxiety and depression eventuating in death."
Menninger apparently recognizes the traditional diagnostic categories but believes that distinctions between them are trivial compared to the level of disorganization that they represent. With the recent advent of specific somatic therapies for the various psychoses, and the demonstrated role of genetic factors in specific psychotic disorders, it is hard to understand how one can regard the distinctions between the major psychoses as trivial.

Social learning theorists. The most serious criticisms of nosology in psychiatry come from such social learning theorists as Bandura (1969), Paul (in press), and Kanfer and Saslow (1969), who are identified with the "behavioral" approach to psychopathology. Their criticisms are first of all based on the weaknesses of the current nosology. They point to its low reliability and the generally poor relationship between diagnosis and treatment. They even question its value as a short-hand method for communicating an accurate clinical picture. They also argue cogently that giving entity status to psychiatric problems often leads to ignoring the importance of environmental variables in initiating and maintaining the "pathological" behavior. Finally, they assert that all behavior is subject to the principles of learning and that what distinguishes "normal" from "pathological" behavior is the value judgments made about it by an observer (who may be the patient), rather than by any intrinsic property of the behavior.

In the authors' view, many of their criticisms seem painfully accurate, although, many of their polemics involve those misunderstand-
lings of the medical model which have already been alluded to. In addition, in their eagerness to attack the validity of the medical model, they overlook the growing body of data that documents the role of genetic factors in the etiology of the major disorders and the efficacy of specific somatic therapies.

These critics not only contribute often-valid criticisms of the traditional system of psychiatric classification, but also proposals for alternative systems. In a major critique of the standard nosology in psychiatry, Kanfer and Saslow (1969) call for a "behavioral diagnosis." Unlike traditional diagnosis, which is based on a multipurpose synthetic classification system, behavioral diagnosis is a single-purpose analytic system. That purpose is to modify the patient's problem behavior. The analytic classification system of behavioral diagnosis calls for describing the patient in terms of seven areas. They are: (1) the behavioral excesses or deficits that constitute the patient's complaint and the behavioral assets available for use in therapy, (2) the factors that maintain the problem behaviors, (3) a motivational analysis to determine the dominant positive and negative reinforcement contingencies, (4) analysis of relevant biological, sociological and behavioral events in the patient's history, (5) the patient's capacity for participation in the treatment as measured by his self-control, (6) social resources in the patient's environment which affect his current behavior or may affect the treatment, and finally, (7) an analysis of the limits placed on therapeutic goals by the patient's social and physical environment.
Although behavioral diagnosis is presented by Kanfer and Saslow as an alternative to traditional diagnosis, it can be viewed as a valuable system that can be used in conjunction with a standard diagnostic formulation and treatment plan. It is worth noting that in traditional psychiatric practice, treatment has always in fact been based upon a broad assessment of the patient's capacities, strengths, motivation, environmental stresses and resources, as well as upon his "diagnosis."

History of Nosology in Psychiatry

Ancient, Medieval and Modern European Nosology. Menninger, in *The Vital Balance* (1967), presents a fascinating compendium of psychiatric nosologies from ancient times to the modern era. The material on the history of ancient, medieval and modern European psychiatric nosology which follows is largely based on his account. According to him, the first specific description of a mental illness appeared about 3000 B.C. in a depiction of senile deterioration, ascribed to Prince Ptah-hotep. The syndromes of melancholia and hysteria appear in the Sumerian and Egyptian literature as far back as 2600 B.C. In the Ebers papyrus (1500 BC) both senile deterioration and alcoholism are also described.

Hippocrates (about 460-377 BC) is usually regarded as the one who introduced the concept of psychiatric illness into medicine. His writings describe acute mental disturbances with fever (perhaps acute
organic brain syndromes), acute mental disturbances without fever (probably analogous to functional psychoses but called mania), chronic disturbances without fever (called melancholia), hysteria (broader than its later use), and Scythian disease (which is similar to transvestism).

Caelius Aurelianus, a fifth-century physician living in the Roman Empire, described homosexuality as an affliction of a diseased mind, found in both females and males. Mental deficiency and dementia were noted by the Swiss Renaissance physician Felix Platter (1536-1614).

Prior to the time of the English physician, Sydenham (1624-1663), all illness, despite the differences in appearance between the different syndromes, was attributed to a single pathogenic process, either a disturbance of the humoral balance or a disturbance in the tensions of the solid tissues. Sydenham, on the other hand, believed that each illness had a specific cause. He called for the study of morbid processes and likened the investigation of the specificity of diseases to the botanist's search for species of plants.

Philippe Pinel (1745-1826), the French physician, simplified the complex diagnostic systems that preceded him by recognizing four fundamental clinical types: mania (conditions with acute excitement or fury), melancholia (depressive disorders and delusions with limited topics), dementia (lack of cohesion in ideas), and idiotism (idiocy and organic dementia). Pinel thus reacted against the specific disease entity tradition of Sydenham and went back to a non-complex Hippocratic
system of classification. All mental illnesses were in a category of physical illnesses called "neuroses" which were defined as "functional diseases of the nervous system," i.e., illnesses which were not accompanied by fever, inflammation, hemorrhage or anatomic lesion.

Benjamin Rush (1745-1813), the famous American psychiatrist who founded the American Psychiatric Association, also rejected complicated nosological systems. He did this by nosologizing to the point of absurdity with such sayings as "Rum-phobia is a very rare distemper. I have known but five instances of it in the course of my life... Doctor phobia is complicated with other diseases. It arises often from the dread of taking physic, or of submitting to the remedies of blistering and bleeding."

By the 19th century, mental disease began to be regarded consistently as the manifestation of physical pathology and scientists searched for specific lesions, parallel to the investigation of bodily diseases. Benedict-Augustin Morel (1809-1873) was the first to use the course of an illness as a basis for classification. His démence précoce was not a disease entity, but a particular form of course of mental disease.

Karl Ludwig Kahlbaum (1828-1899), the German descriptive psychiatrist who foreshadowed Kraepelin introduced the concepts of temporary symptom-complex as opposed to the underlying disease; the distinction between organic and non-organic mental disease; and considering the patient's age
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at the time of onset and characteristic development of the disorder as bases for classification.

The finding made by Bayle (1822) that progressive paresis was a specific organic disease of the brain and the discovery of Paul Broca (1861) that some forms of aphasia were related to definite lesions of the cortex increased attempts to base all classification of mental disorders on demonstrated brain lesions or disturbances in vascular or nutritional physiology. It led Wilhelm Greisinger (1818-1868) to coin the slogan "mental diseases are brain diseases." Because knowledge of brain pathology was limited, he recognized the need for a provisional "functional" category for mental illnesses with as yet unknown somatic pathology.

In the last two decades of the 19th century, Emil Kraepelin (1856-1926) synthesized three approaches: the clinical-descriptive, the somatic, and the consideration of the course of the disease. He viewed mental illnesses as organic disease entities that could be classified on the basis of knowledge about their etiology, course and outcome. He brought together the manic and depressive disturbances into one illness, manic-depressive psychosis, and distinguished it -- on the basis of its periods of remission -- from the chronic deteriorating illness, dementia praecox, which Bleuler later renamed schizophrenia. Kraepelin also recognized paranoia as distinct from dementia praecox, distinguished the deliria (acute organic brain syndromes) from the
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dementias (chronic brain syndromes), and for the first time in a classification system of mental diseases, included the concepts of psychogenic neuroses, and psychopathic personalities (the born criminal, the unstable, pathological liars and swindlers, and litigious paranoids).

As Klein (1969) has noted, the basic approach of Kraepelin towards classification was to search for that combination of clinical features that would best predict outcome. In contrast, Eugene Bleuler (1857-1937), who expanded the concepts of dementia praecox and coined the term schizophrenia, based his classification system on an inferred psychopathological process, e.g., a disturbance in the associative process in schizophrenia. The advantage of the Kraepelinian approach is that prognosis is a testable criterion by which a classification system can be appraised, whereas an inferred psychopathological process, such as associative disturbance, cannot be directly appraised.

The personality disorders were first noted in the psychiatric literature by J. C. Prichard (1835) with his introduction of the concepts of "moral insanity" and "moral imbecility." August Koch (1891) coined the phrases "psychopathic personality," and "psychopathic constitutional inferiority."

The dynamic concepts of Freud expanded the boundaries of what was considered to be "mental illness" so that it included the milder forms of personality deviation. Personality deformity as a general rubric (as distinguished from psychopathic personality) was first
listed in a classification system devised by William Menninger based on his experiences in the Second World War.

As Akiskal and McKinney (1973) have noted, despite the advances in our understanding of mental disorders in the last fifty years, the major categories in the current Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-II), are based primarily on the concepts of Kraepelin (manic-depressive illness), Bleuler (schizophrenia) and Freud (neuroses and personality disorders).

Psychiatric Classification in the United States. The first official system for tabulating mental illness in the United States was used for the decennial census of 1840. It contained only one category for all mental illness and lumped together the "idiotic" and the "insane." Forty years later, in the census of 1880, the mentally ill were subdivided into separate categories for the first time. Seven were recognized: mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy. It is sobering to realize that the conceptual issues that modern classifiers wrestle with were well recognized by the authors of that system. In the introductory remarks to the census office report, the authors lamented about the difficulties of creating a classification system for the mentally ill: "Much effort has been put forth to secure uniformity in the classification of the insane in every country of the world; but it seems impossible for those best qualified to form an opinion to agree upon any scheme which can be devised. Some classifications are based upon symptoms and some upon
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physical causes; others are a mixture of the two; and still others take into account the complications of insanity. For the purposes of the census, it seemed to us advisable to disregard all minute subdivisions and to adopt a simple analysis on the broadest possible outlines” (Kramer, 1973).

In order to conduct a special census of patients in hospitals for mental disease in 1923, the Bureau of the Census used a classification system developed in collaboration with the American Psychiatric Association (then the American Medico-Psychological Association) and the National Committee for Mental Health. This system had been adopted by the American Psychiatric Association in 1917 and it was used until 1934, when it was revised for incorporation into the first edition of the American Medical Association’s Standard Classified Nomenclature of Disease.

This 1934 classification was designed primarily for chronic in-patients and therefore proved inadequate for use with the psychiatric casualties of World War II, who required classifications for acute disturbances, psychosomatic disorders, and personality disorders, which were not represented in the 1934 classification. In addition, the system was considered anachronistic by the increasing number of psychodynamically oriented psychiatrists who were emerging from training programs and whose interests lay more in the treatment of private outpatients.

To fill this void, competing systems were developed in this country by the Veteran's Administration and the military services. In addition,
In 1948 there appeared the first international classification of mental disorders, as a section of the 6th edition of the International Classification of Diseases (ICD-6), published by the World Health Organization in Geneva, Switzerland. Despite the merits of an international system, the lack of provision in ICD-6 for such important categories as the chronic brain syndromes, many personality disorders, and transient situational reactions rendered it unsatisfactory for use in America. Consequently, in 1951 the U.S. Public Health Service commissioned a working party, with representation from the American Psychiatric Association, to develop an alternative to the mental disorder section of ICD-6 for use in this country. This document, prepared largely by Dr. George Raines and based heavily on the Veteran's Administration classification system developed by Dr. William Menninger, was published in 1952 by the American Psychiatric Association as the Diagnostic and Statistical Manual Mental Disorders (DSM-1).

The significance of DSM-1 was that it replaced the now-outdated mental illness section of the Standard Classified Nomenclature of Disease and the systems devised by the military and the Veteran's Administration, and for the first time it provided a glossary of definitions of categories.

In the definitions of the diagnostic categories, the frequent use of the term "reaction" (e.g., "schizophrenic reaction" and "psychoneurotic reaction") expressed the strong environmental orientation of Adolph Meyer while the frequent reference to defense mechanisms, particularly as an
explanation of the neuroses and personality disorders, reflected the widespread acceptance of psychoanalytic concepts. Despite its widespread influence and impact on American psychiatric literature, it was not universally accepted as the official nomenclature throughout the country. (The New York State Department of Mental Hygiene retained the old Standard Classified Nomenclature of Disease until 1968).

Because most of the other countries that used ICD also found the mental disorder section of the 6th edition unsatisfactory, the World Health Organization sponsored an international effort to develop a classification system for mental disorders that would improve on ICD-6 and be acceptable to all member nations. This task was coordinated in this country by the U.S. Public Health Service, which sent American representatives to the international committees preparing revisions of the mental disorder section of ICD-8, which was approved by WHO in 1966 and became effective in 1968.

The Second Edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-II). In 1965 the American Psychiatric Association, which had maintained close liaison with the international committees preparing ICD-8, assigned its Committee on Nomenclature and Statistics, under the chairmanship of Dr. Ernest M. Grunberg, the task of preparing for the APA a new diagnostic manual of disorders compatible with the ICD-8 list of mental disorders, but defining each disorder for American use. A draft of the new manual, DSM-II, was circulated in 1967 to 120 psychiatrists known to have a special interest in the area of diagnosis and was revised on the basis of their criticisms and suggestions. After further study it was adopted by the APA in 1967, and published and officially accepted throughout the country in 1968. (A discussion of the defining characteristics of the disorders classified
In each of the sections of DSM-III, some of the criticisms that have been made of these sections, comparisons with DSM-I, and other features of DSM-II appears in the second part of this section.)

The reaction to the publication of DSM-II in 1968 was mixed. Those who were most critical of DSM-II regarded it, as one commentator stated, as a "giant leap into the nineteenth century and a return to a Kraepelinian view of mental disorders as fixed disease entities," -- this despite the fact that the word "disease" is limited to certain categories in the mental retardation and organic brain syndrome sections and even though the word "illness" appears only in the manic-depressive conditions, where it was adopted to avoid the ICD term manic-depressive psychosis. Karl Menninger (1968) summarized this view most articulately when he said, "This year the American Psychiatric Association took a great step backward when it abandoned the principle used in the simple useful nosology (DSM-I) which Dr. Will (Dr. William Menninger) worked so hard to get installed . . . . In the interest of uniformity, in the interest of having some kind of international code of designations for different kinds of human troubles, in the interest of statistics and computers, the American medical scientists were asked to repudiate some of the advances they had made in conceptualization and in designation of mental illness." Those who were most enthusiastic pointed to the potential benefits that could now accrue to international research and to communication between psychiatrists of different nations because
this country had adopted a system based largely on the International Classification of Diseases. Praise was also given to DSM-II for recognizing the fluidity of disorders and providing for diagnosable periods of remission in the episodic affective disorders and periods of non-psychotic functioning in some patients suffering from schizophrenia. Many also applauded the elimination of the term "reaction," appended to most of the DSM-I terms, as an honest retreat from the position that by adding the term "reaction" to diagnostic labels one thereby somehow communicates some important knowledge about their etiology. As Gruenberg (1969) explained, "...the routinizing of the word 'reaction' in our standard nomenclature (DSM-I) has accomplished little that is positive — it has given many psychiatrists the false notion that mental disorders are reactions of the organism to circumstances but that tuberculosis and diabetes and nephritis and measles and mumps are 'things' independent of the patient's nature. For all medical diseases are also reactions of the organism to certain life circumstances and do not exist independently of the people who are sick."

Relationship between DSM-II and other national glossaries. Although DSM-II is the basis for the official diagnostic manuals used in Canada, India, and several Latin American countries, other national glossaries have also been prepared and they have defined the ICD list of terms in their own way. The most influential glossary, other than DSM-II, is Great Britain's Glossary of Mental Disorders (1968), prepared under the direction of Sir Aubrey Lewis.
In the absence of an internationally accepted glossary, it was inevitable that different countries would define categories somewhat differently. (At the time of this writing, 1973, a draft glossary of definitions has been prepared by the WHO for use with ICD-8, so that for the first time in history there is a uniform set of definitions of diagnostic terms for international use.) One example of inconsistent usage is reflected in the interpretation of the ICD category "Mental disorders not specified as psychotic associated with physical conditions," which was understood by the American committee preparing DSM-II to represent "Non-psychotic organic brain syndromes." Hence this shorter term was used in the American publication and DSM-II in its glossary defined this category as being "for patients who have an organic brain syndrome but are not psychotic." However, the same ICD category was apparently interpreted by our British colleagues in their glossary to refer to such personality disorders as post-traumatic or post-encephalitic conditions, or to so-called epileptic personality disorders. They could also include in this category neurotic symptoms apparently associated with certain physical conditions, such as cardiac neurosis. This latter definition is obviously much broader than the corresponding category in DSM-II, and therefore groups of patients diagnosed in this category in DSM-II and in the British glossary are not truly equivalent.

Another example of inconsistent definition occurs with schizophrenia. DSM-II defines schizophrenia broadly, which is customary in this country and which includes mild cases that most European psychiatrists would
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not consider schizophrenic, whereas the British glossary defines the condition in a way that by the standards of most American psychiatrists applies to only the most obvious or far-advanced cases. The differences in the reported prevalence of schizophrenia in the two countries is actually due mainly to these differences in diagnostic definition, rather than to differences in psychopathology. This was demonstrated in a series of studies by Kramer (1969), Cooper (1969), Zubin (1969), and Gurland (1969).

Reliability of Psychiatric Diagnosis.

The **reliability** of psychiatric diagnosis is usually determined by having two or more diagnosticians independently examine the same series of patients. The interjudge reliability is then reported for the entire set of diagnoses or, more meaningfully, for specific diagnoses or broad diagnostic categories.

One of the problems that occurs in comparing the results of different studies of diagnostic reliability is an inconsistency and incompleteness in the manner of reporting results. Moreover, there are also statistical problems in choosing an appropriate index of agreement for nominal categories, such as diagnosis, as opposed to ordinal categories such as severity of psychopathology.

A suitable statistic was proposed originally by Cohen (1960), and later generalized to the problems of psychiatric diagnosis for two or more raters. The index, named kappa, contrasts the observed rate of agreement with the rate expected by chance. Kappa varies from negative values
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for less than chance agreement, through 0 for chance agreement to plus 1.0 for perfect agreement. It has the advantage over the usual methods of reporting agreement, such as simple "percent agreement," in that it takes into account the base rates of the diagnoses so that only agreement not accounted for by chance alone is indexed.

Spitzer and Fleiss (1973, in preparation) reviewed nine major studies of interjudge reliability where presentation of the raw data permitted the calculation of chance-corrected agreement, kappa. Although the different studies used slightly different classification schemes (DSM-I, DSM-II, ICD-8) the definitions of the major diagnostic categories are similar. The values for the nine studies for those diagnostic categories for which original data were presented is shown in Table 3.

There are only three categories where the level of agreement reaches satisfactory values: **mental deficiency**, **organic brain syndrome** and **alcoholism**. Only fair agreement is reached for **psychosis** and **schizophrenia**. For the remaining categories, the agreement is clearly poor. Most of the studies involved diagnosticians of similar background and training, a factor that one would expect to contribute to good reliability. In addition, in some of the studies, special efforts were made to have the participant diagnosticians come to some agreement regarding diagnostic principles prior to the beginning of the study. One can only assume, therefore, that agreement between run-of-the-mill diagnosticians of different orientations and backgrounds, as they work in routine clinical
Reasons for Unreliability of Psychiatric Diagnosis. Few studies of diagnostic reliability have examined the entire diagnostic process to identify the sources of diagnostic disagreement and their relative contribution to the findings of overall unreliability. A notable exception is a study of Ward (1962) involving the independent diagnostic evaluation of a group of patients by a pair of psychiatrists who subsequently conferred and discussed the reasons for any diagnostic disagreements. The results are reported for 40 patients for whom there were significant diagnostic disagreements.

Nine specific causes for disagreement were identified and grouped into three major categories: inconsistency on the part of the patient (5%), inconsistency on the part of the diagnostician (32.5%), and inadequacy of the nosology (62.5%).

The relative unimportance of the factor of inconsistency on the part of the patient was probably due to the contiguity of the two evaluation interviews, which meant that there was little opportunity for change associated with the passage of time. An appreciable change in the clinical picture as a result of the diagnostic interview was considered crucial in only a single case (2.5%), in which the effect of the first interview was to make the patient aware of a sizable amount of previously unrealized depression which then became the focus of the patient's complaints in the second interview and led to a disagreement regarding anxiety versus depressive neurosis.

Nearly a third of the diagnostic disagreements (32.5%) could be accounted for by differences between the diagnosticians. This involved different interviewing techniques which led to differences in the material elicited, differential weighting of the significance of symptoms
which often led to differences in diagnosing a subtype of neurosis, and differences in how patient material was conceptualized in terms of psychopathological symptoms.

As might be expected, the largest source of disagreement was considered to result from the nosology (62.5%). Within this category, the most common reason was that the nosology (DSM-I) required a choice between neurosis symptoms and personality disorder when both entities were present. Of the nine specific causes for unreliability, this was the most common and accounted for 30% of the disagreements. Although DSM-II generally encourages multiple diagnoses, since it says nothing about whether personality disorder and neurosis can coexist similar disagreements resulting from the nosology are still likely.

The second most common specific reason for disagreement was unclear criteria as specified by the nosological system (25%). These were all conflicts involving psychotic versus non-psychotic disorders and 8 of the 10 involved the DSM-I category of chronic undifferentiated schizophrenia. Most of the conflicts involved cases that in DSM-II would be called latent schizophrenia, or "borderline schizophrenia," distinguishing these cases from severe schizoid personality or neuroses.

A small number (7.5%) of the disagreements were due to an inability to make fine distinctions required by the nomenclature. Each of these involved the diagnosis of psychophysiological reaction as distinguished from either conversion reaction or anxiety neurosis.

Although the number of patients in this study was small (40), and the study was confined to DSM-I diagnoses, there is no reason to doubt
the generalizability of the conclusions to the sources of unreliability
with DSM-II: the major difficulty is in the ambiguity in the nomenclature,
and a second is the variability in the interviewing behavior of clinicians.

Improving Psychiatric Nosology

The strengths of the multipurpose synthetic classification system of
the type used in DSM-II (and ICD-8) suggest that this type of classifi-
cation system will probably be with us for many years despite the real
problems of reliability and validity surrounding many of its categories.
At the same time that the social-learning theorists are proposing alter-
native systems, recent work is going a long way towards refining and
strengthening the existing system. This work includes refining the
criteria for diagnosis so as to improve its predictive validity, genetic
studies to validate diagnostic concepts, and improving methods for
gathering clinical data. In addition, there has been work with non-
clinical methods utilizing mathematical models for generating diagnostic
types and computer programs for simulating the differential diagnostic
process of clinicians.

Research Criteria. Robins, Winokur, Guze and their colleagues have
conducted a series of studies attempting to develop criteria for psychia-
tric diagnosis that can be used in research studies to develop homogeneous
groups (Feighner, 1972).

They assert that, on the basis of their own studies and studies of
other workers, there are at present only 14 psychiatric illnesses that
meet their criteria for a valid diagnostic entity. The illnesses are:
primary affective disorders, schizophrenia, anxiety neurosis, obsessive-compulsive neurosis, phobic neurosis, hysteria, antisocial personality disorder, alcoholism, drug dependence, mental retardation, organic brain syndrome, homosexuality, transsexualism and anorexia nervosa.

The unique feature of their approach is the precise specification of the diagnostic criteria for each illness. For example, for a diagnosis of the depressive form of primary affective disorder there are three requirements: dysphoric mood, a psychiatric illness lasting at least one month with no pre-existing psychiatric condition, and five of the following eight symptoms: poor appetite or weight loss, sleep difficulty, loss of energy, agitation or retardation, loss of interest in usual activities or decrease in sexual drive, feelings of self-reproach or guilt, complaints of or actually diminished ability to think or concentrate, and thoughts of death or suicide. Another salutory feature of their system is the recognition that many patients do not meet the criteria for any one of the validated diagnostic entities. They therefore propose using an undiagnosed psychiatric illness category rather than following the usual procedure of assigning patients to the category the diagnostician believes fits best in the absence of adequate data.

Genetic Studies as a Method for Validating Diagnostic Concepts. In the typical study of the role of genetic factors in psychiatric disorders, the investigator applies a single set of diagnostic criteria to the disorder being studied. The finding of a relationship between the presence of the disorder and a measure of heritability, such as the ratio of
identical to fraternal twin concordance rates, is evidence for the role of genetic factors in that condition. However, as Shields and Gottesman (1972) have shown, the validity of various diagnostic criteria for a single psychiatric disorder can be tested by examining the relative heritability found in patients classified by these different criteria.

Other things being equal, a set of diagnostic criteria for a given disorder that results in high heritability possesses more validity than another set of diagnostic criteria for the same disorder that results in low or zero heritability.

This approach to assessing the validity of various diagnostic criteria for schizophrenia was applied by Shields and Gottesman in a study of 114 twins in the Maudsley Hospital schizophrenic twin study. An international panel of seven diagnosticians from Japan, Sweden, the United Kingdom and the United States blindly diagnosed the histories of each twin. As expected, the judges varied considerably in the frequency with which they made the diagnosis of schizophrenia. The broadest concept of schizophrenia, resulting in the highest frequency, was employed by an American clinical psychologist who is a psychoanalytic therapist; the narrowest concept, resulting in the lowest frequency, was used by a British social psychiatrist. A consensus diagnosis based on the diagnoses of six of the judges resulted in a "middle of the road" concept of schizophrenia that would be regarded as too narrow in the United States and too broad in the United Kingdom. The highest heritability (ratio of identical to fraternal twin concordance rates) was found for the con-
census diagnosis suggesting that both a "too narrow" and a "too broad"
concept of schizophrenia have less validity than a "middle of the road"
concept.

In the future, similar genetic studies will undoubtedly be conducted
to investigate various diagnostic criteria for other psychiatric disorders.
The validity of different diagnostic criteria for a disorder can also be
studied with treatment response or long-term course of illness as the
dependent variable. Such studies will enable the profession to critically
evaluate alternative conceptions of various psychiatric disorders rather
than to accept concepts because of tradition, training, and rhetoric.

Multidimensional Systems. Many suggestions for a multidimensional
classification scheme have been made on the grounds that they would be
of more value than the standard nosological system for case management,
epidemiological studies, and interdisciplinary communication. Between
1964 and 1970, for example, a committee of the American Orthopsychiatric
Association tried to develop a standard classification of psychosocial
functioning that could be used by all of the professions that deal with
the spectrum of mental and social disorders (Bahn, 1971). The aims of
such a system include classifying positive functioning as well as dis-
orders and dysfunctioning. That this committee, despite years of work,
was unable to produce a viable classification of psychosocial functioning
attests to the difficulty of reaching a consensus among potential users,
each of whom has different purposes in mind for such a classification.

At a workshop on the development of a standard classification of
psychosocial functioning, Spitzer (1971), proposed that the standard nosology be supplemented by a multidimensional classification of each patient on the following five dimensions:

1. current level of impairment on the following dimensions:
   a. subjective distress
   b. behavioral disturbance
   c. impulse control disturbance
   d. reality-testing disturbance
   e. impaired social role functioning

2. stage of illness as either:
   a. exacerbation of a chronic condition
   b. recurrence of a similar previous condition
   c. indistinguishable from past
   d. significant change from any previous condition

3. prognosis for recovery from current episode or condition within one year, with and without specific treatment

4. stress of precipitating events

5. extent to which environment suffers

Such a system would be more informative than the standard nosology alone. However, there is no indication that these particular additional axes of classification would be more useful than several others that could be proposed. In addition, given the difficulties of training clinicians to apply the standard nosology in a consistent manner, it is unlikely that one could get clinicians to use such an elaborate system
routinely except for special research studies.

The only proposal for a multidimensional classification system that seems to have been greeted with some enthusiasm is one by a World Health Organization study group investigating the problems of classification in child psychiatry. It proposes that in addition to being categorized by a psychiatric syndrome or disorder, each child be classified on the following dimensions: intellectual level of functioning regardless of etiology, associated organic etiological factors, and psychosocial factors in the etiology of the disorder being classified. Studies of this system by Rutter (1969) indicate its potential for routine use in child psychiatry. The World Health Organization is studying the feasibility of such a multi-axial system for the entire psychiatric nomenclature.

Structured Interviews. As noted previously, an important component in the unreliability of psychiatric diagnosis is the variability in the behavior of the clinician as he gathers clinical information. This variability can be minimized by the use of structured interview schedules. Spitzer (1964), Wing (1967) and Spitzer and Endicott (1970) have developed rating scales with structured interview schedules that are used by the interviewer to elicit the information. In this way, each patient is asked the same questions in the same order so that differences between patients are more likely to be "real" rather than due to differences in the interviewing behavior of the interviewers. Symptom ratings based on these interviews have been shown to be both very reliable and valid.

Computer Programs for Psychiatric Diagnosis. Clinicians can be
trained to make very reliable observations of psychiatric symptomatology with the use of carefully constructed rating scales if the definitions of the items are carefully specified. Computer programs have been developed for psychiatric diagnosis which use these clinical observations as input. By applying a set of algorithms, the computer program integrates the data to produce one or more psychiatric diagnoses.

There are several advantages to computer-generated diagnoses. First of all, there is necessarily perfect reliability in the sense that given the same data the computer program will always yield the same diagnosis. Secondly, the computer program can utilize rules developed from a larger and more diverse sample of patients than any single clinician can command. In addition, the rules by which a computer assigns a diagnosis are explicit and public. Finally, the formulation of empirically based rules advances our scientific understanding of the complex relationship between symptom characteristics and diagnosis.

Most of the computer programs for psychiatric diagnosis have used a statistical method, such as Bayes and discriminant function. In the statistical approach, data is first collected on a sample of patients for each of whom the diagnosis is known and for each of whom a series of measures is available. This is the "developmental" sample and is used to derive the empirical classification scheme. Using each subject's observed series of scores, the scheme quantifies how "close" the subject is to each diagnostic group and the subject is assigned the diagnosis to which he is "closest." Both methods need to be validated on new samples
because they capitalize on accidental features in the developmental sample.

The Bayes method has been applied to psychiatric classification by Birnbaum (1960), Overall (1963), and Smith (1966). The discriminant function method has been used by Rao (1949), Melrose (1970) and Sletten (1971).

Spitzer, Endicott, and their colleagues (1968, 1969, 1973) have employed a non-statistical model, called the logical decision-tree approach. In this method the computer program consists of a sequence of questions, each of which is either true or false. The truth or falsity of each question rules out one or more diagnoses and determines which question is to be examined next. Some questions may specify the presence of a single sign or symptom, others may specify that a numeric score is in a certain range, and still others may specify a complex pattern of both signs and scores. This approach is similar to the differential diagnostic method used by clinicians in making a psychiatric diagnosis. It has the obvious advantage over the two statistical models in that it does not require a data base and is not dependent upon the specific characteristics of a development sample.

The logical decision-tree approach has been used in three computer programs, DIAGNO, DIAGNO II, and DIAGNO III. The first two programs have been used in various research projects for describing samples of subjects, selecting subjects for experiments in epidemiological and cross-cultural studies, and investigating problems in classification. DIAGNO III is the most complicated of the logical decision-tree programs and uses information
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on both current and past psychopathology as input data. It makes multiple diagnoses and notes the "most likely" diagnoses as well as diagnoses "also to be considered." The output includes 79 standard diagnoses from DSM-II. To increase the value of the program as an aid to clinicians in the differential diagnostic process, a subroutine indicates to the clinician the logic used by the program in arriving at its conclusions. An example of the output from DIAGNO III is presented in Figure 1.

The validity of the DIAGNO programs has been evaluated by examining the agreement between the diagnoses of the program and the diagnoses made by experts who examined protocols completed by clinicians who knew the patients (the raw data used by the computer program). The agreement between the computerized diagnoses and the diagnoses made by the clinicians was as good as the agreement between the experts. This indicates that the computer synthesized the data from the protocols as well as the experts did. In addition, the level of agreement is comparable to the interjudge reliability of psychiatric diagnosis, that is, the kappa values are in the forties.

It should be noted that all of the computerized diagnostic programs that have been mentioned tried to simulate current diagnostic practice with all of the imprecision of the current nosology. Although such programs have been shown to have some modest validity and can already be an aid to the differential diagnostic practice of clinicians, their real contribution requires improvements in the specificity of criteria used in the nosology itself.
Audio-visual Aids. An essential step towards the truly uniform use of diagnostic concepts requires the preparation of a common body of audio-visual clinical material to be used in the training of all psychiatrists that use the diagnostic system. This would insure that all have the same experiential (as contrasted with verbal) associations with each diagnostic category. Such material has been developed for teaching medical students descriptive psychiatry (Miller, 1972, and Ryan, 1970).

Mathematically derived diagnostic types. In recent years, some workers have suggested that a variety of mathematical procedures be used to generate diagnostic categories based on various statistical models. The simplest model is based on correlating a large number of traits, usually aspects of the patient's current symptomatology. The result is a series of factors that describe dimensions of symptomatology on which patients vary (Lorr, 1966). Another method involves comparing profiles of patients so that similarity on all traits is examined together (Overall, 1964). The major difficulty with this procedure is ignorance as to what should constitute the item set of traits and the arbitrariness of the various distance measures. Another procedure is to cluster profiles into naturally occurring types (Paykel, 1971). Although all of these mathematical procedures have been shown to be of some value, none of the mathematically derived types have been more useful than the standard diagnostic types developed on the basis of clinical experience. Although it is likely that a mathematically
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derived typology might be more useful for a specific purpose, such as response to a
specific treatment, it is unlikely that it will be more useful for a multi-purpose
classification system than clinically derived categories.

The Categories and Some Features of DSM-II

Table 2 presents the nomenclature and classification of DSM-II. As can be seen,
it divides disorders into ten major categories. The system of classification differs
from one section to another. DSM-II therefore is actually a collection of classifi-
cation systems that together attempt to encompass the entire field of mental disorders.

For each of the major sections of DSM-II there follows a discussion of the
defining characteristics of the disorders, some of the criticisms that have been made
of the section, and changes from DSM-I.

1 Mental Retardation. This category includes all subnormal general intellectual
functioning that originates during the developmental period (prior to approxi-
mately age 16) and is associated with impairment of either learning and social
adjustment, or of maturation, or both. The primary basis for subclassification is the
level of retardation, and each level of retardation is further subdivided by presumed
etiology.

Because this section of DSM-II was adopted from the Manual on Terminology
and Classification in Mental Retardation (Second Edition, 1961), it reflects the
most advanced thinking of experts in this field. Not surprisingly, there have been
no major criticisms of it.

This category was called mental deficiency in DSM-I and was only applied to
the idiopathic or familial varieties of the disorder. When the retardation resulted
from a chronic brain syndrome it was classified as a chronic brain syndrome with mental deficiency. In DSM-II, however, mental retardation is diagnosed whenever it is present and regardless of cause. Seven of the nine specified causes of mental retardation listed in DSM-II are brain syndromes that are roughly equivalent to DSM-I brain syndrome categories. The other two, following major psychiatric disorder and with psycho-social (environmental) deprivation represent new ways of viewing possible causes of mental retardation. There are also changes in the levels of severity that can be diagnosed: DSM-I provided three levels, DSM-II has five.

II. Organic Brain Syndromes. This category corresponds to the ICD category "Disorders caused by or associated with impairment of brain tissue function," but in DSM-II this condition is defined more restrictively and is limited to conditions that manifest the symptoms of impaired orientation, memory, intellectual functions and judgment, and lability and shallowness of affect. This is the only major category in DSM-II in which the etiology of the condition is explicit, namely, impairment of brain tissue function.

The main subclassifications of the organic brain syndromes are the psychotic and the non-psychotic conditions, which are then further subdivided into specific etiological sub-categories, such as due to alcohol, due to drugs, etc. The distinction between acute (reversible) and chronic (irreversible) brain syndromes is relegated to a qualifying phrase — coded by a fifth digit — for those brain syndromes that can exist in both forms, such as the organic syndromes associated with
drug intoxication.

To most American psychiatrists, the most fundamental distinction is between the acute and chronic brain syndromes, which is roughly analagous to the European division between acute confusional states and dementia. In adopting the ICD diagnostic format, the American psychiatrists must first make a psychotic-non-psychotic distinction in the organic brain syndromes, which is awkward and sometimes difficult. The fundamental distinction between acute and chronic brain syndromes is unfortunately relegated to a qualifying phrase which, in practice also makes this distinction difficult to preserve.

Many have noted the confusion in the use of the words "acute" and "chronic" as they apply to brain syndromes, when the meanings are actually "reversible" and "irreversible." These observers suggest that "reversible" and "irreversible" brain syndromes replace the designation "acute and chronic brain syndromes." An alternative solution is the adoption in this country of the European terminology of "acute confusional state" and "dementia."

DSM-II defines psychotic as manifesting "mental functioning...sufficiently impaired to interfere grossly with (the) capacity to meet the ordinary demands of life." This was apparently done in an effort to help the clinician distinguish psychotic from non-psychotic organic brain syndromes on the basis of functional impairment, since many grossly impaired individuals with organic brain syndromes may not be suffering from impaired reality-testing. However, it has been noted
that this definition would include many conditions (e.g., severe obsessional neuroses) that are not thought of as psychotic, and that conversely, many individuals with impaired reality-testing are able, perhaps at some cost to themselves, to meet the demands of everyday life quite well. Furthermore, the phrase "ordinary demands of life" is too vague to be used as a criterion for such a fundamental distinction as that between psychotic and non-psychotic.

DSM-II lists eight specific alcoholic brain syndromes which in DSM-I were all subsumed under either acute brain syndrome associated with alcohol intoxication or chronic brain syndrome associated with alcohol intoxication. They are: delirium tremens, Korsakov's psychosis, other alcoholic hallucinosis, alcohol paranoid state, acute alcohol intoxication, alcoholic deterioration, pathological intoxication, and non-psychotic OBS with alcohol (simple drunkenness).

III Psychoses not Attributed to Physical Conditions Listed Previously. This awkward but extremely precise term corresponds to the clinical term "functional psychoses." Its wisdom lies in its avoiding specific etiological explanations for the functional psychoses while at the same time acknowledging that specific physical bases for them may one day be discovered. It assumes, however, that whatever physical bases may be discovered in the future will not include such agents as alcohol, drugs, and other toxins which are responsible for the organic brain syndromes. It is evident that the criteria for inclusion in this important category are (1) psychosis (either current, previous, or potential), (2) not due to an organic brain syndrome and (3) permanent enough to rule out a transient situational reaction.
Therefore this category is logically a residual category defined largely by exclusion.

The two largest subdivisions of this category reflect the basic distinction between the disorders of mood (major affective disorders such as manic-depressive illness and involitional melancholia, as delineated by Kraepelin), and the more chronic disorders of thinking (schizophrenia as described by Bleuler). In addition, there are two other categories, the paranoid states, which are characterized by persecutory delusions not explainable by a disorder of thinking or mood, and disorders of mood presumably due to external stresses (psychotic depressive reaction).

The DSM-II definition of schizophrenia offers no stringent guide to the scope of this term. Although a precise definition that indicated specific criteria would have undoubtedly met with the disapproval of many psychiatrist in this country, it would have allowed for more nearly uniform use of the term. There is also recent evidence from family studies suggesting that good prognosis schizophrenia (schizo-affective and, acute schizophrenic episode) is actually more closely related to affective disorder than to nuclear schizophrenia (Winokur, 1972; McCabe, 1971).

Although ICD-8 has a provision for unspecified psychosis, this category was specifically restricted in DSM-II to use by librarians and statisticians in coding incomplete diagnoses. This would have been a most useful category for acute psychotic reactions, often referred to as "hysterical psychosis" or "24-hour schizophrenia," which are probably unrelated to schizophrenia. It would also be useful as an interim diagnosis for acutely psychotic patients before it is possible to make a more specific diagnosis...
Because of the various studies that have challenged the entity status of involitional melancholia, it would perhaps have been wiser to put this category to rest, or at least to be more precise in specifying what it meant by the phrase "in the involitional period."

DSM-II gave official sanction to the dichotimization between affective illnesses that are caused by a "precipitating life experience" (the psychotic depressive reactions), and those whose "onset of mood does not seem to be related directly to a precipitating life experience" (the endogeneous depressions), such as manic-depressive illness. This distinction flies in the face of common clinical experience suggesting that many manic-depressive episodes are seemingly precipitated by life events. Also, research evidence indicates that even with single episodes of depression, which ordinarily would be considered "reactive depressions," the relationship to life stress is by no means well understood (Alarcon, 1972).

Recent research in affective illness (Perris, 1964; Winokur, 1969) suggests that there are two distinctions more fundamental than the one based on presence or absence of precipitating stress. These are the distinctions between unipolar (always depressed) and bipolar (manic and depressed) depressions, and the distinction between depressions with physiological symptoms and autonomous course (endogenous symptomatology) and depressions without physiological symptomatology and whose course is reactive to environmental events.

DSM-II added several subtypes of schizophrenia to the DSM-I subtypes by sub-
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dividing old categories. For example, catatonic schizophrenia is further divided into excited and withdrawn subtypes. In a similar manner, the schizo-affective type of schizophrenia is divided into two subtypes, excited and depressed. When the subtype cannot be specified the more general diagnosis can be made.

The DSM-II category, acute schizophrenic episode, has the identical meaning as the DSM-I term, schizophrenic reaction, acute undifferentiated type.

A new diagnostic category, schizophrenia, latent type was included in DSM-II to cover disorders that previously had unofficially been labeled as incipient, pre-psychotic, pseudo-neurotic, pseudo-psychopathic or borderline. This diagnosis is applied to patients who display clear symptoms of schizophrenia but who are not psychotic at the time of examination and who have never been psychotic previously. These patients were classified under schizophrenic reaction, chronic undifferentiated type, in DSM-I.

The residual type of schizophrenia is defined the same way in both DSM-I and DSM-II; it is used for patients who have had a psychotic schizophrenic episode but who are no longer psychotic. The distinctions between the chronic undifferentiated type of schizophrenia in both DSM-I and DSM-II and the residual and latent types in DSM-II, which may be confusing, depend upon whether the patient is psychotic at the time of diagnosis and whether he was ever previously psychotic (Table 2).

DSM-II states that the onset of the mood disorder found in the major affective disorders does not seem to be directly related to a precipitating life experience and that it is therefore distinguishable from psychotic depressive reaction and
depressive neurosis. Thus the term major affective disorders in DSM-II conveys a
more restrictive, non-reactive meaning than affective reactions, the corresponding
DSM-I category, which had no connotations about the mode of onset.

Increasing emphasis in DSM-II on the presence or absence of a precipitating life
experience in the onset of affective disorders can also be found in a slight change
in the definition of psychotic depressive reaction. DSM-I described this disorder as
including "frequent presence of environmental precipitating factors (italics added);" DSM-II flatly states that the depressive mood in this disorder "is...attributable to
some experience (italics added)."

Two new subcategories of manic-depressive illness, circular type appear in
DSM-II to indicate the nature of the current episode: manic-depressive illness,
circular type, manic and manic-depressive illness, circular type, depressed.

The diagnosis, involutional psychotic reaction, found in DSM-I, has been
divided into involutional melancholia and involutional paranoid state in DSM-II.
The latter is the paranoid variety of the old diagnosis and is therefore included under
the paranoid states in DSM-II. Involutional melancholia is the depressive variety
of DSM-I's involutional psychotic reaction. Its presence among the major affective
disorders reflects the fact that it is intended only for situations in which "the disorder
of mood is not due to some experience."

As previously indicated, the category involutional paranoid state has been in-
cluded in the group of primary paranoid conditions. The rather elusive diagnosis,
paranoid state, found in DSM-I no longer exists as a discrete diagnosis.

IV Neuroses. This category includes disorders characterized by a specific
symptom which is usually ego-dystonic and which dominates the clinical picture, (e.g., anxiety, depression, phobia, obsessions or compulsions). The definition in DSM-II is based upon the psychoanalytic notion that the neuroses are defenses against anxiety, and so the criterion for classification would seem to be based upon the presence of a presumed pathological mechanism. Since classical neurotic symptoms are commonly associated with the functional psychoses, the diagnosis of a neurosis is thus actually made by exclusion. A neurosis is considered to be present when a neurotic symptom exists in the absence of a functional psychosis or a transient situational reaction.

Some students of psychiatric classification have challenged the entity status of the neuroses, claiming that they are, in reality, nothing more than symptom complexes. They argue that these conditions are analogous to the special symptoms in that they are diagnosed only in the absence of more fundamental disturbances.

DSM-II implies that 1) anxiety plays a central role in the neuroses but presumably, by implication, does not play a central role in other mental disorders, and 2) anxiety is involved in the development of all of the neuroses. Both suppositions are open to question. Anxiety would appear to play a role in many different types of disorders, including some of the functional psychoses. Furthermore, there is reason to believe that depression in itself is a primary affect in other primates as well as in man, so that it is not necessary to postulate that anxiety is a more fundamental element than depression in the pathogenesis of depressive neurosis.
The DSM-I diagnoses conversion reaction and dissociative reaction have been renamed in DSM-II as hysterical neurosis, conversion type and hysterical neurosis, dissociative type. These two subcategories were created by dividing the unitary ICD-8 category hysterical neurosis. The single ICD-8 diagnostic term, it was felt, obliterates the important distinction between these two different conditions.

Three new diagnostic terms, neurasthenic neurosis, depersonalization neurosis, and hypochondriacal neurosis have been added in DSM-II. The first, neurasthenic neurosis is equivalent to and replaces psychophysiological nervous system reaction, its counterpart in DSM-I. The diagnosis depersonalization neurosis is distinguished with difficulty from episodes of depersonalization occurring either with other mental disorders, or as transient experiences in the absence of any psychiatric disorder.

V Personality Disorders and Certain Other Non-Psychotic Mental Disorders.

This broad rubric actually covers four different categories: personality disorders, sexual deviations, alcoholism, and drug dependence.

The personality disorders are characterized by life-long, generally ego-syntonic maladaptive patterns of behavior. Thus the criterion for classification is the phenomenology (ego-syntonic behavior patterns rather than ego-dystonic symptoms) and the course of the disorder (life-long rather than episodic). Subdivisions within the personality disorders are based on stereotypes manifesting typical clusters of behavior, such as the obsessive-compulsive personality or the hysterical personality.

The other three categories, sexual deviation, alcoholism, and drug dependence, are actually symptom diagnoses in that each of these diagnoses can presumably
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co-exist with any other diagnosis in DSM-II. Thus, within any group of individuals having any of these three diagnoses, some would be free of any other mental disorders, some would have a neurosis, some a personality disorder, some a functional psychosis, etc.

In defining the personality disorders, DSM-II notes that "this group of disorders is characterized by deeply ingrained maladaptive patterns of behavior that are perceptibly different in quality from psychotic and neurotic symptoms." The reader is not told what the "perceptible" differences are.

DSM-II interpreted the ICD category "Affective personality" to mean cyclothymic personality, which requires "recurrent and alternating periods of depression and elation." On the other hand, other countries have interpreted the term to include not only individuals who have alternating moods, but also individuals with persistent depressed mood (depressive character) or elated mood (hypomanic character). The consequence of the DSM-II definition is that a category is provided for the comparatively few truly cyclothymic individuals, but no adequate classification is furnished for the much larger number of characterologically depressed individuals.

In the absence of clear criteria and follow-up studies, the wisdom of including such categories as explosive personality, asthenic personality and inadequate personality might be questioned.

Although DSM-II has an introductory definition of the sexual deviations, the individual disorders (homosexuality, fetishism, pedophilia) are not defined.
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With the exception of the special symptoms section, these are the only disorders in DSM-II for which there are no definitions. Some critics point out the inadequacy of DSM-II in failing to categorize the large number of sexual dysfunctions, such as premature ejaculation, vaginismus, and feminine orgasmic dysfunction, which are clinically far more important than some of the sexual deviations that are classified in DSM-II.

Controversy rages over whether homosexuality per se should be included in a manual of mental disorders. Spitzer (1973, in press) has argued that the criteria for considering a condition to be a mental disorder should be that the condition is regularly associated with either subjective distress or generalized social impairment, or both. With the exception of homosexuality, and perhaps some of the milder sexual deviations, all of the conditions listed in DSM-II meet these criteria. Since homosexuality per se does not regularly meet these criteria, it should, therefore, not be considered a mental disorder. The danger of including conditions that meet neither of these criteria in a manual of mental disorders is that it encourages psychiatry to function more as an agent for social control of culturally unacceptable behavior than as a help to troubled people. Many homosexuals, however, are bothered by, are in conflict with, or wish to change their homosexual behavior. It is argued that such individuals be assigned a new diagnostic category, sexual orientation disturbance, which would replace the category homosexuality.

The subdivision of alcoholism into 1) episodic excessive drinking, 2) habitual
excessive drinking and 3) alcohol addiction is made on the basis of what appears to be a meaningless distinction (i.e., the number of times drunk per year) and does not allow for categorizing the various stages in the progression of alcoholism.

In DSM-I the personality disorders included sexual deviation, alcoholism and drug dependence, which in DSM-II are major headings, under each of which appear whole sets of new diagnoses that allow for greater specificity than was possible before.

DSM-II includes three new personality disorders: explosive personality, hysterical personality and asthenic personality. The explosive personality category shares many features of the diagnosis, passive-aggressive personality, aggressive type, found in DSM-I. Hysterical personality was not recognized in DSM-I even though it was a well known category commonly used in psychiatric discussion. This diagnosis is appropriate for many patients who would have been given the diagnosis of emotionally unstable personality in the past, a category found in DSM-I but not in DSM-II.

According to the DSM-I definition, drug addiction could only be diagnosed when the patient was actually addicted. DSM-II provides a more comprehensive diagnosis, drug dependence, which does not require the presence of physiological addiction; "evidence of habitual use or a clear sense of need for the drug" suffices for making the diagnosis.

VI Psychophysiologic Disorders. This group of disorders is characterized by physical symptoms that are caused by emotional factors and that involve a single
organ system, usually under autonomic nervous system innervation. The diagnostic
criteria for this category are thus: 1) a physical symptom mediated by the autonomic
nervous system, and 2) the presumed role of emotional factors in the initiation or
maintenance of the symptom. The mere presence of a physical symptom such as
high blood pressure or peptic ulcer is not sufficient to warrant the diagnosis.

There are many difficulties with this category. First of all, one could question
whether one should classify a condition that manifests itself entirely in a medical
(non-behavioral) way as a mental disorder. Secondly, this category of disorder
often looks very similar to some forms of hysterical neurosis. In practice it is rarely
used as a primary diagnosis. Finally, one might question whether anyone has ever
seen a psychophysiological hemic and lymphatic disorder.

This DSM-II section corresponds exactly to the psychophysiological autonomic
and visceral disorders section of DSM-I except that psychophysiological nervous system
reaction had been eliminated and is equivalent to DSM-II’s neurasthenic neurosis.
Anorexia nervosa, which was given as an example of the DSM-I category psychophysiologic gastrointestinal reaction is listed by DSM-II as an example of feeding
disturbance in the special symptoms section.

VII Special Symptoms. This category is for a small list of symptoms occurring
in the absence of any other mental disorder. Most of the symptoms are more likely
to be seen in children than in adults.

Child psychiatrists would like to be able to use this diagnosis in conjunction
with diagnoses of other disorders so as to indicate developmental problems in addition to a mental disorder (e.g., specific learning disturbance in addition to overanxious reaction of childhood). The rules for special symptoms specifically limit their use to situations in which there is no other mental disorder.

It should be noted that this section includes anorexia nervosa which is not merely a symptom but has all of the features of a complete psychiatric disorder.

In DSM-I this section contained only four diagnoses: learning disturbance, speech disturbance, enuresis, and somnambulism. DSM-II includes six additional diagnoses: tic, other psychomotor disorder, disorders of sleep, feeding disturbance, encopresis, and cephalalgia.

VIII Transient Situational Disturbances. This category is reserved for more or less transient disorders of any severity (including those of psychotic proportion) that occur as acute reactions to overwhelming environmental stress in individuals without any apparent underlying mental disorders.

The diagnostic criteria for these disorders are: 1) absence of previous history of psychopathology, 2) overwhelming environmental stress, and 3) brief duration. The category is subdivided according to the patient's developmental stage.

Transient situational personality disorders in DSM-I seemingly did not include acute reactions to stress that reached psychotic proportion, unlike the transient situational disturbances of DSM-II.

In addition two discrete changes were made in this section in DSM-II. DSM-I's
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Spitzer and Wilson

gross stress reaction was eliminated. Adjustment reaction of childhood is no longer divided into habit disturbances, conduct disturbances and neurotic traits. Instead, many disorders previously categorized into one of these three subdivisions of the adjustment reaction of childhood can now be diagnosed as one of the special symptoms or one of the behavior disorders of childhood and adolescence, with greater appropriateness and specificity.

IX Behavior Disorders of Childhood and Adolescence. This major category is reserved for childhood and adolescent disorders that are more stable, internalized, and resistant to treatment than transient situational disturbances but less so than psychoses, neuroses, and personality disorders. This is the only major category in DSM-II that is based on age. The other criterion is severity, excluding disorders that are too mild or too severe. Within this category, as within the personality disorders, the subdivisions are based upon stereotypes manifesting typical clusters of behavior. Although child psychiatrists have been pleased that DSM-II, unlike DSM-I, has provision for this special category for children and adolescents, many were disappointed that the Group for the Advancement of Psychiatry's Psychopathological Disorders in Childhood: Theoretical Considerations and a Proposed Classification (1966), which had been available for several years, was not considered by the committee that developed DSM-II.

In addition, several child psychiatrists have expressed dissatisfaction with the subgroups chosen. For example, Fish (1969) has questioned the entity status of runaway reaction as well as the reason for group delinquent reaction not being
classified as is its adult counterpart, dysocial behavior, in the section, conditions
without manifest psychiatric disorder, and non-specific conditions. She stressed
the need for describing each child not only in terms of the presenting behavioral
problem, but also in terms of personality and level of development, which cannot
be done easily when using DSM-II. Consequently, she fears that the diagnosis of
hyperkinetic reaction will be a wastebasket category that will obscure distinctions
between important subgroups of children within this symptom category.

X Conditions Without Manifest Psychiatric Disorder and Non-Specific
Conditions. This category, not present in DSM-I, performs the function of en-
compassing the "conditions of individuals who are psychiatrically normal but who
nevertheless have severe enough problems to warrant examination by a psychiatrist." These conditions are therefore not "mental disorders." The category is subdivided
into three groups: 1) social maladjustment without manifest psychiatric disorder
(e.g., marital or occupational maladjustment), 2) non-specific conditions (for
conditions that cannot be classified under any of the previous categories), and 3)
no mental disorder. The inclusion of a group of conditions without mental disorder
poses no problem to those who view mental disorders as being defined by certain
criteria and therefore having boundaries that separate them from other conditions of
general human unhappiness. However, it is an anachronism to those who feel that
all forms of human misery or deviant behavior are the professional responsibility of
psychiatry.
Multiple Diagnoses. Unlike its predecessor, DSM-II encourages clinicians to diagnose every disorder that is present even if one is the symptomatic expression of another. (The only exception is a diagnosis from the section 'special symptoms not elsewhere classified', which by definition, is made only when it is not part of another disorder).

Furthermore, DSM-II gives clear principles for determining which of two or more diagnoses should be listed first -- the condition that most urgently requires treatment, or, when there is no issue of disposition or treatment priority, the more serious condition.

Unfortunately, DSM-II does not provide any guidelines as to what combinations of diagnoses are legitimate. For example, can an individual have both a functional psychosis as well as an underlying personality disorder? Does the presence of paranoid schizophrenia preclude the diagnosis of pre-existing paranoid personality? Can an individual have both a personality disorder and a neurosis?

Qualifying Phrases. In DSM-I any of four qualifying phrases could be used (except where redundant) with any disorder; in DSM-II there are seven different qualifying phrases, but all except one are limited to specific sections (Table 4).

The qualifying phrases 'acute' and 'chronic' can be used and coded in section II (organic brain syndrome). This continues the distinction observed in this country between the two forms of these disorders.
The qualifying phrase *not psychotic* can be used and coded in section III (functional psychoses) for patients who are *not psychotic at the time of the evaluation* but who nevertheless have a disorder traditionally classified as a psychosis. This paradox arises because these disorders, in the full-blown form in which they were first recognized, were generally seen in psychotic patients. This qualifying phrase would be appropriate, for example, for individuals who *are not psychotic* but who nevertheless show clear signs of *schizophrenia*.

The qualifying phrases *mild, moderate, and severe* are appropriate for disorders in sections IV and IX. This is particularly useful for recording many of those disorders, such as *phobic neurosis,* whose range of impairment may extend from trivial inconvenience to incapacitation.

Finally, the qualifying phrase *in remission* can be used and coded, at least theoretically, with all disorders. This qualifying phrase should not be confused with a diagnosis of *no mental disorder;* it is most appropriate for conditions that consist of episodes separated by symptom-free intervals, such as the *manic-depressive illnesses.*
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REFERENCES


REFERENCES


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THE INFORMATION CONTAINED ON THE MENTAL STATUS EXAMINATION RECORD WAS ANALYZED BY MEANS OF A COMPUTER PROGRAM, DIAGNOIII-MSER, VERSION 2, NOVEMBER 1972. THE RESULTS OF THIS ANALYSIS ARE GIVEN BELOW AND ARE INTENDED TO SERVE AS AN AID IN THE DIFFERENTIAL DIAGNOSTIC PROCESS. BECAUSE THIS PROGRAM DOES NOT HAVE HISTORICAL INFORMATION, SOME DIAGNOSES CANNOT BE MADE (E.G., PERSONALITY DISORDERS). ALSO, ALL BRAIN SYNDROMES ARE CALLED ACUTE. IN ADDITION, SOME SCHIZOPHRENIC SUBTYPES ARE CLASSIFIED AS 'SCHIZOPHRENIA, UNSPECIFIED TYPE' AND SOME SPECIFIC AFFECTIVE ILLNESSES ARE CLASSIFIED AS 'PSYCHOTIC DEPRESSIVE MOOD DISORDER'. A MORE DETAILED AND ACCURATE DIAGNOSTIC EVALUATION IS POSSIBLE BY SUBMITTING A PSYCHIATRIC ANAMNESTIC RECORD ON THIS PATIENT WITHIN TWO WEEKS, PROVIDING THIS MSER IS STORED ON THE DATA BASE.

PATIENT IDENTIFICATION NUMBER- 13705
FACILITY CODE- 14
RATER CODE- 29
DATE OF MSER EVALUATION- MAR. 7, 1973

THE MOST LIKELY DIAGNOSIS IS-

295.24 SCHIZOPHRENIA, CATATONIC TYPE, WITHDRAWN

HOWEVER, THE FOLLOWING CONDITION(S) SHOULD ALSO BE CONSIDERED-

295.3 SCHIZOPHRENIA, PARANOID TYPE

296.8 PSYCHOTIC DEPRESSIVE MOOD DISORDER

SUMMARY OF BASIS FOR COMPUTERIZED MAIN DIAGNOSIS BASED ON MSER RATINGS

A MAIN DIAGNOSIS OF SCHIZOPHRENIA IS MADE BECAUSE

THERE IS NO EVIDENCE STRONGLY SUGGESTIVE OF AN ORGANIC BRAIN SYNDROME

FUNCTIONAL PSYCHOSIS IS STRONGLY SUGGESTED BY RATINGS OF
-DELUSIONS
-AT LEAST MODERATE IDEAS OF REFERENCE

ALTHOUGH THERE IS EVIDENCE OF AN AFFECTIVE DISTURBANCE, RATINGS ON THE FOLLOWING ITEMS SUGGEST SCHIZOPHRENIA, RATHER THAN A MOOD DISORDER
- CATATONIC MOTOR BEHAVIOR
- DELUSIONS OF INFLUENCE
- AT LEAST MODERATE BIZARRE THOUGHTS
- MARKED DYSURIA OF SPEECH (IN THE ABSENCE OF SIGNIFICANT EUPHORIA OR A DEFINITE ORGANIC BRAIN SYNDROME)

CATATONIC TYPE, WITHDRAWN, BECAUSE OF RATINGS OF
- CATATONIC BEHAVIOR
Table 1
Narrow and Broad Approaches Towards Defining a Mental Disorder for Three Groups of Conditions

<table>
<thead>
<tr>
<th>Group</th>
<th>Examples of Conditions</th>
<th>Attitude Towards Experiencing the Manifestations of the Condition by Those Who Have the Condition</th>
<th>Those Who Don't have the Condition</th>
<th>Classified as Illness by Narrow Approach</th>
<th>Classified as Illness by Broad Approach</th>
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<tr>
<td>3</td>
<td>extroversion, heterosexuality, genius</td>
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### Table 3.

**DIAGNOSTIC NOMENCLATURE OF THE AMERICAN PSYCHIATRIC ASSOCIATION (DSM-II)**

<table>
<thead>
<tr>
<th>I</th>
<th>MENTAL RETARDATION</th>
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<tbody>
<tr>
<td>310</td>
<td>Borderline</td>
</tr>
<tr>
<td>311</td>
<td>Mild</td>
</tr>
<tr>
<td>312</td>
<td>Moderate</td>
</tr>
<tr>
<td>313</td>
<td>Severe</td>
</tr>
<tr>
<td>314</td>
<td>Profound</td>
</tr>
<tr>
<td>315</td>
<td>Unspecified</td>
</tr>
</tbody>
</table>

With each. Following or associated with:
- .0 Infection or intoxication
- .1 Trauma or physical agent
- .2 Disorders of metabolism, growth, or nutrition
- .3 Gross brain disease (congenital)
- .4 Unknown prenatal influence
- .5 Chromosomal abnormality
- .6 Prematurity
- .7 Major psychiatric disorder
- .8 Psycho-social (environmental) deprivation
- .9 Other condition

<table>
<thead>
<tr>
<th>II</th>
<th>ORGANIC BRAIN SYNDROMES (OBS)</th>
</tr>
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<tbody>
<tr>
<td>A</td>
<td>PSYCHOSES</td>
</tr>
<tr>
<td>290.0</td>
<td>Senile dementia</td>
</tr>
<tr>
<td>290.1</td>
<td>Pre-senile dementia</td>
</tr>
</tbody>
</table>

Alcoholic psychosis
- 291.1 Delirium tremens
- 291.2 Korsakoff's psychosis
- 291.3 Other alcoholic hallucinosis
- 291.4 Alcohol paranoid state
- 291.5* Acute alcohol intoxication
- 291.6* Alcoholic dementia

Psychosis associated with intracranial infection
- 292.0 General paralysis
- 292.1 Syphilis of central nervous system
- 292.2 Epidemic encephalitis
- 292.3 Other and unspecified encephalitis
- 292.9 Other intracranial infection

Psychosis associated with other cerebral condition
- 293.0 Central arteriosclerosis
- 293.1 Other cerebrovascular disturbance
- 293.2 Epilepsy
- 293.3 Intracranial neoplasm
- 293.4 Degenerative disease of the CNS
- 293.5 Brain trauma
- 293.9 Other cerebral condition

Psychosis associated with other physical condition
- 294.0 Endocrine disorder
- 294.1 Metabolic and nutritional disorder
- 294.2 Systemic infection
- 294.3 Drug or poison intoxication
- 294.4 Other than alcohol
- 294.5 Childbirth
- 294.8 Other and unspecified physical condition

<table>
<thead>
<tr>
<th>B</th>
<th>NON-PSYCHOTIC OBS</th>
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<tbody>
<tr>
<td>300.0</td>
<td>Intracranial infection</td>
</tr>
<tr>
<td>300.13*</td>
<td>Alcohol (simple drunkenness)</td>
</tr>
<tr>
<td>300.14*</td>
<td>Other drug, poison or systemic intoxication</td>
</tr>
<tr>
<td>302.2</td>
<td>Brain trauma</td>
</tr>
<tr>
<td>303.0</td>
<td>Circulatory disturbance</td>
</tr>
<tr>
<td>303.4</td>
<td>Epilepsy</td>
</tr>
<tr>
<td>303.9</td>
<td>Disturbance of metabolism, growth, or nutrition</td>
</tr>
<tr>
<td>304.0</td>
<td>Similar or pre-senile brain disease</td>
</tr>
<tr>
<td>304.7</td>
<td>Intracranial neoplasm</td>
</tr>
<tr>
<td>304.8</td>
<td>Degenerative disease of the CNS</td>
</tr>
<tr>
<td>305.9</td>
<td>Other physical condition</td>
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</table>

- Categories added to ICD 8 for use in U.S. only.

<table>
<thead>
<tr>
<th>III</th>
<th>PSYCHOSES NOT ATTRIBUTED TO PHYSICAL CONDITIONS LISTED PREVIOUSLY</th>
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<tbody>
<tr>
<td>Schizophrenia</td>
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<tr>
<td>261.0</td>
<td>Simple</td>
</tr>
<tr>
<td>261.4</td>
<td>Irresponsible</td>
</tr>
<tr>
<td>261.5</td>
<td>Catatonic</td>
</tr>
<tr>
<td>261.6</td>
<td>Catatonic, undifferentiated</td>
</tr>
<tr>
<td>261.7*</td>
<td>Catatonic, undifferentiated</td>
</tr>
<tr>
<td>261.8</td>
<td>Catatonic, undifferentiated</td>
</tr>
<tr>
<td>261.9</td>
<td>Catatonic, undifferentiated</td>
</tr>
<tr>
<td>Major affective disorders</td>
<td></td>
</tr>
<tr>
<td>296.0</td>
<td>Insulinovulational melancholia</td>
</tr>
<tr>
<td>296.1</td>
<td>Manic-depressive illness, manic</td>
</tr>
<tr>
<td>296.2</td>
<td>Manic-depressive illness, depressed</td>
</tr>
<tr>
<td>296.3</td>
<td>Manic-depressive illness, undifferentiated</td>
</tr>
<tr>
<td>296.5*</td>
<td>Manic-depressive illness, undifferentiated</td>
</tr>
<tr>
<td>296.5*</td>
<td>Manic-depressive illness, undifferentiated</td>
</tr>
<tr>
<td>296.8</td>
<td>Other major affective disorder</td>
</tr>
<tr>
<td>Paranoid states</td>
<td></td>
</tr>
<tr>
<td>297.0</td>
<td>Paranoid</td>
</tr>
<tr>
<td>297.1</td>
<td>Paranoid, undifferentiated</td>
</tr>
<tr>
<td>297.9</td>
<td>Other paranoid state</td>
</tr>
<tr>
<td>Other psychoses</td>
<td></td>
</tr>
<tr>
<td>298.0</td>
<td>Psychotic depressive reaction</td>
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<thead>
<tr>
<th>IV</th>
<th>NEUROSES</th>
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<tbody>
<tr>
<td>300.0</td>
<td>Anxiety</td>
</tr>
<tr>
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<td>Hysterical</td>
</tr>
<tr>
<td>300.13*</td>
<td>Hysterical, conversion type</td>
</tr>
<tr>
<td>300.14*</td>
<td>Hysterical, dissociative type</td>
</tr>
<tr>
<td>300.2</td>
<td>Phobic</td>
</tr>
<tr>
<td>300.3</td>
<td>Obsessive-compulsive</td>
</tr>
<tr>
<td>300.4</td>
<td>Obsessive</td>
</tr>
<tr>
<td>300.5</td>
<td>Neurotic</td>
</tr>
<tr>
<td>300.6</td>
<td>Neurotic, post-traumatic</td>
</tr>
<tr>
<td>300.7</td>
<td>Hypochondriasis</td>
</tr>
<tr>
<td>300.8</td>
<td>Other neurosis</td>
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<table>
<thead>
<tr>
<th>V</th>
<th>PERSONALITY DISORDERS AND CERTAIN OTHER NON-PSYCHOTIC MENTAL DISORDERS</th>
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</thead>
<tbody>
<tr>
<td>Personality disorders</td>
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<tr>
<td>301.0</td>
<td>Paraphrenia</td>
</tr>
<tr>
<td>301.1</td>
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<tr>
<td>301.2</td>
<td>Schizoid</td>
</tr>
<tr>
<td>301.3</td>
<td>Hysterical</td>
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<tr>
<td>301.4</td>
<td>Obsessive-compulsive</td>
</tr>
<tr>
<td>301.5</td>
<td>Hysteric</td>
</tr>
<tr>
<td>301.6</td>
<td>Anxious personality</td>
</tr>
<tr>
<td>301.7</td>
<td>Antisocial</td>
</tr>
<tr>
<td>301.8*</td>
<td>Passive-aggressive</td>
</tr>
<tr>
<td>301.8*</td>
<td>Passive-aggressive</td>
</tr>
<tr>
<td>301.8*</td>
<td>Passive-aggressive</td>
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<tr>
<td>Sexual deviation</td>
<td></td>
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<tr>
<td>302.0</td>
<td>Homosexuality</td>
</tr>
<tr>
<td>302.1</td>
<td>fetishism</td>
</tr>
<tr>
<td>302.2</td>
<td>Pedophilic</td>
</tr>
<tr>
<td>302.3</td>
<td>Transvestism</td>
</tr>
<tr>
<td>302.4</td>
<td>Exhibitionism</td>
</tr>
<tr>
<td>302.5*</td>
<td>Voyeurism</td>
</tr>
<tr>
<td>302.6*</td>
<td>Sadism</td>
</tr>
<tr>
<td>302.7*</td>
<td>Masochism</td>
</tr>
<tr>
<td>302.8*</td>
<td>Other sexual deviation</td>
</tr>
</tbody>
</table>

| Alcoholism |
| 303.0 | Episodic excessive drinking |
| 303.1 | Habitual excessive drinking |
| 303.2 | Alcohol addiction |
| 303.3 | Other alcoholism |

| Drug dependence |
| 304.0 | Opium, opium alkaloids and their derivatives |
| 304.1 | Synthetic analgesics with morphine-like effects |
| 304.2 | Barbiturates |
| 304.3 | Other hypnotics and sedatives or "tranquilizers" |
| 304.4 | Cocaine |
| 304.5 | Cannabis sativa (hashish, marihuana) |
| 304.6 | Other psycho-stimulants |
| 304.7 | Hallucinogens |
| 304.8 | Other drug dependence |

<table>
<thead>
<tr>
<th>VI</th>
<th>PSYCHOPHYSIOLOGIC DISORDERS</th>
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<tbody>
<tr>
<td>305.0</td>
<td>Skin</td>
</tr>
<tr>
<td>305.1</td>
<td>Musculoskeletal</td>
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<td>305.2</td>
<td>Respiratory</td>
</tr>
<tr>
<td>305.3</td>
<td>Cardiovascular</td>
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<tr>
<td>305.4</td>
<td>Hemat and lymphatic</td>
</tr>
<tr>
<td>305.5</td>
<td>Gastro-intestinal</td>
</tr>
<tr>
<td>305.6</td>
<td>Genito-urinary</td>
</tr>
<tr>
<td>305.7</td>
<td>Endocrine</td>
</tr>
<tr>
<td>305.8</td>
<td>Organ of special sense</td>
</tr>
<tr>
<td>305.9</td>
<td>Other</td>
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<table>
<thead>
<tr>
<th>VII</th>
<th>SPECIAL SYMPTOMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>306.0</td>
<td>Speech disturbance</td>
</tr>
<tr>
<td>306.1</td>
<td>Specific learning disturbance</td>
</tr>
<tr>
<td>306.2</td>
<td>Tic</td>
</tr>
<tr>
<td>306.3</td>
<td>Other psychomotor disorder</td>
</tr>
<tr>
<td>306.4</td>
<td>Disorders of sleep</td>
</tr>
<tr>
<td>306.5</td>
<td>Feeding disturbance</td>
</tr>
<tr>
<td>306.6</td>
<td>Enuresis</td>
</tr>
<tr>
<td>306.7</td>
<td>Encopresis</td>
</tr>
<tr>
<td>306.8</td>
<td>Cephalalgia</td>
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<tr>
<td>306.9</td>
<td>Other special symptom</td>
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<thead>
<tr>
<th>VIII</th>
<th>TRANSIENT SITUATIONAL DISTURBANCES</th>
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<tbody>
<tr>
<td>307.0*</td>
<td>Adjustment reaction of infancy</td>
</tr>
<tr>
<td>307.1*</td>
<td>Adjustment reaction of childhood</td>
</tr>
<tr>
<td>307.2*</td>
<td>Adjustment reaction of adolescence</td>
</tr>
<tr>
<td>307.3*</td>
<td>Adjustment reaction of adult life</td>
</tr>
<tr>
<td>307.4*</td>
<td>Adjustment reaction of late life</td>
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</table>

<table>
<thead>
<tr>
<th>IX</th>
<th>BEHAVIOR DISORDERS OF CHILDHOOD AND ADOLESCENCE</th>
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<tbody>
<tr>
<td>308.0*</td>
<td>Hyperkinetic reaction</td>
</tr>
<tr>
<td>308.1*</td>
<td>Withdrawing reaction</td>
</tr>
<tr>
<td>308.2*</td>
<td>Overactive reaction</td>
</tr>
<tr>
<td>308.3*</td>
<td>Runaway reaction</td>
</tr>
<tr>
<td>308.4*</td>
<td>Unsocialized aggressive reaction</td>
</tr>
<tr>
<td>308.5*</td>
<td>Group delinquent reaction</td>
</tr>
<tr>
<td>308.9*</td>
<td>Other reaction</td>
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<thead>
<tr>
<th>X</th>
<th>CONDITIONS WITHOUT MANIFEST PSYCHIATRIC DISORDER AND NON-SPECIFIC CONDITIONS</th>
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<tbody>
<tr>
<td>Social maladjustment without manifest psychiatric disorder</td>
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<tr>
<td>316.0*</td>
<td>Marital maladjustment</td>
</tr>
<tr>
<td>316.1*</td>
<td>Social maladjustment</td>
</tr>
<tr>
<td>316.2*</td>
<td>Occupational maladjustment</td>
</tr>
<tr>
<td>316.3*</td>
<td>Dysocial behavior</td>
</tr>
<tr>
<td>316.9*</td>
<td>Other social maladjustment</td>
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</tbody>
</table>

- Non-specific conditions
- 317* Non-specific conditions
- No Mental Disorder
- 318* No mental disorder

<table>
<thead>
<tr>
<th>XI</th>
<th>NON-DIAGNOSTIC TERMS FOR ADMINISTRATIVE USE</th>
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<tbody>
<tr>
<td>319.0*</td>
<td>Diagnosis deferred</td>
</tr>
<tr>
<td>319.1*</td>
<td>Boarder</td>
</tr>
<tr>
<td>319.2*</td>
<td>Experiment only</td>
</tr>
<tr>
<td>319.3*</td>
<td>Other</td>
</tr>
<tr>
<td>Term</td>
<td>Previously Psychotic</td>
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<tr>
<td>-----------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>DSM-I</td>
<td></td>
</tr>
<tr>
<td>Chronic undifferentiated</td>
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<tr>
<td>DSM-II</td>
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<tr>
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<td>Yes</td>
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<tr>
<td>Latent</td>
<td>No</td>
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<tr>
<td>Residual</td>
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### Table 5

Qualifying Phrases and Their Code Numbers

<table>
<thead>
<tr>
<th>Section II</th>
<th>Section III</th>
<th>Sections IV through IX</th>
<th>All Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>.X1 Acute</td>
<td>.X6 Not psychotic now</td>
<td>.X6 Mild</td>
<td>.X5 In remission</td>
</tr>
<tr>
<td>.X2 Chronic</td>
<td></td>
<td>.X7 Moderate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>.X8 Severe</td>
<td></td>
</tr>
</tbody>
</table>