The Genera in Certain Great Groups or Orders of Mental Disease

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THE GENERA IN CERTAIN GREAT GROUPS OR ORDERS OF MENTAL DISEASE*

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I want to present to the American Neurological Association certain amplifications of material presented in 1917 as a key to the practical grouping of mental diseases. Under the eleven groups of mental diseases defined in 1917, I wish to place such practical subdivisions as seem to me confirmed by American psychiatric experience.

As I find that many persons hardly distinguish between a classification and a key and labor under the impression that I am trying to erect a novel classification of mental diseases, let me insist that I am proposing nothing but a key to the classification of mental diseases according to the entities which I find in common diagnostic usage. I am elsewhere insisting on the extraordinary unanimity which American psychiatrists are now displaying on the matter of psychotic entities. There is, in fact, hardly enough controversy to indicate a healthy progress in the matter of theoretical psychiatry. (There is, to be sure, one large controversy concerning the nature and dimensions of psychogenesis and the part it may play in sundry mental diseases; but this controversy has to do with more general aspects of psychiatry than the question of its contained psychotic entities. Nothing is more hopeless than a discussion, for example, of psychogenesis in dementia praecox when the controversialists do not agree as to the clinical symptomatology of the cases under discussion.) This unanimity of view as to the psychotic entities of modern psychiatric science is so marked that a committee of the American Medico-Psychological Association has been able to formulate an acceptable list of such entities now in process of adoption by most of the institutions for the insane in the country. The progress in mental hygiene secured by this universal adoption of a list of psychotic entities is certainly a subject for congratulation.

PURPOSES OF THE AUTHOR'S INVESTIGATIONS

What I have been attempting of recent years on the basis of the diagnostic sifting-machine material afforded by the Psychopathic Hospital is to study the logical processes of psychiatric diagnosis and to

find, if possible, some simpler ways in which to arrive logically at one or other of the psychotic entities which we virtually all agree on.

I have placed some larger considerations on this matter of the "process-types" of diagnosis in a paper read this year before the Association of American Physicians, to be published in the *Journal of Clinical and Laboratory Medicine*. The paper is entitled "Diagnosis *per Exclusionem in Ordine*: General and Psychiatric Remarks." I do not need to rehearse the points of this paper before the American Neurological Association. I was, in fact, trying to read something of a lesson to the diagnosticians of the eminent internist group represented by the Association of American Physicians, calling to their attention the need for more elaborate logical methods of approach to diagnosis in psychiatry than in many branches of medicine. Some of the elders amongst the internists had for years denounced the method of diagnosis by exclusion; one of them said that the method was bound to fail because of our ignorance of pathology and went on to say that diagnosis by exclusion was a tedious method. Of course, tediousness ought not to stand in the way of accuracy, and pathology is bound to remain imperfect for many decades, not to say centuries. The fact is that in fields of diagnosis where there are no indicator symptoms, the method of diagnosis by exclusion is unconditionally necessary; for, in the absence of an index of differentiation or indicator symptom (or "presenting symptom" as Dr. Richard Cabot sometimes calls it), the diagnostician is bound to take into account all forms of mental diseases when he is trying to eliminate and differentiate the particular psychosis displayed by his patient.

Hence, I went into some detail in the paper mentioned, on a method of diagnosis which I called *diagnosis per exclusionem in ordine*. The central part of the idea had already been presented in the paper entitled "A Key to the Practical Grouping of Mental Diseases," presented before you in 1917.

The advance which I want to make this year is implicit in the method of the key presented last year. Last year I suggested that the tyro in diagnosis might well consider and exclude in sequence the great groups of mental diseases A, B, C, D, etc. I put A before B, B before C, etc., simply because the methods of diagnosis in Group A appealed to me as more certain, practical and general in their scope than the method available for Group B; the same for the methods of Group B as against those for Group C, etc.

This year I want to set down the subgroups of mental diseases which it seems to me practically all of us admit exist (if we admit that any entities whatever exist), in a proper diagnostic order. I want
to extend the principle of orderly diagnosis, that is, of diagnosis per exclusionem in ordine (genera) under groups (orders, in the botanical or zoological sense). Now I must acknowledge at the outset that the farther we go into detail, the less unanimity must a priori be expected in the psychiatric world. Accordingly, I would concede that my proposals are bound to be far less acceptable in their details than the proposals in the more general key to the main orders of mental diseases presented in 1917, but if the principle of exclusion in order be accepted for practical diagnosis, then I shall have no quarrel with those who feel that the entities are too many, too few or even non-existent.

**IMPORTANCE OF GROUPING DISEASES**

One more general remark: I feel that the history of modern developments in logic indicates that the part of order is the one part which has undergone great developments in recent years. We have discovered that though we cannot always measure things, we can sometimes put them in order unmeasured. It seems to me that the development of orderly diagnosis is quite on the carpet for modern workers. It may not be superficial to say that expert diagnosticians may not need to employ the method of diagnosis by exclusion in order simply because the facts in a given case may immediately suggest to them (by processes of mere inspection or of very rapid comparison) the right diagnosis. Time and again, however, the best experts fail in their attempt to apply the methods of diagnosis by inspection and by comparison, and surely the inexpert youthful psychiatrist needs some key to guide him. How frequently in the clinic do we find that the youthful diagnostician is by very little emphasis here and there able to press the phenomena of his case either into the dementia praecox or the manic depressive group or into the senile or the focal brain disease group, respectively. The point of this difficulty lodges in the fact that there are practically no indicator symptoms in mental diseases, and actually any symptom you may specify is quite able to lead you in any one of the main diagnostic directions. Let a young diagnostician of the dogmatic or slightly paranoid type get the initial idea that a case belongs in the dementia praecox group, he will be able to defend his thesis against all comers by the use of symptom lists founded on the very best textbooks; in fact, the better the textbook the easier for the young tyro to carry his point—for the time being.

Following are tabulated suggestions for the generic classification of mental disease groups, each group followed by some general remarks.
I. **SYPHILOPSYCHOSES** (the syphilitic mental diseases):

<table>
<thead>
<tr>
<th>Genera:</th>
<th>Less common genera:</th>
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</thead>
<tbody>
<tr>
<td>General paresis</td>
<td>Syphilitic feeblemindedness</td>
</tr>
<tr>
<td>Juvenile paresis</td>
<td>Syphilitic epilepsy</td>
</tr>
<tr>
<td>Nonparetic forms:</td>
<td>Tabetic psychoses</td>
</tr>
<tr>
<td>Meningitis</td>
<td>Syphilitic paranoia</td>
</tr>
<tr>
<td>Vascular</td>
<td></td>
</tr>
<tr>
<td>Gummatous</td>
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</tr>
</tbody>
</table>

Of course, the syphilopsychoses are by no means coterminous with neurosyphilis. The term neurosyphilis generally taken, must be supposed to include both the syphilopsychoses and the syphiloneuroses. The systematist will find a certain difficulty in placing many forms of neurosyphilis amongst the psychoses and the neuroses, respectively. We are here dealing with the psychoses, and our classification does not include the neuroses.

If one were asked how to distinguish the syphilopsychoses from the syphiloneuroses, one would have to reply on practical grounds that, if the case showed psychotic symptoms, it should be placed among the psychoses even if there were also present, is is usually the case, a number of neurotic symptoms. In short, owing to their practical significance, psychoses might be supposed to have the first call in classification as against neuroses. On this account the disease commonly known as general paresis would fall amongst the syphilopsychoses, despite the existence therein of any number of symptoms pointing to nonpsychical part of the nervous system. On the other hand, the disease commonly known as tabes dorsalis would best be placed amongst the organic neuroses, despite the appearance in tabes from time to time of a few mental symptoms. If, however, a case of tabes develops symptoms of a paretic nature, then the common rule is to term the case one of taboparesis. If in the course of the tabes certain characteristic excitements with hallucinations appear, then we have a rare entity known as tabetic psychosis. I am not sure that there has even been a well established case of this disease, tabetic psychosis, in the Psychopathic Hospital clinics amongst 10,000 admissions. So much for the general relation of the syphilopsychoses to the syphiloneuroses.

The issue is a practical one, and decision is made on the appearance of psychotic symptoms in the case. If these dominate the scene, then

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*Re-syphilopsychoses: Dr. Solomon and I in a recent case-book tried to bring order into the nomenclature of neurosyphilis by reducing the main forms thereof to:

- **(a)** Paretic
- **(b)** Tabetic
- **(c)** Diffuse
- **(d)** Vascular
- **(e)** Gummatous
- **(f)** Juvenile*
the case should in my opinion be termed syphilopsychotic. Of course, if the syphilitic infection precedes and in a psychogenic way occasions a neurasthenia, then from this point of view we should not be dealing with a case of syphilopsychosis, but with a case of psychoneurosis. If, as in one of the war cases, a syphilitic infection appears to bring about an epilepsy, we are not dealing according to this grouping with an epilepsy which is syphilitic, but an epilepsy presumably brought about in some psychogenic way and only indirectly due to the operations of spirochetes. These two exceptional diseases might be then named psychoneurosis syphigenica and epilepsia syphigenica, in which we place in the adjective the exciting factor and place in the abstract noun the general nature of the disease in question.

Syphilopsychoses, then, are diseases in which the psychosis is essentially spirochetal. Where the spirochete acts after the fashion of an occasioning factor, it would seem wiser in the interests of the patient to place the disease elsewhere.

A note on the order in which the genera under the syphilopsychoses have been placed is in point. I have placed, in the foregoing grouping, general paresis first because it seems to me that the means for its diagnosis are more exact and reliable than the means for the diagnosis of the other forms of syphilopsychosis. I have placed juvenile paresis second, hoping that the systematic examiner of cases of this group will consider very early in his logical work the question of congenital neurosyphilis. It has seemed to us at the Psychopathic Hospital that a good many errors in diagnosis have been made by the lack of consideration of congenital factors. These errors do not stand out so strongly in district state hospital material as in Psychopathic Hospital material.

The third genus or group of genera under the syphilopsychoses is constituted by the nonparetic forms. Despite the difficulty of the mutual differentiation of this group, I am inclined to separate the genera as indicated into meningitic, vascular and gummatous. To define a genus through negative features is a device which should not be resorted to except in extremity. Accordingly, I hold that the diagnosis cerebral syphilis, cerebrospinal syphilis, as made in many of our clinics, is as a rule no more exact than the more general diagnosis neurosyphilis. When this diagnosis is rendered, there are often no prognostic data available. As a matter of fact, as pointed out by Solomon and myself in the book previously mentioned, much damage may be done to a patient by terming him either general paresis or cerebrospinal syphilis at a time when it is strictly impossible to tell to which genus of the order syphilopsychoses the patient really belongs. At a little later stage in diagnosis, when more data have been collected, it is
virtually always possible, especially with the laboratory data now available, to indicate whether one regards a case as meningitic, vascular or gummatous. Why then, should we stop with the diagnosis "cerebrospinal syphilis," which amounts to little more than the statement that a man has either syphilopsychosis or syphiloneurosis, when we can profitably permit ourselves a generic diagnosis which may indeed practically help the patient a good deal.

Accordingly, I hold that general paresis, juvenile paresis, meningitic, vascular and gummatous syphilopsychoses form fairly well recognized genera in the order of syphilopsychoses. I do not propose a nomenclature, however, for these genera, hoping to excite a critique on the matter.

In addition to these five more or less readily distinguished genera under the order syphilopsychoses, there are a number of less common ones.

Shall we term syphilitic feeblemindedness a form of feeblemindedness or shall we term it a form of syphilopsychosis? According to the general principles of diagnosis by exclusion in order and in the pragmatic and therapeutic interest of the patient, I very much prefer to have the disease classified under the syphilopsychoses. Order Number ii, that of the hypophrenias, is made to include practically all kinds of feeblemindedness which have been defined. Why then, should we not speak of a hypophrenia syphilitica? Would it not help the specialists in feeblemindedness so to classify their material? From that more limited standpoint I should agree that hypophrenia syphilitica might be a proper term for the somewhat rare disease, but from the standpoint of neurologic clinics, neurologic and psychiatric clinics, district state hospitals, psychopathic hospitals, I would still think it best to insist on the pragmatic side of the situation by regarding this disease as one amongst the syphilopsychoses. It might be termed neurosyphilis hypophrenica.

Identical considerations hold for syphilitic epilepsy; in fact, it seems to me that the considerations are here stronger; for it is certainly much more definite to term a condition neurosyphilis epileptica than it is to call it epilepsy syphilitica. From the more limited standpoint of the epileptologist, of course epilepsy syphilitica may approve itself, but epilepsy is so much broader and vaguer a concept that it seems to me highly worth while to place all cases of epilepsy regarded as syphilitic in origin amongst the cases of neurosyphilis.

I called attention in the foregoing to one of the war cases in which the acquisition of a syphilitic infection brought out an epilepsy: that case presumably belonged neither in the syphilopsychoses nor in the epileptoses, but rather amongst the psychogenic cases which we rele-
gate to a much lower place on the scale. Such a case might very possibly be classed in the genus hysteria, of the order psychoneuroses. If we hold the diagnostician down in such a case to an exact definition of what he means by making him specify the genus or order in question, we shall greatly improve our logical technic in diagnosis. For instance, is the case one of syphilopsychosis epileptica? Then we would suppose that the spirochetes were in some way acting on the brain so that a true epilepsy hardly distinguishable from sundry other organic forms was being produced. Or, is the case one of hysteria epileptica or hysteria epileptoides in which the adjective conforms with the degree of doubt concerning the observed phenomena themselves? Under the latter circumstance a quite different genesis is to be suspected at work. But, you will reply, how often are we unable to tell which form of genesis is in play? Quite right, one must reply, but until one knows what form of genesis is in play, the true or indicative diagnosis, the really pragmatic diagnosis which will help treatment, has not been rendered.

It seems to me that the diagnostic sheets and statistical tables of many clinics are full of these hedging diagnoses.

As for other less common genera, tabetic psychosis and syphilitic paranoia, something has been said in the foregoing concerning tabetic psychosis (note again that we do not mean by tabetic psychosis that subform of general paresis called tabo-paresis); and I shall not delay on syphilitic paranoia, an exceedingly rare genus if it at all occurs.

Under the term atypical, as under other orders of mental disease, I propose to leave room for syphilitic mental diseases of doubtful or hitherto undefined nature, for it is no part of the present endeavor to enumerate and fixate a nomenclature for the psychoses. As in several places stated, I am simply trying to take the groups which modern clinics recognize and place them in a practical diagnostic sequence.

II. HYPOPHRENOSES (the feeblemindednesses, including graded forms of idiocy, imbecility, moronity (in the English nomenclature feeblemindedness proper) and subnormals):

[Syphilitic]
Encephalopathic:
Microcephaly, hydrocephalus, focal brain.
Glandular:
Cretinism, infantilism, dysadenoidism, mongolism (?).
Hereditary:
Feeblemindedness, amaurotic family idiocy.
Atypical.

I have placed the syphilitic group, which might possibly be regarded a good genus, under the hypophrenias in brackets. These brackets here and elsewhere are intended to indicate that the genus has been suffi-
ciently covered in the higher group to which the orderly diagnostician will have already had access.

Refer to what has preceded for notes on whether we should prefer neurosyphilis hydrophrenica to hypophrenia syphilitica. The decision is a close one. I regard it as in the practical interest of the patient to have him classified under the syphilopsychoses. One example of this sort in which an ordinary form of feeblemindedness was found due to syphilis has been given in the Southard-Solomon collection previously mentioned; also in the Waverley Series on the Pathology of the Feebleminded there are data which indicate that we must take into account more than in the past the question of the relation of syphilis to feeblemindedness.

As for the nomenclature of hypophrenia, I have drawn up the arguments for the use of the term hypophrenia as against several others in the literature in a special paper which I hope will be shortly published, entitled, “Hypophrenia and Hypophrenics: Suggestions in the Nomenclature of the Feeblemindednesses.” (Mental Hygiene, in press.)

Passing to the genera themselves, I am inclined to think that the encephalopathic, the glandular and hereditary groups ought to be regarded as suborders or collections of genera rather than as genera themselves. I do not here propose to suggest a nomenclature for the genera themselves, but have picked out microcephaly, hydrocephalus, other forms of focal brain disorder, cretinism, infantilism, dysadenoidism, mongolism, amaurotic family idiocy and the common form of hereditary feeblemindedness as suitable genera in the present phase of development of the theory of the feeblemindednesses.

With some doubt I place mongolism under the glandular diseases because many workers whom I have met feel that this disease will prove to belong there.

As for the common hereditary form of feeblemindedness, which might be named hypophrenia hereditaria, I feel that it will bulk much smaller than specialists have recently given us reason for supposing. If the encephalopathic cases are pulled to one side (regardless of their possessing tainted heredity, since it is obvious that other factors than mere hereditary germ plasm factors must have been at work), and if many of the glandular cases are set to one side as being directly due to sundry nonhereditary factors, the number of cases which we should be entitled to call hypophrenia hereditaria will be greatly diminished. A number of theoretically preventable cases of feeblemindedness and a number of cases due to brain-destroying and body-destroying factors of a nongerm-plasm nature have been defined in recent work. Of course, the anatomists and pathologists will give
statistics that are possibly unfair to the hypothesis of germ-plasm heredity, since the anatomists and pathologists may overvalue sundry of their brain and body findings; but with all due allowance for this anatomic prejudice, certainly the number of cases of hereditary feeblemindedness in the sense in which we use the term hereditary in the rest of medicine, is year by year diminishing with the progress of medical science.

In my paper of last year entitled, "A Key to the Practical Grouping of Mental Diseases," I endeavored to divide the hypophrenias into genera according to the quantitative results of mental tests. I am inclined to think, however, that this suggestion, however compatible with the spirit of the times with respect to the increasing accuracy of mental tests, is unsuited to the practical work of a clinic. After all, the question whether a patient is a mongolian hypophrenic is more important than whether he is an imbecile or an idiot. The same holds true for hydrocephalus and in fact for a majority of the hypophrenics. The procedure would be to determine your genus and estimate the amount of intelligence shown by the particular example in hand.

As under Group I, I have made provision by the term atypical for genera of an unknown or undescribed nature.

### III. Epileptoses (the epileptic group):

- [Syphilitic, Group I]
- [Feeblemindedness with epilepsy, Group II]
- Alcoholic: Idiopathic
- Traumatic: Equivalent
- Encephalopathic: Narcoleptic
- Jacksonian: Borderland
- Symptomatic

Concerning the bracketing of the syphilitic and feebleminded forms, refer to the remarks under Group II.

I will not here attempt to justify the selection of genera under the epileptoses. This is a veritable mare's nest in classification and the man who wishes to use a classification by putting the elements in order of consideration is greatly at a loss. Practically it has seemed to me that if one could push on one side early the alcoholic and traumatic question that one would come down on the questions of brain tumor, etc., with a great deal more confidence than if one started in with the latter. Also, practically there are many questions concerning the proper classification of all sorts of diseases having convulsions. The pragmatic answer to the question whether a given disease should be classified under epileptoses or under some other group depends, it seems to me, on the kind of treatment which you propose on your basis of analysis to give the patient. If the kind of treatment is nothing but the regimen, custodial or otherwise, which you prefer for epileptics in general, then the case should be classified amongst the
epileptics. If, however, the convulsions are incidental in some bodily disease, or even in some brain disease in which special surgical treatment or other special treatment may be indicated, then it seems to me that we do the patient a pragmatic injury by classifying him among the epileptics and not in some more definite group of diseases. On this line refer to the remarks concerning epilepsy in syphilis under Group I.

The thumb rule would be: Never classify a case as epileptic if you can be more definite as to its nature and especially its cause.

IV. Pharmacopsychoses (the group of mental diseases due to alcohol, drugs and poisons):

[Epileptic, Group III]

Alcoholic
A. Pseudonormal:
   Drunkenness, pathologic intoxication, dipsomania
B. Peripheral-Central:
   Delirium tremens, hallucinosis, Korsakow, pseudoparesis.
C. Central:
   Jealousy-psychosis, paranoia (?), dementia

Drug:
   Morphin, cocain, alkaloid

Poison:
   Lead, gas, mercurichlorid, special

I will not pause to discuss the details under Group IV. It would seem to me that the designation pharmacopsychoses is a good one, as the Greek word on which the term is founded can be used for both drugs and poisons.

A great deal of theoretical interest attaches to the nature as well as to the diagnosis of the subforms of alcoholic psychoses. I have cast these into three groups, rather inadequately termed pseudonormal, peripheral-central and central. My point is that ordinary drunkenness and so-called pathologic intoxication and dipsomania form three conditions which are, if not normal, then distinctly less abnormal than the other diseases. Drunkenness, it may be stated, is not a form of insanity, and many legislators have so determined, but that drunkenness is not a kind of psychosis I think hardly any one would deny. Here is an instance in which the distinction between a mental disease and insanity comes out very clearly.

But is it possible to distinguish the peripheral-central group from a central one? Practical workers, it seems to me, would agree that delirium tremens, alcoholic hallucinosis, Korsakow's disease and the so-called alcoholic pseudoparesis (if this latter disease at all exists) more closely resemble one another than they do in any of the other forms of alcoholic mental disease. If some one could provide a good designation for this small fraternity of alcoholic disease genera which I have called peripheral-central, he would help our practical work a
good deal. I find a good deal of almost useless discussion in early phases of observation of alcoholic cases as to whether they are instances of delirium tremens or alcoholic hallucinosis. I do not wish to deny a generic value to the distinction, but if we could halt our diagnostic process at the point where the observations stop, we should help psychiatric diagnosis not a little.

The third group that I have termed "central" is composed of the jealousy psychoses which most workers acknowledge that they find in certain instances, paranoia (a much more doubtful matter) and dementia. Here are diseases in which the peripheral element, histologically and symptomatically, is far less in evidence. To be sure there may have been some element of a peripheral nature in the disease at some time, but the chances are that such cases with strong peripheral element belong in the peripheral-central group rather than in the central group. An exact and elegant nomenclature would be a bonanza for practical workers among the pharmacopsychoses.

V. Encephalopsychoses (focal brain lesion group of mental diseases):

- Syphilis*
- Feeblemindedness*
- Epilepsy*
- Alcohol, gas*

Traumatic. Note that the traumatic neuroses, although they form a group of mental diseases, belong not here in Group V, but below in Group X, the psychoneuroses.

Neoplastic.

Infectious. The infectious group of encephalopsychoses here listed refers to cases like brain abscess and meningitis in which the organism has produced local destructive effects in the brain.

Vascular. Under this group would fall the great group of arteriosclerotic dementias which, be it noted, are parted out from the old age psychoses; Group VIII, below.

Degenerative.

VI. Somatopsychoses† (the so-called symptomatic group of mental diseases):

- Glandular feeblemindedness
- Symptomatic epilepsy
- Infectious, e. g., typhoid
- Exhaustive, e. g., puerperal
- Metabolic, e. g., cardiorenal
- Glandular, e. g., thyrotoxic
- Pellagrous

*These have been classified, respectively, under syphilopsychoses, Group I; hypophrenoses, Group II; epileptoses, Group III, and pharmacopsychoses, Group IV.

†The term "somatic" is here used following a frequent neurologic plan which employs the term "soma" for the body at large, as against the "encephalon" or brain.
I have tried to define the genera under the five subgroups here mentioned, though I assume that the progress of science will show that a symptomatic psychosis due to the typhoid bacillus is to be distinguished from a symptomatic psychosis due to the pneumococcus; but these are matters for the future to decide.

In practice one should not term a case infectious psychosis, in my opinion, unless an organism has been cultivated from the case or unless there is exceedingly strong evidence that an infection is in play. A good many puerperal cases, when organisms are cultivated therefrom, become on this basis infectious cases rather than exhaustive cases; but who would say that such a translation from one group to another would not be of benefit to the case.

Many authors speak of a toxic-infectious group, of an infectious-exhaustive group or even of a toxic-infectious-exhaustive group, but it seems to me with these double and triple designations we get on not much better than if we confine our statements to saying that the case belongs among the symptomatic psychoses. In short, we are making a very rough diagnosis and placing a case in a large group, but we are rather deluding ourselves that we are making entitative diagnosis.

When infection is not in play and when exhaustion is not in play, I can hardly see the advantage of using the term toxic. The term toxic suggests to the medical hearer that there may well be a toxin in play, that is, such a substance as may be demonstrated in the test tube or under other strictly scientific rules. If pinned down to the meaning of the term, the physician is apt to be reduced to saying that the term toxic refers to certain clinical symptoms that resemble those that are the known effects of toxins or poisons, infectious or otherwise. But is not this a retreat to ground altogether too general to be of value in diagnosis? Perhaps others will not agree with me; but when I see the term toxic and feel that there is no possible laboratory approach to the toxin-poison question, I fall into a marsh of doubt.

The third group of genera here termed metabolic is also sometimes laden with the term toxic, in fact, possibly the term autotoxic might be preferred by many to the term metabolic here used. I can see that the term metabolic is too general a term, but, on the other hand, the term autotoxic seems to specify too much.

The point in the ordering of these subgroups is that, in practical diagnosis, one ought to exclude in succession conditions in which there is a known infectious agent, conditions in which an exhaustive state without known infection, conditions of a general metabolic or autotoxic nature. Those ought to be eliminated from the scene before the glandular cases are brought under consideration. Possibly the pellagrous group might be placed first under the symptomatic group. Indeed, in regions where pellagra is infrequent,
now and then grave errors of diagnosis have been made. I well remember that one of the first cases of pellagra which came to the Psychopathic Hospital was one of an obscure kind of depression with apparently a cyanosis of the hands regarded as a very proper vaso-motor by-effect in his psychosis. By the systematic sequential consideration of these conditions, including pellagra, the question was definitely raised concerning this man whether he might not be pellagrous. The psychosis was then more carefully examined and sundry other features were brought into alignment with the manual lesions. A tentative diagnosis of pellagra was made and the patient thereafter developed a classic form of the disease.

VII. Geriopsychoses* (the presenile-senile group of mental diseases):

Epilepsy
Vascular
Alzheimer's
Progeria
Late catatonia
Involution melancholia
Presenile psychoses
Senile dementia
Presbyophrenia
Senile psychoses

One of the peculiar advantages of this pragmatic sequence of consideration is that the senile dementes are removed so far from the arteriosclerotic cases. (Refer to note under Group V.) Kraepelin rightly terms the presenile division of psychiatric cases the darkest field in psychiatry. I am aware how many subgroups Kraepelin has proposed among the preseniles, but for the moment am unable to define what types should be given under the heading presenile psychoses.

VIII. Schizophrenoses (the dementia praecox group):

Hebephrenia Schizophrenia
Catatonia D. praecocissima
Paranoid D. simplex
Cyclothymoid† Paraphrenia

*This term is adopted provisionally as against the possible term presbyopsychooses, because of Nascher's choice of the term "geriatrics" for his proposed branch of medicine, dealing with the diseases of old age.

† This genus, if it be such, is devised to include the practically very important group of cases in which the schizophrenic process is precipitated by phenomena that resemble manic depressive psychosis, or in which there is a definitely cyclothymic course in itself suggesting the true cyclothymoses.
As for Group VIII, no discussion need be given concerning hebephrenia, catatonia and paranoid. To be sure, concerning the latter Kraepelin has endeavored to distinguish two forms, mitis and gravis, but whether this is a pragmatic distinction of great importance to the future of the patient is doubtful.

As for the term cyclothymoid, I feel that this concept is of some value. First, concerning the term cyclothymoid. The name of this genus, if it be such, would be “schizophrenia cyclothymoides.” The ending *oides* used in the specific adjective would be in general borrowed, as in this instance, from some other genus or group. By “schizophrenia cyclothymoides” we would then mean a dementia praecox that somehow very closely resembled a manic-depressive psychosis, that is, a schizophrenia that somehow closely resembled a cyclothymia. If now there were a true cyclothymia (that is, manic depressive) that closely resembled a schizophrenia, we should be forced to dub it “cyclothymia schizophrenoides,” borrowing for our specific adjective from another genus and adding the ending *oides*. This procedure would be roughly in accordance with botanical procedure. It would be purely a question of fact whether there is such a condition as “cyclothymia schizophrenoides.”

As for the existence of cyclothymoid types of schizophrenia, there can hardly be any doubt that these forms exist. When Kraepelin expanded his original three forms of dementia praecox to nine, he found himself with three new subforms that I have here lumped together under the heading “schizophrenia cyclothymoides.” There can be no practical doubt of their existence.

As for the other subheads under the schizophrenias, schizophasia is a small group of Kraepelin’s own, of which we now and then see examples. I have added dementia praecocissima group of de Sanctis not because its existence is necessarily well established, but because there seemed to be cases which might well belong in the group if they could be held under observation for some decades longer and their course made out.

It is a question whether dementia simplex should form a genus alongside hebephrenia and whether dementia simplex is more than a mild form of hebephrenia. The term is useful for those cases of slight deterioration which we see in subjects that remain sufficiently well to be self-supporting and only slightly eccentric or dull.

The genus paraphrenia is as Kraepelin has proposed, practically Magnan’s disease, that is the délire chronique à évolution systématisée. Kraepelin gives four subclasses of this disease which may possibly be species or varieties, namely, paraphrenia systematica, confabulans, phantastica, expansiva.
IX. _Cyclothymoses_ (the manic-depressive and cyclothymic group of mental diseases):

<table>
<thead>
<tr>
<th>Cyclothymic constitution</th>
<th>Mania</th>
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</thead>
<tbody>
<tr>
<td>Manic-depressive</td>
<td>Mixed</td>
</tr>
<tr>
<td>Melancholia</td>
<td>Involution-melancholia</td>
</tr>
</tbody>
</table>

As to the distinction between manic-depressive and the mixed forms of cyclothymia, I would suppose it wise to call manic-depressive cases (in this generic sense) those in which both mania and depression in different phases of the patient's course are developed.

It would be wise in my opinion to replace the term manic-depressive as a group designation with the term cyclothymia, which brings out the affective features and the phasic features of the disease. If a case is cyclothymic, we shall be able to arrive at the diagnosis having excluded all its competitors for preference down through the schizophrénias.

Now let us say that we are confronted by a case of pure mania or pure depression which we know is not syphilitic, or alcoholic, or symptomatic of some somatic condition, or schizophrenic. We shall be entitled to term it cyclothymic with a high degree of probability, unless perchance on further investigation we determine it to be a psychoneurotic phenomenon. But, again, can we say that this phase of mania or depression is going to be followed by its opposite, depression or mania? It seems to me that we decidedly cannot. The prognosis would better be confined to saying that emotional disorder is likely again to occur. Is not this approximately the extent to which one can now go in making a prognosis in cyclothymic cases? The future may do more for us than has the past. Wernicke remarks that no case of chronic mania was ever initiated by an acute mania. A number of important and easily manageable statistical researches could be made on this line; but psychiatrists are not particularly interested in such statistical researches, however valuable in prognosis their results might be, because they seem to be under the spell of the idea "manic-depressive." According to my conception, the idea of manic-depressive is the idea of a large group of diseases. It is questionable whether Kraepelin discovered a new disease. He defined a great group of diseases, each of which had already been defined, as having certain affinities with one another.

As for the term mixed, I wish by this term to signify cases in which depressive and maniacal phenomena are commingled within a single phase of the disease.

As for involution-melancholia and its placing among the cyclothymias, I do not wish to take a definite stand. Very possibly this disease would better be placed amongst the old age phenomena, as the term involution would suggest.
X. Psychoneuroses:

Hysteria
Neurasthenia
Psychasthenia

This is not the place to discuss the genera and species and varieties of the psychoneuroses. Walton some years since insisted on the value of not making generic diagnoses of neurasthenia, psychasthenia or hysteria. He would have the diagnostician confine himself to terming the case psychoneurosis.

Regarding hysteria, I am inclined to think that in many early phases of these psychoneuroses, Walton's plan is beneficial. It is a question how far a diagnostician wishes to go. Some physicians are perfectly content to call a case mental, that is to say, under the morbi mentales, and let it go at that. Others will be content to place a case, for example, under the psychoneuroses and then call in some person especially qualified to cure the case; for the psychoneuroses form essentially the psychotherapeutic group. The specialist may wish to go farther and identify the genus or species, or even the varieties of the large group. No doubt the progress of science depends on further developments in these directions, provided that these developments be pragmatic ones in the interest of helping the patient.

XI. Psychopathoses (the psychopathic group of mental diseases):

Prison psychoses
Folie à Deux
Litigation psychosis
Paranoia

Sense-deprivation psychosis
Monomania
Psychopathy sexualis
Psychopathic personality

Concerning the last or eleventh group, there might be much to say. Let me say here that I would speak of this group in common parlance as the psychopathias, not using the ordinal term psychopathoses except in contradistinction to other ordinal groups. The existence of these scientific terms having relatively exact distinction should not preclude our every-day use in the clinic of commoner terms. Just as one would not order Rosaceae at the florist's or Leguminosae at the grocer's, so one would not use these scientific terms except when one was in doubt exactly where a case ought to belong. In the progress of psychiatric science, the genera under this eleventh group ought to become more and more definite. Some of the genera will doubtless be relegated to pre-existent groups; others may form new orders suitable to elevation to the rank of groups like the psychoneuroses, the syphilopsychoses, etc. I have given in the preceding a small collection of these doubtful psychopathias. None of these require special mention here, perhaps.
Paranoia, I place among the doubtful psychopathias because I do not see that it has been proved to have a schizophrenic nature, and feel that it cannot otherwise be placed in the previous groups. The suggestion that it is a sort of intellectual infantilism is an attractive one, but it seems a little far fetched to place our apparently complex paranoias amongst the feebleminded.

Some persons might object to the use of the term monomania, but if we do not use this term we should need to enumerate such genera as kleptomania, pyromania and poriomania (Wanderlust). The polemic in which the term monomania was overthrown is long since reduced to ashes: The term it seems to me remains a good one for precisely those nonsexual cases with unusual development of particular instincts.

As for the term psychopathic personality, it is surely a bone of contention; but if we exclude the sexual cases under the term psychopathia sexualis and exclude the cases with special instincts in strong relief (the monomanias), we shall then have on our hands certain cases of psychopathic personality that are apparently worthy of a place. Many of the so-called defective delinquents very probably fall in this group, though an endeavor should constantly be made to place them amongst the hypophrenics, the epileptics, the schizophrenics, the psychopathic monomanias, etc. All psychiatrists agree that we should not prejudice the situation in criminology by terming all defective delinquents forthwith psychopathic personalities. Let us leave room for the existence of criminals that are not psychopathic.

One might inquire whether there are not certain psychogenic cases that might belong in this eleventh group, that is, cases which cannot be regarded as hysterical, neurasthenic or psychasthenic. Doubtless the neuropsychiatry of the war will help to resolve that question.

**SUMMARY**

In this paper I have tried to amplify the key to the practical grouping of mental diseases presented to the American Neurological Association in 1917. I have amplified it by proposing certain genera comprised under each of the eleven major groups of mental diseases. These genera have been placed in the sequence supposed to be the pragmatic sequence in which the inexpert diagnostician should seek to exclude successively the various genera; in short, just as the key to the practical grouping of mental diseases dealt in a certain sequence with eleven major groups, so here the diagnostician is given an idea as to the proper method of considering one after another the genera comprised in each great group. No endeavor has been made to revamp or especially modify the ideas of psychiatrists as to what psychotic entities exist. Finality cannot be hoped for either theoreti-
call y or practically. The principle of diagnosis *per exclusionem in ordine* is the special principle insisted on. *It is applicable to any diagnostic problem after the data of observation are collected.* True diagnosis can only take place after sufficient data are collected, and efforts to make diagnoses early in the stage of collecting data are apt to result in prejudice.

The writer earnestly hopes for critique of his propositions. Such critique he hopes will be separated into:

(a) Critique of the general principle of *diagnosis per exclusionem in ordine*.

(b) Critique of the genera chosen for the different groups.

(c) Critique of nomenclature.

But judging from the world's experience in the past, it is unlikely that many persons will be able to distinguish nomenclature from the objects named and the method of using a classification from the classification itself. Herein some nomenclatural suggestions are made; but they have nothing to do with the main line of argument. Herein a certain classification is adopted, but there is absolutely no pretence to originality therein. The writer's main emphasis is on the pragmatic principle of diagnosis, namely, the principle of diagnosis by exclusion in order which principle will prove useful or useless without regard to the classification which it endeavors to exploit or the nomenclature which it uses by the way.