DIAGNOSTIC AND STATISTICAL MANUAL

MENTAL DISORDERS

AMERICAN PSYCHIATRIC ASSOCIATION

DIAGNOSTIC AND STATISTICAL
MANUAL

MENTAL DISORDERS

Prepared by
The Committee on Nomenclature and Statistics of the
American Psychiatric Association

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[1] Reprinted from "Standard Nomenclature of Diseases and Operations," Fourth Edition, Published for American Medical Association, The Blakistone Co., Philadelphia, 1952, by permission of the copyright owners.

[2] Reprinted from "Textbook and Guide to the Standard Nomenclature of Diseases and Operations," Physicians Record Co., Chicago, Ill., by permission of the copyright owners.

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FOREWORD

The development of a uniform nomenclature of disease in the United States is comparatively recent. In the late twenties, each large teaching center employed a system of its own origination, no one of which met more than the immediate needs of the local institution. Despite their local origins, for lack of suitable alternatives, these systems were spread in use throughout the nation, ordinarily by individuals who had been trained in a particular center, hence had become accustomed to that special system of nomenclature. Modifications in the transplanted nomenclatures immediately became necessary, and were made as expediency dictated. There resulted a polyglot of diagnostic labels and systems, effectively blocking communication and the collection of medical statistics.

In late 1927, the New York Academy of Medicine spearheaded a movement out of this chaos towards a nationally accepted standard nomenclature of disease. In March, 1928, the first National Conference on Nomenclature of Disease met at the Academy; this conference was composed of representatives of interested governmental agencies and of the national societies representing the medical specialties. A trial edition of the proposed new nomenclature was published in 1932, and distributed to selected hospitals for a test run. Following the success of these tests, the first official edition of the Standard Classified Nomenclature of Disease was published in 1933, and was widely adopted in the next two years.[1] Two subsequent revisions have been made, the last in 1942. The nomenclature in this manual constitutes the section on Diseases of the Psychobiologic Unit from the Fourth Edition of the Standard Nomenclature of Diseases and Operations, 1952.

Prior to the first edition of the Standard, psychiatry was in a somewhat more favorable situation regarding standardized nomenclature than was the large body of American medicine. The Committee on Statistics of the American Psychiatric Association (then the American Medico-psychological Association) had formulated a plan for uniform statistics in hospitals for mental disease which was officially adopted by the Association in May, 1917. This plan included a classification of mental disease which, although primarily a statistical classification, was usable in a limited way as a nomenclature. The National Committee for Mental Hygiene introduced the new

[1] For details of the development of the Standard, see "Textbook and Guide to the Standard Nomenclature of Diseases and Operations," Physicians Record Co., Chicago, Illinois.

classification and statistical system in hospitals throughout the country, and continued to publish the "Statistical Manual for the Use of Hospitals for Mental Diseases" through the years. The Committee on Nomenclature and Statistics of the American Psychiatric Association collaborated with the National Committee in this publication. With approval of the Council, and by agreement with the National Committee for Mental Hygiene (now the National Association for Mental Health), the Mental Hospital Service of the American Psychiatric Association now assumes responsibility for future publication of the Statistical Manual, which has been re-titled, "Diagnostic and Statistical Manual for Mental Disorders," and is presented here in its first edition.

The American Psychiatric Association cooperated, as the representative national society, in the establishment of the Standard Nomenclature of Disease. With the publication of the first edition of the Standard, a considerable revision in the Statistical Manual became necessary. This revision was accomplished in the Eighth Edition of the Statistical Manual, 1934. The classification system of the new Standard Nomenclature was included, together with a condensed list for statistical use. For the first time the difference in a system of nomenclature and a system of statistical classification was underscored (see Appendix A).

Only minor changes were made in the section on Mental Disorders in later revisions of the Standard, this section being essentially the same in the 1933 and 1942 editions. Many teaching centers devised modified systems of nomenclature for their own use, but the official nomenclature into which diagnoses were coded for statistical and medical record files remained the original 1933 nomenclature, as published in the Standard. As a result, at the beginning of World War II, American psychiatry, civilian and military, was utilizing a system of naming developed primarily for the needs and case loads of public mental hospitals. The origin of this system was in itself predictive of the difficulties which would soon be encountered.

The Armed Forces faced an increasing psychiatric case load as mobilization and the war went on. There was need to account accurately for all causes of morbidity, hence the need for a suitable diagnosis for every case seen by the psychiatrist, a situation not faced in civilian life. Only about 10% of the total cases seen fell into any of the categories ordinarily seen in public mental hospitals. Military psychiatrists, induction station psychiatrists, and Veterans Administration psychiatrists, found themselves operating within the limits of a nomenclature specifically not designed for 90% of the cases handled. Relatively minor personality disturbances, which became

of importance only in the military setting, had to be classified as "Psychopathic Personality." Psychosomatic disorders turned up in the nomenclature under the various organ systems by whatever name a gastroenterologist or cardiologist had devised for them. The "psychoneurotic label" had to be applied to men reacting briefly with neurotic symptoms to considerable stress; individuals who, as subsequent studies have shown, were not ordinarily psychoneurotic in the usual meaning of the term. No provision existed for diagnosing psychological reactions to the stress of combat, and terms had to be invented to meet this need. The official system of nomenclature rapidly became untenable.

In 1944, the Navy made a partial revision of its nomenclature to meet the deficiencies mentioned, but attempted to stay within the limits of the Standard where possible. In 1945, the Army established a much more sweeping revision, abandoning the basic outline of the Standard and attempting to express present day concepts of mental disturbance. This nomenclature eventually was adopted by all Armed Forces, and in 1946 the Veterans Administration adopted a new nomenclature which resembled closely that of the Armed Forces. In 1948, a revised International Statistical Classification was adopted, and categorized mental disorders in rubrics similar to those of the Armed Forces nomenclature.

By 1948, then, the situation in psychiatric nomenclature had deteriorated almost to the point of confusion which existed throughout medical nomenclature in the twenties. At least three nomenclatures (Standard, Armed Forces, and Veterans Administration) were in general use, and none of them fell accurately into line with the International Statistical Classification. One agency found itself in the uncomfortable position of using one nomenclature for clinical use, a different one for disability rating, and the International for statistical work. In addition, practically every teaching center had made modifications of the Standard for its own use and assorted modifications of the Armed Forces nomenclature had been introduced into many clinics and hospitals by psychiatrists returning from military duty.

Following the adoption of new nomenclatures by the Army and Veterans Administration, the Committee on Nomenclature and Statistics of the American Psychiatric Association postponed change in its recommended official nomenclature pending some evidence as to the usability of the new systems. In 1948, the Committee undertook to learn from the Army and Veterans Administration how successful the changes had been, and what the shortcomings of the new systems were. Simultaneously, an effort was made to determine the sentiments of the membership regarding the need for a change in the then current Standard.

A high percentage of psychiatrists contacted felt that change in the nomenclature was urgently needed, with special attention to the areas of personality disorders and transient reactions to special stress. The need for change seemed to be felt more strongly by those in clinic and private practice than by those in mental hospital or institutional work. However, a considerable proportion of mental hospital staffs urged change; this was especially true where outpatient clinics had been established in connection with the hospitals.

The Army and Veterans Administration reported that their revisions were considered successful by clinicians and statisticians. Statistically, the revisions were said to be more easily handled than the old nomenclatures, particularly when it became necessary to code diagnoses into the revised International. After some expected initial difficulties in using the new terms, clinicians reported that the revisions were much more useful than the old listing. Psychiatrists who had become accustomed to the revised nomenclature in the Army were unwilling to return to the Standard Nomenclature upon return to civilian life. The major shortcoming in both revisions was reported to be the classification of mental disorders accompanying organic brain disease, a minor problem in military psychiatry but a major item in civilian psychiatry.

With a need for a revision established, and guidelines drawn from the experience of the Armed Forces and Veterans Administration, the Committee set about drafting a proposed revision. Source material received by the Army and Veterans Administration during the process of their revisions was utilized, psychiatric teaching units were contacted for ideas, especially concerning the organic brain disorders, and efforts were made to obtain all possible suggestions from the body of American psychiatry, as well as from the literature. From March, 1950, the Chief of the Biometrics Branch, National Institute of Mental Health, served as a consultant to the Committee to assist with the statistical aspects of the revision.

In April, 1950, the Committee distributed mimeographed copies of a proposed revision of the psychiatric nomenclature to approximately 10% of the membership of the American Psychiatric Association. Addressees were picked from the geographical listing of members, 10% of the members in each State and Canada being selected. In addition, addressees were selected by position held, in order to give complete coverage to all areas of psychiatry. Attention was paid to membership in other organizations (American Neurological Association, American Psychoanalytic Association, Academy of Neurology, American Psychopathological Association, etc.), so that a fair

sampling of those groups was included. Members of the staffs of State Departments of Mental Health were included in order to obtain an expression of opinion from such departments concerning the statistical and clinical impact of the proposed revision.

The proposed revision was accompanied by a nine-page questionnaire asking for opinions and suggestions on all sections of the revision. A deadline of July 1, 1950, was set for return of the questionnaire in order that the work might be completed in time for the November, 1950 meeting of Council. As the questionnaires were returned, they were broken down into sections and mailed out to individual members of the Committee, each of whom had been assigned a specific area of the revision for study. A master file of questionnaire returns was established in the Office of the Medical Director for quick reference.

There were 520 questionnaires distributed; 241 were returned in time for consideration by the Committee. Of these, 224 (93%) expressed general approval of the suggested revision, 11 (5%) expressed general disapproval, and 6 (2%) were neutral. Such overwhelming approval was not accorded all sections of the revision, but the lowest approval rate on any section was 72%. The returns were not simply blanket approvals or disapprovals; more than half contained specific suggestions and recommendations. An unexpectedly high proportion of addressees had made the revision and questionnaire points of extensive discussion with colleagues. Several mental hospitals held a number of staff meetings devoted to such discussions, other clinics and administrative groups did the same. It therefore appeared that the Committee had received the considered opinion of a very large portion of American psychiatry.

Armed with this wealth of thoughtful material, the Committee prepared a second revision, incorporating the information obtained from the questionnaires. As had been done in the case of the first revision, this second revision was sent to the Editor of the Standard Nomenclature for comment, and particularly to learn whether it could be incorporated in the general framework of the Standard. With minor changes in wording and coding, this second revision was acceptable to the Standard.

Accordingly, the revision was presented to Council of the American Psychiatric Association at its meetings on November 6, 1950, with the recommendations that it be adopted as the officially supported nomenclature of the American Psychiatric Association, that it be recommended by Council to the Standard Nomenclature for inclusion in the 1951 edition, and that the Committee be authorized to prepare this Diagnostic and Statistical

Manual for publication by the Association. These recommendations were approved by Council.

The collection of statistics on mental illness morbidity has long been a stepchild of Federal Government. Delegated from year to year on a fiscal basis to the Bureau of the Census, morbidity statistics in this most important area perhaps would never have been collected had it not been for the untiring efforts of former Committees on Statistics of the American Psychiatric Association and the National Committee on Mental Hygiene. It has therefore been most important in the past that this manual devote most of its attention to statistics, as was indicated by its name.

In 1946, an Act of Congress authorized the establishment of the National Institute of Mental Health, under the United States Public Health Service. A Biometrics Branch has been established in that Institute, and concerns itself with the operational features of statistical reporting. It is, therefore, no longer necessary for the American Psychiatric Association to remain in the operational field as far as statistics are concerned. In keeping with the status of this Association as a scientific professional society, it has seemed appropriate to limit the statistical section of this Manual to a statement of general principles and procedures, leaving the preparation of detailed operating manuals to the operational agency created for that purpose, this Committee acting in a consultant capacity to that agency.

Despite its recent origin, the Biometrics Branch of the National Institute of Mental Health has made handsome strides toward major statistical objectives. A conference has been held of statisticians and mental hygiene administrators from 11 States, having together 55% of the average daily resident patient population in all State hospitals. The need for basic agreement concerning definition of terms and minimum tabulations has been emphasized. A model area for the reporting of morbidity statistics on the hospitalized mentally ill has been established. Further progress along these lines can be expected. Valuable operational data in the field of statistics has been, and is being, brought together, and is available to those who have detailed operational questions not covered by this Manual. This information may be obtained by correspondence with the Chief of the Biometrics Branch, National Institute of Mental Health, Bethesda 14, Maryland.

Dr. Morton Kramer, Chief, Biometrics Branch, National Institute of Mental Health, has worked with this Committee as Consultant in Statistics, and has prepared the majority of Sections IV and V. In addition, he and members of the Committee have worked assiduously with Dr. Selwyn Collins, Head Statistician, Division of Public Health Methods, United States Public

Health Service, and his assistant, Mrs. Louise E. Bollo, Nosologist, in preparing the crosscoding of Diseases of the Psychobiologic Unit of the Standard, with the International Classification, an effort of no small note. Dr. Richard J. Plunkett, Editor of the Standard Nomenclature of Diseases and Operations, has been most cooperative and helpful. His Associate Editor, Mrs. Adaline C. Hayden, has been doubly assistive in her role of associate editor of the Standard and as co-author of the "Textbook and Guide to the Standard Nomenclature of Diseases and Operations," with Dr. Edward T. Thompson, who himself has spent much time working with such tedious problems as crosscoding the old and new nomenclatures.

The American Medical Association and P. Blakiston and Sons, Inc., publishers of the Standard Nomenclature, have permitted republication of several portions of the Standard necessary to make this Manual complete. The Physicians Record Company, publisher of "Textbook and Guide to the Standard Nomenclature of Diseases and Operations," has permitted republication of parts of that book. These are indicated appropriately in the footnotes of the Manual.

As may be surmised from the narrative account above, it would be impossible to acknowledge the assistance received from various members of the American Psychiatric Association and others, as they number many.

It would be unjust to list here only the names of those who were members of the Committee on Nomenclature and Statistics at the time of completion of this revision, since those who went before each contributed in some way to the information which finally led to this particular revision. For that reason, the names of those who have served on the Committee since 1946, with their terms of service, are listed.

George N. Raines, M.D
Chairman
Committee on Nomenclature and Statistics

Washington, D. C.
November, 1951

COMMITTEE ON NOMENCLATURE AND STATISTICS, 1951

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SECTION I

0– DISEASES OF THE PSYCHOBIOLOGIC UNIT †

INTRODUCTION

Previous changes of the Psychobiologic unit have been restricted by the timing of each revision. This revision is perfectly timed to include the experiences of psychiatrists of World War II, the results of several years usage by the military and Veterans Administration of a revised army nomenclature, the pattern of a new international code and the results of several years deliberation of the Nomenclature Committee of the American Psychiatric Association. As a result of all these we were enabled to offer a completely new classification in conformity with newer scientific and clinical knowledge, simpler in structure, easier to use and virtually identical with other national and international nomenclatures.

Qualifying Phrases

.x1 With psychotic reaction

.x2 With neurotic reaction

.x3 With behavioral reaction

The above qualifying phrases may be added to any diagnosis in the Psychobiologic Unit when needed to further define or describe the clinical picture. They will not be used where such use is redundant. In general, the phrase will be redundant when it repeats the major heading of any group of diagnosis, for example:

.x1 is redundant when used with a diagnosis listed under Psychotic Disorders

.x2 is redundant when used with Psychoneurotic Disorders

.x3 is redundant when used with Personality Disorders

A qualifying phrase is not ordinarily needed with any diagnosis in the group of acute organic brain disorders, as the diagnosis itself implies a delirium, a temporary psychotic state.

† Reprinted from "Standard Nomenclature of Diseases and Operations," Fourth Edition, Published for American Medical Association, the Blakistone Co., Philadelphia, 1952.

DISORDERS CAUSED BY OR ASSOCIATED WITH IMPAIRMENT OF BRAIN TISSUE FUNCTION

(Note: The number in parenthesis in the right hand margin is the appropriate code number from the International Statistical Classification. See Appendix A.)

ACUTE BRAIN DISORDERS

—1 DISORDERS DUE TO OR ASSOCIATED WITH INFECTION

009–100 Acute Brain Syndrome associated with intracranial infection. *Specify infection* *(308.5)* •

000–100 Acute Brain Syndrome associated with systemic infection. *Specify infection* *(308.3)* •

—3 DISORDERS DUE TO OR ASSOCIATED WITH INTOXICATION

000–3.. Acute Brain Syndrome, drug or poison intoxication. *Specify drug or poison* *(308.5)* •

000–3312 Acute Brain Syndrome, alcohol intoxication *(307)* •

000–33122 Acute hallucinosis *(307)*

000–33123 Delirium tremens *(307)*

—4 DISORDERS DUE TO OR ASSOCIATED WITH TRAUMA

000–4.. Acute Brain Syndrome associated with trauma. *Specify trauma* *(308.2)* •

—50 DISORDERS DUE TO OR ASSOCIATED WITH CIRCULATORY DISTURBANCE

000–5.. Acute Brain Syndrome associated with circulatory disturbance. *(Indicate cardiovascular disease as additional diagnosis)* *(308.4)* •

—55 DISORDERS DUE TO OR ASSOCIATED WITH DISTURBANCE OF INNERVATION OR OF PSYCHIC CONTROL

000–550 Acute Brain Syndrome associated with convulsive disorder. *(Indicate manifestation by Supplementary Term)* *(308.1)* •

—7 DISORDERS DUE TO OR ASSOCIATED WITH DISTURBANCE OF METABOLISM, GROWTH OR NUTRITION

000–7.. Acute Brain Syndrome with metabolic disturbance. *Specify* *(308.5)* •

—8 DISORDERS DUE TO OR ASSOCIATED WITH NEW GROWTH

000–8.. Acute Brain Syndrome associated with intracranial neoplasm. *Specify* *(308.0)* •

—9 DISORDERS DUE TO UNKNOWN OR UNCERTAIN CAUSE

000–900 Acute Brain Syndrome with disease of unknown or uncertain cause. *(Indicate disease as additional diagnosis)* *(308.5)* •

—X DISORDERS DUE TO UNKNOWN OR UNCERTAIN CAUSE WITH THE FUNCTIONAL REACTION ALONE MANIFEST

000–xx0	Acute Brain Syndrome of unknown cause	*(309.1)* *

CHRONIC BRAIN DISORDERS [1]

—0 DISORDERS DUE TO PRENATAL (CONSTITUTIONAL) INFLUENCE

009–0..	Chronic Brain Syndrome associated with congenital cranial anomaly. *Specify anomaly*	*(328.0)* *
009–016	Chronic Brain Syndrome associated with congenital spastic paraplegia	*(328.0)* *
009–071	Chronic Brain Syndrome associated with Mongolism	*(328.0)* *
009–052	Chronic Brain Syndrome due to prenatal maternal infectious diseases	*(328.0)* *

—1 DISORDERS DUE TO OR ASSOCIATED WITH INFECTION

0..–147.0	Chronic Brain Syndrome associated with central nervous system syphilis. *Specify as below*	*(026.9)* *
009–147.0	Meningoencephalitic	*(025.9)* *
004–147.0	Meningovascular	*(026.9)* *
0y0–147.0	Other central nervous system syphilis	*(026.9)* *
009–1...0	Chronic Brain Syndrome associated with intracranial infection other than syphilis. *Specify infection* [2]	*(328.1)* *

—3 DISORDERS ASSOCIATED WITH INTOXICATION

009–300	Chronic Brain Syndrome associated with intoxication	*(328.2)* *
009–3..	Chronic Brain Syndrome, drug or poison intoxication. *Specify drug or poison*	*(328.2)* *
009–3312	Chronic Brain Syndrome, alcohol intoxication *Specify reaction* .x1, .x2, .x3 *when known*	*(322.9)* *

—4 DISORDERS ASSOCIATED WITH TRAUMA

009–050	Chronic Brain Syndrome associated with birth trauma	*(328.3)* *
009–400	Chronic Brain Syndrome associated with brain trauma	*(328.4)* *
009–4..	Chronic Brain Syndrome, brain trauma, gross force. *Specify. (Other than operative)*	*(328.4)* *
009–415	Chronic Brain Syndrome following brain operation	*(328.4)* *
009–462	Chronic Brain Syndrome following electrical brain trauma	*(328.4)* *

[1] The qualifying phrase "Mental Deficiency" .x4 (mild .x41, moderate .x42, or severe .x43) should be added at the end of the diagnosis in disorders of this group which present mental deficiency as the major symptom of the disorder. Include intelligence quotient (I. Q.) in the diagnosis.

009–470 Chronic Brain Syndrome[a] following irradiational brain trauma *(328.4)* *

—5 DISORDERS ASSOCIATED WITH CIRCULATORY DISTURBANCES

009–516 Chronic Brain Syndrome associated with cerebral arteriosclerosis *(328.5)* *

009–5.. Chronic Brain Syndrome associated with circulatory disturbance other than cerebral arteriosclerosis. *Specify* *(328.6)* *

—55 DISORDERS ASSOCIATED WITH DISTURBANCES OF INNERVATION OR OF PSYCHIC CONTROL

009–550 Chronic Brain Syndrome associated with convulsive disorder *(353.9)* *

—7 DISORDERS ASSOCIATED WITH DISTURBANCE OF METABOLISM, GROWTH OR NUTRITION

009–79x Chronic Brain Syndrome associated with senile brain disease *(794.9)* *

009–700 Chronic Brain Syndrome associated with other disturbance of metabolism, growth or nutrition (Includes presenile, glandular, pellagra, familial amaurosis) *(328.8)* *

—8 DISORDERS ASSOCIATED WITH NEW GROWTH

009–8.. Chronic Brain Syndrome associated with intracranial neoplasm. *Specify neoplasm* *(328.9)* *

9 DISORDERS ASSOCIATED WITH UNKNOWN OR UNCERTAIN CAUSE

009–900 Chronic Brain Syndrome associated with diseases of unknown or uncertain cause (Includes multiple sclerosis, Huntington's chorea, Pick's disease and other diseases of a familial or hereditary nature). *Indicate disease by additional diagnosis* *(328.9)* *

—x DISORDERS DUE TO UNKNOWN OR UNCERTAIN CAUSE WITH THE FUNCTIONAL REACTION ALONE MANIFEST

009–xx0 Chronic Brain Syndrome of unknown cause *(328.9)* *

[a] When infection is more important than the reaction or mental deficiency, specify the infection. If both infection and reaction or mental deficency are important two diagnoses are required.

MENTAL DEFICIENCY [8]

—x DISORDERS DUE TO UNKNOWN OR UNCERTAIN CAUSE WITH THE FUNCTIONAL REACTION ALONE MANIFEST; HEREDITARY AND FAMILIAL DISEASES OF THIS NATURE

000–x90	Mental deficiency (familial or hereditary)	*(325.5)* *
000–x901	Mild	*(325.3)* *
000–x902	Moderate	*(325.2)* *
000–x903	Severe	*(325.1)* *

—y DISORDERS DUE TO UNDETERMINED CAUSE

000–y90	Mental deficiency, idiopathic	*(325.5)* *
000–y901	Mild	*(325.3)* *
000–y902	Moderate	*(325.2)* *
000–y903	Severe	*(325.1)* *

DISORDERS OF PSYCHOGENIC ORIGIN OR WITHOUT CLEARLY DEFINED PHYSICAL CAUSE OR STRUCTURAL CHANGE IN THE BRAIN

PSYCHOTIC DISORDERS

—7 DISORDERS DUE TO DISTURBANCE OF METABOLISM, GROWTH, NUTRITION OR ENDOCRINE FUNCTION

000–796	Involutional psychotic reaction	*(302)*

—x DISORDERS OF PSYCHOGENIC ORIGIN OR WITHOUT CLEARLY DEFINED TANGIBLE CAUSE OR STUCTURAL CHANGE

000–x10	Affective reactions	*(301.2)*
000–x11	Manic depressive reaction, manic type	*(301.0)*
000–x12	Manic depressive reaction, depressive type	*(301.1)*
000–x13	Manic depressive reaction, other	*(301.2)*
000–x14	Psychotic depressive reaction	*(309.0)* *
000–x20	Schizophrenic reactions	*(300.7)* *
000–x21	Schizophrenic reaction, simple type	*(300.0)*
000–x22	Schizophrenic reaction, hebephrenic type	*(300.1)*
000–x23	Schizophrenic reaction, catatonic type	*(300.2)*
000–x24	Schizophrenic reaction, paranoid type	*(300.3)*
000–x25	Schizophrenic reaction, acute undifferentiated type	*(300.4)*
000–x26	Schizophrenic reaction, chronic undifferentiated type	*(300.7)*
000–x27	Schizophrenic reaction, schizo-affective type	*(300.6)*

[8] Include intelligence quotient (I. Q.) in the diagnosis.

000–x28	Schizophrenic reaction, childhood type	*(300.8)* *
000–x29	Schizophrenic reaction, residual type	*(300.5)*
000–x30	Paranoid reactions	*(303)*
000–x31	Paranoia	*(303)*
000–x32	Paranoid state	*(303)*
000–xy0	Psychotic reaction without clearly defined structural change, other than above	*(309.1)* *

PSYCHOPHYSIOLOGIC AUTONOMIC AND VISCERAL DISORDERS

—55 DISORDERS DUE TO DISTURBANCE OF INNERVATION OR OF PSYCHIC CONTROL

001–580	Psychophysiologic skin reaction. *(Indicate manifestation by Supplementary Term)*	*(317.3)* *
002–580	Psychophysiologic musculoskeletal reaction. *(Indicate manifestation by Supplementary Term)*	*(317.4)*
003–580	Psychophysiologic respiratory reaction. *(Indicate manifestation by Supplementary Term)*	*(317.0)*
004–580	Psychophysiologic cardiovascular reaction. *(Indicate manifestation by Supplementary Term)*	*(315.2)* *
005–580	Psychophysiologic hemic and lymphatic reaction. *(Indicate manifestation by Supplementary Term)*	*(317.5)*
006–580	Psychophysiologic gastrointestinal reaction. *(Indicate manifestation by Supplementary Term)*	*(316.3)* *
007–580	Psychophysiologic genito-urinary reaction. *(Indicate manifestation by Supplementary Term)*	*(317.1)* *
008–580	Psychophysiologic endocrine reaction. *(Indicate manifestation by Supplementary Term)*	*(317.5)*
009–580	Psychophysiologic nervous system reaction. *(Indicate manifestation by Supplementary Term)*	*(318.3)* *
00x–580	Psychophysiologic reaction of organs of special sense. *(Indicate manifestation by Supplementary Term)*	*(317.5)*

PSYCHONEUROTIC DISORDERS

—x DISORDERS OF PSYCHOGENIC ORIGIN OR WITHOUT CLEARLY DEFINED TANGIBLE CAUSE OR STRUCTURAL CHANGE

000–x00	Psychoneurotic reactions	*(318.5)* *
000–x01	Anxiety reaction	*(310)*
000–x02	Dissociative reaction	*(311)*
000–x03	Conversion reaction	*(311)*
000–x04	Phobic reaction	*(312)*
000–x05	Obsessive compulsive reaction	*(313)*
000–x06	Depressive reaction	*(314)*
000–x0y	Psychoneurotic reaction, other	*(318.5)* *

PERSONALITY DISORDERS

—x DISORDERS OF PSYCHOGENIC ORIGIN OR WITHOUT CLEARLY DEFINED TANGIBLE CAUSE OR STRUCTURAL CHANGE

000–x40	Personality pattern disturbance	*(320.7)* *
000–x41	Inadequate personality	*(320.3)*
000–x42	Schizoid personality	*(320.0)*
000–x43	Cyclothymic personality	*(320.2)*
000–x44	Paranoid personality	*(320.1)*
000–x50	Personality trait disturbance	*(321.5)* *
000–x51	Emotionally unstable personality	*(321.0)*
000–x52	Passive-aggressive personality	*(321.1)* *
000–x53	Compulsive personality	*(321.5)*
000–x5y	Personality trait disturbance, other	*(321.5)* *
000–x60	Sociopathic personality disturbance	*(320.7)* *
000–x61	Antisocial reaction	*(320.4)*
000–x62	Dyssocial reaction	*(320.5)*
000–x63	Sexual deviation. *Specify Supplementary Term*	*(320.6)*
000–x64	Addiction	
000–x641	Alcoholism	*(322.1)*
000–x642	Drug addiction	*(323)*
000–x70	Special symptom reactions	*(321.4)* *
000–x71	Learning disturbance	*(326.0)* *
000–x72	Speech disturbance	*(326.2)* *
000–x73	Enuresis	*(321.3)*
000–x74	Somnambulism	*(321.4)*
000–x7y	Other	*(321.4)* *

TRANSIENT SITUATIONAL PERSONALITY DISORDERS

000–x80	Transient situational personality disturbance	*(326.4)* *
000–x81	Gross stress reaction	*(326.3)* *
000–x82	Adult situational reaction	*(326.6)* *
000–x83	Adjustment reaction of infancy	*(324.0)* *
000–x84	Adjustment reaction of childhood	*(324.1)* *
000–x841	Habit disturbance	*(324.1)* *
000–x842	Conduct disturbance	*(324.1)* *
000–x843	Neurotic traits	*(324.1)* *
000–x85	Adjustment reaction of adolescence	*(324.2)* *
000–x86	Adjustment reaction of late life	*(326.5)* *

NONDIAGNOSTIC TERMS FOR HOSPITAL RECORD

011–332	Alcoholic intoxication (simple drunkenness)	(322.0)
y00–y01	Boarder	(Y09) *
y00–yyy	Dead on admission	(795.5)
y00–y00	Diagnosis deferred. *Change as many of first three digits as possible, to indicate site*	(795.5)
y00–000	Disease none. *Change first digit to indicate suspected system if any*	(793.2) *
y00–002	Examination only. *Change first three digits as needed*	(Y00.0)
y00–004	Experiment only. *Change first three digits as needed*	(Y09)
y00–005	Malingerer	(795.1)
y00–001	Observation. *Change first three digits as needed*	(793.2) *
y00–003	Tests only. *Change first three digits as needed*	(Y00.3) *

Section II A

INTRODUCTION TO THE REVISED NOMENCLATURE

This revision of psychiatric nomenclature attempts to provide a classification system consistent with the concepts of modern psychiatry and neurology. It recognizes the present day descriptive nature of all psychiatric diagnoses, and attempts to make possible the gathering of data for future clarification of ideas concerning etiology, pathology, prognosis, and treatment in mental disorders. It attempts to provide for inclusion of new ideas and advances yet to be made without radical revision of the system of nomenclature.

This nomenclature limits itself to the classification of the disturbances of mental functioning. It does not include neurologic diagnoses or diagnoses of intracranial pathology, per se. Such conditions should be diagnosed separately, whether or not a mental disturbance is associated with them. When an intracranial lesion is accompanied by a mental disorder, it is the mental disorder which is diagnosed in this present classification. Provision is made for contributory etiological factors to be stated as a part of the diagnosis, or as an additional diagnosis, as necessary (see Section III).

This diagnostic scheme employs the term "disorder" generically to designate a group of related psychiatric syndromes. Insofar as is possible, each group is further divided into more specific psychiatric conditions termed "reactions." The code numbers are assigned in accordance with the overall plan of the Standard Nomenclature of Diseases and Operations, a system fully explained in that publication.

All mental disorders are divided into two major groups:

(1) those in which there is disturbance of mental function resulting from, or precipitated by, a primary impairment of the function of the brain, generally due to diffuse impairment of brain tissue; and

(2) those which are the result of a more general difficulty in adaptation of the individual, and in which any associated brain function disturbance is secondary to the psychiatric disorder.

Perhaps the greatest change in this revision from previous listings lies in the handling of the disorders with known organic etiological factors. In these disorders [Group (1)] the psychiatric picture is characterized by impairment of intellectual functions, including memory, orientation, and

judgment, and by shallowness and lability of affect. This is a basic condition, and may be mild, moderate, or severe. It may be, and more often than not is, the *only* mental disturbance present, or it may be associated with additional disturbances which in this nomenclature are descriptively classified as "psychotic," "neurotic," or "behavioral" reactions (see Qualifying Phrases). These associated reactions are not necessarily related in severity to the degree of the organic brain syndrome, and are as much determined by inherent personality patterns, the social setting, and the stresses of interpersonal relations as by the precipitating organic impairment. For this reason, these associated reactions are to be looked upon as being released by the organic brain syndrome and superimposed upon it. The organic brain syndrome thereupon becomes the proper focus of diagnosis; associated reactions should be specified, when necessary, by adding to the diagnosis a qualifying phrase describing the manifestation: .x1 with psychotic reaction, .x2 with neurotic reaction, or .x3 with behavioral reaction. It is anticipated that the majority of organic disorders will require no qualifying phrase (see Qualifying Phrases).

When the organic brain syndrome is produced by prenatal or natal factors or in the formative years of infancy and childhood, the disturbance in intellectual development and learning ability may be prominent. Such disturbances, formerly diagnosed "Mental deficiency, secondary," are here listed under the chronic brain syndromes, where they seem more properly to belong. In these cases, when it is desired to stress the disorder of intelligence as the primary clinical problem, the diagnosis may be qualified with the phrase, .x4 with Mental deficiency, .x41 mild, .x42 moderate, or .x43 severe, and the current intelligence quotient will be included in the diagnosis. This categorization relegates the defect of intelligence to the sphere of symptomatology, rather than recognizing it as a primary mental disturbance.

An unsuccessful attempt was made to find a substitute for the long used term "mental deficiency." Mental deficiency is a legal term, comparable to the term "insanity," it has little meaning in clinical psychiatry. The term has been defined by law in England, and in some parts of the United States. The same objection is raised to the terms "idiot," "imbecile," and "moron." They have the further fault of being based upon psychological testing alone. In the borderline areas of each term, groupings vary with the immediate condition of the patient, as well as with the skill and training of the examiner. These last named terms have been eliminated.

It was necessary to retain a term for those cases presenting clinically primarily a disturbance of intellect, with no recognizable organic brain

impairment prenatally, at birth, or in childhood. Since no adequate substitute could be found, the title, "Mental Deficiency" was retained for this group. Degree is indicated by the terms "mild," "moderate," or "severe." No I.Q. limit has been set for these qualifying terms (see Section II B), as it is believed that such arbitrary usage of a variable measure is not justifiable in clinical work. Authorities in this field have stated that persons classified under the older groupings of idiot and imbecile (in this classification both are included under "severe") always show postmortem evidence of chronic brain disorder. It would then appear that a primary diagnosis of Mental deficiency, severe, is inaccurate.

The Schizophrenic reactions have been increased in number and type to allow more detailed diagnosis. The Manic depressive reactions have been reduced in number, and, with a Psychotic depressive reaction, have been grouped into the "Affective reactions."

The "psychosomatic" disorders have been given a separate category to allow more accurate accumulation of data concerning them. The generic term, "Psychophysiologic Autonomic and Visceral Disorders," has been selected for this group because it seems to express best the interplay of psychic and somatic factors involved in these disturbances.

The Psychoneurotic Disorders have been classified on the basis of their psychopathology as it is generally understood today. The titles for Personality Disorders and Transient Situational Disorders have been elaborated and expanded.

Attention is called to the fact that the Section on Diseases of the Psychobiologic Unit is only one section of the Standard Nomenclature of Diseases and Operations; adequate use of any one section requires knowledge and use of the entire Standard Nomenclature of Diseases and Operations.

More detailed instructions concerning the use of diagnostic terms applied to Disorders of the Psychobiologic Unit are to be found in the section which follows.

Section II B

DEFINITION OF TERMS

QUALIFYING PHRASES

The basic division in this nomenclature is into those mental disorders associated with organic brain disturbance, and those occurring without such primary disturbance of brain function, and *not* into psychoses, psychoneuroses, and personality disorders. Other categorizations are secondary to the basic division.

This nomenclature permits the modification of any of the primary psychiatric diagnoses by the qualifying phrases, .x1 with psychotic reaction, .x2 with neurotic reaction, and .x3 with behavioral reaction. These are intended to describe any major alteration of the clinical picture of a diagnosed condition which may appear when further mental symptoms are superimposed on the basic disorder.

Grouped together under Psychotic Disorders are: (1) affective disorders, characterized by severe mood disturbance, with associated alterations in thought and behavior, in consonance with the affect; (2) schizophrenic reactions, characterized by fundamental disturbances in reality relationships and concept formations, with associated affective, behavioral, and intellectual disturbances, marked by a tendency to retreat from reality, by regressive trends, by bizarre behavior, by disturbances in stream of thought, and by formation of delusions and hallucinations; (3) paranoid reactions, characterized by persistent delusions and other evidence of the projective mechanism.

From this grouping, a psychotic reaction may be defined as one in which the personality, in its struggle for adjustment to internal and external stresses, utilizes severe affective disturbance, profound autism and withdrawal from reality, and/or formation of delusions or hallucinations. The qualifying phrase, .x1 with psychotic reaction, may be used to amplify the diagnosis when, in the presence of another psychiatric disturbance, a *symptomatic* clinical picture appears which might be diagnosed under Psychotic Disorders in this nomenclature. Specific examples may be seen in severe depression occurring in Chronic Brain Syndrome associated with senile brain disease, or paranoid delusions accompanying Chronic Brain Syndrome, alcohol intoxication.

Grouped as Psychoneurotic Disorders are those disturbances in which "anxiety" is a chief characteristic, directly felt and expressed, or automatically controlled by such defenses as depression, conversion, dissociation, displacement, phobia formation, or repetitive thoughts and acts.

For this nomenclature, a psychoneurotic reaction may be defined as one in which the personality, in its struggle for adjustment to internal and external stresses, utilizes the mechanisms listed above to handle the anxiety created. The qualifying phrase, .x2 with neurotic reaction, may be used to amplify the diagnosis when, in the presence of another psychiatric disturbance, a *symptomatic* clinical picture appears which might be diagnosed under Psychoneurotic Disorders in this nomenclature. A specific example may be seen in an episode of acute anxiety occurring in a homosexual.

Grouped as Personality Disorders are those cases in which the personality utilizes primarily a pattern of action or behavior in its adjustment struggle, rather than symptoms in the mental, somatic, or emotional spheres.

For this nomenclature a behavioral reaction (personality disorder) may be defined as one in which the personality, in its struggle for adjustment to internal and external stresses, utilizes primarily a pattern of action or behavior. The qualifying phrase, .x3 with behavioral reaction, may be used to amplify the diagnosis when, in the presence of another psychiatric disturbance, a *symptomatic* clinical picture appears which might be diagnosed Personality Disorder in this nomenclature. The changes in behavior, sufficiently gross to require diagnostic recognition, occurring in many of the chronic brain syndromes (Alzheimer's, cerebral arteriosclerosis, epidemic encephalitis, trauma) are specific examples.

In general, it should be noted that the qualifying phrases are provided when needed to further define or describe the clinical picture. They are applied only when superimposed symptoms are so marked that they definitely color the clinical picture. Mild or transient superimposed symptoms will not justify the use of a qualifying phrase. It is anticipated that a diagnosis of chronic brain syndrome will be sufficient in itself under ordinary conditions, and qualifying phrases will be needed only for further refinement of the diagnosis.

A qualifying phrase will not be used where such use is redundant. In general, the phrase will be redundant when it repeats the major heading of any group of diagnoses, for example: .x1 is redundant when used with a diagnosis listed under Psychotic Disorders; .x2 is redundant when used with Psychoneurotic Disorders; .x3 is redundant when used with Personality Disorders (see Section III A, "Multiple psychiatric diagnoses" for incompatible diagnoses).

A qualifying phrase is not ordinarily needed with a diagnosis of acute brain syndrome but a qualifying phrase may be used when superimposed manifestations warrant such use by their significant modification of the clinical picture.

DISORDERS CAUSED BY OR ASSOCIATED WITH IMPAIRMENT OF BRAIN TISSUE FUNCTION

These disorders are all characterized by a basic syndrome consisting of:

1. Impairment of orientation
2. Impairment of memory
3. Impairment of all intellectual functions (comprehension, calculation, knowledge, learning, etc.)
4. Impairment of judgment
5. Lability and shallowness of affect

This syndrome of organic brain disorder is a basic mental condition characteristic of diffuse impairment of brain tissue function from any cause. It may be mild, moderate, or severe, but most of the basic symptoms of the syndrome are generally present to a similar degree in any one patient at any one time. The severity of this basic syndrome is generally parallel to the severity of the impairment of brain tissue function.

This syndrome may be the only mental disturbance present or it may be associated with psychotic manifestations, neurotic manifestations, or behavioral disturbance. These associated reactions are not necessarily related in severity to the degree of the organic brain disorder or to the degree of brain damage; they are determined by inherent personality patterns, current emotional conflicts, the immediate environmental situation, and the setting of interpersonal relations, as well as by the precipitating organic disorder. These associated reactions are to be looked upon as being released by the organic brain disorder and superimposed upon it. Since personality function depends greatly upon the integrity of brain function, various changes in personality reaction are to be expected with organic brain disorders. When these associated reactions are present to a significant degree, they are recognized by the addition of one of the qualifying statements listed (see Qualifying Phrases).

The organic brain disorders are separated into acute and chronic, because of the marked differences between these two groups in regard to prognosis, treatment, and general course of illness. The terms, "acute" and "chronic," refer primarily to the reversibility of brain pathology and its accompanying organic brain syndrome; and not to the etiology, onset, or duration of the illness. Since the same etiology may produce either temporary or permanent brain damage, a brain disorder which appears reversible, hence acute, at its beginning, may prove later to have left permanent damage and a persistent organic brain syndrome, which will then be diagnosed as chronic.

ACUTE BRAIN DISORDERS

These are the organic brain syndromes from which the patient recovers. They are the result of temporary, reversible, diffuse impairment of brain tissue function such as is present in acute alcoholic intoxication or "acute delirium." The basic disturbance of the sensorium may release other disturbances such as hallucinations, poorly organized, transient delusions, and behavior disturbances of varying degree. While a qualifying phrase may not ordinarily be needed with any diagnosis in this group, a qualifying phrase may be used when superimposed manifestations warrant such use by their severe modifications of the clinical picture.

These disorders are subclassified according to the cause of the impairment of brain tissue function.

009–100 Acute Brain Syndrome associated with intracranial infection. ***Specify infection***

Here are to be classified those conditions due primarily to intracranial infection, such as encephalitis, epidemic and other, meningitis of all causes, and brain abscess, which appear to be temporary and reversible.

000–100 Acute Brain Syndrome associated with systemic infection. ***Specify infection***

Here are to be classified those temporary, recoverable mental disturbances directly resulting from severe general systemic infections. Among the more common systemic infections producing such a reaction are pneumonia, typhoid fever, and acute rheumatic fever. Care must be taken to distinguish these reactions from other disorders, particularly manic depressive and schizophrenic reactions, which may be made manifest by even a mild attack of infectious disease.

000–3.. Acute Brain Syndrome, drug or poison intoxication. ***Specify drug or poison***

Drug: This category is intended for the inclusion of acute reversible brain syndromes due to drugs generally used in medical practices, such as bromides, barbiturates, opiates, or hormonal and similarly acting principles.

Poison: Here should be classified the acute brain syndromes associated with chemical action on the brain by substances not ordinarily used in

medical practice, such as lead, other metals, gas, and other sources of intoxication (except alcohol) as listed in Category Three of the Standard Nomenclature of Diseases and Operations.

000–3312 Acute Brain Syndrome, alcohol intoxication

This group is given separate status from other intoxications for statistical purposes. Here will be classified the acute recoverable brain syndromes attributable to alcohol, notably delirium tremens and acute alcoholic hallucinosis. When simple alcoholic intoxication produces an acute brain syndrome requiring diagnosis, it will be classified here. Habitual alcoholism without brain syndrome should be diagnosed under Addiction. "Pathological Intoxication" may cause difficulty in proper diagnosis. When, without apparent preexisting mental disorder, there is a marked behavioral or psychotic reaction with an acute brain syndrome after minimal alcoholic intake, the case will be classified here. When a preexisting psychotic, psychoneurotic, or personality disorder is made more manifest after minimal alcoholic intake, the case will be classified under the diagnosis of the underlying condition.

000–4.. Acute Brain Syndrome associated with trauma. *Specify trauma*

Here are to be classified those cases of acute brain syndrome developing immediately after head injury produced by external trauma of a gross physical nature, including surgery. Mental disturbances following injuries to other parts of the body are not to be classified here. Brain syndromes in which head trauma acts as a contributing or precipitating cause should be diagnosed under the proper etiological heading and not included in this group. This category does not include the chronic organic results of head injury.

000–5.. Acute Brain Syndrome associated with circulatory disturbance. (*Indicate cardiovascular disease as additional diagnosis*)

Here are to be classified those acute recoverable brain syndromes occurring as a result of such circulatory disturbances as cerebral embolism, arterial hypertension, cardio-renal disease and especially cardiac disease, particularly in decompensation. Acute fluctuations in the chronic progressive course of circulatory disturbances such as cerebral arteriosclerosis will not be diagnosed here, but will be placed under the listing of Chronic Brain Syndrome.

000–550 Acute Brain Syndrome associated with convulsive disorder. (***Indicate manifestation by Supplementary Term***)

Under this heading will be classified only cases which show acute brain syndrome in connection with "idiopathic" epilepsy. Most common disturbance of this group is the epileptic clouded state occurring in those epileptics who develop, preceding or following convulsive attacks, or as equivalents of attacks, dazed reactions with deep confusion, bewilderment, and anxiety or excitement, with hallucinations, fears and violent outbreaks. Those cases in which the convulsive manifestations are symptomatic of other disease are to be classified under the headings for such other disease.

000–7.. Acute Brain Syndrome associated with metabolic disturbance. ***Specify***

Here will be classified those acute reversible brain syndromes resulting from metabolic disturbance, such as uremia, diabetes, hyperthyroidism, vitamin deficiency, and so forth.

000–8.. Acute Brain Syndrome associated with intracranial neoplasm. (***Indicate neoplasm as additional diagnosis***)

Here will be classified those acute reversible brain syndromes resulting from intracranial neoplasms, whether the neoplasm be primary or secondary. Reversibility of the pathological process underlying the acute brain syndrome (pressure, edema, etc.) is the basis of differentiation between acute and chronic syndromes of this category.

000–900 Acute Brain Syndrome with disease of unknown or uncertain cause. (***Indicate disease as additional diagnosis***)

Here will be classified those acute reversible brain syndromes resulting from diseases of unknown cause, such as multiple sclerosis. This diagnosis progressive disturbances of brain function.

This category differs from the one that follows, in that here the disease causing the acute brain syndrome is recognized and diagnosed although the etiology of the disease is unknown.

000–xx0 Acute Brain Syndrome of unknown cause

This category is intended for those acute brain syndromes whose cause cannot be recognized. It may also be used for acute brain syndromes of

known cause, not elsewhere classifiable, in which case the causative disease will be separately diagnosed. Record librarians and statisticians may use this category for incomplete diagnoses.

CHRONIC BRAIN DISORDERS

The chronic organic brain syndromes result from relatively permanent, more or less irreversible, diffuse impairment of cerebral tissue function. While the underlying pathological process may partially subside, or respond to specific treatment, as in syphilis, there remains always a certain irreducible minimum of brain tissue destruction which cannot be reversed, even though the loss of function may be almost imperceptible clinically. The chronic brain syndrome may become milder, vary in degree, or progress, but some disturbance of memory, judgment, orientation, comprehension and affect persists permanently.

Other mental disturbances of psychotic, neurotic, or behavioral type may be superimposed on the chronic brain syndrome; when clinically significant, these will be recognized by addition of the appropriate qualifying phrase to the diagnosis (see Qualifying Phrases). When the chronic organic disorder is present during infancy and childhood, and results in significantly disturbed intellectual development, this may be recognized by addition of the qualifying phrase, .x4 with Mental deficiency.

These disorders are classified according to the cause of the impairment of brain function. Some of the diagnostic categories are identical with those of the acute brain syndromes; the differentiation is based on the permanent impairment of brain function in the chronic group.

009–0.., 009–016, 009–071, 009–052, 009–050 Chronic Brain Syndrome associated with congenital cranial anomaly, congenital spastic paraplegia, Mongolism, prenatal maternal infectious disease, birth trauma

These categories are provided for the group of mental disturbances formerly diagnosed as secondary mental deficiency. Clinically, a general developmental defect of mentation is superimposed on the chronic brain syndrome, and when prominent may require the addition of the qualifying phrase .x4 Mental deficiency. The degree of defective intelligence will be specified as *mild, moderate,* or *severe,* and the current IQ rating will be added to the diagnosis (see Mental deficiency).

009–147.0 Chronic Brain Syndrome associated with central nervous system syphilis (*Meningoencephalitic*)

Here will be classified the cases formerly diagnosed as general paresis. In addition to the organic brain syndrome, these cases show physical signs and symptoms of parenchymatous syphilis of the nervous system, and usually positive serology, including the paretic gold curve. The psychotic reaction, when such occurs, may simulate one of the "functional" psychoses but is to be classified here, with the Qualifying Phrase, .x1 with psychotic reaction.

004–147.0 Chronic Brain Syndrome associated with central nervous system syphilis (*Meningovascular*)

The mental disturbance is that of the chronic brain syndrome, and is indistinguishable from the mental disturbance of Meningoencephalitic syphilis. A differential diagnosis may be possible in those cases in which the history, signs, and symptoms, including serology, suggest a primary and predominating involvement of the meninges and blood vessels rather than of the parenchyma of the nervous system. Suggestive of this type of syphilis (cerebral) rather than general paresis, are: comparatively early onset after infection, sudden onset of mental disturbance, focal signs, particularly cranial nerve palsy, apoplectiform seizures, very high spinal fluid cell count, positive blood and spinal fluid serology, and prompt response to general systemic antisyphilitic treatment. Cases showing mental disturbances on a basis of cerebral lesions from syphilitic vascular disease will be classified here rather than under the heading Chronic Brain Syndrome associated with disturbance of circulation.

0y0–147.0 Chronic Brain Syndrome associated with other central nervous system syphilis

Here will be classified the comparatively infrequent cases of chronic brain syndrome associated with syphilis of the central nervous system not covered in the previous groups, including intracranial gumma.

009–1...0 Chronic Brain Syndrome associated with intracranial infection other than syphilis. *Specify infection*

Here are to be classified chronic brain syndromes associated with intracranial infection other than syphilis. Many of these disorders will have been diagnosed acute brain syndrome early in the course of the illness. The case

should be categorized here when it becomes apparent that there is diffuse, permanent damage to brain function. In addition to the primary diagnosis, many of these cases will require the use of a qualifying phrase; for example, encephalitides occurring in adolescence often develop a chronic brain syndrome with behavioral reaction.

009–300 Chronic Brain Syndrome associated with intoxication. ***Specify***

In these two groups will be classified those chronic, organic reactions which remain permanently following toxic insult to the brain by such agents as lead, arsenic, mercury, carbon monoxide, illuminating gas, miscellaneous drugs and alcohol.

Chronic Brain Syndrome, alcohol intoxication, includes all degrees of permanent brain damage resulting from the use of alcohol, ranging from very mild up to and including severe. The latter may manifest itself by the type of chronic delirium formerly diagnosed as Korsakoff's psychosis. Under such conditions the psychosis will be recognized by the proper qualifying phrase.

Many of these reactions are ushered in with an acute brain reaction to the intoxicant. The case will be placed in the chronic category when it becomes apparent that permanent, irreversible damage to the brain has occurred.

009–400 Chronic Brain Syndrome associated with brain trauma

Here will be classified the post-traumatic chronic brain disorders, which produce impairment of mental function. Permanent brain damage which produces only neurologic changes because of its focal nature, without significant changes in the areas of sensorium and affect, will not be classified here. Generally, trauma producing a chronic brain syndrome would have to be diffuse and would have to leave permanent brain damage. Post-traumatic personality disorder associated with chronic brain syndrome will be placed in this group with the appropriate qualifying phrase.

If the brain injury occurs in early life, it may manifest itself primarily in a developmental defect of intelligence. Such cases will be qualified by the phrase .x4 Mental deficiency, and the current I.Q. included in the diagnosis.

A head injury may usher in, or expedite the course of, a chronic brain disease, especially cerebral arteriosclerosis. The differential diagnosis in such cases may be extremely difficult. If the case history shows symptoms of circulatory disturbance, particularly arteriosclerosis, before the injury, and

the physical examination confirms the presence of arteriosclerosis, the case will be classified under Chronic Brain Syndrome associated with cerebral arteriosclerosis.

009–516 Chronic Brain Syndrome associated with cerebral arteriosclerosis

Here are to be classified those chronic, progressive, mental disturbances occurring in connection with cerebral arteriosclerosis. Clinical differentiation of the chronic brain syndrome associated with cerebral arteriosclerosis from that associated with senile sclerosis and presenile sclerosis may be impossible. Both underlying pathological changes may be present simultaneously. The age, history, and careful survey of the symptoms may assist in determining the predominate pathology. Commonly, the organic brain syndrome will be the only mental disturbance present. When significant psychotic, neurotic, or behavioral reactions are superimposed, the diagnosis will be qualified by the appropriate phrases (see Qualifying Phrases).

009–5.. Chronic Brain Syndrome associated with circulatory disturbance other than cerebral arteriosclerosis. *Specify*

Here are to be classified those chronic organic mental disturbances occurring in connection with circulatory disturbance other than cerebral arteriosclerosis, such as cerebral embolism, cerebral hemorrhages, arterial hypertension, and other chronic cardiovascular disease. Differentiation from the acute brain syndrome of like cause must be made on the irreversibility of the underlying brain damage. The circulatory disturbance will be specified.

009–550 Chronic Brain Syndrome associated with convulsive disorder

Here will be included only those cases which show chronic brain syndrome in connection with "idiopathic" epilepsy. Most of the etiological agents underlying chronic brain syndromes can and do cause convulsions. Convulsions are particularly common in the presence of syphilis, intoxication, trauma, cerebral arteriosclerosis, and intracranial neoplasm. When the convulsions are symptomatic of such other etiological agents, the chronic brain syndrome will be classified under the headings for those disturbances rather than here.

The most common type of case to be categorized here is seen in those epileptics who show a gradual development of mental dullness, slowness of associative thinking, impairment of memory and other intellectual functions, as well as apathy. Qualifying phrases are to be used when indicated.

009–79x Chronic Brain Syndrome associated with senile brain disease

This category is designed for the classification of organic brain syndrome occurring with senile brain disease, whether this be mild, moderate or severe. These cases vary from mild organic brain syndrome with self-centering of interest, difficulty in assimilating new experiences, and "childish" emotionality, up to and including those so severely affected by senile brain disease as to require institutional care. Deterioration may be minimal or it may progress to a state of vegetative existence, with or without superimposed psychotic, neurotic, or behavioral reactions (see Qualifying Phrases).

009–700 Chronic Brain Syndrome associated with other disturbance of metabolism, growth or nutrition (includes presenile, glandular, pellagra, familial amaurosis). *Specify*

This category includes the chronic brain syndromes associated with disorders formerly classified separately, such as Alzheimer's disease, endocrine disorders, pellagra, and others of a similar nature.

In Alzheimer's disease, the brain pathology is characteristic. Clinically, the disorder may be suspected in severe progressive brain syndromes occurring at a comparatively early age period, as in the forties. The degree of brain atrophy, which is generalized, is usually severe, and can be demonstrated by pneumoencephalogram.

Chronic brain syndromes associated with complications of diabetes (not due to accompanying cerebral arteriosclerosis), disorders of the thyroid, pituitary, adrenals, and other disorders of metabolism, are to be classified under this heading. The majority of organic reactions occurring on a glandular or metabolic basis are acute and recoverable. They will be classified here only when there is evidence of permanent impairment of brain function.

Chronic brain syndromes associated with pellagra or other avitaminosis are included in this group. Cases developing pellagra or avitaminosis during the course of some other psychiatric disorder will not be classified under this heading, unless permanent brain damage occurs as a result of the avitaminosis.

009–8.. Chronic Brain Syndrome associated with intracranial neoplasm. ***Specify neoplasm***

This category includes the chronic brain syndromes resulting from intracranial neoplasms, whether the neoplasm be primary or secondary. This category does not include reactions to new growths elsewhere in the body than in the cranium. Differentiation from the acute brain syndrome of like cause is made by the presence of irreversible brain damage.

009–900 Chronic Brain Syndrome associated with diseases of unknown or uncertain cause (includes multiple sclerosis, Huntington's chorea, Pick's disease and other diseases of a familial or hereditary nature). ***Indicate disease by additional diagnosis***

Here will be classified those chronic brain syndromes associated with irreversible disruption of brain function by such disorders of unknown etiology as multiple sclerosis, Pick's disease, and Huntington's chorea.

This category differs from the one that follows (009–xx0), in that here the disease causing the chronic brain syndrome is recognized and diagnosed, although the etiology of the disease is unknown.

009–xx0 Chronic Brain Syndrome of unknown cause

This category is intended for those chronic brain syndromes whose cause cannot be recognized. It may also be used for chronic brain syndrome of known cause, not elsewhere classifiable, in which case the causative disease will be specified. Record librarians and statisticians may use this category for incomplete diagnoses.

MENTAL DEFICIENCY

000–x90 and 000–y90 Mental deficiency

Here will be classified those cases presenting primarily a defect of intelligence existing since birth, without demonstrated organic brain disease or known prenatal cause. This group will include only those cases formerly known as familial or "idiopathic" mental deficiencies. The degree of intelligence defect will be specified as *mild, moderate,* or *severe,* and the current I.Q. rating, with the name of the test used, will be added to the diagnosis. In general, *mild* refers to functional (vocational) impairment, as would be ex-

pected with I.Q.'s of approximately 70 to 85; *moderate* is used for functional impairment requiring special training and guidance, such as would be expected with I.Q.'s of about 50-70; *severe* refers to the functional impairment requiring custodial or complete protective care, as would be expected with I.Q.'s below 50. The degree of defect is estimated from other factors than merely psychological test scores, namely, consideration of cultural, physical and emotional determinants, as well as school, vocational and social effectiveness. The diagnosis may be modified by the appropriate qualifying phrase, when, in addition to the intellectual defects, there are significant psychotic, neurotic, or behavioral reactions.

DISORDERS OF PSYCHOGENIC ORIGIN OR WITHOUT CLEARLY DEFINED PHYSICAL CAUSE OR STRUCTURAL CHANGE IN THE BRAIN

PSYCHOTIC DISORDERS

These disorders are characterized by a varying degree of personality disintegration and failure to test and evaluate correctly external reality in various spheres. In addition, individuals with such disorders fail in their ability to relate themselves effectively to other people or to their own work.

000–796 Involutional psychotic reaction

In this category may be included psychotic reactions characterized most commonly by depression occurring in the involutional period, without previous history of manic depressive reaction, and usually in individuals of compulsive personality type. The reaction tends to have a prolonged course and may be manifested by worry, intractable insomnia, guilt, anxiety, agitation, delusional ideas, and somatic concerns. Some cases are characterized chiefly by depression and others chiefly by paranoid ideas. Often there are somatic preoccupations to a delusional degree.

Differentiation may be most difficult from other psychotic reactions with onset in the involutional period; reactions will not be included in this category merely because of their occurrence in this age group.

000–x10 Affective reactions

These psychotic reactions are characterized by a primary, severe, disorder of mood, with resultant disturbance of thought and behavior, in consonance with the affect.

000–x11—000–x13 Manic depressive reactions

These groups comprise the psychotic reactions which fundamentally are marked by severe mood swings, and a tendency to remission and recurrence. Various accessory symptoms such as illusions, delusions, and hallucinations may be added to the fundamental affective alteration.

Manic depressive reaction is synonymous with the term manic depressive psychosis. The reaction will be further classified into the appropriate one of the following types: manic, depressed, or other.

000–x11 Manic depressive reaction, manic type

This group is characterized by elation or irritability, with overtalkativeness, flight of ideas, and increased motor activity. Transitory, often momentary, episodes of depression may occur, but will not change the classification from the manic type of reaction.

000–x12 Manic depressive reaction, depressed type

Here will be classified those cases with outstanding depression of mood and with mental and motor retardation and inhibition; in some cases there is much uneasiness and apprehension. Perplexity, stupor or agitation may be prominent symptoms, and may be added to the diagnosis as manifestations.

000–x13 Manic depressive reaction, other

Here will be classified only those cases with marked mixtures of the cardinal manifestations of the above two phases (mixed type), or those cases where continuous alternation of the two phases occur (circular type). Other specified varieties of manic depressive reaction (manic stupor or unproductive mania) will also be included here.

000–x14 Psychotic depressive reaction

These patients are severely depressed and manifest evidence of gross misinterpretation of reality, including, at times, delusions and hallucinations. This reaction differs from the manic depressive reaction, depressed type, principally in (1) absence of history of repeated depressions or of marked cyclothymic mood swings, (2) frequent presence of environmental precipitating factors. This diagnostic category will be used when a "reactive depression" is of such quality as to place it in the group of psychoses (see 000–x06 Depressive reaction).

000–x20 Schizophrenic reactions

This term is synonymous with the formerly used term dementia præcox. It represents a group of psychotic reactions characterized by fundamental disturbances in reality relationships and concept formations, with affective, behavioral, and intellectual disturbances in varying degrees and mixtures. The disorders are marked by strong tendency to retreat from reality, by emotional disharmony, unpredictable disturbances in stream of thought, regressive behavior, and in some, by a tendency to "deterioration." The predominant symptomatology will be the determining factor in classifying such patients into types.

000–x21 Schizophrenic reaction, simple type

This type of reaction is characterized chiefly by reduction in external attachments and interests and by impoverishment of human relationships. It often involves adjustment on a lower psychobiological level of functioning, usually accompanied by apathy and indifference but rarely by conspicuous delusions or hallucinations. The simple type of schizophrenic reaction characteristically manifests an increase in the severity of symptoms over long periods, usually with apparent mental deterioration, in contrast to the schizoid personality, in which there is little if any change.

000–x22 Schizophrenic reaction, hebephrenic type

These reactions are characterized by shallow, inappropriate affect, unpredictable giggling, silly behavior and mannerisms, delusions, often of a somatic nature, hallucinations, and regressive behavior.

000–x23 Schizophrenic reaction, catatonic type

These reactions are characterized by conspicuous motor behavior, exhibiting either marked generalized inhibition (stupor, mutism, negativism and waxy flexibility) or excessive motor activity and excitement. The individual may regress to a state of vegetation.

000–x24 Schizophrenic reaction, paranoid type

This type of reaction is characterized by autistic, unrealistic thinking, with mental content composed chiefly of delusions of persecution, and/or of grandeur, ideas of reference, and often hallucinations. It is often character-

ized by unpredictable behavior, with a fairly constant attitude of hostility and aggression. Excessive religiosity may be present with or without delusions of persecution. There may be an expansive delusional system of omnipotence, genius, or special ability. The systematized paranoid hypochondriacal states are included in this group.

000–x25 Schizophrenic reaction, acute undifferentiated type

This reaction includes cases exhibiting a wide variety of schizophrenic symptomatology, such as confusion of thinking and turmoil of emotion, manifested by perplexity, ideas of reference, fear and dream states, and dissociative phenomena. These symptoms appear acutely, often without apparent precipitating stress, but exhibiting historical evidence of prodromal symptoms. Very often the reaction is accompanied by a pronounced affective coloring of either excitement or depression. The symptoms often clear in a matter of weeks, although there is a tendency for them to recur. Cases usually are grouped here in the first, or an early, attack. If the reaction subsequently progresses, it ordinarily crystallizes into one of the other definable reaction types.

000–x26 Schizophrenic reaction, chronic undifferentiated type

The chronic schizophrenic reactions exhibit a mixed symptomatology, and when the reaction cannot be classified in any of the more clearly defined types, it will be placed in this group. Patients presenting definite schizophrenic thought, affect and behavior beyond that of the schizoid personality, but not classifiable as any other type of schizophrenic reaction, will also be placed in this group. This includes the so-called "latent," "incipient," and "pre-psychotic" schizophrenic reactions.

000–x27 Schizophrenic reaction, schizo-affective type

This category is intended for those cases showing significant admixtures of schizophrenic and affective reactions. The mental content may be predominantly schizophrenic, with pronounced elation or depression. Cases may show predominantly affective changes with schizophrenic-like thinking or bizarre behavior. The prepsychotic personality may be at variance, or inconsistent, with expectations based on the presenting psychotic symptomatology. On prolonged observation, such cases usually prove to be basically schizophrenic in nature.

000–x28 Schizophrenic reaction, childhood type

Here will be classified those schizophrenic reactions occurring before puberty. The clinical picture may differ from schizophrenic reactions occurring in other age periods because of the immaturity and plasticity of the patient at the time of onset of the reaction. Psychotic reactions in children, manifesting primarily autism, will be classified here. Special symptomatology may be added to the diagnosis as manifestations.

000–x29 Schizophrenic reaction, residual type

This term is to be applied to those patients who, after a definite psychotic, schizophrenic reaction, have improved sufficiently to be able to get along in the community, but who continue to show recognizable residual disturbance of thinking, affectivity, and/or behavior.

000–x30 Paranoid reactions

In this group are to be classified those cases showing persistent delusions, generally persecutory or grandiose, ordinarily without hallucinations. The emotional responses and behavior are consistent with the ideas held. Intelligence is well preserved. This category does not include those reactions properly classifiable under Schizophrenic reaction, paranoid type.

000–x31 Paranoia

This type of psychotic disorder is extremely rare. It is characterized by an intricate, complex, and slowly developing paranoid system, often logically elaborated after a false interpretation of an actual occurrence. Frequently, the patient considers himself endowed with superior or unique ability. The paranoid system is particularly isolated from much of the normal stream of consciousness, without hallucinations and with relative intactness and preservation of the remainder of the personality, in spite of a chronic and prolonged course.

000–x32 Paranoid state

This type of paranoid disorder is characterized by paranoid delusions. It lacks the logical nature of systematization seen in paranoia; yet it does not manifest the bizarre fragmentation and deterioration of the schizophrenic reactions. It is likely to be of a relatively short duration, though it may be persistent and chronic.

000–xy0 PSYCHOTIC REACTION WITHOUT CLEARLY DEFINED STRUCTURAL CHANGE, OTHER THAN ABOVE

This classification is introduced primarily for the use of librarians and statisticians in those instances where the diagnosis has been left incomplete, and is not classifiable. This diagnosis is not intended for mixed reactions, which should be classified according to the predominant reaction.

PSYCHOPHYSIOLOGIC AUTONOMIC AND VISCERAL DISORDERS

This term is used in preference to "psychosomatic disorders," since the latter term refers to a point of view on the discipline of medicine as a whole rather than to certain specified conditions. It is preferred to the term "somatization reactions," which term implies that these disorders are simply another form of psychoneurotic reaction. These disorders are here given a separate grouping between psychotic and psychoneurotic reactions, to allow more accurate accumulation of data concerning their etiology, course, and relation to other mental disorders.

These reactions represent the visceral expression of affect which may be thereby largely prevented from being conscious. The symptoms are due to a chronic and exaggerated state of the normal physiological expression of emotion, with the feeling, or subjective part, repressed. Such long continued visceral states may eventually lead to structural changes.

This group includes the so-called "organ neuroses." It also includes some of the cases formerly classified under a wide variety of diagnostic terms, such as "anxiety state," "cardiac neurosis," "gastric neurosis," and so forth. Differentiation is made from conversion reactions by (1) involvement of organs and viscera innervated by the autonomic nervous system, hence not under full voluntary control or perception; (2) failure to alleviate anxiety; (3) physiological rather than symbolic origin of symptoms; (4) frequent production of structural changes which may threaten life. Differentiation is made from anxiety reactions primarily by predominant, persistent involvement of a single organ system.

Each diagnosis of this type of reaction will be amplified with the specific symptomatic manifestations, e.g., anorexia, loss of weight, dysmenorrhea, hypertension, and so forth.

001–580 Psychophysiologic skin reaction

This category includes such skin reactions as neurodermatoses, pruritus, atopic dermatitis, hyperhydrosis, and so forth, in which emotional factors play a causative role.

002–580 Psychophysiologic musculoskeletal reaction

This category includes muscuoloskeletal disorders such as "psychogenic rheumatism," backache, muscle cramps, myalgias (to include some cases of cephalagia, tension headaches) in which emotional factors play a causative role. In this group, differentiation from conversion reactions is of prime importance and at times is extremely difficult.

003–580 Psychophysiologic respiratory reaction

This category includes cases of bronchial spasm, some hyperventilation syndromes, sighing respirations, hiccoughs, and so forth, in which emotional factors play a causative role.

004–580 Psychophysiologic cardiovascular reaction

This category includes such types of cardiovascular disorders as paroxysmal tachycardia, hypertension, vascular spasms, migraine, and so forth, in which emotional factors play a causative role.

005–580 Psychophysiologic hemic and lymphatic reaction

Here may be included any disturbances in the hemic and lymphatic system in which emotional factors are found to play a causative role.

006–580 Psychophysiologic gastrointestinal reaction

This category includes such specified types of gastrointestinal disorders as peptic-ulcer-like reaction, chronic gastritis, ulcerative or mucous colitis, constipation, hyperacidity, pylorospasm, "heartburn," "irritable colon," "anorexia nervosa," and so forth, in which emotional factors play a causative role.

007–580 Psychophysiologic genitourinary reaction

This category includes some types of menstrual disturbances, dysuria, and so forth, in which emotional factors play a causative role.

008–580 Psychophysiologic endocrine reaction

This category includes endocrine disorders in which emotional factors play a causative role. Specify endocrine disturbance.

009–580 Psychophysiologic nervous system reaction

This category includes psychophysiologic asthenic reaction, in which general fatigue is the predominating complaint. There may be associated visceral complaints. The term includes many cases formerly called "neurasthenia." In some instances, an asthenic reaction may represent a conversion reaction; if so, it will be so classified, with asthenia as a manifestation. In other instances it may be a manifestation of anxiety reaction and should be recorded as such.

Also included in this category are convulsive disorders not otherwise classifiable in which emotional factors play a causative role. Differentiation must be made from the convulsions of conversion reaction.

00x–580 Psychophysiologic reaction of organs of special sense

Here may be included any disturbances in the organs of special sense in which emotional factors are found to play a causative role and in which conversion reactions are excluded (see 000–x03).

PSYCHONEUROTIC DISORDERS

The chief characteristic of these disorders is "anxiety" which may be directly felt and expressed or which may be unconsciously and automatically controlled by the utilization of various psychological defense mechanisms (depression, conversion, displacement, etc.). In contrast to those with psychoses, patients with psychoneurotic disorders do not exhibit gross distortion or falsification of external reality (delusions, hallucinations, illusions) and they do not present gross disorganization of the personality. Longitudinal (lifelong) studies of individuals with such disorders usually present evidence of periodic or constant maladjustment of varying degree from early life. Special stress may bring about acute symptomatic expression of such disorders.

"Anxiety" in psychoneurotic disorders is a danger signal felt and perceived by the conscious portion of the personality. It is produced by a threat from within the personality (e.g., by supercharged repressed emotions, including

such aggressive impulses as hostility and resentment), with or without stimulation from such external situations as loss of love, loss of prestige, or threat of injury. The various ways in which the patient attempts to handle this anxiety results in the various types of reactions listed below.

In recording such reactions the terms "traumatic neurosis," or "traumatic reaction" will not be used; instead, the particular psychiatric reaction will be specified. Likewise, the term "mixed reaction" will not be used; instead, the predominant type of reaction will be recorded, qualified by reference to other types of reactions as part of the symptomatology.

000–x01 Anxiety reaction

In this kind of reaction the anxiety is diffuse and not restricted to definite situations or objects, as in the case of phobic reactions. It is not controlled by any specific psychological defense mechanism as in other psychoneurotic reactions. This reaction is characterized by anxious expectation and frequently associated with somatic symptomatology. The condition is to be differentiated from normal apprehensiveness or fear. The term is synonymous with the former term "anxiety state."

000–x02 Dissociative reaction

This reaction represents a type of gross personality disorganization, the basis of which is a neurotic disturbance, although the diffuse dissociation seen in some cases may occasionally appear psychotic. The personality disorganization may result in aimless running or "freezing." The repressed impulse giving rise to the anxiety may be discharged by, or deflected into, various symptomatic expressions, such as depersonalization, dissociated personality, stupor, fugue, amnesia, dream state, somnambulism, etc. The diagnosis will specify symptomatic manifestations.

These reactions must be differentiated from schizoid personality, from schizophrenic reaction, and from analogous symptoms in some other types of neurotic reactions. Formerly, this reaction has been classified as a type of "conversion hysteria."

000–x03 Conversion reaction

Instead of being experienced consciously (either diffusely or displaced, as in phobias) the impulse causing the anxiety is "converted" into functional symptoms in organs or parts of the body, usually those that are mainly under

voluntary control. The symptoms serve to lessen conscious (felt) anxiety and ordinarily are symbolic of the underlying mental conflict. Such reactions usually meet immediate needs of the patient and are, therefore, associated with more or less obvious "secondary gain." They are to be differentiated from psychophysiologic autonomic and visceral disorders. The term "conversion reaction" is synonymous with "conversion hysteria." Dissociative reactions are not included in this diagnosis.

In recording such reactions the symptomatic manifestations will be specified as anesthesia (anosmia, blindness, deafness), paralysis (paresis, aphonia, monoplegia, or hemiplegia), dyskinesis (tic, tremor, posturing, catalepsy).

000–x04 Phobic reaction

The anxiety of these patients becomes detached from a specific idea, object, or situation in the daily life and is displaced to some symbolic idea or situation in the form of a specific neurotic fear. The commonly observed forms of phobic reaction include fear of syphilis, dirt, closed places, high places, open places, animals, etc. The patient attempts to control his anxiety by avoiding the phobic object or situation.

In recording this diagnosis the manifestations will be indicated. The term is synonymous with the former term "phobia" and includes some of the cases formerly classified as "anxiety hysteria."

000–x05 Obsessive compulsive reaction

In this reaction the anxiety is associated with the persistence of unwanted ideas and of repetitive impulses to perform acts which may be considered morbid by the patient. The patient himself may regard his ideas and behavior as unreasonable, but nevertheless is compelled to carry out his rituals.

The diagnosis will specify the symptomatic expression of such reactions, as touching, counting, ceremonials, hand-washing, or recurring thoughts (accompanied often by a compulsion to repetitive action). This category includes many cases formerly classified as "psychasthenia."

000–x06 Depressive reaction

The anxiety in this reaction is allayed, and hence partially relieved, by depression and self-depreciation. The reaction is precipitated by a current situation, frequently by some loss sustained by the patient, and is often associated with a feeling of guilt for past failures or deeds. The degree of

the reaction in such cases is dependent upon the intensity of the patient's ambivalent feeling toward his loss (love, possession) as well as upon the realistic circumstances of the loss.

The term is synonymous with "reactive depression" and is to be differentiated from the corresponding psychotic reaction. In this differentiation, points to be considered are (1) life history of patient, with special reference to mood swings (suggestive of psychotic reaction), to the personality structure (neurotic or cyclothymic) and to precipitating environmental factors and (2) absence of malignant symptoms (hypochondriacal preoccupation, agitation, delusions, particularly somatic, hallucinations, severe guilt feelings, intractable insomnia, suicidal ruminations, severe psychomotor retardation, profound retardation of thought, stupor).

000–x0y Psychoneurotic reaction, other

Under this classification will come all reactions considered psychoneurotic and not elsewhere classified. (Psychoneurotic manic reactions, etc.) This category is designed also for the use of record librarians and statisticians dealing with incomplete diagnoses. It does not include "mixed" reactions, which are to be diagnosed according to the predominant reaction.

PERSONALITY DISORDERS

These disorders are characterized by developmental defects or pathological trends in the personality structure, with minimal subjective anxiety, and little or no sense of distress. In most instances, the disorder is manifested by a lifelong pattern of action or behavior, rather than by mental or emotional symptoms. Occasionally, organic diseases of the brain (epidemic encephalitis, head injury, Alzheimer's disease, etc.) will produce clinical pictures resembling a personality disorder. In such instances, the condition is properly diagnosed as a Chronic Brain Syndrome (of appropriate origin) with behavioral reaction.

The personality disorders are divided into three main groups with one additional grouping for flexibility in diagnosis (Special symptom reactions). Although the groupings are largely descriptive, the division has been made partially on the basis of the dynamics of personality development. The Personality pattern disturbances are considered deep seated disturbances, with little room for regression. Personality trait disturbances and Socio-

pathic personality disturbances under stress may at times regress to a lower level of personality organization and function without development of psychosis.

000–x40 Personality pattern disturbance

These are more or less cardinal personality types, which can rarely if ever be altered in their inherent structures by any form of therapy. Their functioning may be improved by prolonged therapy, but basic change is seldom accomplished. In some, "constitutional" features are marked and obvious. The depth of the psychopathology here allows these individuals little room to maneuver under conditions of stress, except into actual psychosis.

000–x41 Inadequate personality

Such individuals are characterized by inadequate response to intellectual, emotional, social, and physical demands. They are neither physically nor mentally grossly deficient on examination, but they do show inadaptability, ineptness, poor judgment, lack of physical and emotional stamina, and social incompatibility.

000–x42 Schizoid personality

Inherent traits in such personalities are (1) avoidance of close relations with others, (2) inability to express directly hostility or even ordinary aggressive feelings, and (3) autistic thinking. These qualities result early in coldness, aloofness, emotional detachment, fearfulness, avoidance of competition, and day dreams revolving around the need for omnipotence. As children, they are usually quiet, shy, obedient, sensitive and retiring. At puberty, they frequently become more withdrawn, then manifesting the aggregate of personality traits known as introversion, namely, quietness, seclusiveness, "shut-in-ness," and unsociability, often with eccentricity.

000–x43 Cyclothymic personality

Such individuals are characterized by an extratensive and outgoing adjustment to life situations, an apparent personal warmth, friendliness and superficial generosity, an emotional reaching out to the environment, and a ready enthusiasm for competition. Characteristic are frequently alternating moods of elation and sadness, stimulated apparently by internal factors rather than

by external events. The individual may occasionally be either persistently euphoric or depressed, without falsification or distortion of reality. The diagnosis in such cases should specify, if possible, whether hypomanic, depressed or alternating.

000–x44 Paranoid personality

Such individuals are characterized by many traits of the schizoid personality, coupled with an exquisite sensitivity in interpersonal relations, and with a conspicuous tendency to utilize a projection mechanism, expressed by suspiciousness, envy, extreme jealousy and stubbornness.

000–x50 Personality trait disturbance

This category applies to individuals who are unable to maintain their emotional equilibrium and independence under minor or major stress because of disturbances in emotional development. Some individuals fall into this group because their personality pattern disturbance is related to fixation and exaggeration of certain character and behavior patterns; others, because their behavior is a regressive reaction due to environmental or endopsychic stress.

This classification will be applied only to cases of personality disorder in which the neurotic features (such as anxiety, conversion, phobia, etc.) are relatively insignificant, and the basic personality maldevelopment is the crucial distinguishing factor. Evidence of physical immaturity may or may not be present.

000–x51 Emotionally unstable personality

In such cases the individual reacts with excitability and ineffectiveness when confronted by minor stress. His judgment may be undependable under stress, and his relationship to other people is continuously fraught with fluctuating emotional attitudes, because of strong and poorly controlled hostility, guilt, and anxiety.

This term is synonymous with the former term "psychopathic personality with emotional instability."

000–x52 Passive-aggressive personality

Reactions in this group are of three types, as indicated below, and the diagnosis can be further elaborated, if desired, by adding the specific type

of reaction observed. However, the three types of reaction are manifestations of the same underlying psychopathology, and frequently occur interchangeably in a given individual falling in this category. For these reasons, the reactions are classified together. The clinical picture in such cases often has, superimposed upon it, anxiety reaction which is typically psychoneurotic (see Qualifying Phrases).

Passive-dependent type: This reaction is characterized by helplessness, indecisiveness, and a tendency to cling to others as a dependent child to a supporting parent.

Passive-aggressive type: The aggressiveness is expressed in these reactions by passive measures, such as pouting, stubbornness, procrastination, inefficiency, and passive obstructionism.

Aggressive type: A persistent reaction to frustration with irritability, temper tantrums, and destructive behavior is the dominant manifestation. A specific variety of this reaction is a morbid or pathological resentment. A deep dependency is usually evident in such cases. The term does not apply to cases more accurately classified as Antisocial reaction.

000–x53 Compulsive personality

Such individuals are characterized by chronic, excessive, or obsessive concern with adherence to standards of conscience or of conformity. They may be overinhibited, overconscientious, and may have an inordinate capacity for work. Typically they are rigid and lack a normal capacity for relaxation. While their chronic tension may lead to neurotic illness, this is not an invariable consequence. The reaction may appear as a persistence of an adolescent pattern of behavior, or as a regression from more mature functioning as a result of stress.

000–x5y Personality trait disturbance, other

This category is included to permit greater latitude in diagnosis. Instances in which a personality trait is exaggerated as a means to life adjustment (as in the above diagnoses), not classifiable elsewhere, may be listed here.

This category is designed also for the use of record librarians and statisticians dealing with incomplete diagnoses. It is not intended for use with "mixed" states, which are to be properly diagnosed according to the predominant trait disturbance.

000–x60 Sociopathic personality disturbance

Individuals to be placed in this category are ill primarily in terms of society and of conformity with the prevailing cultural milieu, and not only in terms of personal discomfort and relations with other individuals. However, sociopathic reactions are very often symptomatic of severe underlying personality disorder, neurosis, or psychosis, or occur as the result of organic brain injury or disease. Before a definitive diagnosis in this group is employed, strict attention must be paid to the possibility of the presence of a more primary personality disturbance; such underlying disturbance will be diagnosed when recognized. Reactions will be differentiated as defined below.

000–x61 Antisocial reaction

This term refers to chronically antisocial individuals who are always in trouble, profiting neither from experience nor punishment, and maintaining no real loyalties to any person, group, or code. They are frequently callous and hedonistic, showing marked emotional immaturity, with lack of sense of responsibility, lack of judgment, and an ability to rationalize their behavior so that it appears warranted, reasonable, and justified.

The term includes cases previously classified as "constitutional psychopathic state" and "psychopathic personality." As defined here the term is more limited, as well as more specific in its application.

000–x62 Dyssocial reaction

This term applies to individuals who manifest disregard for the usual social codes, and often come in conflict with them, as the result of having lived all their lives in an abnormal moral environment. They may be capable of strong loyalties. These individuals typically do not show significant personality deviations other than those implied by adherence to the values or code of their own predatory, criminal, or other social group. The term includes such diagnoses as "pseudosocial personality" and "psychopathic personality with asocial and amoral trends."

000–x63 Sexual deviation

This diagnosis is reserved for deviant sexuality which is not symptomatic of more extensive syndromes, such as schizophrenic and obsessional reactions.

The term includes most of the cases formerly classed as "psychopathic personality with pathologic sexuality." The diagnosis will specify the type of the pathologic behavior, such as homosexuality, transvestism, pedophilia, fetishism and sexual sadism (including rape, sexual assault, mutilation).

000–x64 Addiction

Addictions will be classified as defined below.

000–x641 Alcoholism

Included in this category will be cases in which there is well established addiction to alcohol without recognizable underlying disorder. Simple drunkenness and acute poisoning due to alcohol are not included in this category.

000–x642 Drug addiction

Drug addiction is usually symptomatic of a personality disorder, and will be classified here while the individual is actually addicted; the proper personality classification is to be made as an additional diagnosis. Drug addictions symptomatic of organic brain disorders, psychotic disorders, psychophysiologic disorders, and psychoneurotic disorders are classified here as a secondary diagnosis.

000–x70 Special symptom reactions

This category is useful in occasional situations where a specific symptom is the single outstanding expression of the psychopathology. This term will not be used as a diagnosis, however, when the symptoms are associated with, or are secondary to, organic illnesses and defects, or to other psychiatric disorders. Thus, for example, the diagnosis Special symptom reaction, speech disturbance would be used for certain disturbances in speech in which there are insufficient other symptoms to justify any other definite diagnosis. This type of speech disturbance often develops in childhood. It would not be used for a speech impairment that was a temporary symptom of conversion hysteria or the result of any organic disease or defect.

The diagnosis should specify the particular "habit." (000–x71 Learning disturbance; 000–x72 Speech disturbance; 000–x73 Enuresis; 000–x74 Somnambulism; 000–x7y Other.)

TRANSIENT SITUATIONAL PERSONALITY DISORDERS

This general classification should be restricted to reactions which are more or less transient in character and which appear to be an acute symptom response to a situation without apparent underlying personality disturbance.

The symptoms are the immediate means used by the individual in his struggle to adjust to an overwhelming situation. In the presence of good adaptive capacity, recession of symptoms generally occurs when the situational stress diminishes. Persistent failure to resolve will indicate a more severe underlying disturbance and will be classified elsewhere.

000–x80 Transient situational personality disturbance

Transient situational disorders which cannot be given a more definite diagnosis in the group, because of their fluidity, or because of the limitation of time permitted for their study, may be included in this general category. This category is designed also for the use of record librarians and statisticians dealing with incomplete diagnoses.

000–x81 Gross stress reaction

Under conditions of great or unusual stress, a normal personality may utilize established patterns of reaction to deal with overwhelming fear. The patterns of such reactions differ from those of neurosis or psychosis chiefly with respect to clinical history, reversibility of reaction, and its transient character. When promptly and adequately treated, the condition may clear rapidly. It is also possible that the condition may progress to one of the neurotic reactions. If the reaction persists, this term is to be regarded as a temporary diagnosis to be used only until a more definitive diagnosis is established.

This diagnosis is justified only in situations in which the individual has been exposed to severe physical demands or extreme emotional stress, such as in combat or in civilian catastrophe (fire, earthquake, explosion, etc.). In many instances this diagnosis applies to previously more or less "normal" persons who have experienced intolerable stress.

The particular stress involved will be specified as (1) combat or (2) civilian catastrophe.

000–x82 Adult situational reaction

This diagnosis is to be used when the clinical picture is primarily one of superficial maladjustment to a difficult situation or to newly experienced environmental factors, with no evidence of any serious underlying personality defects or chronic patterns. It may be manifested by anxiety, alcoholism, asthenia, poor efficiency, low morale, unconventional behavior, etc. If untreated or not relieved such reactions may, in some instances, progress into typical psychoneurotic reactions or personality disorders. This term will also include some cases formerly classified as "simple adult maladjustment."

000–x83 Adjustment reaction of infancy

Under this term are to be classified those transient reactions in infants occurring on a psychogenic basis without organic disease. In most instances these will be outgrowths of the infant's interaction with significant persons in the environment or a response to the lack of such persons. Undue apathy, undue excitability, feeding and sleeping difficulties are common manifestations of such psychic disturbances in infants.

000–x84 Adjustment reaction of childhood

Under this heading are included only the transient symptomatic reactions of children to some immediate situation or internal emotional conflict. The more prolonged and definitive disturbances will be classified elsewhere.

Although the symptomatic manifestations are usually mixed, one type of manifestation may predominate. This group may be subclassified according to the most prominent manifestations as follows:

000–x841 Habit disturbance

When the transient reaction manifests itself primarily as a so-called "habit" disturbance, such as repetitive, simple activities, it may be subclassified here.

Indicate symptomatic manifestations under this diagnosis; for example, nail biting, thumb sucking, enuresis, masturbation, tantrums, etc.

000–x842 Conduct disturbance

When the transient reaction manifests itself primarily as a disturbance in social conduct or behavior, it will be classified here. Manifestations may

occur chiefly in the home, in the school, or in the community, or may occur in all three. Conduct disturbances are to be regarded as secondary phenomena when seen in cases of mental deficiency, epilepsy, epidemic encephalitis, and other well-recognized organic diseases.

Indicate symptomatic manifestations under this diagnosis; for example, truancy, stealing, destructiveness, cruelty, sexual offenses, use of alcohol, etc.

000–x843 Neurotic traits

When the transient reaction manifests itself primarily as physical or emotional symptoms, it will be classified here. Care must be taken to differentiate these transitory situational responses from the psychoneurotic reactions.

Neurotic traits are closely related to habit disturbances and a distinction between the two is not always possible or desirable. Tics of organic origin should be classified under organic nervous diesase.

Under this diagnosis indicate symptomatic manifestations; for example, tics, habit spasms, somnambulism, stammering, over-activity, phobias, etc.

000–x85 Adjustment reaction of adolescence

Under this diagnosis are to be included those transient reactions of the adolescent which are the expression of his emancipatory strivings and vacillations with reference to impulses and emotional tendencies. The superficial pattern of the behavior may resemble any of the personality or psychoneurotic disorders. Differentiation between transient adolescent reactions and deep-seated personality trait disorders or psychoneurotic reactions must be made.

000–x86 Adjustment reaction of late life

Under this diagnosis will be included those transient reactions of later life which are an expression of the problems of physiological, situational, and environmental readjustment. Involutional physiological changes, retirement from work, breaking up of families through death, or other life situation changes frequently precipitate transient undesirable personality disturbances, or accentuate previous personality disorders. Such disturbances are to be differentiated from other psychogenic reactions and from reactions associated with cerebral arteriosclerosis, pre-senile psychosis, and other organic disorders.

NON-DIAGNOSTIC TERMS FOR HOSPITAL RECORD

These terms are included in the Standard Nomenclature of Diseases and Operations, and reprinted here for the use of hospitals in completing records and statistics. The reprinted list represents only a portion of those listed in the Standard Nomenclature, but includes the terms most commonly used by hospitals for mental disease and psychiatric services in general hospitals. The terms Diagnosis deferred, Disease none, Examination only, Experiment only, Observation, and Tests only, must be elaborated by the addition of explanatory phrases, such as, Observation (psychiatric).

The terms themselves are self-explanatory. In the six diagnoses listed in the preceding paragraph, it is necessary to change the code number to indicate more specifically the cause of hospital admission. The Psychobiologic Unit takes a first code number of 0.. The y must be retained in the first three digits, hence is moved to second position when the first digit is changed to indicate the Psychobiologic Unit. The diagnosis, Observation, Psychiatric, then receives the code number of 0y0–001. Similarly, observation for disease of the nervous system will be recorded as 9y0–001, Observation, Neurological. Admission for psychological tests will be recorded under 0y0–003, Tests only (psychological tests).

Section III

RECORDING OF PSYCHIATRIC CONDITIONS

A. General Requirements

1. *Lowest sub-classification to be used in recording diagnoses:* The specific psychiatric conditions (reactions) are sufficiently well defined to justify their use without inclusion of the terms indicating the broader generic groups (disorders). In recording a psychiatric condition, the lowest sub-classification of the disorder will be used without being prefaced by generic terms such as "Personality disorder," "psychoneurosis" (psychoneurotic disorder), "Psychosis" (psychotic disorder), or to intermediate classifications such as "Personality pattern" and "Sociopathic personality." Examples:

(a) Schizophrenic reaction, catatonic type.
(b) Psychophysiologic gastro-intestinal reaction.
(c) Phobic reaction.
(d) Paranoid personality.
(e) Adjustment reaction of childhood: conduct disturbance.

2. *Qualifying terms:* In addition to the diagnostic term used for specifying the particular psychiatric condition, the diagnosis may also include terms qualifying the severity of the condition. The term "severity" refers to the seriousness of the condition. It will not be determined solely by the degree of ineffectiveness, since other factors, such as underlying attitudes, or other psychiatric or physical conditions might have contributed to the total ineffectiveness. Severity will be described as "mild," "moderate," or "severe." Such terms as "moderately severe" or "mildly severe" are not sanctioned. Outstanding or conspicuous symptomatology may be added to the diagnosis as manifestations. Example: "Anxiety reaction, mild, manifested by loss of appetite and insomnia."

3. *Order of diagnosis:* The general principles for recording diagnoses as prescribed in the Standard Nomenclature of Diseases and Operations apply to the recording of psychiatric diagnoses. The immediate condition which necessitated the current admission of the patient will be considered as the primary cause of admission, and so recorded. In cases of several related conditions simultaneously necessitating treatment or hospitalization, the condition which is first in the chain of etiology will be designated as the

primary cause of admission. For unrelated conditions simultaneously necessitating treatment or hospitalization, the most serious condition will be recorded as the primary cause of admission. Within the limits of these general principles the following specific conditions will be considered with respect to cases involving psychiatric disorders.

(a) Unrelated diagnoses:

Physical and mental disorders may coexist but be causally unrelated. In such instances all conditions will be listed as separate diagnoses with the primary diagnosis being selected as above.

(b) Related diagnoses:

Physical and mental disorders may coexist and be causally related. The nature of the coexisting conditions determines whether the conditions will be recorded as separate diagnoses or as only one diagnosis.

(1) Related conditions requiring only one diagnosis:

In some instances, the mental reaction, although related to the physical disorder, is not sufficiently developed as a clinical psychiatric entity to require a formal psychiatric diagnosis. For example, a patient with pneumonia may be apprehensive and tense. While this mental status should be described in the patient's clinical history, or in his physical examination, along with any other symptoms or signs, on the individual medical record, the diagnosis will state only the non-psychiatric condition.

There are other instances where physical and mental disorders may coexist and where the physical disorder is a manifestation of the psychiatric condition, rather than a separate condition. Whenever this is true, only the psychiatric condition will be listed as a diagnosis, and the physical condition will be shown by a supplementary term. Example: Psychophysiologic skin reaction, severe (pruritis ani).

(2) Related conditions requiring separate diagnoses:

Physical and mental disorders may coexist and be causally related, with both conditions being sufficiently marked and well defined to justify separate diagnoses. In such cases the causal relationship of the diagnoses should be indicated. The condition which caused or directly led to the other condition will precede the other condition in the order of diagnoses. This diagnostic procedure will be followed despite the fact that the psychiatric symptomatology is related to personality factors which existed prior to the immediate physical disease or trauma. For example in the illustration above

[Paragraph (b) (1)], should the state of apprehension or tension associated with pneumonia progress to a severe delirium, the double condition will require separate diagnoses of "Pneumonia, etc." and "Acute Brain Syndrome associated with systemic infection, pneumonia."

(3) Multiple psychiatric diagnoses:

(a) Whenever two separate psychiatric conditions exist, such as Acute Brain Syndrome, drug or poison intoxication, and Depressive reaction, both will be recorded. If a diagnostic entity (which would be recorded as the only diagnosis, if encountered as an isolated personality disturbance) is a part of a more extensive process or secondary to it, the primary condition will be recorded as the diagnosis, with the less important or secondary condition given as a manifestation. Examples:

(1) Anxiety reaction manifested by somnambulism.
(2) Passive-aggressive reaction, manifested by enuresis.

(b) Some psychiatric diagnoses are incompatible with certain other diagnoses and will not be recorded as existing together, such as psychoneurotic and psychotic reactions. Many conditions may progress from one to another but are not present simultaneously. Only one type of psychoneurotic reaction will be used as a diagnosis, even in the presence of symptoms of another type. The diagnosis will be based on the predominant type, followed by a statement of its manifestations, including symptoms of the other types of of reaction. Examples:

(1) Anxiety reaction with minor conversion symptom.
(2) Phobic reaction, manifested by claustrophobia, with obsessive-compulsive symptoms, counting and recurring thoughts.

B. Special Requirements

1. *General.*

The general requirements outlines above for the recording of diagnoses for statistical purposes, apply also to the recording of diagnoses on the clinical records. In view of the fact, however, that the clinical records fulfill wider function than the statistical records, the mere stating of the diagnosis (including its qualifying terms) is not sufficient for certain conditions, since it does not furnish enough information to describe the clinical picture. For example, a diagnosis "Anxiety reaction" does not convey whether the illness has oc-

curred in a previously normal or previously neurotic personality. Furthermore, it does not indicate the degree and nature of the external stress nor does it reveal the extremely important information as to the degree to which the patient's functional capacity has been impaired by the psychiatric condition. Therefore, for most conditions a complementary evaluation must be entered in the clinical records. This additional evaluation will consist of the following elements:

(a) External precipitating stress.
(b) Premorbid personality and predisposition.
(c) Degree of psychiatric impairment.

Under this system the diagnosis becomes one of four factors to be considered in evaluating a case. It is essential to recognize that the time element is all-important in this evaluation. The diagnostic formulation on any particular date may be changed on a subsequent date. A patient may show severe impairment of function upon admission but at the time of discharge may have mild or no impairment. For this reason, it is essential that a beginning and terminating evaluation be recorded in each case. Degree of impairment is not synonymous with the terms, "Recovered," "Improved," and "Unimproved." The latter terms are more inclusive, inasmuch as they indicate a change in the patient's total condition over a period of time.

2. *Conditions Requiring Complementary Diagnostic Evaluation.*

All disorders in this nomenclature will be given complementary diagnostic evaluation except those grouped under Mental Deficiency.

3. *External Precipitating Stress.*

While it is recognized that multicausal factors operate, the apparent or obvious external stress precipitating the condition is to be evaluated as to type, degree, and duration. The stress will generally refer to the immediate emotional, economic, environmental, or cultural situation which is directly related to the reaction manifest in the patient. Unconscious internal conflicts are not to be considered as external stress. Whenever the stress cannot be determined, it should be recorded as "undetermined." The degree of stress must be evaluated in terms of its effect on the "average man" of the society from which the patient comes. It must not be presumed that a particular environmental stress is severe because of one or even several individuals reacting poorly to it, since these individuals may have had poor

resistance to that particular stress. Stress will be classified as "none," "mild," "moderate," or "severe." Severe stress is such that the average individual when exposed to it could be expected to develop psychiatric symptoms. Moderate stress is such that some evidence of a causal relationship can be established between the symptoms and the precipitating factors. Mild stress is such that the average individual could be exposed to it without developing psychiatric symptoms. In classifying the stress according to one of these terms, the actual stress should be described in a brief phrase in order to allow more accurate evaluation of the case. Example: "Moderate stress (business failure)."

4. *Pre-Morbid Personality and Predisposition.*

The description of predisposition will consist of the patient's outstanding personality traits or weaknesses, which have resulted from inheritance and development, and an evaluation of the degree of this predisposition based on the patient's past history and personality traits. Frequently, the premorbid personality may be such that classification can be made as one of the personality disorders. When the predisposition cannot be determined, it will be recorded as "undetermined." The degree of predisposition will be reported as "none," "mild," "moderate," or "severe."

(a) None: No predisposition evident. This description will be used when the patient shows no evidence of previous personality traits or make-up appearing to be related to his present illness (and when there has been no positive history of a mental illness in the immediate family).

(b) Mild predisposition: This description will be used when the patient's history reveals mild, transient, emotional upsets, and/or abnormal personality traits or defects of intelligence which, however, do not significantly incapacitate or did not require medical care. (It will be used also where there is a past history of mental illness in the patient's family.) Examples: History of mild, transient, psychoneurotic reaction or mild personality disorder, or borderline mental deficiency.

(c) Moderate predisposition. This description will be used when the patient has a personal history of partially incapacitating emotional upsets, or definitely abnormal personality traits, or defects in intelligence, which have resulted in social maladjustment. Examples: Mild, chronic, psychoneurotic reaction; moderate psychoneurotic reaction of limited duration; mental deficiency of mild degree.

(d) Severe predisposition. This description will be used in the presence of a definite history of previous overt mental disorder. Examples: Definite

psychotic reaction, moderate or severe chronic psychoneurotic reaction, marked degree of personality disorder, moderate or marked mental deficiency.

5. *Degree of Psychiatric Impairment.*

The psychiatric impairment represents the degree to which the individual's total functional capacity is affected by the psychiatric condition. This is not necessarily the same as general ineffectiveness. The degree of effectiveness in any particular job is a result of the individual's emotional stability, intellect, physical condition, attitudes, motivation, training, etc., as well as of the degree and type of his psychiatric impairment. Under some circumstances, an individual with a moderate psychiatric impairment may be more effective than another individual with a minimal impairment. Degree of impairment, as used here, refers only to ineffectiveness resulting from the current psychiatric impairment.

The degree of the impairment at the time of original consultation or admission will often vary from the degree of impairment after treatment. Impairment after termination of treatment represents the residual or persistent impairment. Depending on the degree of the impairment, it will be recorded as, "No Impairment," "Minimal Impairment," "Mild Impairment," "Moderate Impairment," "Severe Impairment." The individual's pre-illness capacity in terms of occupational and social adjustment will be used as a base line for estimating the degree of impairment.

(a) No impairment.

This term will be used whenever there are no medical reasons for changing employment or life situation.

(b) Minimal impairment.

This term will be used to indicate incapacity of perceptible degree and, in terms of percentage, not to exceed 10%.

(c) Mild impairment.

This term will be used to indicate impairment in social and occupational adjustment, such as a 20 to 30% disability.

(d) Moderate impairment.

This term will be used to indicate a degree of impairment which seriously, but not totally, interferes with the patient's ability to carry on his pre-illness social and vocational adjustment, such as a 30 to 50% disability.

(e) Severe impairment.

This term will be used to indicate a degree of impairment which for practical purposes prevents a patient from functioning at his pre-illness social and vocational levels. Over 50% disability.

6. *Manner of Recording.*

The manner of recording diagnosis on clinical records is illustrated by the following examples:

(a) Acute brain syndrome associated with drug intoxication (bromide)

Stress: none apparent.

Predisposition: moderate; history of emotional instability requiring medical care.

Impairment: none; recovered under treatment.

(b) Chronic brain syndrome associated with cerebral arteriosclerosis

Stress: mild; malnutrition and minor respiratory infection.

Predisposition: none.

Impairment: moderate; able to adjust outside hospital under supervision.

(c) Schizophrenic reaction, hebephrenic type, severe.

Stress: none.

Predisposition: severe; Schizoid personality since childhood.

Impairment: severe; requires hospitalization.

(d) Psychophysiologic gastro-intestinal reaction, moderate, manifested by nausea, vomiting, loss of appetite and epigastric pains.

Stress: moderate; in train wreck with a number of people killed.

Predisposition: moderate; emotionally unstable personality since childhood.

Impairment: mild; able to return to previous social and vocational situation under treatment.

(e) Obsessive-compulsive reaction, moderate, manifested by counting, recurring thoughts and ceremonials.

Stress: Mild; promotion to a more responsible job.

Predisposition: moderate; compulsive personality and history of emotional upsets since childhood.

Impairment: moderate; able to carry less responsible job after treatment.

(f) Passive aggressive personality.

Stress: none apparent.

Predisposition: mild; sister hospitalized with schizophrenic reaction.

Impairment: mild; returned to work but shows increase in unauthorized absences.

(g) Adult situational reaction, severe, manifested by anxiety, asthenia and poor efficiency.

Stress: Severe; sudden loss of immediate family.

Predisposition: none.

Impairment: none; recovered under psychotherapy.

Section IV

STATISTICAL REPORTING

A. BASIC PRINCIPLES

Mental Hospitals

There is an increasing need for adequate statistical data on the mental hospital population of the country. As a result, many State hospital systems have expressed a desire for guidance in the development of statistical systems.

On the basis of the records described in the *Statistical Manual for the Use of Hospitals for Mental Disease,*[1] and modifications of them, several States already have developed extensive record systems which include procedures for establishing punch card files and for carrying out machine tabulations. These State systems are not identical in their details of operation or in the record forms used. Nevertheless, they all have certain elements in common and can yield certain common types of basic statistical information.

The following discussion is not intended to serve as an operations manual. Its purpose is to provide a guide line to those States and hospitals that contemplate organizing or revising their statistical systems by focusing attention on the minimum elements found in existing State systems which are essential to adequate reporting. Persons interested in obtaining operating details may do so by writing to the Mental Hospital Authorities in the States listed in Appendix D for copies of manuals which describe their reporting systems, forms, punch cards, codes and machine tabulating procedures.

A primary requisite in the establishment of a reporting system is that the basic objectives of the system should be clearly stated at the outset. With these objectives in mind, the system should be set up and kept in operation by a person who is familiar with statistical methods, preferably a trained statistician with some experience in the application of statistical methods to hospital and public health problems. Such a person can design record forms and procedures needed to collect pertinent data, can set up the appropriate tabulations needed to answer specific questions, and can analyze the data adequately. There are available sorting and tabulating machines (such as International Business Machines and Remington Rand Powers Equipment)

[1] *Statistical Manual for the Use of Hospitals for Mental Disease,* 10th Edition, 1942, National Association for Mental Health.

which help produce facts rapidly and accurately by eliminating tedious hand operations and which make possible certain operations and tabulations that are impractical to carry out by hand. It should be kept in mind, however, that such machines are not a substitute for the well-trained statistician but merely a tool to help the statistician perform the sorting and other operations incidental to obtaining the necessary tabulations.

A reporting system does not have to be complex to be effective. An efficient reporting system can be designed to provide basic facts concerning the admissions, patients under treatment, discharges, and deaths by having a limited number of basic variables reported to a central office for every patient admitted to the hospital system. For example, the following items should be reported at time of admission:

(1) Patient's name
(2) Residence (street address, city or town, county, state)
(3) Serial number assigned to patient
(4) Hospital to which admitted
(5) Date of current admission
(6) Birth date (month, day, year)
(7) Age (last birthday) on admission
(8) Sex (male, female)
(9) Race (White, Negro, American Indian, Chinese, Japanese, etc.)
(10) Marital status (single, married, widowed, divorced, separated)
(11) Admission status (first, readmission, transfer)
(12) Type of commitment[2] (voluntary; medical certification, standard nonjudicial procedure; medical certification, emergency procedure; without medical certification, emergency procedure; court order, judicial procedure)
(13) Mental disorder.

The following facts should be reported subsequent to admission at the time each event occurs:

(1) Changes in diagnosis
(2) Dates of placement on trial visit, family care or temporary visit and return from such leave
(3) Dates of escape and return from escape
(4) Dates of transfer

[2] These terms are the ones used in the *Draft Act Governing Hospitalization of the Mentally Ill*, Federal Security Agency, Public Health Service, Publication No. 51. Types of commitment procedures practiced in a given State can be substituted for these.

(5) Date of discharge and whether discharge is from hospital direct, trial visit, family care, temporary visit or while otherwise absent
(6) Date of death and whether death occurred in hospital, on trial visit, family care, temporary visit, or while otherwise absent
(7) Causes of death.[3]

These items should be collected on a single card, such as is shown in figure 1. Included on the card are several other items which may be found useful for identification or other purposes such as religion, usual occupation,[4] business or industry, veteran status, social security number, patient's birthplace, parents' names and birthplaces. Spaces are also provided for recording the degree of psychiatric impairment patient was found to have at time of admission, discharge, and intermediate dates as well as the outcome of hospitalization.

It should be pointed out that certain basic facts are needed on the book population of the hospital—that is, the residents in hospital and patients on trial visit, family care, escape, etc.—as of the date the reporting system starts. To obtain these facts entails carrying out a census of the book population as of the appropriate date (for example, January 1), recording for these individuals the same items as are to be obtained on the patients admitted after that date. By making the appropriate additions to and subtractions from

[3] Causes of death should be recorded in the same manner as on the Medical Certification Section of the Standard Certificate of Death. For information on the completion of this section of the death certificate see "Physicians Handbook on Death and Birth Registration," 10th Edition, Government Printing Office, Washington 25, D. C. (15 cents.) The classification of causes of death for statistical tabulation should be done in accordance with the "International Statistical Classification of Diseases, Injuries and Causes of Death." Volume I includes an Introduction, List of Categories, Tabular List of Inclusions, a section on medical certification and rules for classification, and special lists for tabulation purposes. Volume II is the Alphabetical Index to the List. The index is a working tool for use in coding medical records and death certificates. The manual also contains rules for uniform selection of underlying cause of death and three lists recommended for use by all member nations of the World Health Organization in tabulating morbidity and mortality data. The manual can be obtained from the Columbia University Press, International Documents Service, 2960 Broadway, New York 27, N. Y.

[4] "Usual occupation" refers to the occupation the patient pursued for the longest part of his working life. It is the one occupation out of several the patient may have had that accounted for the greatest number of years of his working life. This item and "kind of business or industry" are useful for identification and, if death occurs, for completing the death certificate. It is also of some use in research, although studies of association between occupation and mental illness would probably require detailed occupational histories. If the patient was retired prior to hospitalization, enter his usual occupation and industry in items 12 and 13 and insert "ret" after the usual occupation. For more specific details regarding terms to be used in the recording of occupation and industry see "Guide for Reporting Occupation and Industry on Death Certificates" issued by the Public Health Service, National Office of Vital Statistics, Washington 25, D. C., and "Alphabetical Index of Occupations and Industries," Bureau of the Census, Washington 25, D. C.

the various categories of patients, it is then possible to keep the book population up-to-date.

If additional information is desired, as for example on the type of therapy each patient receives, the occurrence of non-psychiatric illness such as cancer, tuberculosis, diabetes, etc., the form could be enlarged to provide additional fields for such data or special forms could be designed to obtain such data which could later be collated with the basic record outlined above.

From the basic facts collected on the patients the following kinds of statistical tabulations may be obtained (these tables are set up in outline form at the end of this Section):

(1) Gross movement table which tells how many patients are admitted to, die in, or are discharged from the hospital, how many are on trial visit, escape, etc. These data are needed to compute crude separation, discharge and death rates (table 1).

(2) More specific data about the characteristics of the patients who are admitted, discharged, on extramural care (trial visit and family care) or resident in the hospital at the end of the year. For example:

(a) Annual Admissions:

1. By mental disorder, sex, race, age at admission and admission status (table 2)

(b) Annual Discharges:

1. By mental disorder, sex, race, age at discharge and admission status (table 3)
2. By mental disorder, sex, race, admission status and net length of time in hospital for this admission (table 4)
3. By mental disorder, sex, race and condition on discharge (table 5)

(c) Annual Deaths:

1. By mental disorder, sex, race, age at death and admission status (table 6)
2. By mental disorder, sex, race, admission status and net length of time in hospital for this admission (table 7)

(d) Resident Patients at the End of the Year:

1. By mental disorder, sex, race, and age at the end of the year (table 8)
2. By mental disorder, sex, race and time on books (table 9)

INSTITUTION

1. PATIENT'S NAME (*Last, first, middle*)					3. SERIAL NUMBER	
2. PATIENT'S ADDRESS (*No., street, city or town, county, state*)					4. DATE ADMITTED	
5. LEGAL RESIDENCE (*State or county*)	6. PATIENT'S BIRTHPLACE (*State or foreign country*)	7. DATE OF BIRTH	8. ADMISSION AGE (*Yrs. last birthday*)	9. SEX	10. RACE	11. RELIGION
12. MARITAL STATUS	13a USUAL OCCUPATION		13b KIND OF BUSINESS OR INDUSTRY			
14. WAS PATIENT EVER IN U.S. ARMED FORCES? ☐ YES ☐ NO ☐ UNK.	14a IF YES, GIVE WAR OR DATES OF SERVICE	17a FATHER'S NAME			17b BIRTHPLACE	
15. SOCIAL SECURITY NUMBER	16. CITIZEN OF WHAT COUNTRY?	18a MOTHER'S MAIDEN NAME			18b BIRTHPLACE	

19. TYPE OF ADMISSION
- ☐ VOLUNTARY
- ☐ MED. CERTIF., STAND. NON-JUDICIAL
- ☐ MED. CERTIF., EMERGENCY
- ☐ WITHOUT MED. CERTIF., EMERGENCY
- ☐ COURT ORDER, JUDICIAL PROCEDURE
- ☐ OTHER (*Specify*)

20. ADMISSION STATUS
- ☐ FIRST ADMISSION
- ☐ READMISSION
- ☐ TRANSFER IN

21. RECORD OF PREVIOUS HOSPITALIZATIONS FOR MENTAL DISORDER

INSTITUTION (*Include public and private mental hospitals and general hospitals with psychiatric wards*)	DATES OF ADMISSION	DATES OF DISCHARGE

22. DIAGNOSIS OF MENTAL DISORDER (*Include severity*)

DATE	DIAGNOSIS

23. DATE OF DISCHARGE

24. AGE AT DISCHARGE

25. DISCHARGED FROM
- ☐ HOSPITAL
- ☐ TRIAL VISIT
- ☐ FAMILY CARE
- ☐ TEMP. VISIT
- ☐ ESCAPE
- ☐ OTHER

27. TRANSFERRED TO DATE

26. OUTCOME
- ☐ RECOVERED
- ☐ IMPROVED
- ☐ UNIMPROVED
- ☐ DEAD
- ☐ WITHOUT MENTAL DISORDER

FIG. 1. Statistical card for use in hospitals for mental illness (front)

28. RECORD OF CHANGES OF STATUS *(Enter date patient is placed on and returned from trial visit, family care, temporary visit, escape, etc.*

TYPE OF LEAVE	DATE OUT	DATE OF RETURN	DAYS ABSENT

29. LENGTH OF HOSPITALIZATION FOR THIS ADMISSION

	YRS.	MOS.	DAYS
(a) TIME ON BOOKS			
(b) TIME ABSENT *(Except on temporary visit)*			
NET LENGTH OF RESIDENCE *(a minus b)*			

30. DEGREE OF IMPAIRMENT *(Enter dates at which evaluations are made and check appropriate column. Minimum evaluation dates are date of admission and date of discharge)*

DATE	IMPAIRMENT				
	NONE	MINIMAL	MILD	MODERATE	SEVERE

31. CAUSES OF DEATH *(As recorded on death certificate)*

INTERVAL BETWEEN ONSET AND DEATH

a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH _____

ANTECEDENT CAUSES DUE TO

b. _____

c. _____

d. OTHER SIGNIFICANT CONDITIONS

FIG. 1. (Cont'd.) Statistical card for use in hospitals for mental illness (back)

(c) Patients on Extramural Care (trial visit plus family care) at End of Year:

1. By mental disorder, sex, race and age at the end of year (table 10)
2. By mental disorder, sex, race and time on books (table 11)

(3) Data that tell what happens to a cohort of patients admitted in a specific year, i.e., follow-up data on a group of annual admissions to determine how many of the first admissions of 1948, for example, were in the hospital, discharged, on trial visit, in family care or otherwise absent or dead twelve months following their date of admission, by such factors as mental disorder, sex, and race (table 12).

Additional tables can be prepared that may be useful for administrative and other purposes within a State hospital system. For example:

(a) Resident population as of end of year by county of residence at time of admission, and sex with corresponding rates per 100,000 population
(b) Annual first admissions and readmissions to State mental hospitals by county of residence and sex with corresponding rates per 100,000 population
(c) Overcrowding: Excess of average daily resident patients over rated capacity of hospital
(d) Administrative staff, full-time, by occupation and ratio of patients to various occupational categories as for example, physicians, nurses, attendants and social workers.

Actual examples of tabulations such as those mentioned above may be obtained by writing to the State Mental Hospital Authority in the list of States in Appendix D for copies of their annual reports or to the Biometrics Branch, National Institute of Mental Health of the Public Health Service.

The annual reports of New York, New Jersey, Virginia and California and the monthly bulletin of the Ohio Department of Public Welfare are particularly useful in this respect.[5] Mention should also be made of the annual Census of Patients in Mental Institutions, issued by the National

[5] The Ohio Bulletin for the months of May 1947, May 1948 and May 1949, and a paper in the American Journal of Psychiatry, Vol. 104, No. 9, March 1948, "New Facts on Prognosis in Mental Disease," by Robert H. Israel, M. D. and Nelson A. Johnson, B. A., contain good examples of tabulations that show the status of a group of annual admissions on the anniversary of their admission.

Institute of Mental Health, Public Health Service. This volume includes the following data for each State and for the United States:

1. Movement of population by sex
2. First admissions by sex, age and mental disorder
3. Discharges by sex, mental disorder and condition on discharge
4. Administrative staff as of end of year
5. Expenditures by purpose.

Copies of the Census and of Mental Health Statistics—Current Reports, a series of special studies on mental hospital data and other pertinent subjects may be obtained from the National Institute of Mental Health, Public Health Service, Bethesda 14, Maryland.

Outpatient Psychiatric Clinics

Relatively little has been done in the development of statistical reporting and record systems in outpatient psychiatric clinics. Several States have instituted reporting systems, in particular, California, New York, Ohio, Michigan, New Jersey and Virginia. Copies of record forms and operating manuals may be obtained by writing to the Mental Hospital Authority in each of these States (Appendix D). In the interim, operational information will be collected by the Biometrics Branch, National Institute of Mental Health, and may be obtained, as it becomes available, by letter to that agency.

It is anticipated that in the next few years more work will be done in the development of this important area of psychiatric statistics. As additional data become available they will be collected for publication in future manuals.

B. SUGGESTED TABULATIONS

Definitions of Terms in Movement Table

First Admission: A patient admitted for the first time to any hospital for the treatment of mental disease, except institutions for temporary care only.

Readmission: A patient admitted who has previously been under treatment in a hospital for mental disease, excepting transfers and those who have been hospitalized only in institutions for temporary care.

Transfer: A patient brought directly from one hospital to another without a break in custody and without being formally discharged from the first hospital and formally admitted by the second.

Trial visit (conditional discharge, convalescent status, convalescent care,

indefinite leave): 'Status of patients absent from the hospital but still on the books or in its custody. This is a type of care for patients, usually in their homes, in which the ability of the patient to adjust to normal community life is tested. He might be returned to the hospital at any time before discharge for his own protection or that of the community.

Family Care: Status of patients who have been placed in the community in private families other than their own, under State supervision. The expense of maintenance may be borne by the State, the patient's estate, relatives, Old Age Assistance or some other person or agency.

Temporary Visit (leave of absence): Status of patients temporarily absent from the hospital for short periods of time with the understanding that the patient will return to the hospital within a specified time.

Otherwise Absent: Status of patients leaving the hospital without permission (escape or elopement) or remaining away without leave and who are not discharged from the hospital books.

Discharge: Status of patients removed from the hospital books (except by death).

Death: Patients who die while on the hospital books.

TABLE I

Hospital for Mental Disease

Movement of Patient Population by Sex [1]

Report for Year Ending _____ (Month) _____ (Day) _____ (Year)

	Total	Male	Female
A. Total Population			
1. On books beginning of year (total)			
In hospital			
On trial visit			
In family care			
On temporary visit			
Otherwise absent			
2. Admissions during year (total)			
First admissions			
Readmissions			
Transfers from other hospitals for mental disease			
3. Separations during year (total)			
Discharges direct from hospital			
Discharges while on trial visit			
Discharges from family care			
Discharges from temporary visit			
Discharges while otherwise absent			
Deaths in hospital			
Deaths on trial visit			
Deaths in family care			
Deaths on temporary visit			
Deaths while otherwise absent			
Transfers to other hospitals for mental disease			
4. On books end of year (total)			
In hospital			
On trial visit			
In family care			
On temporary visit			
Otherwise absent			
B. Population on Leave (trial visit, family care, on temporary visit, or otherwise absent)			
1. On leave beginning of year (total)			
On trial visit			
In family care			
On temporary visit			
Otherwise absent			
2. Placed on leave from hospital during year (total)			
To trial visit			
To family care			
To temporary visit			
To otherwise absent			
3. Returns to hospital from leave during year (total)			
From trial visit			
From family care			
From temporary visit			
From otherwise absent			
4. Separations from leave by discharge, death or transfer during year (total)			
From trial visit			
From family care			
From temporary visit			
From otherwise absent			
5. On leave end of year (total)			
On trial visit			
In family care			
On temporary visit			
Otherwise absent			

[1] Similar tabulations should be made by race.

TABLE 2

Hospital for Mental Disease

FIRST ADMISSIONS [1] DURING THE YEAR BY AGE AT ADMISSION AND MENTAL DISORDER: WHITE — MALE [2]

Report for Year Ending _____ (Month) (Day) (Year)

Mental disorder [3]	Total	Age (in years)																
		Under 15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85 and over	Age unknown
I Acute Brain Syndromes.....																		
— —																		
— —																		
II Chronic Brain Syndromes with psychotic reaction																		
— —																		
— —																		
III Chronic Brain Syndromes with neurotic reaction																		
— —																		
— —																		
Etc.[3]																		

[1] Similar tabulations should be made for readmissions.
[2] Similar tabulations should be made for white females and for non-white males and females.
[3] The statistical classification of mental disorder is given in detail in Section V.

TABLE 3

HOSPITAL FOR MENTAL DISEASE

ALL DISCHARGES [1]
FIRST ADMISSIONS [2] BY AGE AT DISCHARGE AND MENTAL DISORDER:
WHITE — MALE [3]

Report for Year Ending _____
(Month) (Day) (Year)

MENTAL DISORDER [4]	Total	AGE (in years)																
		Under 15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85 and over	Age unknown
I Acute Brain Syndromes.....																		
— —																		
— —																		
— —																		
II Chronic Brain Syndromes with psychotic reaction																		
— —																		
— —																		
— —																		
III Chronic Brain Syndromes with neurotic reaction																		
— —																		
— —																		
Etc.[4]																		

[1] Include all first admissions discharged from the books of the hospital.
[2] Similar tabulations should be made for readmissions.
[3] Similar tabulations should be made for white females and for non-white males and females.
[4] The statistical classification of mental disorder is given in detail in Section V.

TABLE 4

Hospital for Mental Disease

ALL DISCHARGES [1]
FIRST ADMISSIONS [2] BY NET LENGTH OF TIME [3] IN HOSPITAL AND MENTAL DISORDER:
WHITE — MALE [4]

Report for Year Ending _____ (Month) _____ (Day) _____ (Year)

Mental disorder [5]	Total	Net length of time in hospital for this admission												
		Under 3 mos.	3-5 mos.	6-11 mos.	1 year	2 years	3 years	4 years	5-9 years	10-14 years	15-19 years	20-24 years	25-29 years	30 years and over
I Acute Brain Syndromes.....														
——														
——														
——														
II Chronic Brain Syndromes with psychotic reaction														
——														
——														
——														
III Chronic Brain Syndromes with neurotic reaction														
——														
——														
Etc.[5]														

[1] Include all first admissions discharged from the books of the hospital.
[2] Similar tabulations should be made for readmissions.
[3] Net length of time is total time on books for this admission minus time on trial visit or otherwise absent, that is, on escape or away without leave.
[4] Similar tabulations should be made for white females and for non-white males and females.
[5] The statistical classification of mental disorder is given in detail in Section V.

TABLE 5

Hospital for Mental Disease

ALL DISCHARGES [1] BY CONDITION ON DISCHARGE AND MENTAL DISORDER:
WHITE — MALE [2]

Report for Year Ending _____
(Month) (Day) (Year)

Mental disorder [3]	Total	Condition on discharge			
		Recovered	Improved	Unimproved	Unclassified
I Acute Brain Syndromes.....					
— —					
— —					
— —					
II Chronic Brain Syndromes with psychotic reaction					
— —					
— —					
— —					
III Chronic Brain Syndromes with neurotic reaction					
— —					
— —					
Etc.[3]					

[1] Include all patients discharged from the books of the hospital.
[2] Similar tables should be made for white females and for non-white males and females.
[3] The statistical classification of mental disorder is given in detail in Section V.

TABLE 6

Hospital for Mental Disease

ALL DEATHS,[1] FIRST ADMISSIONS [2] BY AGE AT DEATH AND MENTAL DISORDER:
WHITE — MALE [3]

Report for Year Ending _____ (Month) _____ (Day) _____ (Year)

Mental disorder [4]	Total	Age (in years)																
		Under 15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85 and over	Age unknown
I Acute Brain Syndromes.....																		
——																		
——																		
——																		
II Chronic Brain Syndromes with psychotic reaction																		
——																		
——																		
——																		
III Chronic Brain Syndromes with neurotic reaction																		
——																		
——																		
Etc.[4]																		

[1] Include all deaths occurring among first admissions while on the books of the hospital.
[2] Similar tabulations should be made for readmissions.
[3] Similar tabulations should be made for white females and for non-white males and females.
[4] The statistical classification of mental disorder is given in detail in Section V.

TABLE 7

Hospital for Mental Disease

ALL DEATHS,[1] FIRST ADMISSIONS [2] BY NET LENGTH OF TIME [3] IN HOSPITAL AND MENTAL DISORDER: WHITE — MALE [4]

Report for Year Ending _____ (Month) (Day) (Year)

Mental disorder [5]	Total	Net length of time in hospital for this admission												
		Under 3 mos.	3-5 mos.	6-11 mos.	1 year	2 years	3 years	4 years	5-9 years	10-14 years	15-19 years	20-24 years	25-29 years	30 years and over
I Acute Brain Syndromes.....														
— —														
— —														
— —														
II Chronic Brain Syndromes with psychotic reaction														
— —														
— —														
— —														
III Chronic Brain Syndromes with neurotic reaction														
— —														
— —														
Etc.[5]														

[1] Include all deaths occurring among first admissions while on the books of the hospital.
[2] Similar tabulations should be made for readmissions.
[3] Net length of time is total time on books for this admission minus time on trial visit or otherwise absent, that is, on escape or away without leave.
[4] Similar tabulations should be made for white females and for non-white males and females.
[5] The statistical classification of mental disorder is given in detail in Section V.

TABLE 8

Hospital for Mental Disease

RESIDENT PATIENTS [1] AT END OF YEAR BY AGE AT END OF YEAR AND MENTAL DISORDER:
WHITE — MALE [2]

Report for Year Ending _____
(Month) (Day) (Year)

Mental disorder [3]	Total	Age (in years)																
		Under 15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85 and over	Age unknown
I Acute Brain Syndromes.....																		
— —																		
— —																		
— —																		
II Chronic Brain Syndromes with psychotic reaction																		
— —																		
— —																		
— —																		
II Chronic Brain Syndromes with neurotic reaction																		
— —																		
— —																		
Etc.[3]																		

[1] Tabulations should be made separately for first admissions and for readmissions. Patients on temporary visit are considered as in residence.
[2] Similar tabulations should be made for white females and for non-white males and females.
[3] The statistical classification of mental disorder is given in detail in Section V.

TABLE 9

Hospital for Mental Disease

RESIDENT PATIENTS [1] AT END OF YEAR BY TIME ON BOOKS [2] AND MENTAL DISORDER:
WHITE — MALE [3]

Report for Year Ending _____
(Month) (Day) (Year)

Mental disorder [4]	Total	Time on books												
		Under 3 mos.	3-5 mos.	6-11 mos.	1 year	2 years	3 years	4 years	5-9 years	10-14 years	15-19 years	20-24 years	25-29 years	30 years and over
I Acute Brain Syndromes.....														
— —														
— —														
— —														
II Chronic Brain Syndromes with psychotic reaction														
— —														
— —														
— —														
III Chronic Brain Syndromes with neurotic reaction														
— —														
— —														
Etc.[4]														

[1] Tabulations should be made separately for first admissions and for readmissions. Patients on temporary visit are considered as in residence.
[2] Time on books is interval between date of admission for this admission and last day of year covered by this report.
[3] Similar tabulations should be made separately for females and for non-white patients.
[4] The statistical classification of mental disorder is given in detail in Section V.

TABLE 10

Hospital for Mental Disease

PATIENTS IN EXTRAMURAL CARE [1] AT END OF YEAR
BY AGE AT END OF YEAR AND MENTAL DISORDER:
WHITE — MALE [2]

Report for Year Ending _____
(Month) (Day) (Year)

Mental disorder [3]	Total	Age (in years)																
		Under 15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85 and over	Age unknown
I Acute Brain Syndromes.....																		
— —																		
— —																		
— —																		
II Chronic Brain Syndromes with psychotic reaction																		
— —																		
— —																		
— —																		
III Chronic Brain Syndromes with neurotic reaction																		
— —																		
— —																		
Etc.[3]																		

[1] Tabulations should be made separately for first admissions and for readmissions. Patients in extramural care are patients on trial visit and those in family care.
[2] Similar tabulations should be made for white females and for non-white males and females.
[3] The statistical classification of mental disorder is given in detail in Section V.

TABLE 11

Hospital for Mental Disease

PATIENTS IN EXTRAMURAL CARE [1] AT END OF YEAR
BY TIME ON BOOKS [2] AND MENTAL DISORDER:
WHITE — MALE [3]

Report for Year Ending _____
(Month) (Day) (Year)

Mental disorder [4]	Total	Time on books												
		Under 3 mos.	3-5 mos.	6-11 mos.	1 year	2 years	3 years	4 years	5-9 years	10-14 years	15-19 years	20-24 years	25-29 years	30 years and over
I Acute Brain Syndromes.....														
— —														
— —														
— —														
II Chronic Brain Syndromes with psychotic reaction														
— —														
— —														
— —														
III Chronic Brain Syndromes with neurotic reaction														
— —														
— —														
Etc.[4]														

[1] Tabulations should be made separately for first admissions and for readmissions. Patients in extramural care are patients on trial visit and those in family care.
[2] Time on books is interval between date of admission for this admission and last day of year covered by this report.
[3] Similar tabulations should be made separately for white females and for non-white males and females.
[4] The statistical classification of mental disorder is given in detail in Section V.

TABLE 12

HOSPITAL FOR MENTAL DISEASE

DISPOSITION [1] OF FIRST ADMISSIONS WITHIN THE TWELVE MONTH PERIOD FOLLOWING ADMISSION BY MENTAL DISORDER:
WHITE — MALE [2]

Report for Admissions during Year Ending _____ (Month) _____ (Day) _____ (Year)

MENTAL DISORDER [3]	Total first admissions	Resident in hospital [3]	DISPOSITION					
			OUT OF HOSPITAL					
			Discharges [4]	On trial visit	In family care	Otherwise absent [5]	Deaths [6]	Transfers out [7]
I Acute Brain Syndromes.....								
— —								
— —								
— —								
II Chronic Brain Syndromes with psychotic reaction								
— —								
— —								
— —								
III Chronic Brain Syndromes with neurotic reaction								
— —								
— —								
Etc.[8]								

[1] All first admissions occurring during a given year are considered a cohort. Each person in the cohort is traced for a year. The disposition of each individual patient as of the end of 12 months following admission to the State hospital system is recorded.
[2] Similar tabulations should be made separately for white females and for non-white males and females.
[3] Include first admissions resident in the hospital at the end of the 12 month period following admission. Patients on temporary visit are considered as in residence.
[4] Include only first admissions discharged from the books of the hospital within the 12 month period following admission.
[5] Include first admissions who at the end of the 12 month period following admission are on escape, elopement, or out of the hospital against advice or authorization and who are not discharged from the hospital books.
[6] Include only first admissions who died while on the books of the hospital within the 12 month period following admission.
[7] Include patients who are transferred from one hospital for mental disease to another without a break in custody, that is, without a formal discharge from the first hospital or a formal admission to the second.
[8] The statistical classification of mental disorder is given in detail in Section V.

SECTION V

STATISTICAL CLASSIFICATION OF MENTAL DISORDER

As discussed in Appendix A, the International Statistical Classification,[1] 1948 revision, has been used to convert the entire Standard Nomenclature into a form suitable for statistical purposes. However, certain problems were encountered in making Section V of the International Classification, which deals with mental, psychoneurotic and personality disorders, conform to the concepts of the Psychobiological Unit of the Standard Nomenclature. For example, the International Classification provides for the coding of Chronic Brain Syndromes with psychotic reaction associated with various diseases and conditions in terms of psychoses of demonstrable etiology under titles 304–308.2 and in titles 020.1, 025, 083.2 and 688.1. It does not provide for coding Chronic Brain Syndrome associated with any disease or condition with neurotic reaction, behavioral reaction or without qualifying phrase except in title 083.1—postencephalitic, personality and character disorders. Nor does it provide for coding acute brain syndrome within the group of psychotic conditions, except alcoholic delirium (included in 307) and exhaustion delirium (included in 309).

In the process of converting the above terms and certain others in the section dealing with Diseases of the Psychobiological Unit to the International equivalent codes, certain amendments and additional 4-digit subdivisions and three special 3-digit codes were set up for use with the Standard Nomenclature only. Since it was necessary to stay within the basic framework of the International Classification, certain limitations were imposed upon the number of additions that could be made. As a result of these limitations, the International Statistical Classification contains some categories which may be too inclusive for adequate tabulation of diagnostic data, especially with respect to diagnostic distribution of patients under treatment in mental hospitals. For example, the categories 307, 308.1 and 308.5 in the International Statistical Classification include the following diagnoses:

307. Alcoholic Psychosis, includes
   (a) Acute Brain Syndrome associated with alcohol intoxication
   (b) Chronic Brain Syndrome associated with alcohol intoxication with psychotic reaction.

[1] Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death, Vols. I and II, World Health Organization, Geneva, Switzerland, 1948. This may be obtained from Columbia University Press, International Documents Service, 2960 Broadway, New York 27, N. Y.

308.1 Psychosis of other demonstrable etiology resulting from epilepsy and other convulsive disorders: includes
(a) Acute Brain Syndrome with convulsive disorder
(b) Chronic Brain Syndrome with convulsive disorder with psychotic reaction.

308.5 Acute Brain Syndrome associated with other causes not elsewhere classified includes
Acute Brain Syndrome associated with:
(a) Intracranial infection, except encephalitis
(b) Drug or poison intoxication, except alcohol
(c) Metabolic disturbance
(d) Diseases of unknown or uncertain cause.

In order to provide mental hospitals with a scheme that permits detailed tabulation of diagnostic data as well as easy contraction of the detailed classification into summary form, a code suitable for machine tabulation has been devised for the titles in the Psychobiological Unit of the Standard Nomenclature. This is presented in detail at the end of this section. The inclusions for each category are cross-referenced with the appropriate International List and Standard Nomenclature numbers. This code consists of four digits in which the first represents the broad class of mental disorder; the second, major categories within each of these broad classes; the third, subdivisions within major categories; and the fourth, qualifying phrases where applicable.

The new nomenclature is somewhat of a departure from that being used currently in mental hospitals. The use of the terms acute and chronic brain syndromes is new, as well as the use of the qualifying phrases, *with psychotic reaction, with neurotic reaction* and *with behavioral reaction.* In addition, the categories dealing with psychoneuroses, psychophysiologic autonomic and visceral disorders and personality disorders are considerably expanded over what was included in the 1934 Classification of Mental Disorders. Because of these differences between the 1934 Classification of Mental Disorders and the present one, it is desirable for hospitals to classify diagnoses by both codes for at least a year in order to determine what differences the new classification will effect in their historical statistical series dealing with admissions, discharges and resident patients by diagnosis.

Below is a scheme for presenting tabulations of mental disorder. The arrangement follows essentially the underlying subdivisions of the new nomenclature.

I. *Acute Brain Syndromes Associated With:*

Epidemic encephalitis
Other intracranial infections
Systemic infections
Alcohol intoxication
Drug or poison intoxication, except alcohol
Trauma
Circulatory disturbance
Convulsive disorder
Disturbance of metabolism, growth or nutrition
New growth
Other diseases and conditions, NEC (not elsewhere classified), or unspecified disease or condition

II. *Chronic Brain Syndromes With Psychotic Reaction, Associated With:*

Conditions and diseases due to prenatal influence
Central nervous system syphilis
Epidemic encephalitis
Other intracranial infections, except syphilis
Alcohol intoxication
Drug or poison intoxication, except alcohol
Birth trauma
Other trauma
Cerebral arteriosclerosis
Circulatory disturbance other than cerebral arteriosclerosis
Convulsive disorder
Senile brain disease
All other disturbance of metabolism, growth or nutrition
New growth
Other diseases and conditions, NEC, or unspecified disease or condition

III. *Chronic Brain Syndromes With Neurotic Reaction, Associated With:*

Conditions and diseases due to prenatal influence
Central nervous system syphilis
Epidemic encephalitis
Other intracranial infections, except syphilis

Alcohol intoxication
Drug or poison intoxication, except alcohol
Birth trauma
Other trauma
Cerebral arteriosclerosis
Circulatory disturbance other than cerebral arteriosclerosis
Convulsive disorder
Senile brain disease
All other disturbance of metabolism, growth or nutrition
New growth
Other diseases and conditions, NEC, or unspecified disease or condition

IV. *Chronic Brain Syndromes With Behavioral Reactions Associated With:*

Conditions and diseases due to prenatal influence
Central nervous system syphilis
Epidemic encephalitis
Other intracranial infections, except syphilis
Alcohol intoxication
Drug or poison intoxication, except alcohol
Birth trauma
Other trauma
Cerebral arteriosclerosis
Circulatory disturbance other than cerebral arteriosclerosis
Convulsive disorder
Senile brain disease
All other disturbance of metabolism, growth or nutrition
New growth
Other diseases and conditions, NEC, or unspecified disease or condition

V. *Chronic Brain Syndrome Without Qualifying Phrase Associated With:*

Conditions and diseases due to prenatal influence
Central nervous system syphilis
Epidemic encephalitis
Other intracranial infections, except syphilis
Alcohol intoxication
Drug or poison intoxication, except alcohol

Birth trauma
Other trauma
Cerebral arteriosclerosis
Circulatory disturbance other than cerebral arteriosclerosis
Convulsive disorder
Senile brain disease
All other disturbance of metabolism, growth or nutrition
New growth
Other diseases and conditions, NEC, or unspecified disease or condition

VI. *Psychotic Disorders*

Involutional psychotic reaction
Affective reactions
Schizophrenic reactions
Paranoid reactions
Psychotic reactions without clearly defined structural change other than above

VII. *Psychophysiologic Autonomic and Visceral Disorders*

VIII. *Psychoneurotic Disorders*

IX. *Personality Disorders*

Alcoholism (addiction)
Drug addiction
All other personality disorders

X. *Transient Situational Personality Disorder.*

XI. *Mental Deficiency*

TABULATING SCHEME BASED ON STRUCTURE OF NEW NOMENCLATURE WITH CORRESPONDING STANDARD NOMENCLATURE AND INTERNATIONAL LIST NUMBERS

Code No.[1]	Disorder	Standard Nomenclature	Int'l List Nos.
01–09	ACUTE BRAIN DISORDERS		
01	ACUTE BRAIN SYNDROME ASSOCIATED WITH INFECTION		
	01.0 Intracranial infection, except epidemic encephalitis	009–100	308.5 (pt [2])
	01.1 Epidemic encephalitis	009–163	083.2 (pt)
	01.2 With systemic infection, NEC	000–100	308.3
02	ACUTE BRAIN SYNDROME ASSOCIATED WITH INTOXICATION		
	02.1 Alcohol intoxication	000–3312	307 (pt)
	02.2 Drug or poison intoxication (except alcohol)	000–3..	308.5 (pt)
03	ACUTE BRAIN SYNDROME ASSOCIATED WITH TRAUMA	000–4..	308.2
04	ACUTE BRAIN SYNDROME ASSOCIATED WITH CIRCULATORY DISTURBANCE	000–5..	308.4
05	ACUTE BRAIN SYNDROME ASSOCIATED WITH CONVULSIVE DISORDER	000–550	308.1 (pt)
06	ACUTE BRAIN SYNDROME ASSOCIATED WITH METABOLIC DISTURBANCE	000–7..	308.5 (pt)

[1] This code consists of four digits in which the first represents the broad class of mental disorder; the second, major categories within each of these broad classes; the third, subdvisions within these major categories; and the fourth, qualifying phrases where applicable. Where no subdivision exists within a major category the third digit should be punched with an "X" punch. Where no qualifying phrase is applicable the fourth digit should also be punched with an "X" punch, except in the Chronic Brain Syndromes where diagnoses without qualifying phrase are coded "0" in the fourth digit.

[2] The abbreviation "pt" following an International List Number means that the Standard Nomenclature title is only one part of the titles included under the indicated International List Number. For example, International List No. 308.5 Acute Brain Syndrome Associated with Other Causes Not Elsewhere Classified includes the following Standard Nomenclature titles:

Acute Brain Syndrome associated with:

(a) Intracranial infection, except encephalitis
(b) Drug or poison intoxication, except alcohol
(c) Metabolic disturbance
(d) Diseases of unknown or uncertain cause.

Code No.	Disorder	Standard Nomenclature	Int'l List Nos.
07	ACUTE BRAIN SYNDROME ASSOCIATED WITH INTRACRANIAL NEOPLASM	000–8..	308.0
08	ACUTE BRAIN SYNDROME WITH DISEASE OF UNKNOWN OR UNCERTAIN CAUSE	000–900	308.5 (pt)
09	ACUTE BRAIN SYNDROME OF UNKNOWN CAUSE	000–xx0	309.1 (pt)
10–19	CHRONIC BRAIN DISORDERS		
10	CHRONIC BRAIN SYNDROME ASSOCIATED WITH DISEASES AND CONDITIONS DUE TO PRENATAL (CONSTITUTIONAL) INFLUENCE		
	10.0 With congenital cranial anomaly		
	10.00 Without qualifying phrase	009–0..	328.0 (pt)
	10.01 With psychotic reaction	009–0...x1	308.8 (pt)
	10.02 With neurotic reaction	009–0...x2	319.0 (pt)
	10.03 With behavioral reaction	009–0...x3	327.0 (pt)
	10.1 With congenital spastic paraplegia		
	10.10 Without qualifying phrase	009–016	328.0 (pt)
	10.11 With psychotic reaction	009–016.x1	308.8 (pt)
	10.12 With neurotic reaction	009–016.x2	319.0 (pt)
	10.13 With behavioral reaction	009–016.x3	327.0 (pt)
	10.2 With mongolism		
	10.20 Without qualifying phrase	009–071	328.0 (pt)
	10.21 With psychotic reaction	009–071.x1	308.8 (pt)
	10.22 With neurotic reaction	009–071.x2	319.0 (pt)
	10.23 With behavioral reaction	009–071.x3	327.0 (pt)
	10.3 Due to prenatal maternal infectious diseases		
	10.30 Without qualifying phrase	009–052	328.0 (pt)
	10.31 With psychotic reaction	009–052.x1	308.8 (pt)
	10.32 With neurotic reaction	009–052.x2	319.0 (pt)
	10.33 With behavioral reaction	009–052.x3	327.0 (pt)
11	CHRONIC BRAIN SYNDROME ASSOCIATED WITH CENTRAL NERVOUS SYSTEM SYPHILIS		
	11.0 Meningoencephalitic		
	11.00 Without qualifying phrase	009–147.0	025.9
	11.01 With psychotic reaction	009–147.0.x1	025.6
	11.02 With neurotic reaction	009–147.0.x2	025.7
	11.03 With behavioral reaction	009–147.0.x3	025.8
	11.1 Meningovascular		
	11.10 Without qualifying phrase	004–147.0	026.9 (pt)
	11.11 With psychotic reaction	004–147.0.x1	026.6 (pt)

Code No.	Disorder	Standard Nomenclature	Int'l List Nos.
11.12	With neurotic reaction	004–147.0.x2	026.7 (pt)
11.13	With behavioral reaction	004–147.0.x3	026.8 (pt)
11.2	Other central nervous system syphilis		
11.20	Without qualifying phrase	0y0–147.0	026.9 (pt)
11.21	With psychotic reaction	0y0–147.0.x1	026.6 (pt)
11.22	With neurotic reaction	0y0–147.0.x2	026.7 (pt)
11.23	With behavioral reaction	0y0–147.0.x3	026.8 (pt)
12	CHRONIC BRAIN SYNDROME ASSOCIATED WITH INTRACRANIAL INFECTION OTHER THAN SYPHILIS		
12.0	Epidemic encephalitis		
12.00	Without qualifying phrase	009–163.0	083.9
12.01	With psychotic reaction	009–163.0.x1	083.2 (pt)
12.02	With neurotic reaction	009–163.0.x2	083.7
12.03	With behavioral reaction	009–163.0.x3	083.1
12.1	Other intracranial infections		
12.10	Without qualifying phrase	009–1...0	328.1
12.11	With psychotic reaction	009–1...0.x1	308.9 (pt)
12.12	With neurotic reaction	009–1...0.x2	319.1
12.13	With behavioral reaction	009–1...0.x3	327.1
13	CHRONIC BRAIN SYNDROME ASSOCIATED WITH INTOXICATION		
13.0	Alcohol intoxication		
13.00	Without qualifying phrase	009–3312	322.9
13.01	With psychotic reaction	009–3312.x1	307 (pt)
13.02	With neurotic reaction	009–3312.x2	322.7
13.03	With behavioral reaction	009–3312.x3	322.8
13.1	Drug or poison intoxication, except alcohol		
13.10	Without qualifying phrase	009–3..	328.2
13.11	With psychotic reaction	009–3...x1	308.6
13.12	With neurotic reaction	009–3...x2	319.2
13.13	With behavioral reaction	009–3...x3	327.2
14	CHRONIC BRAIN SYNDROME ASSOCIATED WITH TRAUMA		
14.0	Birth trauma		
14.00	Without qualifying phrase	009–050	328.3
14.01	With psychotic reaction	009–050.x1	308.8 (pt)
14.02	With neurotic reaction	009–050.x2	319.3
14.03	With behavioral reaction	009–050.x3	327.3

Code No.	Disorder	Standard Nomenclature	Int'l List Nos.
14.1	Brain trauma, gross force		
14.10	Without qualifying phrase	009–4..	328.4 (pt)
14.11	With psychotic reaction	009–4...x1	308.7 (pt)
14.12	With neurotic reaction	009–4...x2	319.4 (pt)
14.13	With behavioral reaction	009–4...x3	327.4 (pt)
14.2	Following brain operation		
14.20	Without qualifying phrase	009–415	328.4 (pt)
14.21	With psychotic reaction	009–415.x1	308.7 (pt)
14.22	With neurotic reaction	009–415.x2	319.4 (pt)
14.23	With behavioral reaction	009–415.x3	327.4 (pt)
14.3	Following electrical brain trauma		
14.30	Without qualifying phrase	009–462	328.4 (pt)
14.31	With psychotic reaction	009–462.x1	308.7 (pt)
14.32	With neurotic reaction	009–462.x2	319.4 (pt)
14.33	With behavioral reaction	009–462.x3	327.4 (pt)
14.4	Following irradiational brain trauma		
14.40	Without qualifying phrase	009–470	328.4 (pt)
14.41	With psychotic reaction	009–470.x1	308.7 (pt)
14.42	With neurotic reaction	009–470.x2	319.4 (pt)
14.43	With behavioral reaction	009–470.x3	327.4 (pt)
14.5	Following other trauma		
14.50	Without qualifying phrase	009–400	328.4 (pt)
14.51	With psychotic reaction	009–400.x1	308.7 (pt)
14.52	With neurotic reaction	009–400.x2	319.4 (pt)
14.53	With behavioral reaction	009–400.x3	327.4 (pt)
15	CHRONIC BRAIN SYNDROME ASSOCIATED WITH CIRCULATORY DISTURBANCE		
15.0	With cerebral arteriosclerosis		
15.00	Without qualifying phrase	009–516	328.5
15.01	With psychotic reaction	009–516.x1	306
15.02	With neurotic reaction	009–516.x2	319.5
15.03	With behavioral reaction	009–516.x3	327.5
15.1	With circulatory disturbance other than cerebral arteriosclerosis		
15.10	Without qualifying phrase	009–5..	328.6
15.11	With psychotic reaction	009–5...x1	308.9 (pt)
15.12	With neurotic reaction	009–5...x2	319.6
15.13	With behavioral reaction	009–5...x3	327.6
16	CHRONIC BRAIN SYNDROME ASSOCIATED WITH CONVULSIVE DISORDER		
16.00	Without qualifying phrase	009–550	353.9
16.01	With psychotic reaction	009–550.x1	308.1 (pt)

Code No.	Disorder	Standard Nomenclature	Int'l List Nos.
	16.02 With neurotic reaction	009–550.x2	353.7
	16.03 With behavioral reaction	009–550.x3	353.8
17	CHRONIC BRAIN SYNDROME ASSOCIATED WITH DISTURBANCE OF METABOLISM, GROWTH OR NUTRITION		
	17.1 With senile brain disease		
	17.10 Without qualifying phrase	009–79x	794.9
	17.11 With psychotic reaction	009–79x.x1	304
	17.12 With neurotic reaction	009–79x.x2	794.7
	17.13 With behavioral reaction	009–79x.x3	794.8
	17.2 Presenile brain disease		
	17.20 Without qualifying phrase	009–700	328.7
	17.21 With psychotic reaction	009–700.x1	305 (pt)
	17.22 With neurotic reaction	009–700.x2	319.7
	17.23 With behavioral reaction	009–700.x3	327.7
	17.3 With other disturbance of metabolism, etc., except presenile brain disease		
	17.30 Without qualifying phrase	009–700	328.8
	17.31 With psychotic reaction	009–700.x1	308.9 (pt)
	17.32 With neurotic reaction	009–700.x2	319.8
	17.33 With behavioral reaction	009–700.x3	327.8
18	CHRONIC BRAIN SYNDROME ASSOCIATED WITH NEW GROWTH		
	18.0 With intracranial neoplasm		
	18.00 Without qualifying phrase	009–8..	328.9 (pt)
	18.01 With psychotic reaction	009–8...x1	308.0 (pt)
	18.02 With neurotic reaction	009–8...x2	319.9 (pt)
	18.03 With behavioral reaction	009–8...x3	327.9 (pt)
19	CHRONIC BRAIN SYNDROME ASSOCIATED WITH DISEASES OF UNKNOWN OR UNCERTAIN CAUSE; CHRONIC BRAIN SYNDROME OF UNKNOWN OR UNSPECIFIED CAUSE		
	19.0 Multiple sclerosis		
	19.00 Without qualifying phrase	009–900	328.9 (pt)
	19.01 With psychotic reaction	009–900.x1	308.9 (pt)
	19.02 With neurotic reaction	009–900.x2	319.9 (pt)
	19.03 With behavioral reaction	009–900.x3	327.9 (pt)
	19.1 Huntington's chorea		
	19.10 Without qualifying phrase	009–900	328.9 (pt)
	19.11 With psychotic reaction	009–900.x1	308.9 (pt)
	19.12 With neurotic reaction	009–900.x2	319.9 (pt)
	19.13 With neurotic reaction	009–900.x3	327.9 (pt)

Code No.	Disorder	Standard Nomenclature	Int'l List Nos.
19.2	Pick's disease		
19.20	Without qualifying phrase	009–900	328.9 (pt)
19.21	With psychotic reaction	009–900.x1	305 (pt)
19.22	With neurotic reaction	009–900.x2	319.9 (pt)
19.23	With behavioral reaction	009–900.x3	327.9 (pt)
19.3	Other diseases of unknown or uncertain cause		
19.30	Without qualifying phrase	009–900	328.9 (pt)
19.31	With psychotic reaction	009–900.x1	308.9 (pt)
19.32	With neurotic reaction	009–900.x2	319.9 (pt)
19.33	With behavioral reaction	009–900.x3	327.9 (pt)
19.4	Chronic brain syndrome of unknown or unspecified cause		
19.40	Without qualifying phrase	009–xx0	328.9 (pt)
19.41	With psychotic reaction	009–xx0.x1	309.1 (pt)
19.42	With neurotic reaction	009–xx0.x2	319.9 (pt)
19.43	With behavioral reaction	009–xx0.x3	327.9 (pt)
20–24	PSYCHOTIC DISORDERS		
20	INVOLUTIONAL PSYCHOTIC REACTION	000–796	302
21	AFFECTIVE REACTIONS	000–x10	301,309.0
21.0	Manic depressive reaction, manic type	000–x11	301.0
21.1	Manic depressive reaction, depressed type	000–x12	301.1
21.2	Manic depressive reaction, other	000–x13	301.2
21.3	Psychotic depressive reaction	000–x14	309.0
22	SCHIZOPHRENIC REACTIONS	000–x20	300
22.0	Schizophrenic reaction, simple type	000–x21	300.0
22.1	Schizophrenic reaction, hebephrenic type	000–x22	300.1
22.2	Schizophrenic reaction, catatonic type	000–x23	300.2
22.3	Schizophrenic reaction, paranoid type	000–x24	300.3
22.4	Schizophrenic reaction, acute undifferentiated type	000–x25	300.4
22.5	Schizophrenic reaction, chronic undifferentiated type	000–x26	300.7 (pt)
22.6	Schizophrenic reaction, schizo-affective type	000–x27	300.6
22.7	Schizophrenic reaction, childhood type	000–x28	300.8

Code No.	Disorder	Standard Nomenclature	Int'l List Nos.
22.8	Schizophrenic reaction, residual type	000–x29	300.5
22.9	Other and unspecified	000–x20	300.7 (pt)
23	PARANOID REACTIONS	000–x30	303
23.1	Paranoia	000–x31	303 (pt)
23.2	Paranoid state	000–x32	303 (pt)
24	PSYCHOTIC REACTION WITHOUT CLEARLY DEFINED STUCTURAL CHANGE OTHER THAN ABOVE	000–xy0	309.1 (pt)
30–39	PSYCHOPHYSIOLOGIC AUTONOMIC AND VISCERAL DISORDERS		
30	PSYCHOPHYSIOLOGIC SKIN REACTION	001–580	317.3
31	PSYCHOPHYSIOLOGIC MUSCULOSKELETAL REACTION	002–580	317.4
32	PSYCHOPHYSIOLOGIC RESPIRATORY REACTION	003–580	317.0
33	PSYCHOPHYSIOLOGIC CARDIOVASCULAR REACTION	004–580	315.2
34	PSYCHOPHYSIOLOGIC HEMIC AND LYMPHATIC REACTION	005–580	317.5 (pt)
35	PSYCHOPHYSIOLOGIC GASTROINTESTINAL REACTION	006–580	316.3
36	PSYCHOPHYSIOLOGIC GENITO-URINARY REACTION	007–580	317.1
37	PSYCHOPHYSIOLOGIC ENDOCRINE REACTION	008–580	317.5 (pt)
38	PSYCHOPHYSIOLOGIC NERVOUS SYSTEM REACTION	009–580	318.3 (pt)
39	PSYCHOPHYSIOLOGIC REACTION OF ORGANS OF SPECIAL SENSE	00x–580	317.5 (pt)
40	PSYCHONEUROTIC DISORDERS		
40	PSYCHONEUROTIC REACTIONS	000–x00	318.5
40.0	Anxiety reaction	000–x01	310
40.1	Dissociative reaction	000–x02	311 (pt)
40.2	Conversion reaction	000–x03	311 (pt)
40.3	Phobic reaction	000–x04	312

Code No.	Disorder	Standard Nomenclature	Int'l List Nos.
40.4	Obsessive compulsive reaction	000–x05	313
40.5	Depressive reaction	000–x06	314
40.6	Psychoneurotic reaction, other	000–x0y	318.5
50–53	**PERSONALITY DISORDERS**		
50	**PERSONALITY PATTERN DISTURBANCE**		
50.0	Inadequate personality	000–x41	320.3
50.1	Schizoid personality	000–x42	320.0
50.2	Cyclothymic personality	000–x43	320.2
50.3	Paranoid personality	000–x44	320.1
50.4	Personality pattern disturbance, other	000–x40	320.7
51	**PERSONALITY TRAIT DISTURBANCE**		
51.0	Emotionally unstable personality	000–x51	321.0
51.1	Passive-aggressive personality	000–x52	321.1
51.2	Compulsive personality	000–x53	321.5 (pt)
51.3	Personality trait disturbance, other	000–x5y	321.5 (pt)
52	**SOCIOPATHIC PERSONALITY DISTURBANCE**		
52.0	Antisocial reaction	000–x61	320.4
52.1	Dyssocial reaction	000–x62	320.5
52.2	Sexual deviation	000–x63	320.6
52.3	Alcoholism (addiction)	000–x641	322.1
52.4	Drug addiction	000–x642	323
53	**SPECIAL SYMPTOM REACTION**		
53.0	Learning disturbance	000–x71	326.0
53.1	Speech disturbance	000–x72	326.2
53.2	Enuresis	000–x73	321.3
53.3	Somnambulism	000–x74	321.4 (pt)
53.4	Other	000–x7y	321.4 (pt)
54	**TRANSIENT SITUATIONAL PERSONALITY DISORDERS**		
54	**TRANSIENT SITUATIONAL PERSONALITY DISTURBANCE**		
54.0	Gross stress reaction	000–x81	326.3
54.1	Adult situational reaction	000–x82	326.6
54.2	Adjustment reaction of infancy	000–x83	324.0
54.3	Adjustment reaction of childhood	000–x84	324.1
54.4	Adjustment reaction of adolescence	000–x85	324.2
54.5	Adjustment reaction of late life	000–x86	326.5
54.6	Other transient situational personality disturbance	000–x80	326.4

Code No.	Disorder	Standard Nomenclature	Int'l List Nos.
60–62	MENTAL DEFICIENCIES		
60	MENTAL DEFICIENCY (FAMILIAL OR HEREDITARY)		
60.0	Mild	000–x901	325.3 (pt)
60.1	Moderate	000–x902	325.2 (pt)
60.2	Severe	000–x903	325.1 (pt)
60.3	Severity not specified	000–x90	325.5 (pt)
61	MENTAL DEFICIENCY, IDIOPATHIC		
61.0	Mild	000–y901	325.3 (pt)
61.1	Moderate	000–y902	325.2 (pt)
61.2	Severe	000–y903	325.1 (pt)
61.3	Severity not specified	000–y90	325.5 (pt)

The following codes are to be used as the qualifying phrase x4 and will be coded as separate diagnoses. They represent mental deficiency by grades of severity, associated with and as the major symptom in impairment of brain tissue function.

62	MENTAL DEFICIENCY (x4)	
62.0	Severe	325.6 *
62.1	Moderate	325.7
62.2	Mild	325.8
62.3	Severity not specified	325.9

* If Mongolism is specified, code 325.4

APPENDIX A §

APPENDIX TO THE STANDARD NOMENCLATURE AND INTERNATIONAL STATISTICAL CLASSIFICATION [1]

The Appendix lists in numerical order the whole International Statistical Classification (numbers at left, in italics) together with the Standard numbers which are included in each International number. There are also included many notes and explanations designed to make it easier to find the correct equivalent International numbers for Standard terms listed in the body of the book.

The following items of general application are important but others throughout the International Statistical Classification as here listed are essential also.

Special Use of Asterisk

* An asterisk on any International number in the sections, Nomenclature of Diseases and Supplementary terms (pp. 85-505), and in Standard etiologic categories, 1, 2, and 3 (pp. 51-62) indicates that some further explanation is given about that International category in the Appendix.

Symbols and Abbreviations Used in the Appendix

† Indicates some further explanation about this category but it does not change the content or code number of any International category.

†† Indicates an additional 4th digit subdivision to an existing International 3-digit code number which should be earmarked as not part of the official International Classification in any publication of statistics based on this number. The same symbol is used to indicate the following 3-digit codes used in the same way and with the same publication practice: *319, 327,* and *328,* each of which has the same ten subdivisions, *.0–.9.*

** Indicates an International category for which there is no directly expressed Standard equivalent. It usually supplies additional detail as to site, type, etc., and is to be used if specified in the diagnosis.

NOS—not otherwise specified. Used when site, etiology, or other item which should be specified has been omitted.

NEC—not elsewhere classified. Used when the term is complete but the disease or injury can be classified in the International only in an indefinite category such as "all other" diseases of a given broad type. These abbreviations are used to avoid repetition of the longer phrases for which they stand.

Statistical Classification and Nomenclature

Classification is fundamental to the quantitative study of any phenomenon. It is recognized as the basis of all scientific generalization and is therefore an essential element in statistical methodology. Uniform definitions and uniform systems of classification are prerequisites in the advancement of scientific knowledge. In the study of illness and death, therefore, a standard classification of disease and injury for statistical purposes is essential.[2]

§ Reprinted from "Standard Nomenclature of Diseases and Operations," Fourth Edition, published for American Medical Association, The Blakistone Co., Philadelphia, 1952.

[1] "Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death," Adopted 1948: Volume 1, Tabular List with Inclusions; Volume 2, Alphabetical Index. World Health Organization, Geneva, Switzerland. Available in English, French, and Spanish. American agents for Manual: Public Health Conference on Records and Statistics, c/o National Office of Vital Statistics, Washington 25, D. C.; Pan American Sanitary Bureau, Washington 25, D. C.; Columbia University Press, International Documents Service, 2690 Broadway, New York 27, New York.

[2] From the Introduction (pp. xi-xiii) to the "Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death," Volume 1. World Health Organization, Geneva, Switzerland, 1948.

The purpose of a statistical classification is often confused with that of a nomenclature. Basically a medical nomenclature is a list or catalogue of approved terms for describing and recording clinical and pathological observations. To serve its full function, it should be extensive, so that any pathological condition can be accurately recorded. As medical science advances, a nomenclature must expand to include new terms necessary to record new observations. Any morbid condition that can be specifically described will need a specific designation in a nomenclature.[2]

This complete specificity of a nomenclature prevents it from serving satisfactorily as a statistical classification. When one speaks of statistics, it is at once inferred that the interest is in a group of cases and not in individual occurrences. The purpose of a statistical compilation of disease data is primarily to furnish quantitative data that will answer questions about groups of cases.[2]

A statistical classification of disease must be confined to a limited number of categories which will encompass the entire range of morbid conditions. The categories should be chosen so that they will facilitate the statistical study of disease phenomena. A specific disease entity should have a separate title in the classification only when its separation is warranted because the frequency of its occurrence, or its importance as a morbid condition, justifies its isolation as a separate category. On the other hand, many titles in the classification will refer to groups of separate but usually related morbid conditions. Every disease or morbid condition, however, must have a definite and appropriate place as an inclusion in one of the categories of the statistical classification. A few items of the statistical list will be residual titles for other and miscellaneous conditions which cannot be classified under the more specific titles. These miscellaneous categories should be kept to a minimum.[2]

The construction of a practical scheme of classification of disease and injury for general statistical use involves various compromises. Efforts to provide a statistical classification upon a strictly logical arrangement of morbid conditions have failed in the past. The various titles will represent a series of necessary compromises between classifications based on etiology, anatomical site, and circumstance of onset, as well as the quality of information available on medical reports. Adjustments must also be made to meet the varied requirements of vital statistics offices, hospitals of different types, medical services of the armed forces, social insurance organizations, sickness surveys, and numerous other agencies. While no single classification will fit the specialized needs for all these purposes, it should provide a common basis of classification for general statistical use.[2]

The above paragraphs are taken from the Introduction to the International Statistical Classification of Diseases, Injuries, and Causes of Death, 1948. That list represents the result of much thought and work on the part of many committees and subcommittees, and an assembly of representatives of various countries throughout the world. For the most part these representatives were skilled in statistical methods and the classification of diseases and causes of death for statistical purposes. The two-volume book includes not only a numerical listing of the disease and accident categories with a list of representative diseases and injuries included under each title, but an extensive alphabetical index of diseases and injuries with the proper code number attached.

Although this International Classification is not infrequently designated as a nomenclature, it is not and was not intended to serve as a nomenclature. The function of a nomenclature is to train the medical student and practicing physician to use the clearest and most acceptable diagnostic terms to describe a particular clinical case; the function of this coding manual is to aid a capable diagnosis coder or record librarian, with occasional medical advice, to assign the terms and disease names used by the attending

physician to the proper category in the list for the purpose of statistical tabulations. The better the nomenclature the more accurate will be the assignment of diagnoses for statistical purposes.[8]

The index to the International Classification includes both good and poor terminology because all diagnoses must be given a code number even when the assignment is to an ill-defined or completely unknown cause. It is designed to help a diagnosis coder after the physician has determined the diagnosis to his satisfaction and has recorded it in the proper hospital, clinic, or private records.

Conversion of Standard Numbers into International Classification Numbers

Some description of the details of the conversion process should be given. The corresponding International number appears in parentheses and in italics at the right of the Standard title. Usually there will be only one International number for a given Standard term, but occassionally there will be two International numbers, and for neoplasms a few categories have three such numbers. Obviously some footnotes of explanation are needed but to avoid confusion between notes pertaining to the Standard and those pertaining to the International Classification, all such explanations pertaining to International numbers appear in this Appendix (pp. 847-1034).

An asterisk on any number in the body of the Standard means to refer to that International number as it appears in the Appendix for notes and explanations that may affect the International number to be assigned. Probably the most frequent type of explanation refers to what may be designated as "open-end terms" where some item must be supplied by the attending physician before the term can be coded. Any such "open-end terms" can be given only a more or less ill-defined International number until the missing information is supplied. Reference to the International number in the Appendix supplies one or more other International numbers which may be appropriate and the one selected will depend upon the information supplied by the attending physician.

Uses for the Cross-Classification of Numbers in the Two Systems

The Standard Nomenclature is set up for use by physicians, specialists, and hospitals to secure standard and uniform terminology in the diagnosis of the diseases of individual patients. For that purpose it must be detailed and specific, because the attending physician must record the specific disease which he is treating and cannot be satisfied with knowing only the general or semispecific category of diseases of this kind.

The very specificity and detail of a nomenclature makes it cumbersome as a list of diseases for use in statistical tabulations. As already noted, statistical analysis deals with groups of patients rather than individual therapeutic problems. The clinician's problem is the individual patient but the problems of the epidemiologist and statistician are the "herd" or group, and in studying an outbreak of typhoid, influenza, typhus, or cholera, their problem is to find the source of the infection and its mode of spread so the epidemic can be stamped out. In this work they want data on groups of persons and they are more quickly summarized in the form of the International Statistical Classification. With the conversion of the detailed Standard Nomenclature into the shorter International Statistical Classification arranged especially for statistical purposes, one can have the advantages of careful and detailed individual diagnoses classified into useful categories for statistical analysis. Some hospitals and institutions are already converting their records of Standard diagnoses into the International Statistical Classi-

[8] In part from "Manual for Coding Causes of Illness," Miscellaneous Publication No. 32 of the U. S. Public Health Service. Government Printing Office, Washington, 1944.

fication for statistical analysis. This dual Standard Manual will make that job much easier, and for those hosptals which record diagnoses on punchcards, both the Standard and the International Statistical Classification numbers can be put on the same card for use of the data according to either classification.

As already noted, the International numbers with their titles are listed in numerical order in the Appendix. With each International number and title there is listed every Standard number to which that particular International number has been assigned. A single International code, such as *753.1*—"Other congenital malformations of the nervous system and sense organs," includes a considerable number of Standard diagnosis numbers. This situation arises because the Standard lists a different number and title for each specific diagnosis whether it occurs frequently or infrequently, whereas the International Statistical Classification puts many similar but infrequent diagnoses into one category.

V. MENTAL, PSYCHONEUROTIC, AND PERSONALITY DISORDERS

(†† For mental disorders classified elsewhere, *see* Titles 020, 025, 026, 083, 353, 688.1, and 794.)

The International Classification, 1948 Revision, provides for the coding of Chronic Brain Syndrome with psychotic reaction associated with various diseases and conditions in terms of Psychoses of Demonstrable Etiology, under titles *304–308.2*, and in titles *020.1, 025, 083.2,* and *688.1*. It does not provide for coding Chronic Brain Syndrome associated with any disease or condition with neurotic reaction, behavioral reaction, or without qualifying phrase, except in title *083.1*—postencephalitic personality and character disorders. Nor does it provide for coding Acute Brain Syndrome, or acute temporary recoverable mental disturbances, within the group of psychotic conditions, except alcoholic delirium (included in *307*) and exhaustion delirium (included in *309*).

Adjustments In The International Classification To Provide Equivalents For Standard Terms

In the process of converting the revised terminology in Section O—Diseases of the Psychobiological Unit—to the International equivalent codes, certain amendments and additional 4th digit subdivisions and three special 3-digit codes (*319, 327,* and *328*) have been set up, for use with the Standard Nomenclature only. Without these new subdivisions and codes it seemed impossible to maintain the concepts of the Psychobiological Unit of the Standard Nomenclature.

These codes (with ††), (p. 847) and any others which are in addition to or an expansion of the existing International codes, should always be indicated as being such in published tabulations making use of them. They are listed, also, in their numerical position throughout the appendix with the Standard code numbers to which they are equivalent.

Agencies who so desire may code also the physical conditions or diseases giving rise to the various types of mental reactions.

020.1 Juvenile neurosyphilis

Includes chronic brain syndrome with psychotic reaction due to juvenile neurosyphilis.

††*020.7 Chronic brain syndrome with neurotic reaction*	due to juvenile neurosyphilis
††*020.8 Chronic brain syndrome with behavioral reaction*	
††*020.9 Chronic brain syndrome NOS*	

††*025.0 General paralysis of insane, except as below*

††*025.6 Chronic brain syndrome with psychotic reaction*
††*025.7 Chronic brain syndrome with neurotic reaction*
††*025.8 Chronic brain syndrome with behavioral reaction*
††*025.9 Chronic brain syndrome NOS*
} due to syphilitic meningo-encephalitis

††*026.0 Other syphilis of central nervous system except as below*

††*026.6 Chronic brain syndrome with psychotic reaction*
††*026.7 Chronic brain syndrome with neurotic reaction*
††*026.8 Chronic brain syndrome with behavioral reaction*
††*026.9 Chronic brain syndrome NOS*
} due to meningo-vascular and other syphilis of central nervous system

083.1 Postencephalitic personality and character disorders
Includes chronic brain syndrome with behavioral reaction.

083.2 Postencephalitic psychosis
Includes acute brain syndrome or chronic brain syndrome with psychotic reaction.

††*083.7 Chronic brain syndrome with neurotic reaction, postencephalitic*

††*083.9 Chronic brain syndrome NOS, postencephalitic*

300 **Schizophrenic disorders**

††*300.7 Other and unspecified except childhood type*
††*300.8 Childhood type*

301 **Manic-depressive reaction**

301.1 Depressive

†† Excludes Melancholia NOS and Psychotic depressive reaction NOS (††*309.0*).

Titles 304–308.2 include acute brain syndrome or chronic brain syndrome with *psychotic reaction* associated with the diseases and conditions in those titles. They exclude chronic brain syndrome due to those conditions with neurotic reaction, behavioral reaction, or without qualifying phrase (††*319*, ††*322*, ††*327*, ††*328*, ††*353*, ††*794*, with the appropriate 4th digit). Titles *305*, *308.1* have been amended, and *308.2* has been expanded, as follows:

305 Presenile psychosis

†† Excludes conditions assigned to this title (Alzheimer's disease, Circumscribed atrophy of brain, Pick's disease of brain, Presenile sclerosis): with neurotic reaction (††*319.7*); with behavioral reaction (††*327.7*); and NOS (††*328.7*).

308.1 Resulting from epilepsy and other convulsive disorders
†† Includes acute brain syndrome (automatism, furor, clouded state, psychic equivalent, etc.), and chronic brain syndrome with psychotic reaction, due to epilepsy and other convulsive disorders.

††*308.2 Acute brain syndrome associated with trauma*
††*308.3 Acute brain syndrome associated with systemic infection, NEC*
††*308.4 Acute brain syndrome associated with disturbance of circulation*
Note: In rare cases when the additional diagnosis is cerebral arteriosclerosis the cases should be coded to *306*.

††*308.5 Acute brain syndrome associated with other causes, NEC*
Excludes acute brain syndrome of unknown or unspecified cause (††*309.1*).

††*308.6 Chronic brain syndrome with psychotic reaction associated with exogenous poison, except alcohol*

††*308.7 Chronic brain syndrome with psychotic reaction associated with trauma, except birth trauma*

††*308.8 Chronic brain syndrome with psychotic reaction associated with birth trauma and diseases due to prenatal influence*

††*308.9 Chronic brain syndrome with psychotic reaction associated with other causes, NEC*
Excludes chronic brain syndrome with psychotic reaction of unknown or unspecified cause (††*309.1*).

309 Other and unspecified psychoses

††*309.0 Psychotic depressive reactions NOS*
Includes Melancholia NOS

††*309.1 Other and unspecified psychoses*
†† Includes acute brain syndrome or chronic brain syndrome with psychotic reaction of unknown or unspecified cause.
†† Excludes mental deterioration NOS and chronic brain syndrome NOS (††*328.9*).

††*319* Chronic brain syndrome with neurotic reaction

††*327* Chronic brain syndrome wtih behavioral reaction

††*328* Chronic brain syndrome NOS
The following 4th digit subdivisions are to be used with ††*319*, ††*327*, or ††*328* to indicate the associated disease or condition:
.0 Associated with diseases and conditions due to prenatal influence
.1 Associated with intracranial infection, NEC
.2 Associated with drug or poison, except alcohol
.3 Associated with birth trauma
.4 Associated with other trauma
.5 Associated with cerebral arteriosclerosis
.6 Associated with other circulatory disturbance
.7 Associated with presenile brain disease
.8 Associated with other disturbance of metabolism, growth, or nutrition
.9 Associated with other diseases and conditions, NEC, or unspecified disease or condition

321.1 Passive dependency
†† Includes passive-aggressive personality.

321.4 † Includes special symptom reactions NEC, personality disorder.

321.5 † Includes personality trait disturbance, other and unspecified.

322 Alcoholism

††*322.7 Chronic brain syndrome with neurotic reaction* } due
††*322.8 Chronic brain syndrome with behavioral reaction* } to
††*322.9 Chronic brain syndrome NOS* } alcohol

324 Primary childhood behaviour disorders
†† The age limits herein specified are to be used in coding only in the absence of a complete diagnosis by the clinician.

††*324.0 In infancy (under 2 years)*

††*324.1 In childhood (2-11 years)*

††*324.2 In adolescence (12-19 years)*
††*324.3 Period not specified*

325 Mental deficiency
Idiopathic or hereditary:
325.0 } *Severe* (I.Q. *under* 50)
325.1 }
325.2 Moderate (I.Q. from 50 to 69)
325.3 Mild (I.Q. from 70 to 85)
325.5 Severity not specified
Associated with (and major symptom in) specified brain impairments, to be used as equivalents for the Standard qualifying phrase "X4," and to be coded as second diagnoses:
††*325.6* Severe (I.Q. under 50) (If Mongolism is specified, code *325.4*)
††*325.7 Moderate* (I.Q. from 50 to 69)
††*325.8 Mild* (I.Q. from 70 to 85)
††*325.9 Severity not specified*

326.3 Acute situational maladjustment
†† Includes "Gross stress reaction"; excludes abnormal excitability under minor stress (*321.0*).

††*326.4 Other and unspecified character, behavior, and intelligence disorders, except as below*

††*326.5 Adjustment reaction of late life (ages 65 and over)*
The age limits specified in this title and in ††*326.6* are to be used only in the absence of a complete diagnosis by the clinician.

††*326.6 Adult situational reaction (ages 20 and over)*
Includes simple adult maladjustment.
Excludes adjustment reaction of late life (††*326.5*).

††*327* and ††*328—See notes following* ††*319.*

353 Epilepsy
††*353.7 Chronic brain syndrome with neurotic reaction* } due to
††*353.8 Chronic brain syndrome with behavioral reaction* } epilepsy
††*353.9 Chronic brain syndrome NOS* } (any type)

668.1 Puerperal psychosis
Includes acute brain syndrome or chronic brain syndrome with psychotic reaction, after delivery.

794 Senility without mention of psychosis
††*794.0 Senility, except as below*
††*794.7 Chronic brain syndrome with neurotic reaction* } due
††*794.8 Chronic brain syndrome with behavioral reaction* } to
††*794.9 Chronic brain syndrome NOS* } senility

PSYCHOSES (*300–309*)

300 **Schizophrenic disorders (dementia præcox)**
300.0 Simple type
000–x21
300.1 Hebephrenic type
000–x22

300.2 Catatonic type
000–x23
939
300.3 Paranoid type
000–x24
300.4 Acute schizophrenic reaction
000–x25
300.5 Latent schizophrenia
000–x29
300.6 Schizo-affective psychosis
000–x27
††*300.7 Other and unspecified, except childhood type*
000–x20
000–x26
See also notes preceding Title *300.*
††*300.8 Childhood type*
000–x28
See also notes preceding Title *300.*

301 **Manic-depressive reaction**

This title excludes neurotic-depressive reaction (*314*).
301.0 Manic and circular
000–x11
037
301.1 Depressive
000–x12
†† Excludes Melancholia NOS and Psychotic depressive reaction NOS (††*309.0*).
See also notes preceding Title *300.*
301.2 Other
000–x10
000–x13

302 **Involutional melancholia**

000–796

303 **Paranoia and paranoid states**

000–x30
000–x31
000–x32

Titles *304–308:* See *also* notes preceding Title *300.*

304 **Senile psychosis****

†† Excludes chronic brain syndrome, nonpsychotic, due to senility (††*794.7*–††*794.9*).

305 **Presenile psychosis****

†† Excludes chronic brain syndrome, nonpsychotic, due to presenile brain disease (††*319.7*, ††*327.7*, ††*328.7*).

306 **Psychosis with cerebral arteriosclerosis****

†† Excludes chronic brain syndrome, nonpsychotic, due to cerebral arteriosclerosis (††*319.5*, ††*327.5*, ††*328.5*).

307 **Alcoholic psychosis**

000–33122
000–33123
000–3312

†† This title excludes alcoholic addiction without psychosis (*322.0–322.2*) and chronic brain syndrome, nonpsychotic, due to alcohol (††*322.7*–††*322.9*).

308 **Psychosis of other demonstrable etiology**

308.0 Resulting from brain tumour

000–8 . .

308.1 Resulting from epilepsy and other convulsive disorders

000–550	072	074
071	073	930–x0x

†† Includes acute brain syndrome (automatism, furor, clouded state, psychic equivalent, etc.) and chronic brain syndrome with psychotic reaction, due to epilepsy and other convulsive disorders.

†† This title excludes epilepsy without psychosis (*353.0–353.3*), and chronic brain syndrome, nonpsychotic, due to epilepsy (††*353.7*–††*353.9*).

†† *308.2 Acute brain syndrome, associated with trauma*

000–4 . .

††*308.3 Acute brain syndrome associated with systemic infection NEC*

000–100

††*308.4 Acute brain syndrome associated with disturbance of circulation*

000–5 . .

††*308.5 Acute brain syndrome associated with other causes, NEC*

000–3 . .	000–900
000–7 . .	009–100

†† Excludes acute brain syndrome of unknown or unspecified cause (††*309.1*).

††*308.6 Chronic brain syndrome with psychotic reaction associated with exogenous poison, except alcohol***

††*308.7 Chronic brain syndrome with psychotic reaction associated with trauma***

††*308.8 Chronic brain syndrome with psychotic reaction associated with birth trauma and diseases due to prenatal influence***

††*308.9 Chronic brain syndrome with psychotic reaction associated with other causes NEC***

†† Excludes chronic brain syndrome with psychotic reaction of unknown or unspecified cause (††*309.1*).

309 **Other and unspecified psychoses**

See also notes preceding Title *300*.

††*309.0 Psychotic depressive reaction NOS*

000–x14

††*309.1 Other and unspecified psychoses*

000–xx0	014	922
000–xy0	910	926

† Code ill-defined mental conditions to *318.5* or *326.4* if psychoneurosis, NEC, or behavioral reaction, NEC, is indicated.

PSYCHONEUROTIC DISORDERS (*310–318, ††319*)

Numbers *310–318, ††319*, exclude simple adult maladjustment (*††326.6*) and nervousness and debility (*790*).

310 **Anxiety reaction without mention of somatic symptoms**

000–x01
059
083
084

311 **Hysterical reaction without mention of anxiety reaction**

000–x02
000–x03
018
20x
272–555
902
936
942

312 **Phobic reaction**

000–x04
087

313 **Obsessive-compulsive reaction**

000–x05
013
056
066
067
069
078
079
086
088
089
08x
090
091
092
093
908

314 **Neurotic-depressive reaction**

000–x06

†† This title excludes manic-depressive reaction (*301*), and psychotic-depressive reaction NOS (*††309.0*).

315 **Psychoneurosis with somatic symptoms (somatization reaction) affecting circulatory system**

This title excludes functional heart disease (*433*) unless specified as psychogenic.

*315.0 Neurocirculatory asthenia***

*315.1 Other heart manifestations specified as of psychogenic origin***

315.2 Other circulatory manifestations of psychogenic origin

004–580

316 **Psychoneurosis with somatic symptoms (somatization reaction) affecting digestive system**

This title excludes ulcer of stomach (*540*) and of duodenum (*541*). It excludes functional disorders of œsophagus (*539.0*), of stomach (*544*), and of intestines (*573*) unless specified as psychogenic.

*316.0 Mucous colitis specified as of psychogenic origin***

*316.1 Irritability of colon specified as of psychogenic origin***

*316.2 Gastric neuroses***

316.3 Other digestive manifestations specified as of psychogenic origin

006–580
617

317 **Psychoneurosis with somatic symptoms (somatization reactions) affecting other systems**

317.0 Psychogenic reactions affecting respiratory system

003–580

317.1 Psychogenic reactions affecting genito-urinary system

007–580

034

† Excludes masturbation in children (††*324.0*–††*324.3*).

*317.2 Pruritus of psychogenic origin***

317.3 Other cutaneous neuroses

001–580

317.4 Psychogenic reactions affecting musculoskeletal system

002–580

317.5 Psychogenic reactions affecting other systems

005–580

008–580

00x–580

318 **Psychoneurotic disorders, other, mixed, and unspecified types**

*318.0 Hypochondriacal reaction***

318.1 Depersonalization

080

318.2 Occupational neurosis

27x–432

9227

318.3 Asthenic reaction

009–580

*318.4 Mixed***

This title excludes mixed anxiety and hysterical reactions (*310*).

318.5 Of other and unspecified types

000–x00	7x2–555 [8]	937
000–x0y	925	
098	930–550.x	

††***319*** **Chronic brain syndrome with neurotic reaction****

See also notes preceding Title *300*.

††*319.0 Associated with diseases and conditions due to prenatal influence*

††*319.1 Associated with intracranial infection, NEC*

††*319.2 Associated with drug or poison, except alcohol*

††*319.3 Associated with birth trauma*

††*319.4 Associated with other trauma*

††*319.5 Associated with cerebral arteriosclerosis*

††*319.6 Associated with other circulatory disturbance*

††*319.7 Associated with presenile brain disease*

††*319.8 Associated with other disturbance of metabolism, growth, or nutrition*

††*319.9 Associated with other diseases and conditions NEC, or unspecified disease or condition*

DISORDERS OF CHARACTER, BEHAVIOUR, AND INTELLIGENCE

(*320–326, ††327, ††328*)

See also notes preceding Title *300*.

320 **Pathological personality**

320.0 Schizoid personality

000–x42
041

320.1 Paranoid personality

000–x44
040
081

This title excludes paranoia and paranoid states (*303*).

320.2 Cyclothymic personality

000–x43

320.3 Inadequate personality

000–x41

320.4 Antisocial personality

000–x61	03x	
029	044	

320.5 Asocial personality

000–x62	047	049
046	048	055

† Excludes childhood behavior problems (††*324.0*–††*324.3*).

320.6—Sexual deviation

000–x63	057	062
036	060	068
039	061	082

320.7 Other and unspecified

000–x40	026
000–x60	027

321 **Immature personality**

321.0 Emotional instability

000–x51
043

321.1 Passive dependency

000–x52
050

†† Includes passive-aggressive personality.

321.2 Aggressiveness

††See title ††*321.1*.

321.3 Enuresis characterizing immature personality

000–x73

321.4 Other symptomatic habits except speech impediments

000–x70
000–x74
000–x7y

† Includes special symptom reaction NEC, personality disorder.

321.5 Other and unspecified

000–x50
000–x53
000–x5y

† Includes personality trait disturbance other and unspecified.

***322* Alcoholism**

This title excludes alcoholic psychosis (*307*), and acute poisoning by alcohol (*961*). For primary cause classification it excludes cirrhosis of liver with alcoholism (*581.1*).

322.0 Acute

011–332

322.1 Chronic

000–x641
011–3312
076
410–3312

322.2 Unspecified

075

†† *322.7 Chronic brain syndrome with neurotic reaction due to alcohol***

†† *322.8 Chronic brain syndrome with behavioral reaction due to alcohol***

†† *322.9 Chronic brain syndrome NOS due to alcohol*

009–3312

***323* Other drug addiction**

000–x642
011–3217
058

***324* Primary childhood behaviour disorders**

† Any term coded *324* occurring in adults (ages 20 and over) should be coded to *320, 321* according to type: cruelty (sexual) *320.6;* stealing *320.5,* etc.

†† The age limits herein specified are to be used only in the absence of a complete diagnosis by the clinician.

†† *324.0 In infancy* (under 2 years)

000–x83

†† *324.1 In childhood* (2-11 years)

000–x841
000–x842
000–x843
000–x84

†† *324.2 In adolescence* (12-19 years)

000–x85

†† *324.3 Period not specified*

030
031
032
033
045
04x
051
052
053
054

325 Mental deficiency

Idiopathic or hereditary (325.0–325.5):

*325.0 Idiocy***

†† Includes severe mental deficiency (I.Q. under 20).

325.1 Imbecility

000–x903
000–y903

†† Includes severe mental deficiency (I.Q. under 50, except as in *325.0* and *325.4*).

325.2 Moron

000–x902
000–y902
921

†† Includes moderate mental deficiency (I.Q. from 50 to 69).

325.3 Borderline intelligence

000–x901
000–y901

†† Includes mild mental deficiency (I.Q. from 70 to 85).

325.4 Mongolism

010–071
x20–071[8]

325.5 Other and unspecified types

000–x90	902–755	x25–996
000–y90	91x	x27–996
902–7551	9301	x28–996
902–7552	x25–9111	

†† Includes mental deficiency, severity not specified.

†† Associated with specified brain impairments (††*325.6*–††*325.9*). (*See also* notes preceding Title *300*).

††*325.6 Severe (I.Q. under 50)***

If Mongolism is specified, code *325.4*.

††*325.7 Moderate (I.Q. from 50 to 69)***

††*325.8 Mild (I.Q. from 70 to 85)***

††*325.9 Severity not specified***

326 Other and unspecified character, behaviour, and intelligence disorders

326.0 Specific learning defects

000–x71	951	992
932–0453	952	x124
932–0454	958	
932–0455	974	

This title includes alexia (word blindness) and agraphia of unspecified or nonorganic origin.

† Any term coded *326.0* will be coded *781.6* if secondary to organic lesion.

† Excludes word deafness (*326.2*).

326.1 Stammering and stuttering of nonorganic origin

9302

This title includes any condition in *781.5* of unspecified or nonorganic origin.

† Any term coded *326.1* will be coded *781.5* if secondary to organic lesion.

326.2 Other speech impediments of nonorganic origin

000–x72	954	9562
928	9550	9563
9303	9551	9564
9304	9552	957
932–452	9553	95x
932–456	9554	971
932–458	9555	973
946	9557	x03
9501	9558	
950	955x	
953	9561	

† This title includes any condition in *781.6* of unspecified or nonorganic origin, except specific learning defects (*326.0*).

† Any term coded *326.2* will be coded *781.6* if secondary to organic lesion.

326.3 Acute situational maladjustment

000–x81

†† Includes "Gross stress reaction."

†† Excludes abnormal excitability under minor stress (*321.0*).

††*326.4 Other and unspecified except as below*

000–x80	90x	932–045
019	932–0451	
608	932–0457	

††*326.5 Adjustment reaction of late life (ages 65 and over)*

000–x86

The age limits specified in this title and in ††*326.6* are to be used in coding only in the absence of a complete diagnosis by the clinician.

††*326.6 Adult situational reaction (ages 20 and over)*

000–x82

Includes simple adult maladjustment.

Excludes adjustment reaction of late life (††*326.5*).

††*327* Chronic brain syndrome with behavioral reaction

See also notes preceding Title *300*.

††*327.0 Associated with diseases and conditions due to prenatal influence*

††*327.1 Associated with intracranial infection, NEC*

††*327.2 Associated with drug or poison, except alcohol*

††*327.3 Associated with birth trauma*

††*327.4 Associated with other trauma*

††*327.5 Associated with cerebral arteriosclerosis*

††*327.6 Associated with other circulatory disturbance*

††*327.7 Associated with presenile brain disease*

††*327.8 Associated with other disturbance of metabolism, growth or nutrition*

††*327.9 Associated with other diseases and conditions NEC, or unspecified disease or condition*

††*328* Chronic brain syndrome NOS

See also notes preceding Title *300*.

††*328.0 Associated with diseases and conditions due to prenatal influence*

009–016 009–071
009–052 009–0..

††*328.1 Associated with intracranial infection, NEC*

009–1...0

††*328.2 Associated with drug or poison, except alcohol*

009–3..
009–300

††*328.3 Associated with birth trauma*

009–050

††*328.4 Associated with other trauma*

009–415 009–462 009–4..
009–420 009–470

††*328.5 Associated with cerebral arteriosclerosis*

009–516

††*328.6 Associated with other circulatory disturbance*

009–5..

††*328.7 Associated with presenile brain disease*

930–796
939–910

††*328.8 Associated with other disturbance of metabolism, growth or nutrition*

009–700

††*328.9 Associated with other diseases and conditions NEC, or unspecified disease or condition*

009–8.. 009–xx0 908–992
009–900 908–953 923

†Excludes Huntington's chorea NOS (355).

APPENDIX B

DISEASES OF THE PSYCHOBIOLOGIC UNIT[1] OF THE NOMENCLATURE OF DISEASE

Psychiatrists and members of associated specialties have considered for many years that the psychiatric nomenclature was inadequate for their needs. The American Psychiatric Association undertook to revise the psychiatric terminology. The efforts of this Association and its members assisted by advice and council of interested individuals, culminated in the establishing of the "Diagnostic and Statistical Manual for Mental Disorders" (American Psychiatric Association) in the early part of 1951. During the development of the manual, the editors and the committee on psychiatry of the Standard Nomenclature of Diseases and Operations and the committee assigned the task of developing the mentioned manual were in frequent communication and association. Through their cooperative activities, the psychiatric nomenclature as listed in the manual was included in the "Fourth" edition of the Standard Nomenclature of Diseases and Operations. This resulted in a radical revision of section 0 "Diseases of the Psychobiologic Unit" of the Nomenclature of Disease.

The major change, of course, was the substitution of the newly accepted terminology for the old. Many of the new terms were broader in scope than the old to conform to the basic thinking among psychiatrists that some disorders or reactions formerly considered as separate clinical entities are really expressions of a single disease. This concept of unity is characteristic of the new terminology. Hence a rubric assigned to a new term may include two or more rubrics of former editions. This is not a violation of the basic principle of Standard that a rubric is specific for one clinical entity, but is acknowledgement of the basic holistic implications of many psychiatric disorders or reactions. For example, the "Fourth" edition has the entity 006–580 Psychophysiologic gastrointestinal reaction which includes the three listings of previous editions of 640–550 Gastric neurosis, 604–550 Intestinal neurosis, and 668–550 Rectal neurosis. These neuroses are now considered to be allied clinical expressions of the same psychophysiologic autonomic disorder.

A second change is the division of a former Standard rubric into two or more rubrics, thus permitting more refined or detailed classification. An excellent example of this change is the division of the entity of the Third edition, 003–516 Psychosis with cerebral arteriosclerosis. In the "Fourth" edition this entity may be classified into four items, the basic category being chronic brain syndrome associated with cerebral arteriosclerosis 009–516. When the clinical picture is significantly altered by superimposed symptoms, the addition of a qualifying phrase (.x1 with psychotic reaction; .x2 with neurotic reaction; .x3 with behavior reaction) provides three additional rubrics.

This change is one of the most significant in this revision as it provides for the flexibility and variation which is so necessary in a psychiatric nomenclature classification.

The basic construction pattern of the Nomenclature of Disease has not been changed. The diseases of the psychobiologic unit are grouped in divisions cor-

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responding to the categories of the etiologic classification and the listing of the clinical entities within the divisions follow the alphabetic arrangement. However, decimal digits with their usually assigned definitions are not used in association with diseases of the psychobiologic unit with the exception of the decimal digit x, disturbance of function and the decimal digit .0 to denote chronic infection.

The decimal digit x is used to denote disturbance of function but has been qualified by the addition of a digit in the second decimal place with assigned definition as follows: .x1 with psychotic reaction; .x2 with neurotic reaction; .x3 with behavior reaction; and .x4 with mental deficiency. These qualifying phrases may be added to any diagnosis in the psychobiologic unit when needed to further define, describe or clarify the clinical picture. Care must be exercised in their utilization to prevent redundancy. For example, .x1 with psychotic reaction would be redundant when used with a diagnosis listed under psychotic disorders; .x2 would be redundant when used with a diagnosis listed under the psychoneurotic disorders; .x3 when used with a diagnosis of a personality disorder and .x4 when used with the diagnosis of mental deficiency. The use of these decimal combinations may be clarified by considering the use of decimal digit x4 as it relates (1) to a diagnosis other than mental deficiency and (2) to the diagnosis mental deficiency per se.

The rubrics of the diseases of the psychobiologic unit may be qualified by the addition of the decimal digit x4 when necessary to denote mental deficiency as associated with the primary disease. For example, the clinical condition "Chronic brain syndrome associated with trauma" is coded as 009–4 . . If mental deficiency is the major symptom of the disorder and it is desired to indicate this in the diagnosis, the decimal digit x4 may be added to the basic code number, thus, 009–4 . . . x4. Chronic brain syndrome associated with trauma, with mental deficiency.

In the old terminology this diagnosis would have been listed as mental deficiency due to trauma (not birth injury).

The clinical entity "Mental deficiency (familial or hereditary)" is classified in Standard as 000–x90. It becomes immediately obvious that the addition of the decimal digit x4 to this code number, thus 000–x90.x4 is a redundancy, as the diagnosis literally interpreted would be mental deficiency with mental deficiency.

The decimal digit x4 may be further expanded to denote degrees of mental deficiency, thus .x41 with mental deficiency mild; .x42 with mental deficiency moderate; .x43 with mental deficiency severe. For example, "Chronic brain syndrome, associated with trauma, with mental deficiency, mild" would have the code number 009–400.x41.

Mental deficiency per se is recognized also in three degrees, mild, moderate, and severe denoted by the addition of the digits 1, 2 and 3 in the rubric for mental deficiency per se, but these digits are in fourth position of the etiologic portion of the code number and are not decimal digits; thus "Mental deficiency (familial or hereditary) severe" would be coded as 000–x903.

While no provisions have been made for the coding of mild, moderate and severe for the decimal digits x1, x2 and x3, nevertheless if desired by the psychiatrist, diagnoses qualified as above and coded with the double decimal combi-

nations added may be recorded with an additional digit in the 3rd decimal place utilizing digit 1 for mild, 2 for moderate and 3 for severe, thus:

.x11 with mild psychotic reaction
.x12 with moderate psychotic reaction
.x13 with severe psychotic reaction.

Diseases of the psychobiologic unit in previous additions were classified under captions with subdivisions as follows:

A. Mental Deficiencies
B. Other diseases of the Psychobiologic Unit
C. Mental Disorders
   Psychoses
   Psychoneuroses
   Primary Behavior Disorders.

These diseases are classified in the "Fourth" edition under revised captions as follows:

A. Disorders caused by or associated with impairment of brain tissue function
   1. Acute brain disorders
   2. Chronic brain disorders
B. Mental deficiencies
C. Disorders of psychogenic origin or without clearly defined physical cause or structural change in the brain
   1. Psychotic disorders
   2. Psychophysiologic autonomic and visceral disorders
   3. Psychoneurotic disorders
   4. Personality disorders
   5. Transient situational personality disorders.

Basic to the terminology is the word "disorder," which is used in its broadest sense to signify a group of related conditions affecting the psychobiologic unit. Each group of disorders consists of psychiatric syndromes or conditions referred to as "reactions." These "reactions" are all disturbances of mental functioning. Conditions which affect the brain and associated or related structures without major disturbances of mental functioning are classified in the Nomenclature of Disease in the section "Diseases of the Nervous System." When the two are associated, *both* should be diagnosed, coded and recorded.

Mental disorders with known etiologic factors are classified under the first caption "Disorders caused by or associated with impairment of brain tissue function." The brain tissue damage or the cause of it are provided for in the subdivision of the classification. These subdivisions follow the pattern of the etiologic categories. For example, "Delirium due to trauma" formerly classified and coded as 009–42x is now classified as 000–4 . . Acute brain syndrome associated with trauma, specify trauma; "Delirium due to typhoid fever," old code number 009–1y0 is now classified as 000–115 Acute brain syndrome due to systemic infection, typhoid fever.

The classification of Mental deficiency has been restricted to hereditary, or familial and idiopathic. Mental deficiency as a part of the clinical picture associated with organic brain syndromes is compensated for by the use of the decimal digit combination x4.

Psychiatric disorders of psychogenic origin, or without brain tissue impairment are classified under the second caption. A change from previous editions is the expansion of the schizophrenic reactions and the reduction in the number of manic depressive reactions. The major change however, has been the inclusion of the classification of "Psychophysiologic autonomic and visceral disorders." These disorders formerly were classified under the various topographic disease sections of the nomenclature but have now been transferred to this section in recognition of the involvement of both psychic and somatic factors in these conditions. Some of the conditions transferred to this section are:

Code No. 3rd Ed.	Code No. 4th Ed.	Code Supp. Term	Old Diagnosis	New Diagnosis
110–550	001–580		Neurotic excoriations	Psychophysiologic skin reaction
631–550	006–580		Neurosis of pharynx	Psychophysiologic gastrointestinal reaction (Indicate manifestation by Supplementary Term)
631–555	000–x03	9222	Spasm of pharynx, hysterical	Conversion reaction
646–558	006–580	662	Achylia gastric, neurotic	Psychophysiologic gastrointestinal reaction (Indicate manifestation by Supplementary Term)
648–558	006–580	272	Atony of stomach, neurotic	Psychophysiologic gastrointestinal reaction (Indicate manifestation by Supplementary Term)
642–559	006–580	663	Hyperchlorhydria, neurotic	Psychophysiologic gastrointestinal reaction (Indicate manifestation by Supplementary Term)
640–550	006–580		Gastric neurosis	Psychophysiologic gastrointestinal reaction (Indicate manifestation by Supplementary Term)
640–556	006–580	614	Nervous vomiting	Psychophysiologic gastrointestinal reaction (Indicate manifestation by Supplementary Term)

Code No. 3rd Ed.	Code No. 4th Ed.	Code Supp. Term	Old Diagnosis	New Diagnosis
604–550	006–580		Intestinal neurosis	Psychophysiologic gastrointestinal reaction (Indicate manifestation by Supplementary Term)
604–556	006–580	635	Nervous diarrhea	Psychophysiologic gastrointestinal reaction (Indicate manifestation by Supplementary Term)
668–550	006–580		Rectal neurosis	Psychophysiologic gastrointestinal reaction (Indicate manifestation by Supplementary Term)
730–550	007–580		Neurosis of bladder	Psychophysiologic genitourinary reaction (Indicate manifestation by Supplementary Term)
733–558		705	Retention of urine, psychogenic	Since these are symptomatic diagnoses, they will be classified under any of several diagnoses dependent upon the clinician's opinion as to the basis. When the basic mechanism has not been determined or specified a choice of rubric may be made in the following order of priority 1. Conversion reaction 000–x03 2. Psychophysiologic reaction 007–580 Manifestation numbers should also be used
705–550		778	Sex impotence, psychogenic	
705–557		767	Leukorrhea, psychogenic	
781–550		768	Dyspareunia	
780–556		765	Dysmenorrhea, psychogenic	
785–585		761	Amenorrhea due to mental disorder	
782–550		764	Metrorrhagia, psychogenic	
7x4–555	007–580		Parturition due to psychic shock	Psychophysiologic genitourinary reaction (Indicate manifestation by Supplementary Term)
24.–551	000–x03	241	Contracture of, due to hysteria	Conversion reaction
27.–555	000–x03	231	Cramps, hysteria	Conversion reaction
x00–555	000–x03		Psychic anosmia	Conversion reaction

Code No. 3rd Ed.	Code No. 4th Ed.	Code Supp. Term	Old Diagnosis	New Diagnosis
336–550	000–x03		Neurosis, incoordination of vocal cords	Conversion reaction
330–551	000–x03		Neurosis of larynx, hysteria	Conversion reaction
330–552	000–x03	902	Anesthesia of larynx	Conversion reaction
330–553	000–x03	905	Hyperesthesia	Conversion reaction
330–554	000–x03	907	Paresthesia	Conversion reaction
339–555	000–x03		Paralysis of larynx, hysteria	Conversion reaction
339–556	000–x03	9222	Spasm of larynx, hysteria	Conversion reaction
617–550	000–x03		Paralysis of uvula, hysteria	Conversion reaction
620–550	000–x03	610	Ptyalism, hysterical	Conversion reaction
631–552	000–x03	902	Anesthesia	Conversion reaction
631–553	000–x03	905	Hyperesthesia	Conversion reaction
631–554	000–x03	907	Paresthesia	Conversion reaction
672–550	000–x03	721	Incontinence, hysteria	Conversion reaction
x23–551	000–x03	x13	Amblyopia, hysteria	Conversion reaction
x23–552	000–x03	x12	Hysterical amaurosis	Conversion reaction
x30–555	000–x03		Asthenopia hysteria	Conversion reaction
x39–555	000–x03		Hysterical paralysis of accommodation	Conversion reaction
x70–551	000–x03	x06	Deafness, hysteria	Conversion reaction

The "Diagnostic and Statistical Manual for Mental Disorders" (American Psychiatric Association) explains in detail the definitions of the new terminology and gives by example the relationship between the old and the new terminology. The coder and classifier of diseases of the psychobiologic unit must become familiar with the definitions of the new terminology as expressed in the manual if classification and coding is to be accurate.

To simplify this task and as a guide, the old terminology as listed in previous editions of Standard is tabulated below with a cross reference to the new terminology as listed in the "Fourth" edition of Standard. The code numbers for the old terminology are included as well as the code numbers for the new terminology. (See tabulation following.)

In the maintenance of the disease classification index file it is suggested that new disease classification index cards be prepared at an appropriate time in conformity with the new terminology and rubrics. It is not considered advisable to transfer the old terms with their rubrics to the new cards. The old cards should be balanced as of the date of installation of the new cards and maintained as an appendix or an addendum to the active disease classification index file until such time as there is no further reference to them. They should then be placed in the inactive disease classification index file.

Third Edition		Fourth Edition	
000–046	Familial mental deficiency	000–x90	Mental deficiency (familial or hereditary) [1]
		000–x901	Mild
		000–x902	Moderate
		000–x903	Severe
000–071	Mongolism	009–071	Chronic brain syndrome associated with mongolism
000–077	Mental deficiency with developmental cranial anomaly. Specify type such as, microcephalic or oxycephalic	009–0..	Chronic brain syndrome associated with congenital cranial anomaly (Specify anomaly) [1]
000–016.9	Mental deficiency with congenital cerebral spastic infantile paraplegia	009–016	Chronic brain syndrome associated with congenital spastic paraplegia [1]
000–1xx	Mental deficiency, due to infection. Specify organism when known	009–1...0	Chronic brain syndrome associated with intracranial infection other than syphilis (Specify infection) [1]
000–050	Mental deficiency due to trauma during birth	009–050	Chronic brain syndrome associated with birth trauma [1]
000–4xx	Mental deficiency due to trauma after birth	009–4..	Chronic brain syndrome associated with trauma (Specify as below) [1]
		009–4...x4	Chronic brain syndrome, brain trauma gross force (Specify other than operative), with mental deficiency
		009–415.x4	Chronic brain syndrome following brain operation, with mental deficiency
		009–462.x4	Chronic brain syndrome following electrical brain trauma, with mental deficiency
		009–470.x4	Chronic brain syndrome following irradiational brain trauma, with mental deficiency

[1] When Mental Deficiency is the presenting symptom of primary importance, and it is desired to indicate this in the diagnosis, add .x4 to code number.

Third Edition		Fourth Edition	
000–550	Mental deficiency due to epilepsy	009–550	Chronic brain syndrome associated with convulsive disorder [1]
000–770	Mental deficiency with glandular disorder	009–700	Chronic brain syndrome associated with other disturbances of metabolism, growth or nutrition (Includes pre-senile, glandular, pellagra, familial amaurosis) [1]
000–755	Mental deficiency with familial amaurosis	009–700	Chronic brain syndrome associated with other disturbances of metabolism, growth or nutrition (Includes pre-senile, glandular, pellagra, familial amaurosis) Record amaurosis Supplemetary Term code number x12 [1]
000–076	Prematurity	011–076	Transferred to diseases of Body As A Whole
003–3..	Drug addiction	000–x642	Drug addiction
000–332	Alcohol	000–x641	Alcohol addiction
000–3321	Alcohol, periodic	000–x641	Alcohol addiction
000–333	Ether	000–x642	Drug addiction
000–336	Chloroform		
000–361	Absinthe		
000–364	Cannabis		
000–365	Cocaine		
000–369	Nicotine		
000–370	Opium (morphine, heroin diacetylmorphine)		
000–556	Hypertonicity of infancy	000–x83	Adjustment reaction of infancy
010–797	Senility	010–797	Transferred to diseases of Body As A Whole

000–7x4	Pseudocyesis	000–x03	Conversion reaction
		007–580	Psychophysiologic genito-urinary reaction (Indicate Supplementary Term)
0y0–147	Psychosis with syphilis of the central nervous system	0..–147.0	Chronic brain syndrome associated with central nervous system syphilis [2]
002–147	Meningoencephalitic type (general paresis)	009–147.0	Meningoencephalitic [2]
003–147	Meningovascular type (cerebral syphilis)	004–147.0	Meningovascular [2]
004–147	Psychosis with intracranial gumma	0y0–147.0.x1	Chronic brain syndrome associated with other central nervous system syphilis, with psychotic reaction [2]
0y0–147	Other types	0y0–147.0.x1	Chronic brain syndrome associated with other central nervous system syphilis, with psychotic reaction [2]
008–123	Psychosis with tuberculosis meningitis	009–123	Acute brain syndrome associated with intracranial infection (Specify infection) [2]
			or
		009–123.0	Chronic brain syndrome associated with intracranial infection (Specify infection) [2]
008–190	Psychosis with meningitis (unspecified)	009–100.x1	Acute brain syndrome associated with intracranial infection (Specify infection) [2]
			or
		009–100.0.x1	Chronic brain syndrome associated with intracranial infection (Specify infection) [2]
003–163	Psychosis with epidemic encephalitis	009–163.x1	Acute brain syndrome associated with intracranial infection (Specify infection) [2]
			or
		009–163.0.x1	Chronic brain syndrome associated with intracranial infection (Specify infection) [2]

[1] When Mental Deficiency is the presenting symptom of primary importance, and it is desired to indicate this in the diagnosis, add .x4 to code number.

[2] May be classified under four rubrics dependent upon the disturbance of function. See text.

Third Edition		Fourth Edition	
004–196	Psychosis with acute chorea (Sydenham's)	009–196.x1	Acute brain syndrome associated with intracranial infection. Chorea Supplementary Term code number 213
009–1y0	Psychosis with other infectious disease (Specify)	009–100.x1	Acute brain syndrome associated with intracranial infection (Specify infection)
009–1xx	Post infectious psychosis	000–100.x1	Acute brain syndrome associated with systemic infection, with psychotic reaction [2]
001–332	Psychosis due to alcohol	000–3312.x1	Acute brain syndrome, alcohol intoxication, with psychotic reaction [2]
002–332	Pathologic intoxication		Diagnose underlying psychiatric disorder (Conversion reaction or schizophrenic reaction; acute brain syndrome) [2]
003–332	Delirium tremens	000–33123	Delirium tremens
004–332	Korsakoff's psychosis	009–300.x1	Chronic brain syndrome associated with intoxication, with psychotic reaction
007–332	Acute hallucinosis	000–33122	Acute hallucinosis
0y0–332	Other types	000–3312	Acute brain syndrome, alcohol intoxication [2]
			or
		009–3312	Chronic brain syndrome, alcohol intoxication [2]
002–300	Psychosis due to a drug or other exogenous poison	000–3..	Acute brain syndrome, drug or poison intoxication (Specify drug or poison) [2]
			or
		009–3..	Chronic brain syndrome, drug or poison intoxication (Specify drug or poison) [2]

002–310	Due to metal	000–31.	Acute brain syndrome, drug or poison intoxication (Specify drug or poison) [2]
		or	
		009–31.	Chronic brain syndrome, drug or poison intoxication (Specify drug or poison) [2]
002–350	Due to gas	000–35.	Acute brain syndrome drug or poison intoxication (Specify drug or poison) [2]
		or	
		009–35.	Chronic brain syndrome drug or poison intoxication (Specify drug or poison) [2]
002–370	Due to opium or a derivative	000–37.	Acute brain syndrome drug or poison intoxication (Specify drug or poison) [2]
		or	
		009–37.	Chronic brain syndrome drug or poison intoxication (Specify drug or poison) [2]
009–42x	Delirium due to trauma	000–4..	Acute brain syndrome associated with trauma (Specify trauma) [2]
009–4x9	Personality disorders due to trauma	009–4...x3	Chronic brain syndrome associated with trauma, with behavioral reaction
003–4xx	Mental deterioration due to trauma	009–4..	Chronic brain syndrome associated with trama
003–4y0	Other types	000–4..	Acute brain syndrome associated with trauma [2]
		or	
		009–4..	Chronic brain syndrome associated with trauma [2]

[2] May be classified under four rubrics dependent upon the disturbance of function. See text.

Third Edition		Fourth Edition	
003–512	Psychosis with cerebral embolism	009–512.x1	Chronic brain syndrome associated with circulatory disturbance, with psychotic reaction (Indicate cardiovascular disease as additional diagnosis) [2]
003–516	Psychosis with cerebral arteriosclerosis	009–516.x1	Chronic brain syndrome associated with arteriosclerosis, with psychotic reaction [2]
009–5xx	Psychosis with cardiorenal disease	000–5..	Acute brain syndrome associated with circulatory disturbance (Specify) (Indicate cardiovascular disease as additional diagnosis) [2]
		or	
		009–5..	Chronic brain syndrome associated with circulatory disturbance (Specify) (Indicate cardiovascular disease as additional diagnosis) [2]
003–yx0	Other types	000–5..	Acute brain syndrome associated with circulatory disturbance. Specify.[2]
		or	
		009–5..	Chronic brain syndrome associated with circulatory disturbance. Specify.[2]
003–550	Epileptic deterioration	009–550	Chronic brain syndrome associated with convulsive disorder
003–560	Epileptic clouded states	000–550	Acute brain syndrome associated with convulsive disorder
003–5y5	Other epileptic types	000–550	Acute brain syndrome associated with convulsive disorder [2]
		or	
		009–550	Chronic brain syndrome associated with convulsive disorder [2]

001–79x	Senile psychosis	009–79x	Chronic brain syndrome associated with senile brain disease [2]
002–79x	Simple deterioration	009–79x	Chronic brain syndrome associated with senile brain disease
003–79x	Presbyophrenic type		
004–79x	Delirious and confused types	009–79x.x1	Chronic brain syndrome associated with senile brain disease with psychotic reaction
005–79x	Depressed and agitated types		
006–79x	Paranoid types		
930–796	Presenile sclerosis (Alzheimer's disease)	009–700	Chronic brain syndrome associated with other disturbances of metabolism, growth or nutrition (Includes presenile, glandular, pellagra, familial amaurosis) [2]
001–796	Involutional psychosis		
002–796	Melancholia	000–796	Involutional psychotic reaction
003–796	Paranoid types		
0y0–796	Other types		
00x–770	Psychoses with glandular disorder	000–7...x1	Acute brain syndrome with metabolic disturbance, with psychotic reaction (Specify) Usually acute, may be chronic
009–712	Exhaustion delirium	000–712	Acute brain syndrome with metabolic disturbance (Specify)
009–7623	Psychoses with pellagra	000–700.x1	Acute brain syndrome associated with other disturbance of metabolism, growth or nutrition, with psychotic reaction (Specify the disease) May be chronic
009–yxx	Psychoses with other somatic disease	009–700	Chronic brain syndrome associated with other disturbance of metabolism, growth or nutrition (Specify the disease) May be acute

[2] May be classified under four rubrics dependent upon the disturbance of function. See text.

Third Edition		Fourth Edition	
003–8..	Psychoses with intracranial neoplasm	009–8...x1	Chronic brain syndrome associated with intracranial neoplasm with psychotic reaction (Specify)
009–8..	Psychoses with other neoplasm		May be diagnosed under disorders of psychogenic origin in accordance with the clinical picture
006–953	Psychoses with multiple sclerosis	009–900.x1	Chronic brain syndrome associated with diseases of unknown or uncertain cause, with psychotic reaction. Record the multiple sclerosis [2]
004–953	Psychoses with paralysis agitans	009–900.x1	Chronic brain syndrome associated with diseases of unknown or uncertain cause, with psychotic reaction [2]
004–992	Psychoses with Huntington's chorea	009–900.x1	Chronic brain syndrome associated with diseases of unknown or uncertain cause, with psychotic reaction. Diagnose the chorea [2]
004–9y0	Psychoses with other disease of the brain or nervous system	009–900.x1	Chronic brain syndrome associated with diseases of unknown or uncertain cause, with psychotic reaction. Diagnose the other disease of the brain [2]
001–x10	Manic depressive psychoses	000–x10	Affective reactions
001–x11	Manic type	000–x11	Manic depressive reaction manic type
001–x12	Depressed type	000–x12	Manic depressive reaction depressed type
001–x13	Circular type	000–x13	Manic depressive reaction other (Specify)
001–x14	Mixed type		
001–x15	Perplexed type		
001–x16	Stuporous type		
001–x17	Other types		

001–x20	Dementia praecox (Schizophrenia)	000–x20	Schizophrenic reactions
001–x21	Simple type	000–x21	Simple type
001–x22	Hebephrenic type	000–x22	Hebephrenic type
001–x23	Catatonic type	000–x23	Catatonic type
001–x24	Paranoid type	000–x24	Paranoid type
001–x25	Other types	000–x25	Acute undifferentiated type
		000–x26	Chronic undifferentiated type
		000–x27	Schizo-affective type
		000–x28	Childhood type
		000–x29	Residual type
001–x30	Paranoia	000–x31	Paranoia
001–x31	Paranoid conditions	000–x32	Paranoid state
001–x40	Psychoses with psychopathic personality	000–x61·x1	Antisocial reaction with psychotic reaction. May be any of personality disorders with psychotic reaction
001–x50	Psychoses with mental deficiency	000–x90·x1	Mental deficiency with psychotic reaction. May be chronic brain syndrome with psychotic reaction. See text
002–x00	Anxiety hysteria	000–x04	Phobic reaction. May be conversion or dissociative reaction depending upon predominant symptomatology
002–x10	Conversion hysteria	000–x03	Conversion reaction
002–x11	Anesthetic type (Indicate manifestation)		
002–x12	Paralytic type (Indicate manifestation)		
002–x13	Hyperkinetic type (Indicate manifestation)	000–x03	Conversion reaction
002–x14	Paresthetic type (Indicate manifestation)		

[2] May be classified under four rubrics dependent upon the disturbance of function. See text.

Third Edition		Fourth Edition	
002–x15	Autonomic type (Indicate manifestation)	000–x03	Conversion reaction
			or
		00.–580	Psychophysiologic autonomic and visceral disorders
002–x16	Amnesic type	000–x02	Dissociative reaction
002–x1x	Mixed hysterical psychoneurosis		Diagnose major type of reaction
002–x21	Obsession	000–x05	Obsessive compulsive reaction
002–x22	Compulsive tics and spasms	000–x05	Obsessive compulsive reaction
002–x23	Phobia	000–x04	Phobic reaction
002–x2x	Mixed compulsive states		Diagnose major type of reaction
002–x30	Neurasthenia	009–580	Psychophysiologic nervous system reaction
002–x31	Hypochondriasis	000–x0y	Psychoneurotic reaction, other Systematized paranoid hypochondriacal states are classified under 000–x24 Schizophrenic reaction, paranoid type.
002–x32	Reactive depressive	000–x06	Depressive reaction
002–x33	Anxiety state	000–x01	Anxiety reaction
002–x34	Anorexia nervosa	006–580	Psychophysiologic gastrointestinal reaction manifested by anorexia
002–x0x	Mixed psychoneurosis		Diagnose major type of reaction
001–y00	Undiagnosed psychosis	000–y00.x1	Psychotic disorder, undiagnosed
0y0–y00	Without mental disorder	0y0–000	For hospital record only Without mental disorder
930–yxx	Epilepsy	930–x01	Classified in Diseases of Nervous System
000–332	Alcoholism	000–x641	Alcoholism

000–3xx	Drug addiction	000–x642	Drug addiction
000–yxx	Mental deficiency	000–x90	Mental deficiency (familial or hereditary)
		000–x901	Mild
		000–x902	Moderate
		000–x903	Severe
			or
		000–y90	Mental deficiency, idiopathic
		000–y901	Mild
		000–y902	Moderate
		000–y903	Severe
000–163	Disorders of personality due to epidemic encephalitis	009–163.x3	Chronic brain disorder associated with epidemic encephalitis, with behavior reaction
000–x40	Psychopathic personality	000–x61	Antisocial reaction
000–x41	With pathologic sexuality	000–x63	Sexual deviation
000–x42	With pathologic emotionality	000–x51	Emotionally unstable personality (or see types)
000–x43	With asocial or amoral trends	000–x62	Dyssocial reaction
000–x4x	Mixed types	000–x40	Diagnose major personality disorder
0y0–y05	Other nonpsychotic diseases or conditions		Each group of disorders contains a rubric for unclassified reactions
000–x61	Simple adult maladjustment	000–x82	Adult situational reaction
	Primary behavior disorders in children	000–x84	Adjustment reaction of childhood
000–x71	Habit disturbance	000–x841	Habit disturbance
000–x72	Conduct disturbance	000–x842	Conduct disturbance
000–x73	Neurotic traits	000–x843	Neurotic traits

APPENDIX C

SUPPLEMENTARY TERMS
(Partial List) [1]

0– SUPPLEMENTARY TERMS OF THE BODY AS A WHOLE (INCLUDING SUPPLEMENTARY TERMS OF THE PSYCHE AND OF THE BODY GENERALLY) AND THOSE NOT AFFECTING A PARTICULAR SYSTEM EXCLUSIVELY

088	Acarophobia	(313)
089	Acrophobia	(313)
08x	Agoraphobia	(313)
044	Antisocialism	(320.4)
084	Anxiety	(310)
0x1	Asthenia	(790.1) *
030	Breath holding	(324.3) *
098	Bruxism	(318.5)
00x	Cachexia	(790.1) *
090	Cancerophobia	(313)
016	Causalgia	(366)
091	Claustrophobia	(313)
020	Cheiromegaly (enlargement of hands and fingers)	(787.2)
0x3	Chills	(788.9)
0x4	Chilly sensations	(788.9)
0x9	Collapse	(782.5)
079	Counting (steps, etc.)	(313)
052	Cruelty	(324.3) *
046	Deficiency, moral	(320.5)
010	Dehydration	(788.0)
078	Delire de toucher	(313)
080	Depersonalization	(318.1) *
085	Depression	(790.2)
053	Destructiveness	(324.3) *
02x	Diabetes insipidus	(272)
076	Dipsomania	(322.1) *
051	Disobedience	(324.3) *
018	Edema, hysterical	(311)
0x7	Edema, other types	(782.6) *
043	Emotional instability	(321.0)
05x	Enuresis	(786.2) *
057	Erotomania	(320.6)
019	Facetiousness	(326.4)
0x0	Fatigue, abnormal	(790.1) *

[1] Reprinted from "Standard Nomenclature of Diseases and Operations," Fourth Edition, published for American Medical Association, The Blakistone Co., Philadelphia, 1952.

087	Fears, mixed	(312)
035	Feeding problem in children	(772.0) *
059	Folie du doute	(310)
055	Forgery	(320.5)
028	Fugue	(780.8) *
006	Gain in weight	(788.9)
036	Homosexuality	(320.6)
000	Hypothermia	(788.9)
069	Kleptomania	(313)
008	Loss in weight	(788.4) *
037	Mania	(301.0) *
034	Masturbation	(317.1) *
047	Mendacity pathologic: untruthfulness	(320.5) *
03x	Misanthropy	(320.4)
039	Misogyny	(320.6)
014	Moria (Witzelsucht)	(309.1) *
086	Mysophobia	(313)
031	Nail biting	(324.3) *
029	Negativism	(320.4)
068	Nymphomania	(320.6)
007	Obesity	(287) *
045	Overactivity	(324.3) *
0x2	Pain, general	(788.9)
083	Panic	(310)
082	Panic, acute homosexual	(320.6)
081	Paranoid trends	(320.1)
072	Paroxysmal automatism	(308.1) *
074	Paroxysmal clouded states	(308.1) *
073	Paroxysmal furor	(308.1) *
071	Paroxysmal psychic equivalents	(308.1) *
027	Personality, dual	(320.7)
026	Personality, dissociated	(320.7)
040	Personality, paranoid	(320.1)
041	Personality, schizoid	(320.0)
042	Personality, syntonic	(No equivalent)
093	Phthisiophobia	(313)
003	Pyrexia; hyperthermia	(788.8)
056	Pyromania; setting fires	(313)
050	Quarrelsomeness	(321.2)
061	Sexual immaturity	(320.6)
060	Sex offenses	(320.6)
062	Sexual perversion	(320.6)
0x8	Shock	(782.9)
011	Simulation, malingering	(795.1)
024	Somnambulism	(780.7)

025	Somniloquism	(780.7)
054	Stealing	(324.3) *
0xx	Syncope	(782.5)
092	Syphilophobia	(313)
033	Tantrums	(324.3) *
0x5	Tetany	(788.5)
0x6	Tetany due to hyperventilation	(783.2)
032	Thumb sucking	(324.3) *
038	Tongue swallowing	(538)
012	Trance	(795.0)
066	Trichokryptomania	(313)
067	Trichotillomania	(313)
04x	Truancy	(324.3) *
013	Urge to say words	(313)
075	Use of alcohol	(322.2) *
058	Use of drugs	(323)
048	Vagabondage	(320.5)
049	Vagrancy	(320.5)
009	Xanthomatosis (symptomatic)	(289.0)

1– SUPPLEMENTARY TERMS OF THE INTEGUMENTARY SYSTEM (INCLUDING SUBCUTANEOUS AREOLAR TISSUE, MUCOUS MEMBRANES OF ORIFICES AND THE BREAST)

121	Acroasphyxia	(453.0)
122	Acrocyanosis	(453.3)
155	Anhidrosis	(714.0)
103	Blushing	(782.3)
104	Cyanosis	(782.3)
132	Dermatographia (excessive local circulatory reaction due to scratching the skin)	(716)
105	Erythema, general	(705.5)
106	Erythema, local	(705.5)
161	Hirsutism	(713)
153	Hyperhidrosis, general	(788.1)
154	Hyperhidrosis, local	(788.1)
156	Hyperhidrosis, nocturnal	(788.1)
162	Loss of hair	(713)
125	Night sweats	(788.1)
101	Pallor	(782.3)
182	Pilomotor disturbances	(781.7)
143	Pruritis	(708.5) *
152	Trophoneuroses	(368) *
159	Ulceration	(715) *

2–	SUPPLEMENTARY TERMS OF THE MUSCULOSKELETAL SYSTEM	
206	Arthralgia, general joint pain	(787.3)
246	Arthropathy	(738)
271	Ataxia; incoordination	(780.5)
272	Atonia (loss of muscle tone)	(744.2)
208	Coccygodynia	(787.5)
241	Contracture	(744.2) *
202	Hydrarthrosis	(738)
207	Lumbago, lumbosacral pain	(726.0)
231	Muscular cramp	(787.1)
251	Myalgia (muscle pain)	(726.3)
230	Myoidema (local increased muscular irritability)	(744.2)
232	Myotonia (increased muscular irritability)	(744.1)
20x	Postures hysterical	(311)

3–	SUPPLEMENTARY TERMS OF THE RESPIRATORY SYSTEM	
326	Asthma	(241) *
31x	Bronchial spasm	(527.2)
320	Change in voice	(783.5)
314	Cough	(783.3)
311	Dyspnea	(783.2)
321	Hoarseness	(783.5)
310	Incoordination of vocal cords	(517)
312	Orthopnea	(783.2)
330	Pain in thorax (noncardiac)	(783.7)
323	Paralysis of larynx	(517)
313	Paroxysmal dyspnea	(783.2)
318	Sneezing, intractable	(517)

4–	SUPPLEMENTARY TERMS OF THE CARDIOVASCULAR SYSTEM	
401	Anginal syndrome	(420.2) *
451	Arrhythymia (generally and unspecified)	(433.1)
412	Arrhythmia (sinus)	(433.1)
425	Atrial paroxysmal fibrillation	(433.1)
423	Atrial paroxysmal flutter	(433.1)
422	Atrial paroxysmal tachycardia	(433.1)
421	Atrial premature contraction	(433.1)
413	Bradycardia (sinus)	(433.1)
402	Palpitation	(782.1)
400	Precordial pain of cardiac origin	(782.0)
456	Premature beats, unspecified	(433.1)
441	Ventricular premature contractions	(433.1)

5– SUPPLEMENTARY TERMS OF THE HEMIC AND LYMPHATIC SYSTEMS

542	Acidosis	(788.6)
541	Alkalosis	(788.7)
554	Disturbance of creatine and creatinine metabolism	(289.2)
571	Hyperglycemia	(260)
574	Hypoglycemia	(270)
531	Leukemoid blood picture	(299)
510	Leukocytosis, simple	(299)

6– SUPPLEMENTARY TERMS OF THE DIGESTIVE SYSTEM

645	Abnormality of duodenal filling	(545)
647	Abnormality of intestinal filling	(578)
661	Achlorhydria	(544.0)
662	Achylia	(544.0)
617	Aerophagia	(316.3)
612	Anorexia (loss of appetite)	(784.0)
668	Blood in gastric contents	(784.5)
669	Blood in feces, occult	(785.8)
616	Bulimia (excessive appetite)	(783.9)
630	Constipation	(573.0)
635	Diarrhea	(785.6) *
631	Dysphagia (difficulty in swallowing)	(784.4)
615	Eructation	(784.8)
643	Gastric hypermotility	(544.1)
644	Gastric hypomotility	(544.1)
042	Gastric stasis	(544.2)
619	Halitosis	(788.9)
671	Hiccup, singultus	(784.7)
663	Hyperchlorhydria	(544.0)
664	Hypersecretion, gastric	(544.0)
666	Hypochlorhydria	(544.0)
639	Incontinence of feces	(785.7)
649	Intestinal hypermotility	(573.2)
64x	Intestinal hypomotility	(573.3)
632	Intestinal stasis	(578)
611	Nausea	(784.1)
648	Obstipation	(573.0)
625	Pain in the abdomen	(785.5)
624	Pain in epigastrium, (544.2); heartburn, (784.3); purosis, (784.3); cardialgia, (782.0)	
628	Paralysis of uvula	(517)
618	Pyloric obstruction	(545)
626	Rigidity of abdomen, general or local	(788.9)
623	Rumination or merycism	(784.8)
610	Salivation	(784.6)

61x	Thirst, excessive; polydipsia	(788.9)
614	Vomiting	(784.1)
7–	SUPPLEMENTARY TERMS OF THE UROGENITAL SYSTEM	
730	Abnormal acidity of urine	(789.9)
731	Abnormal alkalinity of urine	(789.9)
761	Amenorrhea	(634)
708	Ammoniacal urine	(789.9)
703	Anuria	(786.5)
772	Aspermia	(616)
777	Asthenospermia	(616)
766	Delayed menstruation	(634)
765	Dysmenorrhea	(634)
768	Dyspareunia	(786.7)
704	Dysuria	(786.0)
706	Frequency of micturition	(786.3)
707	Frequency of micturition, nocturnal	(786.3)
76x	Frigidity	(781.7)
778	Impotence	(617)
721	Incontinence of urine	(786.2)
767	Leukorrhea	(637.0)
763	Menorrhagia	(634)
764	Metrorrhagia	(634)
724	Nocturnal emissions	(617)
762	Oligomenorrhea	(634)
773	Oligospermia	(616)
702	Oliguria	(786.5)
780	Ovulation pain (Mittelschmerz)	(634)
770	Pain referable to female genital organs	(786.7)
775	Pain referable to male genital organs	(786.7)
710	Pain referable to urinary system	(786.0)
701	Polyuria	(786.4)
725	Premature ejaculation of semen	(617)
776	Priapism	(786.6)
705	Retention of urine	(786.1)
760	Vaginal bleeding	(637.1)
717	Vaginismus	(637.1)
712	Vesical pain	(786.0)
8–	SUPPLEMENTARY TERMS OF THE ENDOCRINE SYSTEM	
802	Depressed basal metabolism	(788.9)
801	Elevated basal metabolism	(788.9)
811	Hibernation and somnolence	(780.7)
806	Male climacteric	(617)
805	Menopausal syndrome	(635)
803	Thyroid crisis	(252.0)

9– SUPPLEMENTARY TERMS OF THE NERVOUS SYSTEM

9525	Absence of sensation of cold	(781.7)
9521	Absence of sensation of heat	(781.7)
9531	Absence of vibratory sensibility	(781.7)
992	Acalculia (inability to do simple arithmetic)	(326.0) *
976	Acroparesthesia	(453.3)
911	Amnesia	(780.8)
9552	Amnestic aphasia (loss of memory for words)	(326.2) *
989	Amusia	(781.3)
903	Analgesia (loss of pain sensitivity)	(781.7)
957	Anarthria (inability to express words or symbols properly)	(326.2) *
902	Anesthesia, hysterical	(311) *
956	Aphonia (inability to vocalize speech)	(783.5) *
9632	Apraxia, ideational	(780.5)
942	Astasia abasia (hysterical inability to stand)	(311)
944	Asynergia (ataxia) (disturbance in coordination)	(780.5)
9211	Athetosis (successive pattern movements, vermicular in character)	(780.4)
975	Autotopagnosia (phantom limb)	(781.7)
936	Cataplexy (falling caused by emotional influences)	(311)
939	Catatonia (maintenance of fixed postures)	(300.2)
9215	Choreoathetosis (combination of chorea and athetosis)	(780.4)
932	Coma	(780.0)
922x	Combined forms of abnormal involuntary movements	(780.4)
908	Compulsive talking	(313)
9631	Constructional apraxia	(780.5)
934	Convulsions, generalized	(780.2)
918	Crying, forced	(781.8)
931	Delirium	(780.1)
925	Delusions	(318.5)
922	Dementia	(309.1) *
9522	Diminution of sensation of heat	(781.7)
9526	Diminution of sensation of cold	(781.7)
904	Dream states	(781.9)
943	Dysbasia (difficulty in standing)	(787.6)
906	Dysesthesia (perverted objective sensitivity)	(781.7)
958	Dyslexia (difficulty in reading)	(326.0) *
945	Dysmetria (incorrect measuring of movements)	(780.5)
953	Dysphasia (difficulty in speech)	(326.2) *
959	Dyspraxia (difficulty in performance of skilled acts)	(780.5)
9216	Dystonic movements (intermittent hyper- and hypotonia)	(780.4)
928	Echolalia (echoing speech of examiner)	(326.2) *
938	Erythromelalgia (pain and redness of extremities due to nervous influence)	(453.3)
937	Flexibilitas cerea (cataleptic retention of postures)	(318.5)

9226	Habit spasm	(780.4)
910	Hallucinosis, general	(309.1) *
9101	Hallucinosis, hypnagogic (on going to sleep)	(780.7)
9102	Hallucinosis, hypnopompic (on awakening)	(780.7)
961	Headache; cephalalgia	(791)
9513	Hemianalgesia	(781.7)
901	Hemianesthesia	(781.7)
9212	Hemiathetosis	(780.4)
9210	Hemiballismus (gross throwing movements of upper and/or lower extremities)	(780.4)
9514	Hemihypalgesia	(781.7)
917	Hemihypesthesia	(781.7)
968	Hemiparesis	(352) *
9512	Hypalgesia (reduction of pain sensitivity)	(781.7)
9515	Hyperalgesia (increased pain sensitivity)	(781.7)
905	Hyperesthesia (increased sensitivity)	(781.7)
9516	Hyperpathia (increased effect from painful stimuli)	(781.7)
914	Hypersomnia	(780.7)
913	Hypesthesia (reduction of feeling)	(781.7)
926	Illusions	(309.1) *
9527	Increase of sensation of cold	(781.7)
9523	Increase of sensation of heat	(781.7)
916	Insomnia; hyposomnia	(780.7)
9555	Interjectional speech	(326.2) *
919	Laughter, forced	(781.8)
923	Mental deterioration	(328.9) *
92x	Migraine	(354)
948	Monoplegia	(352) *
9219	Myoclonus (muscle contractions of a rhythmical character)	(780.4)
930	Narcolepsy (excessive inclination to sleep)	(780.7)
9519	Neuralgia, facial, atypical	(360)
915	Neurotic excoriations	(708.4)
9227	Occupational spasm or tic	(318.2)
973	Palilalia (repetition of words)	(326.2) *
9558	Paragrammatism (ungrammatical speech)	(362.2) *
971	Paraphasia (misuse of words)	(326.2) *
941	Paraplegia	(352) *
907	Paresthesia (tingling, numbness, burning, bursting, crawling, tickling, etc.)	(781.7)
929	Perseveration (repetition of patient's own words, phrases or movements)	(781.8)
940	Pyknolepsy (short lapses of consciousness)	(353.3)
9222	Spasm (780.4); torticollis (726.2); hemispasm facialis (780.4)	
9330	Spasm of glottis	(517)
9224	Spasmus nutans (nodding of head)	(780.4)

933	Stupor	(780.0)
9302	Stuttering (including stammering)	(326.1) *
9225	Tic (muscle contraction, irregular)	(780.4)
9223	Torsion spasm (torsion of shoulder or pelvic girdle)	(355)
9228	Tremor	(780.4)
995	Vasomotor disturbances	(453.3)

x– SUPPLEMENTARY TERMS OF THE ORGANS OF SPECIAL SENSE

x12	Amaurosis (blindness)	(389.1) *
x13	Amblyopia (dimness of vision)	(388.9)
x41	Anosmia	(781.7)
x22	Diplopia	(781.1)
x07	Disturbances of hearing	(781.3) *
x40	Disturbances of olfactory nerve	(781.4)
x50	Disturbances of optic nerve	(781.0) *
x78	Disturbances of secretory and vasomotor nerves	(781.4)
x20	Enophthalmos	(781.1)
x21	Exophthalmos	(781.1)
x31	Extrinsic muscles (eye), spasm (including blepharospasm)	(388.9)
x43	Hallucinations	(781.9)
x432	Hallucinations of hearing	(781.9)
x435	Hallucinations of smell	(781.9)
x431	Hallucinations of taste: ageusia, parageusia	(781.9)
x433	Hallucinations of vision	(781.9)
x34	Intrinsic muscles (eye), spasm	(388.9)
x00	Ménière syndrome (labyrinthine syndrome)	(395)
x2x	Nystagmus	(781.1) *
x123	Psychic blindness	(355)
x04	Tinnitus	(781.3)
x0x	Vertigo	(780.6)
x124	Word blindness	(326.0) *
x03	Word deafness	(326.2) *

APPENDIX D

STATE MENTAL HOSPITAL SYSTEMS WITH STATISTICAL OFFICES

	Commissioner or Director of Mental Hospitals	Statistician
ARKANSAS:	Granville Jones, M.D. Superintendent Arkansas State Hospital Little Rock, Arkansas	Mr. M. T. McMurry Registrar Arkansas State Hospital Little Rock, Arkansas
CALIFORNIA:	Daniel Blain, M.D., Director Dept. of Mental Health 1320 K Street Sacramento, California	Mr. R. D. Morgan Statistical Research Officer Dept. of Mental Health Sacramento 14, California
CONNECTICUT:	Wilfred Bloomberg, M.D. Commissioner Dept. of Mental Health State Office Building Hartford, Connecticut	Mrs. Barbara Hellenga Chief, Mental Health Statistics Dept. of Mental Health Hartford, Connecticut
ILLINOIS:	Otto L. Bettag, M.D., Director Dept. of Public Welfare Springfield, Illinois	Mr. Edmund G. D'Elia, Supervisor Research & Statistics Dept. of Public Welfare Springfield, Illinois
INDIANA:	Stewart T. Ginsberg, M.D. Commissioner Division of Mental Health 1315 West 10th Street Indianapolis 7, Indiana	Miss Marjorie V. May, Director Office of Statistical Research Division of Mental Health 1315 West 10th Street Indianapolis 7, Indiana
IOWA:	J. O. Cromwell, M.D., Director Mental Health Institute Independence, Iowa	Mrs. Hazel Garner, Statistician Board of Control of State Institutions Des Moines, Iowa

	Commissioner or Director of Mental Hospitals	Statistician
KANSAS:	George W. Jackson, M.D. Director of Institutions State Dept. of Social Welfare Topeka, Kansas	Mrs. Arthur E. Schaaf Biometrics Supervisor State Dept. of Social Welfare 801 Harrison Street Topeka, Kansas
KENTUCKY:	Harold L. McPheeters, M.D. Commissioner Dept. of Mental Health 620 South Third Street Louisville 2, Kentucky	Mrs. Anna Barker, Chief Statistical Research Dept. of Mental Health 620 South Third Street Louisville 2, Kentucky
LOUISIANA:	Charles Rosenblum, M.D. Director Dept. of Hospitals State Capitol Building Baton Rouge, Louisiana	Mr. Cecil R. Wurster, Chief Div. of Research and Statistics Dept. of Hospitals State Capitol Building Baton Rouge, Louisiana
MASSACHUSETTS:	Harry Solomon, M.D. Commissioner Dept. of Mental Health 15 Ashburton Place Botson 8, Massachusetts	Thomas Pugh, M.D. Director Division of Mental Statistics and Research Dept. of Mental Health Boston, Massachusetts
MICHIGAN:	Mr. Charles F. Wagg Director Dept. of Mental Health Cass Building Lansing 13, Michigan	Miss Gwen Andrew Chief, Research Dept. of Mental Health Cass Building Lansing 13, Michigan
MINNESOTA:	David J. Vail, M.D. Medical Director Division of Mental Service Minnesota Dept. of Public Welfare St. Paul 1, Minnesota	Miss Thyrza Tyrrell Institutions Statistician Dept. of Public Welfare Centennial Building St. Paul, Minnesota

	Commissioner or Director of Mental Hospitals	Statistician
NEBRASKA:	Cecil L. Wittson, M.D. Director of Mental Health Division of Mental Health Board of Control of State Institutes Omaha, Nebraska	Mr. John Wenstrand, Chief Research and Statistics Div. of Public Welfare Lincoln 9, Nebraska
NEW JERSEY:	V. Terrell Davis, M.D., Director Div. of Mental Health and Hospitals Dept. of Institutions and Agencies Trenton, New Jersey	Mr. Douglas H. McNeil, Chief Bureau of Social Research Dept. of Institutions and Agencies 135 West Hanover Street Trenton 7, New Jersey
NEW YORK:	Paul H. Hoch, M.D., Commissioner State Dept. of Mental Health Gov. Alfred Smith State Office Building Albany, New York	Mr. Robert E. Patton, Director Statistical Services Dept. of Mental Health State Building Albany, New York
OHIO:	Robert C. Anderson, M.D. Acting Commissioner Dept. of Mental Hygiene State Office Building Columbus 16, Ohio	Mr. Grover Chamberlain Administrative Assistant Research and Statistics Dept. of Mental Hygiene Columbus 16, Ohio
OKLAHOMA:	T. Glyn Williams, M.D. Commissioner of Mental Health Dept. of Mental Health State Capitol Building Oklahoma City, Oklahoma	Mr. Donald D. Tolliver Dir. of Biometrics Dept. of Mental Health State Capitol Building Oklahoma City, Oklahoma
PENNSYLVANIA:	John Davis, M.D. Commissioner for Mental Health Dept. of Public Welfare Harrisburg, Pennsylvania	Mr. Paul P. Schroth Chief Statistician Office of Program Research and Statistics Dept. of Public Welfare Harrisburg, Pennsylvania

	Commissioner or Director of Mental Hospitals	Statistician
SOUTH CAROLINA:	William P. Beckman, M.D. Director, Mental Health State Mental Health Commission 1100 Senate Street Columbia 1, South Carolina	Mr. P. G. Reeves, Jr. Statistician State Mental Health Commission Columbia 1, South Carolina
TENNESSEE:	Joseph J. Baker, M.D., Director Dept. of Mental Health Cordell Hull Building Nashville, Tennessee	Mr. Jack Holladay Dir. of Statistical Service Dept. of Mental Health Nashville, Tennessee
TEXAS:	Cyril J. Ruilman, M.D., Director State Mental Hospitals Board for Texas State Hospitals and Special Schools Box S, Capitol Station Austin, Texas	Mr. Alvin Jones Board of Texas State Hospitals and Schools Box S, Capitol Station Austin, Texas
VIRGINIA:	Hiram W. Davis, M.D. Commissioner Dept. of Mental Hygiene and Hospitals 9 North 12th Street Richmond, Virginia	Miss Edna M. Lantz Statistician Dept. of Mental Hygiene and Hospitals 9 North 12th Street Richmond, Virginia
WASHINGTON:	Garrett Heyns, Ph.D., Director Department of Institutions P. O. Box 876 Olympia, Washington	Mr. C. Larry Shull Methods Analyst Dept. of Institutions Olympia, Washington
WISCONSIN:	Leslie A. Osborn, M.D. Director Division of Mental Hygiene 1552 University Avenue Dept. of Public Welfare Madison, Wisconsin	Mr. John Mannering Chief Statistician Bureau of Research and Statistics Dept. of Public Welfare Madison 2, Wisconsin