A KEY TO THE PRACTICAL GROUPING OF MENTAL DISEASES

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ABSTRACT

Steps in the logical classification of disease.
The task of the psychiatrist contrasted with the alienist’s.
Insanity not an entity; neither are all mental diseases sui generis.
Disease-group diagnosis in psychiatry, analogous to botanical classification of “orders.”
Ten disease-groups or “orders” plus an eleventh for the residuum of cases.
-osis and -acea; Rosa gallica and Neurosyphilis paretica.
The key principle.
Special discussion of the eleven groups, syphilitic, feeble-minded, epileptic, alcohol, drug and poison, focal brain (incl. traumatic and arteriosclerotie), somatic, senescent-senile, dementia praecox, manic-depressive, psychoneurotic, and psychopathic.

Conclusions.

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The layman makes out in the great majority of cases the gross fact of sickness. The layman works as it were with the naked eye of mere observation. The practitioner soon replaces the gross "looks sick!" with the more concrete "looks surgical," "contagious," "obstetric," "mental," "nervous," etc. The general practitioner advances from the unarmed eye of mere observation to the lens-like power of trained comparison. He is termed "general" in that he deals with great groups, classes, or orders of diseases. But these great groups fall short of the true aim of diagnosis, the pragmatic aim of showing what is best to do. These group captions indicate general lines of treatment, corresponding with but the lowest power of the logical microscope. Resort must be had to the specialist, if such exists and is available (or the general practitioner must be his own specialist); in short a higher power of the logical microscope is invoked and "surgical," "contagious," etc., get resolved into "abdominal," etc., "exanthematous," etc. Finally still higher powers of the logical microscope, "oil-immersion systems," as it were, are applied, and the so-called entities, the latest constituents of the nosology of the day, roll into view. Thus, with the progress from mere observation to comparison and synthesis, "looks sick" turns, e.g., into "mental," and "mental" turns, e.g., into "syphilitic," and "syphilitic" turns, e.g., into "general paresis."

In the uneven progress of diagnostic science, as roughly marked out by medical-school departments and by the great specialized medical associations, the "mental" has not been the most favored of the great groups. Alienists, however, are slowly but surely being replaced with psychiatrists. Alienists are required by the exigencies of legal medicine to make the generic distinction "mental," i.e., "insane," and the more canny of the alienists stop with this distinction. Psychiatrists are those whose duty requires them to go farther and identify groups of mental diseases and the entities themselves. The task of the psychiatrist is super-legal, special, concrete, not legal, general, and abstract like that of the alienist. When alienists and psychiatrists are brought into the same courtroom, as in the Thaw case of evil memory, havoc is apt to be played both with legal and with medical distinctions.

In presenting this key to the grouping of mental diseases, I want to make clear exactly what stage of classification I am referring to. (1) The layman is supposed to have made his gross observations. (2) The general practitioner is supposed to have placed the case in the great group of the mental. As yet no alienist
is supposed to have approached the case, endeavoring to determine "insanity" for the benefit of some court and to satisfy the dictates of some code of lunacy laws. No! the next phase of inquiry is that of (3) the psychiatrist or of the general practitioner specializing as a psychiatrist.

The object of this psychiatric inquiry is, not to determine what would satisfy a court as to committability, but to determine from a physician's point of view what the disease in question is. The alienist may enter, if he likes or if it is necessary, to determine the medically irrelevant fact of insanity. We shall be even willing to supply the alienist with pertinent records and observations. It is even sometimes true that psychiatrists make reasonably good alienists, just as they may make good hospital superintendents or good laymen. But it must be insisted that the medical problem is distinct from the legal problem, that the problem of the psychiatrist is not that of the alienist.

The psychiatrist now confronts his "mental"—or more exactly his psychopathic—material, freed for the time being of medico-legal (i. e., "committability" or "insanity") considerations. How shall the entity be reached, viz., something to correspond in mental diseases to scarlet fever among the contagious diseases?

The easiest way out perhaps is to deny the existence of entities in mental disease. There are two forms of this contention, first, that mental disease is nothing more or less than insanity, an entity itself, a genus with but one species, or secondly, that all victims of mental disease are individually to be provided with entities, that is, all examples of mental disease are sui generis. The development of psychiatry has killed the former contention stone-dead, but the latter contention still flourishes to an extent among those who over-stress the "individual factor." And this latter contention is bolstered up by the existence of so many psychopathic patients of whom a diagnosis cannot be rendered for practical or theoretical reasons. However, there are no really consistent advocates of the sui generis plan of classification.

Following is my own plan for the analytical consideration of available data in a case of mental disease. I achieve thereby a provisional diagnosis or group-diagnosis which I regard as an important step towards final diagnosis, i. e., diagnosis of the particular group-member or entity. It is hardly necessary to interpolate that, if I can achieve the entity by skipping the stage of provisional diagnosis, I shall do so cheerfully. This list is not a list merely, but a sequence, a key to be followed, when necessary, like a botanical key in the search for the classification of a plant.
I have stressed the key-principle in the method of grouping adopted and shall linger a little on the botanical analogues of the key and the ordered group-list. Omitting details (discussed *infra*), the sequence of mental disease groups I have provisionally arranged as follows:

**Mental Disease Groups (Orders)**

1. Syphilitic ........................................ Syphilopsychoses
2. Feeble-minded ................................. Hypophrenoses
3. Epileptic ......................................... Epileptoses
4. Alcoholic, drug, poison ..................... Pharmacopsychooses
5. Focal brain ("organic," arteriosclerotic)  . Encephalopsychoses
6. Bodily disease ("symptomatic") ........... Somatopsychoses
7. Senescent, senile ............................... Geriopsychoses
8. Dementia praecox, paraphrenic ............ Schizophrenoses
9. Manic-depressive, cyclothymic .............. Cyclothymoses
10. Hysteric, psycho-, neurasthenic .......... Psychoneuroses
11. Psychopathic, paranoia, etc. .............. Psychopathoses

Disregarding for the moment, both the order and the sufficiency of the list, let us consider the nature of the terms. The ending *-osis* was chosen for these groups to correspond exactly with the ending *-aceae* for certain botanical groups, the so-called orders of plants (for simplicity’s sake I pursue here only the botanical, not the zoological analogy). The parallel can be shown thus:

Rosaceae  ........ order  .......... Syphilopsychoses
Rosa  ........ genus  .......... Neurosyphilis
gallica  .......... species  .......... paretica
R. gallica  .......... name  .......... N. paretica
red rose  .......... common name  .......... general paresis

or,

Cucurbitaceae  ........ order  .......... Hypophrenoses
Cucurbita  .......... genus  .......... Hypophrenia
Pepo  .......... species  .......... idiotica
C. pepo  .......... name  .......... H. idiotica
pumpkin  .......... common name  .......... idiocy

or,

Rubiaceae  ........ order  .......... Epileptoses
Coffeea  .......... genus  .......... Epilepsia
Arabica  .......... species  .......... tarda
C. arabica  .......... name  .......... E. tarda
coffee  .......... common name  .......... late epilepsy
From this hint it may be seen that the use of the plan does not necessarily contemplate renaming diseases, although this may be often very desirable. It is not that a sufficient diagnosis of a given disease is, e.g., "syphilopsychois," any more than it would be proper to stop in plant diagnosis with Ranunculaceae when the true goal was Hydrastis canadensis.

Whereas the ending -osis suitably expresses ordinal characters, the ending -ia (as in epilepsia, neurasthenia) suitably indicates generic characters of disease; indeed some dictionaries regard -ia as primarily suggesting disease. The ordinal ending here preferred is accordingly -osis; the generic ending -ia.

So much re nomenclature may suffice at this time (see below under the separate groups for further remarks). Aside from certain novelties in nomenclature, the plan has, I believe, merit as an application of a key-principle. Even if one were content with ordinary English group names ("syphilitic," "feeble-minded," etc.), still the order of consideration of group-data would remain of commanding importance. Should not a shred remain of the nomenclature just presented, the key-principle in the analysis of clinical psychiatric data would remain of use.

I commend the analysis of clinical psychiatric data upon a key-principle, much as by trial and error in the botanical process of classification. I do not, on the other hand, especially commend the gathering of the data in this order or in any special order. After the data are collected by some impartial process of observation and regular process of recording, I would then proceed to the analysis of the data in the order mentioned. I would give every hypothesis the completest opportunity to verify itself. I would even impress slight symptoms and minor indications into the service of each hypothesis in succession. This artificial bias is perfectly safe, since I am going down the line of possibilities giving the same bias in succession to each. For there is one striking difference between botanical classification and medical diagnosis. In botanical identification (as with Gray's botany) if I reach Hydrastis canadensis I hardly need to go farther, so rare are true plant hybrids. But in medicine a man may be victim of several diseases, and one must consider all pertinent possibilities (see below for remarks on "combined psychoses").

The whole matter of quasi botanical and zoological classifications in the psychiatric field would gain from a review on modern lines of the older classifications from de Sauvages and Linnaeus; but this is not the place for an elaborate review.
Without further introduction I pass to remarks on the eleven groups themselves. I purposely omit consideration of the disease "genera" under these "orders," because there must obviously be so much controversial in most groups; for the data are not all gathered for a proper taxonomy! However, under the syphilitic and feebleminded groups I have made suggestions for the "generic" subdivision of these "orders."

1. **Syphilopsychoses** (the syphilitic group). The main representatives of this group are general paresis (otherwise general paralysis of the insane, paralytic dementia, "softening of the brain") and the so-called "cerebral syphilis" preferably termed cerebrospinal syphilis. I have recently tried to bring more order into the nomenclature by throwing together all diseases of the nervous system traceable to syphilis under the term neurosyphilis, the main forms of which are (a) paretic, (b) tabetic, (c) diffuse, (d) vascular, (e) juvenile, and (f) gummatous. The majority of these forms of neurosyphilis are at one or other period characterized by mental symptoms, so that the six-heading neuropathological classification works well enough for the psychoses more narrowly taken. However, the tabetic psychosis (a variety of *Neurosyphilis tabetica*) is exceedingly rare, so rare that I question my ever having seen an instance. On the other hand, mental disease supervening in tabetics is of course common enough and will ordinarily turn out to be part and parcel of general paresis (*Neurosyphilis paretica vel taboparetica*), though sometimes the symptoms will prove due to intercurrent syphilitic blood-vessel disease (*Neurosyphilis arteriosclerotica* plus *Neurosyphilis tabetica*). It is clear that examples will be found of *Neurosyphilis diffusa*, i. e., of a mental disease depending on a widely diffused process, possibly involving meninges, parenchyma, and vessels as well, but having a prognosis far more favorable *quaod vitam* than *Neurosyphilis paretica*. Where possible, the diagnosis should certainly seek to pick out the meningeal, parenchymatous and vascular features, or their combinations, and distinguish these factors in the designations chosen. Something like this has been attempted by Head and Fearnside, although the *syphilis centralis* of these authors seems not too happy a term, permitting the diagnostician to escape without a prognostic comment and without specifying what he really thinks is going on in the "central" substance.¹

¹ For full discussion see Southard and Solomon, Neurosyphilis: Modern Systematic Diagnosis and Treatment Presented in 137 Case Histories (Monograph Number Two of the Psychopathic Hospital, Boston), Boston, W. M. Leonard, 1917.
2. Hypophrenoses (the feeble-minded group). The main representatives of this group are the well-known graded forms of feeble-mindedness (as we use the term generically in America), viz., (a) idiocy, (b) imbecility, and (c) feeble-mindedness proper (the morons of Goddard, collected by Tredgold under the term morosis, in point of fact a term used by Linnaeus). The excellent results of modern mental testing, however, have left us with a fourth group of (a) subnormals, lying between the morons below and the normals above; these may be known as dullards, simples, or stupids (Tredgold), among whom none should be included save those who actually measure low by modern scales and gradings. Thus, above (a) Hypophrenia idiotica, (b) H. imbecilla, and (c) H. morotica, we should find (d) Hypophrenia subnormalis (sc. metricta). But, as practical work abundantly shows, there are other hypophrenoses in which available measurements leave us at loose ends or at a loss. These Tredgold inclines to term Amoralia on account of their moral deficiencies and as a condensed term for Prichard’s moral insanity (or a part thereof). Perhaps the reference to conventional standards implied in such terms as moral insanity or imbecility, or amoralia, is more or less justifiably resented by modern workers. Moreover, sometimes the deficiency is not in morals and yet exists. “Congenital psychopathic inferiority” is a term which covers many of these cases, being perhaps a rough translation of Minderwerthigkeit. “Below par” we sometimes say of these cases, being a figurative usage of the term “par” when no method exists of determining what is par (Minderwerthigkeit has the same air of greater exactitude than exists). On the whole perhaps we do less violence to existing terminology if we speak of (e) Hypophrenia amoralis. I often think of the group as one of non-metric or qualitative feeble-mindedness, though it cannot be denied that “qualitative weakness” is a contradiction in terms. This latter objection would be the stronger if we were trying to describe a scale of intensity in some one attribute. In many instances, it has seemed to me as a psychiatrist, these cases of qualitative inferiority are marked, not so much by a weakening of faculties as by a total absence of various faculties, faculties of course that are not indispensable in life. Without endeavoring to prove or expound the idea, what would happen could the instinct of disgust be conceivably left out of a subject’s make-up? One could not then measure it: one could merely find it lacking. High evolutionary complications, e.g., disgust, have simply not entered the subject’s make-up. Accordingly I personally would prefer (e) H. simplex (sc. non-metrica, qualitativa) to H. amoralis.
The classification might go

2. Hypophrenoses
   (a) H. idiotica
   (b) H. imbecilla
   (c) H. morotica
   (d) H. stupida vel subnormalis (sc. metrica)
   (e) H. simplex vel amoralis (sc. non-metrica, qualitativa)

I may be pardoned a word on behalf of the feeble-minded patients whom we now so often demonstrate in clinics; it has proved of value to use terms which do not possess unfortunate connotations for the minds of these patients. Of course, idiots are not harmed by hearing the term and the imbeciles not to any extent. It is all very well to call a spade a spade; but if the listener transforms a "spade" into a pile-driver in his own mind, Richard Cabot's warnings about belligerent truth-speaking fall into queer cross-lights. I find it of value to use in clinical demonstrations perfectly exact terms which the patients have no chance to misconstrue. Hypophrenia morotica, H. subnormalis, H. simplex, are such terms.

As to the term Hypophrenosis itself, it has been suggested to me that Hypopsychosis would be preferable. Perhaps so. I considered that "phren" had been used by Kraepelin in his proposal of Oligophrenia for feeble-mindedness. Oligophrenosis was then the natural group rendering for the "oligophrenias." I could not see that it was well to preserve the connotation "few" in the prefix "oligo-" which erroneously suggests "few-mindedness" where inferiority is really in question. But the other half of Kraepelin's suggestion seemed good, in view of the intellectual trend of the Greek term "phren" which closely imitates the intellectual trend of the term "mind." The "psyche" seems somehow broader than the "phren," just as "soul" seems broader than "mind," at least when both are used. Accordingly hypophrenosis seemed to be the nearest euphonious Greek equivalent of the term "feeble-mindedness," a term which, lying in the midst of the group, has succeeded in dominating the whole.

3. Epileptoses (the epileptic group). Without here entering the vexed question of the classification of the epilepsies themselves, I will use the heading to call attention to a feature in the usage of the key to classification of which this group forms a part.

If a disease be syphilitic, i.e., if syphilis played an essential part in its causation and is the practically most important factor in that causation, then feeble-mindedness, epilepsy, coarse brain disease,
and the rest remain subordinate. Whether a disease be Neurosyphilis hypophrenica (as a rule, of course, idiotica or imbecilla) or on the other hand Hypophrenia syphililitica may be a matter of discussion: practically, however, it is my present contention that such cases be placed in the syphilitic group, really because of our bounden therapeutic duties to these cases.

The same holds for the epilepsies and so down the line. “Syphilitic epilepsy” is a term good from the epileptologist’s point of view: from the point of view of the physician and therapeutist in general, it is better to classify the case as one of “epileptic syphilis,” viz., in our nomenclature, Neurosyphilis epileptica.

4. Pharmacopsychoses (alcohol, drug and poison group). This designation (like hypophrenoses for the feeble-minded group) is a novel term, but one of such obvious fitness for a well-recognized group that I can conceive no reason against its adoption, if the group principle itself is deemed worthy.

Without entering the familiar field of the alcoholic psychoses (delirium tremens, alcoholic hallucinosis, jealousy-psychosis, dementia, etc.), and without discussing morphinism, etc., I will take occasion to point out how in the successive consideration of data pointing in a given case to (1) syphilis, (2) feeble-mindedness, (3) epilepsy, (4) alcohol and drugs, we are able to collect all the data that would be of commanding value in immediate treatment in special institutions. To be sure, special institutions for neurosyphilis have not so far been established in the world, though there is much to be said for the plan. But, aside from neurosyphilis or “salvarsan” hospitals, advanced communities will always be found providing special institutions for the feeble-minded and the epileptic. It is an established principle of mental hygiene that the feeble-minded and the epileptic shall be treated separately. Placing a case amongst the hypophrenias or the epilepsias means as a rule something wholly practical: it means that special institutional treatment is indicated (e. g., in Massachusetts, “this is a Waverley case” or “this is a Monson case”; in New York, “this is a case for Rome” or “for Sonyea”); or, if the actual state institution is contraindicated, then something equivalent or better along the same line is prescribed. As to the pharmacopsychoses, very few states have proceeded to the experiment of special institutions, though Massachusetts, for example, contains a successful one for moral and physical uplift cases. The “rounder” group and the delirium

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3 The Massachusetts Commission on Mental Diseases and the Grafton State Hospital Board have cooperated in the establishment of a neurosyphilis ward, operated by special investigators.
tremens problem are, so far as I am aware, not adequately dealt with on the planet. Not to launch into a homily on mental hygiene, let me merely insist that by considering, eliminating, or appreciating the data of these four groups, we have dealt with some of the largest social problems in psychiatry. How often in the elaborate discussion of doubtful mental cases do we find our younger officers indulging in long, not to say acrimonious, discussions of the relative merits of dementia praecox and manic-depressive psychosis, only to learn at the end that the case was essentially syphilitic, feeble-minded, epileptic, or alcoholic! And how often do we hear circular controversies about the respective parts played by epilepsy and alcohol, or by alcohol and dementia praecox in certain cases! The practical diagnosis is brought out at once as a rule by the simple inquiry, “Do you desire this case treated as an epileptic primarily or primarily as an alcoholic?” or “Do you fancy this case in a hospital for dipsomaniacs or do you want him placed in a hospital for the insane?” It is especially in this group of pharmacopsychoses that these pragmatic questions acquire their greatest significance.

5. Encephalopsychoses (the focal brain group, including arteriosclerotic, tumor, traumatic cases, etc.). This is the “neurologist’s group” of mental diseases. The classification is of course not as broad as that of nervous diseases as a whole, because there are still many nervous diseases without a characteristic psychotic side. Still, in general, the neurologist’s technique in virtually its entirety is required in the elucidation of the encephalopsychoses. The neurologist is of value elsewhere, notably in the syphilitic group precisely because many of the syphilopsychoses are attended by coarse brain disease or by spinal cord disease deranging brain functions. Here then is the group in which the condition of the reflexes, the sensations, the motor and secretory powers, as determined by the neurologist, is of decisive worth in diagnosis.

The practical worker may be astonished at one feature of this group, seemingly so heterogeneous. It is the habit—a lax one, I believe—of many workers to unite in their minds too closely the arteriosclerotic and the senile psychoses. I place the arteriosclerotic cases in the encephalic (focal brain) group, because I believe that in the present phase of psychiatric science the diagnosis “arteriosclerotic psychosis” cannot be safely made except in the presence of some of the neurologist’s signs or supported by shocks or other seizures in the anamnesis. I do not here speak of the mental sequelae of somatic arteriosclerosis or of generalized arteriosclerosis: the
arteriosclerotic subgroup of the encephalopsychoses is a group, according to this interpretation, of which "organic neurological" symptoms, signs, and history are characteristic. Some may miss the opportunity of ascribing "general deterioration" to arteriosclerosis: the present key requires investigation to learn whether the disease in question is assumed to be due to focal brain vascular lesions (encephalopsychoses) or to senility (see below, geriopsychoses) or to generalized arteriosclerosis (somatopsychoses, cardiovascular group) or, of course, to syphilis itself.

I would maintain a somewhat similar practical value for this key in the traumatic field. How many protracted, nay meaningless, medicolegal discussions could have been dispensed with, could the question, whether the trauma was encephalic structural injury or not, have been settled forthwith! A case for the present key is placed in the encephalopsychoses, traumatic subgroup, if there is good neurologist's evidence of some sort of focal brain disease; but it is placed far away in the group of the psychoneuroses if it has features predominant of the so-called traumatic neuroses. (It may be superfluous to say that this key does not infallibly place a case in the right major group.)

It is only fair to ask whether a line can be drawn between "focal" and "not-focal" brain disease. For instance, sometimes a case with multiple miliary aneurysms of the brain substance comes up for discussion. To be sure, such a case is commonly attended with multiple hemorrhages which would serve to place it forthwith in the focal brain disease-group. Nevertheless, many of the nervous and mental symptoms are doubtless due to lesions that could hardly be seen by the naked eye. The point is not so much what "coarse" lesions are demonstrable post mortem as it is, whether the neurologist with his special logical equipment can make the diagnosis. Or, again, take the brain lesions of certain cases of pernicious anemia. Shall these cases be placed among the encephalopsychoses? The brain lesions are microscopic. But on the criterion of the encephalopsychoses as the neurologist's group, I am inclined to say that these cases should be counted amongst the encephalopsychoses. I believe I should also desire to place the rare Alzheimer's disease here also, on the ground of its "organic," not senile, appearance.

The plot obviously thickens hereabout. Miliary aneurysms and Alzheimer's focal lesions, however largely invisible to the naked eye, are nevertheless lesions which cut mechanisms apart precisely as larger lesions cut them apart. The lesions are, as it were, globar
or molar lesions and not of the diffuse and intimate character of
those in many diseases. With the pernicious-anemia brain, one is
not so dogmatic. Perhaps, if we knew the somatic origin of per-
nicious anemia, we should prefer to classify this condition amongst
the somatic psychoses. As for pellagra, I should prefer to place
its psychosis in the next group.

6. SOMATOPSYCHOSES (the bodily disease group, including infec-
tive and exhaustive cases, cardiac cases, etc.). This is the “in-
ternist’s group” of mental cases.

The term “soma” is sometimes opposed to “psyche,” sometimes
to “head,” sometimes to “brain.” The hylozoist might oppose this
term on the ground that all mental diseases are “somatic.” An
ardent dynamicist might query whether any mental disease is im-
portantly “somatic.” An interactionist might object on both
grounds.

I am here innocently trying to oppose the term to the “brain” or
“encephalon.” After eliminating (1) syphilis, (2) feeble-minded-
ness, (3) epilepsy, (4) alcohol and drugs, (5) the “organic neuro-
logical” conditions, I then turn to (6) the organic non-nervous field.
I apply the internist’s technique. I perhaps find some “sympto-
matic psychoses” that appear to be intimately dependent upon car-
diac or renal conditions. Or again upon infectious disease, such as
typhoid fever or pneumonia. Or again upon non-nervous tumor,
diabetes, metabolic disease, etc. As above mentioned, it would
seem well to consider the possibility of pellagra at this point, perhaps
also pernicious anemia (provisionally however placed among the
encephalopsychoses so far as its mental side is concerned).

There too may be placed the glandular affections, hyperthyroid-
ism, myxedema, cretinism, and the like.

7. GERIOPSYCHOSES4 (the senescent-senile group). Both the
name and the key-position of the senescent-senile group may per-
haps be questioned. As to the key-position, it might be queried
whether it would not be better to exclude dementia praecox and
manic-depressive psychosis before invoking involutional processes
to explain a given mental disease. Still, in the use of this key, one
is not supposed to stop with the first plausible group into which
the clinical picture might fit. Accordingly, one would be assumed
not to omit a study of the data from these other points of view.

I was moved to place the old-age group seventh partly to range
it with more definitely organic psychoses, partly because I felt it
better not to divide the succession that follows (see groups 8, 9, 10).

4 Better, Presbyopsychoses?
"Geriatrics" is a term that is very properly coming in to cover a definite but ill-developed specialty dealing with old-age disorders. I want to use "geriopsychoses" to cover, not merely the pronounced and ultimate disorders of old age, but the disorders of senescence, the presenium, and the involution period. It is at any rate practically important to consider all the data together that look in this direction, along the down gradient.

As above stated, I feel that it is practically important to separate the arteriosclerotic group from the senescent-senile. Not that arteriosclerosis is not a frequent phenomenon in old age (as it is assuredly also often not a marked factor!). One may truly be as old as one's arteries: but the arteries are not always as old as many other parts of the body. Aside from all discussion as to what constitutes old age, the prognosis of arteriosclerotic psychosis is often quite other than that of senile dementia with which it is so frequently confused. Accordingly, I believe that practical psychiatrists will agree that it is a practical advantage to consider the signs of arteriosclerotic psychoses separately from those of the senescent-senile group.

8. Schizophrenoses (the dementia praecox or schizophrenic group). As "dementia praecox" forms no proper adjectives, the choice by Bleuler of the term schizophrenia for dementia praecox has been welcomed on all hands. Kraepelin himself, although he still speaks of the disease dementia praecox, often uses the adjective "schizophrenic" for the victims of the disease.

The idea of schizophrenia, viz., "dissociation" or "splitting" of mental processes, lies at the bottom of much, if not all, that is distinctive of the mental-symptomatic side of dementia praecox.

There is therefore a good deal to say for building a group-designation of schizophrenia, the symptom. Kraepelin, to be sure, in his last edition groups dementia praecox and paraphrenia (a renamed French disease, délire chronique à évolution systematisée) under the general term "endogenous deteriorations." But this term "endogenous deteriorations" seems far too general, besides which "endogenous" is a term which Germans (following Moebius) have specialized to mean "taking rise within the nervous system," a meaning possibly warranted but certainly not generally accepted.

Of course, practical workers are apt to use "dementia praecox" for disease which, though functional-looking, is regarded as fated to deterioration. Although everybody is theoretically aware that not all cases of dementia praecox deteriorate, yet the "lure of the 100 per cent." and the catchiness of the term "dementia" lead to a prac-
tical disregard of the actual guarded prognosis of dementia praecox and a virtual claim that all "real" cases of dementia praecox deteriorate. One is familiar with clinics in which the diagnosis of functional-looking diseases is from time to time revised in favor of dementia praecox if deterioration has set in, and in favor of manic-depressive psychosis if there has been no deterioration! The fact that Kraepelin observed that dementia praecox patients are apt to deteriorate in particular and characteristic ways is revised by practical men to the effect that dementia praecox deteriorates and, if not, the diagnosis is wrong!

In a clinic for doubtful cases, like that of the Psychopathic Hospital in Boston, I find that the diagnoses tend to vary somewhat with the natural pessimism or optimism of the workers. I find it practically of value to limit the diagnosis dementia praecox to cases in which something schizophrenic can be found. We may thus score too low a tally of correct diagnoses of dementia praecox, but I am sure we save some cases from an unjustifiably pessimistic diagnosis. For at best the prognosis of the schizophrenias is not a good one.

9. Cyclothymoses (manic-depressive group). Just as "dementia praecox" forms no proper adjective, so we find the same difficulty with "manic-depressive psychosis." No one has ever been satisfied with the term "manic-depressive psychosis," although the Kraepelinian conception of the disease which goes by that name has been pretty generally accepted.

The term cyclothymia has been used by some authors for all or part of the disease-group known as manic-depressive psychosis. The cyclic nature of the course of many if not the majority of instances of this psychosis is embodied in the first part, cyclo-, of the term cyclothymia. The most prominent feature, psychologically speaking, of manic-depressive psychosis is the emotional disorder, which is demonstrated either in the morbid gaiety, fear, anger, or depression which characterizes different phases of the disease. Even those complex examples of the disease in which mania and depression occur mixed (cases as one might say of "mixed emotions") are still fundamentally examples of emotional rather than intellectual disorder.

Some authors have applied the term "affective" to the group which may be known as the group of the affective psychoses.

The second theme, thym, of the term cyclothymia refers to this predominantly emotional or affective nucleus of the disease or diseases known as manic-depressive psychosis. Kraepelin himself occasionally uses the term cyclothymic. Accordingly, I have felt that
if we desire to place in a single great group the varieties of manic-depressive psychosis and allied diseases, we could do no better than to speak of them as the cyclothymias, or, adopting the common Greek ending for these groups, the cyclothymoses.

It will be noted that the schizophrenias have been placed in this key prior to the cyclothymias. Practical workers will all recognize how easy it is to find "cyclothymic" (that is, "manic-depressive") phenomena in all sorts of mental diseases and conditions which are not genuinely manic-depressive. These cyclothymic symptoms are even not infrequently found in schizophrenic cases. In diagnostic discussions where numerous physicians are consulting, not infrequently one physician is found triumphantly proclaiming dementia praecox on the basis of schizophrenic symptoms, whereas his colleague with equal triumph claims manic-depressive psychosis on the basis of cyclothymic symptoms.

The point of the group arrangement in this key is perhaps nowhere more clearly shown than in the priority that the schizophrenias take as against the cyclothymias. In practice it seems that schizophrenic phenomena blanket cyclothyic phenomena. A victim of dementia praecox may in several parts of his mental life exhibit perfectly good and clear-cut cyclothyic phenomena; yet it is the schizophrenic or dissociation phenomena which, according to this point of view, must command the diagnosis. This situation can the more readily be understood when it is remembered that after all the majority of the manic-depressive or cyclothyic phenomena are merely exaggerations or diminutions of normal functions. After all there is nothing "queer" or dissociative, nothing that definitely proves mental disease in the supernormal gaiety or exaggerated depression of a manic-depressive subject. Perfectly normal subjects may at times show these features, though perhaps not to the extreme extent nor in the rich display that characterizes the manic-depressive patient.

The victim of dementia praecox, according to our point of view as above expressed, must have something in his status or history to show schizophrenia; but elsewhere in his status or history he may very well show those variations above and below the normal in emotions which normal people, as well as manic-depressives and other psychopaths, show. In short, the cyclothymic patient shows variations of emotion which are decidedly within the frame of the normal and can rather readily be understood by the layman.

The manic-depressive is either supernormal or subnormal in his emotional display at a given time, and so far as the layman can tell
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is often doing only what a normal person might do under the circumstances. The concept of schizophrenia on the other hand is not one which the layman readily grasps; it is in fact fundamentally hard to define.

10. Psychoneuroses (the group of neurasthenia, psychasthenia and hysteria). It may seem that the psychoneuroses should not be grouped among mental diseases. One suspects, however, that the authority who takes this line is under the influence of older notions as to the supposed identity of mental disease with certifiable insanity.

From the standpoint of general practice or of clinic which lies nearest to general practice, namely the psychopathic hospital clinic, the psychoneuroses are precisely as much within the frame of psychiatry as the schizophrenias and cyclothymias.

As far as the gravity of these conditions is concerned, there is not much doubt that many of the psychoneuroses are just as grave in prognosis as many of the cyclothymias. It may be suspected that some of the cyclothymias are in practice termed psychoneuroses precisely because the diagnostician fears that the patient and his friends will resent the diagnosis manic-depressive psychosis, when the diagnosis neurasthenia or psychasthenia will not be resented or feared.

It cannot be denied, however, that the demarcation of the psychoneuroses is an extremely important one from the practical standpoint of prognosis. Whereas the schizophrenic group takes its own way and whereas the cyclothymic diseases seem in a sense self-limited or at all events beyond the reach of special therapeutics. on the other hand the psychoneurotic group is the psychotherapeutic group par excellence. We practically mean when we call a case psychoneurotic that we feel that the case has a good chance under methods of direct or indirect psychotherapy.

It might be inquired whether the psychoneuroses should not be placed nearer the head of our key. Errors in diagnosis are undoubtedly found in which some other form of mental disease is asserted to exist when psychoneurosis is the fact. However, we have come upon so many instances in which syphilis, alcoholism, arteriosclerotic brain disease, somatic disease and manic-depressive psychosis have been erroneously regarded as psychoneurotic that I feel confident that these conditions should be considered and eliminated prior to making the diagnosis of neurasthenia, psychasthenia or hysteria. Of course, if a wrong diagnosis of some other form of mental disease is rendered, then it is conceivable that the psychoneurotic patient will fail to get what he so importantly needs, namely, psychotherapy. However, the will to psychotherapy is so deeply
implanted in every physician that I feel few cases have genuinely suffered from the lack of an attempt to carry out psychotherapy. Of course, no one would claim that every psychoneurotic gets the proper kind of psychotherapy or enough of it; but that is another story.

11. PSYCHOPATHOSES (the group of the psychopathias and of a variety of doubtful entities). I shall not here discuss at length this doubtful group. I place therein a variety of ill-defined conditions. Some of these, as the psychopathic personalities, verge very closely upon the normal; others, like the so-called prison-psychoses, are considered by some authorities not to exist at all, at least as entities.

The true nature of the so-called "psychosis of the deaf" is not well enough understood to permit its characterization; at all events, it does not appear to fall amongst the ten well-defined groups listed above.

Those rare cases of true paranoia I personally prefer to place in this ill-defined group of psychopathoses. At any rate, I see no special advantage in making these pure paranoias without signs of mental dissociation or tendency to deterioration tag along behind the schizophrenias.

I would also place in this ill-defined group those rare cases of mental disease which are regarded as certifiable and deserving of institutional regime, but which cannot be practically classified in any one of the above-mentioned ten groups.

Of course, in practice these "undiagnosticated insanities" are really the fruit as a rule of poor observation or of poor opportunity for observation.

At this point it may be inquired whether such entities as combined psychoses need be assumed. For my part, I am wholly willing to agree that a patient might properly enough be theoretically placed in any one of several of the groups above mentioned, thus a patient might well be an old man with coarse brain disease and disease elsewhere in his soma who had acquired syphilis, was extremely alcoholic and had been a feeble-minded subject to start with; and this subject might, of course, have shown a variety of psychoneurotic and cyclothymic symptoms. It is even possible that such a patient might exhibit some phenomena that looked like those of a dementia praecox. Practically, however, such a case would be placed in one of the above-mentioned ten groups precisely because the diagnostician would want to have the case treated primarily either as a syphilitic or as a feeble-minded subject or as an epileptic, etc. Accordingly,
we may provide full scope for the so-called combination of psychoses in theory without damaging the practical validity of the above-mentioned classification.

Summary and Conclusions

I have here presented not so much a classification as a key to the grouping of mental diseases. The key has been worked out to the extent of ten well-defined groups and an eleventh residual group. These groups correspond to the groups of, e.g., the Rosaceae or Leguminosae of botany, and do not correspond to the genera and species of those orders. Some hint is given of the generic and specific distinctions of mental disease that might correspond to the genera and species of botany, provided that there were any practical need for a quasi-botanical or zoological genus-species distinction in mental diseases.

The incentive to this grouping has been practical. No endeavor was made on the library table to construct a hortus siccus of mental diseases. On the contrary, this key is the product of several years of work in the Psychopathic Hospital in Boston where the task of reasonably accurate diagnosis by an ever-changing staff of psychiatrists-in-training was the desideratum. I do not accordingly suggest this key as something to replace the methods of the expert in arriving at a conclusion concerning psychiatric diagnosis. I do offer it, however, as a guide for the tyro and the psychiatrist-in-training. It is not an outline giving an order of examination. It is a scheme for summarizing and evaluating results after the physical, mental and historical data are collected. The plan is eliminative but is subject to this reservation: if one arrives in the chosen sequence of analysis at a plausible or even a correct group diagnosis, one is not thereby absolved from continuing the process of analysis. All data bearing on any of the groups must be considered. Diseases may be “hybrid,” though practically one is almost never in doubt as to the group under which to subsume a case. Theoretically, one may be for example both epileptic and alcoholic; practically one is either an epileptic alcoholic or an alcoholic epileptic. The guide to the grouping here is a pragmatic one and depends upon the institution or the special treatment to which the supposed victim of epilepsy and alcoholism must gravitate. I must especially emphasize that the groups and the group names do not correspond to nosological entities and entity names. The placing of a case in one of these eleven groups is not psychiatric diagnosis in the entitative sense. Accordingly, this grouping does not run into collision with any previous en-
deavor to classify the genera and species of mental disease, such, for example, as the genera and species in the majority of classifications quoted in Hosack.⁵

I would insist further that the group headings given are not special enough to constitute sufficient diagnosis for a classification of use in the statistics of institutions for the insane. The plan is not so much an excursion in nosology as an essay in the technique of psychiatric diagnosis for the tyro. The plan gives hints for a method of arriving at an eventual diagnosis: it does not prescribe the names of diseases. Again, the plan is not an etiological plan, although recent advances in psychiatric etiology have been such that many of the practical groups are actually etiological groups.

It is possible that the sequence has been unduly telescoped. It is possible that there should be a traumatic and an arteriosclerotic group. I have placed both of these groups in the encephalopathic or coarse brain, or "neurologist's" group, feeling that I do the diagnostic tyro a service by pulling the encephalo-traumatic psychoses far apart from the traumatic psychoneuroses on the one hand, and the arteriosclerotic psychoses far apart from the senile psychoses on the other hand.

Lastly, I would insist once more that the plan is one born of Psychopathic Hospital experience and bred in the first place for the inexpert. It is a key to study and not an analytical classification with any pretense to finality. Elements in the sequence can be destroyed and new elements inserted. Indeed such processes of extrapolation and interpolation must needs occur in the progress of practical diagnosis. Whatever novelty the plan may have lodges in the sequential character of the analysis of data already collected and not in the completeness or ultimacy of the groups. The sequential plan of analysis is of course as old as the diagnostic hills. It is superior, however, to the type-matching method of diagnosis in vogue with many tyros, who very often come to their superiors with the plaint that the data in a given case fit the book descriptions of half a dozen diseases. A set sequential analysis of collected data must be superior to a hit-or-miss type-matching of entities.

⁵Hosack, David. A System of Practical Nosology: to which is prefixed A Synopsis of the Systems of Sauvages, Linnaeus, Vogel, Sagar, Macbride, Cullen, Darwin, Crichton, Pinel, Parr, Swediaur, Young, and Good, with References to the Best Authors on each Disease, 1st edition, 1879, 2d edition, 1821, New York.