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CANADA

# MENTAL STATISTICS HANDBOOK

DOMINION BUREAU OF STATISTICS

Health and Welfare Division

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# MENTAL STATISTICS HANDBOOK

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## PREFACE

At the beginning of 1952 more than 60,000 patients were recorded on the books of Canadian mental hospitals or in psychiatric units, 6,000 more than all the patients in all the public hospitals of the country on the same date.

The growing numbers of annual admissions to mental hospitals, the increasing outlay of public funds for institutional accommodation, the perennial shortage of beds, all point up the importance of mental illness as a continuing health problem of the first magnitude. Advances in combatting infective diseases, in prolonging life expectancy and in the general improvement of physical health have not been matched by comparable reductions in the incidence of mental disorders. Indeed, the successful control of a number of deadly diseases has served rather to accentuate the seriousness of mental illness as a cause of much suffering and unhappiness, and, from another viewpoint, of great wastage of our human resources.

There is little doubt that the complex problems involved in the prevention and treatment of mental illness will continue to confront Canadian health and welfare authorities in undiminished measure in the foreseeable future. There is equally little doubt that an indispensable prerequisite to the proper understanding of these problems is the provision of reliable current statistical information on mental illness and on the institutional and other services provided. The task of compiling and publishing such statistics is the statutory responsibility of the Dominion Bureau of Statistics, exercised in collaboration with federal and provincial mental health authorities.

The present handbook sets out the definitions and instructions to be followed by mental hospital authorities in making statistical returns which will be both accurate and uniform. It includes, however, additional material designed to enhance its usefulness for purposes of reference, teaching, and general information. Thus it contains, in addition to specific instructions for completion of the Bureau schedules, separate sections outlining the operation of the statistical system, a selected bibliography, a list of commonly used statistical terms and rates, and several other features.

The Bureau gratefully acknowledges the assistance received from many sources in the preparation of the material. Special acknowledgement is due to Dr. C.A. Roberts, Chief of the Mental Health Division of the Department of National Health and Welfare, and to the Subcommittee on Statistics of the Advisory Committee on Mental Health under the chairmanship of Dr. G.E. Hobbs, Professor, Department of Psychiatry and Preventive Medicine, University of Western Ontario. The Bureau is also indebted to Dr. E.S. Goddard of the Committee on Nomenclature and Statistics of the American Psychiatric Association for assistance in preparing the descriptions of the characteristics of mental disorders contained in Section 3. The handbook was prepared in the Health and Welfare Division of the Bureau.

H. Marshall,  
*Dominion Statistician.*

## CONTENTS

	Page
SECTION 1. Canada's national system of mental illness statistics	7
SECTION 2. Statistics of mental health services:	
Annual return (Schedule 1).....	11
Annual financial statement (Schedule 2) .....	18
Annual return of clinics .....	21
SECTION 3. Statistics of mental illness:	
Admission card .....	23
Separation card .....	26
Monthly statement .....	29
SECTION 4. Classification of mental disorders .....	30
SECTION 5. Index of mental disorders.....	51
SECTION 6. Commonly used statistical terms and rates.....	71
SECTION 7. Selected bibliography .....	75

## SECTION 1

### Canada's national system of mental illness statistics

Canada's "constitution", the British North America Act, allocates responsibility for "the census and statistics" to the federal government in setting out the division of governmental jurisdiction between the Dominion and the provinces.

Out of that early statutory responsibility has evolved the unified system of national statistics now centralized in the Dominion Bureau of Statistics. Operating as a branch of the federal Department of Trade and Commerce, the Bureau's authority to collect, compile and publish statistics on virtually all aspects of national life is based on the Statistics Act of 1948 and sustained by a network of co-operative agreements with other federal departments, provincial governments and non-governmental agencies.

In the field of health, including the special area of mental illness, the events and situations being measured are in the main the constitutional concern of the 10 provincial governments rather than of the federal government. Accordingly, the source data are collected and compiled within the framework of working arrangements between the Bureau and provincial health departments.

#### System started in 1931

The present system of mental illness statistics originated in 1931. In that year the general population census was supplemented by a special census of mental institutions which provided comprehensive statistics on patients in mental hospitals. The next year, in response to a growing demand for detailed information on the institutional care of the mentally ill, the system was placed on an annual basis. The Bureau undertook to publish an annual report on the mental institutions operating in Canada, based on data compiled from two types of return—a schedule completed and submitted yearly by each institution and an individual reporting card on each patient, prepared at the time of admission, transfer, discharge or death.

Few changes have since been made in the basic methods of collecting the source data, although improvements have been introduced from time to time in simplifying the reporting documents, eliminating unnecessary questions, extending the coverage, and consolidating the liaison with provincial health departments and institutions. In recent years supplementary schedules have been designed for mental health clinics and out-patient services, and the individual card system has been broadened to include psychiatric units in general hospitals.

The reporting schedules and cards are basically uniform for all provinces, though not entirely so. The minor differences designed to meet special requirements in several provinces in no way affect nationwide comparability—indeed they tend to strengthen the reporting system by providing the flexibility necessary for full co-operative effort. Similar uniformity in the terms and definitions which underlie the reported data is achieved through the present handbook and its predecessors.

#### **Four main objectives**

The purpose of the system is to make available reliable statistical information on four main aspects of mental illness:

- the amount, nature and utilization of hospital accommodation and facilities available for treatment of the mentally ill,
- the operating costs, revenues and financial condition of mental hospitals.
- the incidence and nature of hospitalized mental illness and the characteristics of patients.
- the nature, duration and results of hospital treatment.

The first two of these are fulfilled by tabulation of the data reported to the Bureau on the two brief schedules completed by mental hospitals at the end of each calendar year. The latter two are compiled from the individual card completed for each patient and from the patient-inventory card file built up from the cards and maintained currently in the Bureau. A third, special schedule reports the yearly volume of service given by mental health clinics.

#### **Provincial liaison**

The returns are not in all cases sent directly from the institution to the Dominion Bureau of Statistics. In several provinces the provincial health department acts as an intermediate link by distributing blank forms to the institutions, collecting them when completed and sending the returns forward in bulk to the Bureau. This system offers mutual advantages—the Bureau reaps the benefit of having the receipt and editing of returns carried out by a division of the provincial health department in close professional and administrative touch with the hospitals while the province secures a more current picture of patient movement and other data than can be provided by the statistics subsequently compiled by the Bureau. In one other province the cards are routed through the provincial department but the schedules are submitted directly. In the remaining provinces the Bureau, with provincial concurrence, deals directly with the individual hospitals.

#### **System tuned to current needs**

The contents and layout of the reporting forms are determined by a number of factors. First and foremost are the requirements of consumers of the data, primarily professional health personnel concerned with various aspects of mental illness but including also social welfare workers, educators, and persons in a number of professions outside the purely psychiatric field. Officers of the Bureau seek constantly to keep in touch with consumer needs through membership in professional organizations, direct consultation with such groups as the Advisory Committee on Mental Health and the Medical Advisory Committee to the Dominion Statistician, and by personal contact with responsible provincial authorities and hospital administrators.

The consultative group most directly involved in giving professional guidance on the psychiatric requirements is the Advisory Committee on Mental Health, which, by including Directors of the Mental Health Divisions of the provinces as members, accurately reflects current provincial and institutional statistical needs.

The requirement factor must, however, be influenced strongly by expediency. The answers to many questions which might be asked are either not available or would be subject to considerable bias and must therefore be excluded in the interests of limiting the returns to data which can be expected to be provided with reasonable completeness and accuracy. Finally, further modification is frequently prompted by the desire to avoid imposing an undue burden on the administrative and clerical staffs of mental hospitals, a hazard which commonly gives rise to delinquent or deficient returns. The net result sought is a compromise between these factors, worded and arranged so as to cause a minimum of inconvenience in completion while affording maximum facility for tabulation.

### **Returns confidential**

Since much of the information collected concerning individual patients is of a highly confidential nature, great care is taken to ensure complete protection of the particulars reported. Not only is strict secrecy specifically enjoined upon all staff by oath, but extra vigilance is exercised to guard against the inadvertent disclosure of identity through very small frequencies in published figures. Experience has amply demonstrated the importance of such confidentiality in securing the full confidence of respondents.

Obviously, the contribution of the individual hospital to the success of the statistical system is all-important. Little effort is needed by the Bureau or provincial authorities to promote institutional co-operation since almost all hospitals appear anxious to give complete and willing compliance with the requirements of reporting. A growing appreciation by hospital personnel of the practical benefits to be derived from comparison of individual hospital experience with provincial and national norms is no doubt partly responsible for this commendable outlook. Unfortunately, however, a multitude of pressing administrative problems not infrequently separates the intention from the deed. The maintenance by mental hospitals of current accurate records and accounts, while much more widespread in recent years, is still by no means universal. Yet such practices, recognized by most institutions as indispensable to sound administration, can at the same time reduce the task of periodic statistical reporting to negligible proportions.

### **Punctual returns important**

Lateness in reporting is still a perennial obstacle to the publication of timely statistics. Figures more than a year old lose much of their value in an era of such rapid growth and change as the present. Although modern equipment and improved methods have greatly accelerated the processes of tabulation, the statistical machine cannot be set in motion until the returns are checked in. Each individual procrastination not only withholds much-needed information from all mental health workers but also, by causing a tightening of deadlines all along the assembly line, reduces substantially the time available for the analysis, interpretation and graphic illustration which enhance the usefulness of statistical publications. The most significant single contribution an institution can make to the advancement of mental illness statistics in Canada is the simple matter of completing and submitting its returns punctually. Specifically, individual cards should

be sent in immediately after the close of each month; the annual Schedule 1 should be sent in by the middle of January each year; the financial return, Schedule 2, as soon as the closing of accounts makes the data available.

The achievement of such prompt reporting, permitting the publication of national and provincial statistics within six months of the end of each year, is an objective of both federal and provincial mental health authorities as well as of the Bureau. Hospital administrators and officials are urged to participate in its early attainment, no less from self-interest than as a public service. They are invited to refer any difficulties promptly to the appropriate provincial authority or to the Bureau and to take full advantage of the advice and assistance available from these sources in establishing accurate, punctual reporting.

### **Future improvements**

What may mental health personnel, in hospitals and in government, expect in return for wholehearted voluntary co-operation in this nationwide statistical network? The indispensability of reliable statistics for planning bed accommodation, for providing specialized treatment services, for sound hospital administration and financing, for initiation of preventive measures and for a wide range of similar practical problems provides the answer. Canada now takes second place to no other country in the comprehensiveness and reliability of its mental health statistics. The task of maintaining this position, of consolidating the improvements being made, and of improving still further the practical usefulness of the statistics, requires above all the voluntary acknowledgement by mental hospitals of their key role in the co-operative effort which can yield such rewarding results.

## SECTION 2

### Statistics of mental health services

The previous Section mentions the two types of return made to the Dominion Bureau of Statistics or to the provincial department of health by Canadian mental hospitals:

- (a) **The annual return**, made at the end of each calendar year in the form of a completed schedule. The annual return yields information about the hospital, its characteristics and year's activities.
- (b) **The individual card**, sent in monthly for each admission or separation which occurred during the month. The cards, described in Section 3, provide the basis for statistics of hospitalized mental illness.

This Section outlines the procedure to be followed in making the annual return; listing, where necessary, the definitions or interpretations to be used in cases where some doubt might exist as to the precise intent of a question.

There are two basic annual schedules. Each is a simple, one-page form especially designed for easy completion, —

- (a) Schedule 1 gives general information about the hospital, including personnel and services.
- (b) Schedule 2 is a brief summary of the financial activities of the hospital during the year.

In addition to these two basic schedules, a third, special, schedule covers the annual activities of mental health clinics and out-patient departments.

#### Schedule 1

Schedule 1, shown below in facsimile, is to be completed at the end of the calendar year by mental hospitals, psychiatric units (in general hospitals, sanatoria, etc.), and training schools, operated solely for the care of in-patients and which are recognized as such by a federal government agency or by the government of the province in which they are located.

When completed fully the Schedule should be returned to Institutions Section, Dominion Bureau of Statistics, Ottawa (or, where a special arrangement exists, to the appropriate provincial government department) not later than January 15 each year.

#### 1. Ownership and type

- (a) **Ownership.** Check the appropriate box to show what type of agency owns the hospital. Ownership ordinarily means the persons, corporation or government agency under whose name the lease or deed to the real estate of the hospital is registered or held.

# ANNUAL RETURN OF MENTAL HOSPITALS - SCHEDULE I

Name of hospital and address \_\_\_\_\_

## 1. OWNERSHIP AND TYPE

- (a) Ownership ☐ Federal ☐ Provincial ☐ Municipal  
☐ Lay corporation ☐ Religious organization ☐ Other private
- (b) Type of hospital ☐ Mental hospital ☐ Psychiatric hospital ☐ Epilepsy hospital  
☐ Training school ☐ Psychiatric unit ☐ Other
- (c) Standard bed capacity .....
- (d) Number of patients in hospital at December 31, 1953 .....
- (e) Number of patient days during 1953 .....
- (f) Average daily in-patient population during 1953 .....
- (g) Number of patients under treatment for tuberculosis at December 31, 1953 .....

## 2. SERVICES

### (a) Organized services -

- |             |   |  |  |
|-------------|---|--|--|
| Psychiatric | <input type="checkbox"/> Psychosurgery          | <input type="checkbox"/> Audio-visual              | <input type="checkbox"/> Psychotherapy               |
|             | <input type="checkbox"/> Psychology             | <input type="checkbox"/> Occupational therapy      | <input type="checkbox"/> Recreational therapy        |
|             | <input type="checkbox"/> Social service         | <input type="checkbox"/> After care                | <input type="checkbox"/> Children's unit             |
|             | <input type="checkbox"/> Out-patient department |  |  |
| General     | <input type="checkbox"/> General medical        | <input type="checkbox"/> General surgery           | <input type="checkbox"/> Neurosurgery                |
|             | <input type="checkbox"/> Neurology              | <input type="checkbox"/> Eye, ear, nose and throat | <input type="checkbox"/> Paediatric                  |
|             | <input type="checkbox"/> Geriatric              | <input type="checkbox"/> Tuberculosis              | <input type="checkbox"/> Other communicable diseases |
|             | <input type="checkbox"/> Dentistry              | <input type="checkbox"/> Dietetics                 |  |
|             |   |  |  |

### (b) Service activities -

- |               |  |   |   |
|---------------|--|---|---|
| Investigation | <input type="checkbox"/> Clinical pathological | <input type="checkbox"/> Electrocardiography                  | <input type="checkbox"/> Electroencephalography |
|               | <input type="checkbox"/> Psychological         | <input type="checkbox"/> Social service                       | <input type="checkbox"/> X-ray                  |
| Treatment     | <input type="checkbox"/> X-ray therapy         | <input type="checkbox"/> Leucotomy                            | <input type="checkbox"/> ECT                    |
|               | <input type="checkbox"/> Insulin               | <input type="checkbox"/> Planned psychotherapeutic interviews | <input type="checkbox"/> Physiotherapy          |
|               | <input type="checkbox"/> Fever                 | <input type="checkbox"/> Hydro                                | <input type="checkbox"/> Social casework        |
|               |  |   |   |

## 3. EDUCATIONAL FACILITIES

### (a) Medical education -

- |   | Yes                                       | No                       |
|---|---|--------------------------|
| Is the hospital affiliated with a medical school for undergraduate education.....                       | <input type="checkbox"/>                  | <input type="checkbox"/> |
| Is the hospital approved by the Canadian Medical Association for affiliated rotating internships .....  | <input type="checkbox"/>                  | <input type="checkbox"/> |
| Is the hospital approved by the Royal College of Physicians and Surgeons of Canada for residencies in - |   |                          |
|   | <input type="checkbox"/> Psychiatry ..... | <input type="checkbox"/> |
|   | <input type="checkbox"/> Neurology .....  | <input type="checkbox"/> |
|   | <input type="checkbox"/> Other .....      | <input type="checkbox"/> |

### (b) Nurse education -

- |  |                          |                          |
|--|--------------------------|--------------------------|
| Has the hospital an approved school of nursing .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Does the school of nursing provide formal training for psychiatric nurses .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Are graduates eligible for registration as psychiatric nurses .....              | <input type="checkbox"/> | <input type="checkbox"/> |
| Number of nurses graduated from the school of nursing during 1953 .....          |                          |                          |
| Is affiliation provided for general hospital student nurses .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| Does the hospital provide organized post-graduate courses in psychiatric nursing | <input type="checkbox"/> | <input type="checkbox"/> |
| Does the hospital provide formal training for - orderlies or attendants .....    | <input type="checkbox"/> | <input type="checkbox"/> |
| - nursing aides .....  | <input type="checkbox"/> | <input type="checkbox"/> |

#### 4. PERSONNEL AT DECEMBER 31, 1953

(g) Nursing staff -

Psychiatric nurses .....	100
Other graduate nurses - Registered .....	100
- Not registered .....	100
Student nurses (incl. affiliate) - For psychiatric .....	100
- For other graduate .....	100
Nursing aides - Trained .....	100
- Untrained .....	100
Orderlies and attendants .....	100
Other nursing staff .....	100

[illegible]

(b) Other personnel -

Administration	Medical superintendent .....	100
	Assistant medical superintendent .....	100
	Administrator .....	100
	Matron or superintendent of nurses .....	100
	Other administrative staff .....	100
Professional core (excl. nurses)		
	Doctors - Clinical director .....	100
	- Staff - Certificated specialists .....	100
	- Physicians .....	100
	- Residents .....	100
	- Interns .....	100
	- Consulting - Certificated specialists .....	100
	- Other .....	100
	Dentists .....	100
	Psychologists .....	100
	Pharmacists - Registered .....	100
	- Other .....	100
	Technicians - Laboratory - Certified .....	100
	- Other .....	100
	Radiology - Registered .....	100
	- Other .....	100
	E E G technicians .....	100
	Other technicians .....	100
	Therapists - Occupational - Registered .....	100
	- Other .....	100
	- Recreational - Qualified .....	100
	- Other .....	100
	- Other therapists .....	100
	Academic teachers .....	100
	Social workers - Psychiatric .....	100
	- Other qualified .....	100
	- Other .....	100
	Dietitians - Certified .....	100
	- Qualified .....	100
	- Other .....	100
	Chaplains .....	100
	Other staff for professional care .....	100
Other staff		
	Dietary .....	100
	Laundry .....	100
	Housekeeping, bedding and linen .....	100
	Building maintenance .....	100
	Garden and farm .....	100
	All other employees .....	100
TOTAL PERSONNEL (excl. nursing staff)		1000

[illegible]

**TOTAL PERSONNEL** (excl. nursing staff)

- (b) **Type of hospital.** Check the appropriate box to show the type of treatment or service which the hospital primarily gives. Use the following definitions in case of doubt—

*Mental hospital*—a hospital organized for the treatment of patients suffering from all types of psychiatric conditions. Most mental institutions are in this class.

*Psychiatric hospital*—a hospital organized for the intensive, short-term treatment of persons suffering from psychiatric conditions.

*Epilepsy hospital*—a hospital organized for the treatment of epilepsy.

*Training school*—an institution organized for the training and care of persons who are mentally defective.

*Psychiatric unit*—a ward or section organized for treating psychiatric conditions in an institution which is not primarily a mental hospital.

*Other*—a hospital which falls within the general class of mental institutions but which is not covered by one of the five definitions above.

- (c) **Standard bed capacity.** Give the bed capacity according to the standards shown below, regardless of the number actually provided or the number of patients accommodated. In applying the standards, psychiatric hospitals and psychiatric units should use the figures shown for "Reception and convalescent" patients.

Minimum number of square feet per bed

Type of patient	Alcoves or wards	Single rooms	Day rooms (per patient)
Reception and convalescent ....	60	100	50
Medical, surgical, tuberculosis	80	100	20
Infirm.....	60	100	30
Continuous care.....	50	100	50

Corridor space does not count unless it is an integral part of the sleeping or day space.

- (d) **Number of patients in hospital at December 31.** Include only the patients actually in residence in the hospital on December 31.
- (e) **Number of patient days during the year.** State the total number of days spent in the hospital by all patients during the year.
- (f) **Average daily in-patient population during the year.** A quick way of calculating this figure is to divide the number of days in question (e) by 365 (for a leap year divide by 366).
- (g) **Number of patients under treatment for tuberculosis at December 31.** State the number of patients who were under treatment for any tuberculosis condition on December 31.

## 2. Services:

- (a) **Organized services.** Check the appropriate boxes to indicate the services available to patients. To qualify, the service must be provided within the hospital under the direction of a properly qualified person.
- (b) **Service activities.** Check those activities which were carried out at any time during the year.

## 3. Educational facilities

### (a) Medical education

*Is the hospital affiliated with a medical school for undergraduate education.* Check "yes" only where the hospital and a university with a medical faculty have entered into an agreement whereby a doctor who is on the teaching staff of the university is also on the active attending staff of the hospital, and whereby undergraduate students of the medical faculty are assigned to the hospital to receive practical experience in the treatment of patients in the hospital as a regular part of their curriculum.

*Is the hospital approved by the Canadian Medical Association for affiliated rotating internships.* Check "yes" if the hospital is a participating member of a group of hospitals approved as a part of a rotating program for the training of internes.

*Is the hospital approved by the Royal College of Physicians and Surgeons of Canada for residencies.* Check "yes" if the hospital has been approved for the specialized training of doctors as residents in psychiatry, neurology or other specialties.

### (b) Nurse education

*Has the hospital an approved school of nursing.* An approved school of nursing is one which meets the legal requirements of the province in which it is located. It refers only to schools whose graduates are eligible to take the qualifying examination for Registered Nurse. It does not include schools for nursing assistants.

*Does the school of nursing provide formal training for psychiatric nurses.* Formal training means an organized program of study and practice in psychiatric nursing.

*Are graduates eligible for registration as psychiatric nurses.* Check "yes" where the graduates are eligible under a provincial statute for a licence as psychiatric nurse or the equivalent.

*Is affiliation provided for general hospital student nurses.* Check "yes" if the hospital has entered into an agreement whereby undergraduate students of an approved school of nursing are assigned to the hospital to receive practical experience in the treatment of patients in the hospital as a regular part of their curriculum.

#### 4. Personnel

Insert the number of paid personnel, of each type, employed by the hospital at December 31. Include as paid personnel members of religious orders who are working in the hospital as staff members without pay. Do not include other unpaid voluntary workers.

##### (a) Nursing staff

*Psychiatric nurses* are persons who have satisfactorily completed a formal course in psychiatric nursing, have graduated from an approved school of psychiatric nursing and have completed the necessary qualifying examination.

*Other graduate nurses—Registered* are persons who have graduated from an approved school of nursing and who are registered with the provincial Nurses' Association.

— *Not registered* are those who have graduated from an approved school of nursing but who are not registered with the provincial Nurses' Association.

*Student nurses—For psychiatric* are those who are taking a specialized formal course of training, leading to a qualifying examination for psychiatric nurse, in the hospital's school of nursing, and those who are taking a similar course of training in another approved school of nursing but who are temporarily attached to the mental institution at December 31 for training purposes.

— *For other graduate* are those who are taking a formal course of training, leading to a qualifying examination for graduate nurse, in the hospital's approved school of nursing, and those who are taking a formal course of training in another approved school of nursing but who are temporarily attached to the mental institution for training purposes.

*Nursing aides—Trained* are persons who have completed a formal course of training below the level of the course for psychiatric or other graduate nurse. This includes nursing assistants, practical nurses and persons of similar status.

— *Untrained* are persons who have enrolled for, but have not yet completed a formal course of training as defined above.

*Orderlies and attendants* are persons who perform nursing duties but who have neither enrolled for nor completed a formal course of training.

*Other nursing staff* includes all other nursing personnel employed by the hospital at December 31.

##### (b) Other personnel

###### Administration

*Other administrative staff* includes such personnel as the controller, secretary, business manager and general office personnel.

###### Professional care

*Doctors—Clinical director* is a qualified psychiatrist freed from administrative responsibilities who is responsible for the professional care of the patients and the training of professional staff.

— *Staff—Certified specialists* are those who are certificated in a specialty by the Royal College of Physicians and Surgeons of Canada.

*Physicians* include all paid full-time and part-time physicians and surgeons on the payroll, including doctors under contract to the hospital, but not including residents.

*Residents* are those who are training in the specialties offered by the hospital.

*Interns* are interns actually training in the hospital.

— *Consulting—Certified specialists* are consulting physicians who have been certificated in a specialty by the Royal College of Physicians and Surgeons of Canada.

*Other* includes consulting physicians who are not certificated specialists.

*Pharmacists—Registered* includes only those who are registered as pharmacists under the Pharmacy Act of the province in which the hospital is located.

— *Other* includes employees who are carrying out the duties of a pharmacist although not registered as above.

*Technicians—Laboratory—Certified* are those who possess a graduation certificate from an approved school for laboratory technologists. Approval is by a committee of the Canadian Medical Association in cooperation with the Canadian Society of Laboratory Technologists.

— *Radiology—Registered* are those who are registered with the Canadian Society of Radiological Technicians or the American Registry of Radiological Technicians.

— *EEG technicians* include only those who are registered as EEG technicians.

*Therapists—Occupational—Registered* include only persons who are registered as occupational therapists.

— *Recreational—Registered* are those who have satisfactorily completed a postgraduate course in recreational therapy.

*Social Workers—Psychiatric* are persons who have graduated from a school of social work approved by the Canadian Association of Social Workers and who have had psychiatric field experience, or those who have had five years experience in social work under qualified supervision, at least one year of which has been under psychiatric supervision.

— *Other qualified* are persons who have graduated from a school of social work approved by the Canadian Association of Social Workers, or those who have had five years experience in social work under qualified supervision.

*Dietitians—Certified* are persons who have satisfactorily completed a postgraduate course in hospital dietetics approved by the Canadian Dietetics Association.

*Qualified* are persons who have satisfactorily completed a postgraduate course in hospital dietetics.

*Other* includes those who, though having graduated in Home Economics, are neither "Certified" nor "Qualified" as defined above but who are carrying out the functions of a dietitian.

### **Other staff**

*Dietary* includes all persons employed in the dietary department, if not enumerated above, such as cooks, pantry maids, kitchen help, etc. Student dietitians will be included here.

*Laundry*—all persons employed in the laundry department.

*Housekeeping, bedding and linen*—all persons in the housekeeping, bedding and linen departments, including cleaning helpers, ward aides, ward maids, etc.

*Building maintenance*—all persons engaged in the repair and maintenance of hospital property including engineers, carpenters, painters, furnace men, etc.

*Garden and farm*—all persons employed in the hospital farm or garden in the production of produce for use or sale.

*All other employees* includes all personnel employed at December 31 who are not enumerated above.

## Schedule 2

Schedule 2, the financial schedule, is to be completed as soon as possible after the end of the fiscal year by mental hospitals, psychiatric hospitals and training schools, but **not** by psychiatric units whose revenues and expenditures form part of the financial system of a general hospital or sanatorium.

When completed fully the schedule should be returned to Institutions Section, Dominion Bureau of Statistics, Ottawa, or, where a special arrangement exists, to the appropriate provincial government department.

The first section, OPERATING STATEMENT, records in summary form the main items of revenue and expenditure for current operation of the hospital. The second section, SOURCE AND APPLICATION OF PLANT FUNDS, records the amounts of **capital funds** provided from various sources for new construction or retirement of debt, and the manner in which capital funds expended during the year have been spent.

Before completing the schedule, read the following instructions and definitions carefully.

**A. REVENUE** includes all revenue which accrued (or became receivable) to the hospital during the year for the operation and maintenance of the hospital.

1. **Grants and payments** include revenue from governments to cover operating deficits or to maintain specific patients but excluding capital grants or payments. Show the amount received or becoming receivable during the year from each type of government authority, federal, provincial and municipal.
2. **Received from or on behalf of paying patients** show all revenue accruing to the hospital from paying patients or from other persons such as relatives or friends on behalf of paying patients. Do **not** include amounts paid by governments on behalf of patients,—these should be shown in item A1.
3. **Received from other sources** include here all other operating revenues of the hospital such as revenue from ancillary operations, interest income, contributed services of personnel, cash discount on purchases, etc.

DOMINION BUREAU OF STATISTICS

ANNUAL RETURN OF MENTAL HOSPITALS - SCHEDULE 2

Name of hospital and address ..... Year ended .....19.....

OPERATING STATEMENT

A. Revenue -

1. Grants and payments: Federal .....		
Provincial .....		
Municipal .....		
2. Received from or on behalf of paying patients .....		
3. Received from other sources .....		
4. Total Operating Revenue .....		

B. Expenditure -

5. Gross salaries and wages .....		
Less: deductions for board, etc. ....		
6. Provisions (food) .....		
7. Fuel, power, light and water .....		
8. Other operating expenditures .....		
9. Total Operating Expenditures .....		

SOURCE AND APPLICATION OF PLANT FUNDS

A. Funds provided -

	For new construction or additions to plant	For retirement of debt
1. Grants: Federal .....		
Provincial .....		
Municipal .....		
2. Mortgages or other long-term borrowings .....		
3. Other sources .....		
4. Total Plant Funds Provided .....		

B. Funds expended -

5. Land and improvements to grounds .....	
6. Buildings (including permanent fixtures) .....	
7. New furniture and equipment .....	
8. Retirement of long-term debt .....	
9. Total Plant Funds Expended .....	

**B. EXPENDITURE** is the actual accrued cost of operating and maintaining the hospital during the year. All operating expenses should be included whether or not payment has actually been made. Do not include any capital expenditures.

5. **Gross salaries and wages** include all wages and salaries earned by personnel during the fiscal year including the value of contributed services by unpaid personnel such as members of religious orders.

*Less deductions for board, etc.*—subtract here the known or estimated value of board, lodging, laundry and similar perquisites supplied to the staff by the hospital, regardless of whether the value of these is normally included in staff salaries or not. Include also the value of the perquisites supplied to unpaid staff. Show on the right the difference between gross salaries and deductions.

6. **Provisions (food)** includes the cost of food used in the hospital during the fiscal year.
7. **Fuel, power, light and water** includes the cost of electricity, coal, oil or other sources of energy and of water consumed during the fiscal year.
8. **Other operating expenditures** includes all items of operating expenditure not enumerated above, such as the cost of drugs and medicines, depreciation of fixed assets, cleaning costs, etc.

The following definitions apply to the second section of the schedule, the **SOURCE AND APPLICATION OF PLANT FUNDS**.

**A. FUNDS PROVIDED** includes the amounts of funds provided from the sources listed and the purpose of each.

1. **Grants** show the amounts provided by each type of government authority on the basis of the original source of the funds, e.g. where funds provided by a federal grant are received by the hospital through the provincial government such amounts should be included as federal.
2. **Mortgages or other long-term borrowings** includes the funds raised for capital purposes through mortgages, debenture loans or bonded debt.
3. **Other sources** includes all other receipts of capital funds such as endowments or bequests.

**B. FUNDS EXPENDED** includes all expenditures made during the year, regardless of when the funds were provided, for the purposes listed in each item.

5. **Land and improvement to grounds** includes all expenditures made to acquire additional land or to improve land and grounds presently owned.
6. **Buildings (including permanent fixtures)** includes the cost of new construction of buildings or of permanent fixtures of buildings, and of all permanent improvements to existing buildings and fixtures.

Expenditure for the maintenance of buildings, equipment or fixtures should not be shown here but as an operating expenditure under item 8 of the OPERATING STATEMENT.

7. **New furniture and equipment** includes the cost of all acquisitions of new furniture and new equipment.
8. **Retirement of long-term debt** includes all expenditures made for the purpose of retiring outstanding debt, such as principal repayments and sinking fund requirements.

## **ANNUAL RETURN OF MENTAL HEALTH CLINICS AND OUT-PATIENT DEPARTMENTS**

This special schedule obtains an annual measure, in broad terms, of the growing volume and utilization of clinic and out-patient services in combatting mental illness.

The schedule is distributed by provincial authorities to the clinics and out-patient departments recognized as such by provincial governments, and is returned to the Dominion Bureau of Statistics through provincial channels.

Under question 2 the class "general" refers to cases where the clinic sessions are not reserved exclusively for either adults or children.

Under section B, ATTENDANCES, the number of patients should be shown rather than the number of visits or interviews.

# DOMINION BUREAU OF STATISTICS

## Institutions Section

### ANNUAL RETURN OF MENTAL HEALTH CLINICS AND OUT-PATIENT DEPARTMENTS

Name \_\_\_\_\_

Address \_\_\_\_\_

Year ended Dec. 31, 195 \_\_\_\_\_

#### A. GENERAL INFORMATION

1. Auspices under which operated \_\_\_\_\_

2. Sessions held:

- (a) General .....
- (b) Adults only .....
- (c) Children only (under 15 years).....

Number per Month	Average Duration (hours)	Psychiatrists attending Sessions

3. Personnel:

- (a) Psychiatrists .....
- (b) Psychologists .....
- (c) Social workers .....
- (d) Nurses .....
- (e) Clerical .....

On Staff		In Training
Full Time	Part Time	

#### B. ATTENDANCES

1. Adults .....
2. Children (under 15 years) .....
3. Total adults and children .....

Number of Patients	
Male	Female

Report Furnished by:

Name \_\_\_\_\_

Title \_\_\_\_\_

Date \_\_\_\_\_

## SECTION 3

### Statistics of mental illness

#### General

Information about the patients in Canadian mental hospitals, and those entering and leaving each year, constitutes the only large-scale source of knowledge concerning the incidence and nature of mental illness in the general population of Canada.

Under an arrangement with provincial mental health authorities, the Dominion Bureau of Statistics compiles statistics on hospitalized mental illness derived from individual reporting cards which are submitted by mental hospitals, psychiatric hospitals, mental deficiency institutions and psychiatric units or wards in other hospitals. Two cards are employed—one for each admission (which includes first admission, readmission or transfer in) and the other for each separation (which includes discharge, death or transfer out).

The completed cards are returned in monthly batches either directly to the Bureau in the envelope provided or, where a special arrangement has been made, to the provincial department of health. Each monthly batch is accompanied by an advice in the form of the Monthly Statement of Population Movement.

In the Bureau the particulars of each patient and illness are transferred to punched cards for statistical tabulation. The reporting cards are then maintained in the fashion of a perpetual inventory of hospitalized patients to provide a continuous census for relationship with general population data and with annual patient movement.

#### Admission card

**First Admission** refers to a patient admitted for the first time to any hospital for mental diseases or to the psychiatric unit of a hospital.

**Readmission** refers to a patient admitted who has previously been under treatment in a hospital for mental diseases or in the psychiatric unit of a hospital, wherever situated, and who is not merely being transferred.

**Transfer** refers to a patient transferred in from another hospital for mental diseases or from the psychiatric unit of a hospital, wherever situated.

**Name of patient** — print or type the surname first, followed by the given names in full.

**Date of Admission** — give the month, day and year of the present admission, whether this be a first admission, readmission or a transfer in.

**Case number** should be the serial number allocated to the patient on admission. The one case number should remain with a patient throughout any one stay in the institution and should thus appear on both his admission and separation card. It is essential that the admission and separation cards for any one hospital stay should bear an identical case number.

☐ First  
Admission☐ Readmission☐ Transfer☐ Male☐ FemaleMental Institution  
Admission Card

Name of Patient \_\_\_\_\_

Date of Admission \_\_\_\_\_ 19\_\_ Case No. \_\_\_\_\_

1. Residence \_\_\_\_\_

(City, town, village, rural municipality) (County)

2. Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

3. Marital Status { ☐ Single ☐ Married ☐ Widowed  
☐ Divorced ☐ Separated

4. Number of Children \_\_\_\_\_

5. Country of Birth { Patient Father Mother  
Canada ☐ ☐ ☐  
Other ☐ ☐ ☐

6. Year of Arrival in Canada \_\_\_\_\_

7. Citizenship { ☐ Canadian Born ☐ Canadian by Naturalization  
☐ Other British ☐ Other  
☐ English ☐ French  
☐ Irish ☐ Scottish

8. Origin { Other (Specify) \_\_\_\_\_

9. Years of Schooling \_\_\_\_\_ 10. Religion \_\_\_\_\_

11. Occupation \_\_\_\_\_ 12. Industry \_\_\_\_\_

13. Method of Admission { ☐ Voluntary ☐ Warrant of Lieut.-Governor  
☐ Certification ☐ Other

14. Source of Admission (Check one only)

☐ Private Physician ☐ Clinic Agency ☐ General Hospital  
☐ Welfare Institution ☐ Penal Institution ☐ Other  
☐ Transfer from other Mental Hospital

(a) Name of Hospital \_\_\_\_\_

(b) Date of Last Admission \_\_\_\_\_ 19\_\_  
(Other than by Transfer)

15. Diagnosis: (a) Describe Fully \_\_\_\_\_

(b) International Statistical Classification No. \_\_\_\_\_

(c) Is the Patient { Mentally Defective ☐ Yes ☐ No  
Epileptic ☐ Yes ☐ No

16. Number of Previous Admissions \_\_\_\_\_

17. Particulars of Last Previous Admission

Hospital \_\_\_\_\_

Date Admitted \_\_\_\_\_ 19\_\_

Date Discharged \_\_\_\_\_ 19\_\_

Hospital \_\_\_\_\_

Location \_\_\_\_\_

1. **Residence** is the last regular home address of the patient before admission. Do not report a temporary address which a patient may have had pending admission.
4. **Number of children** means the number ever born to this patient, including any stillborn or illegitimate children.
5. **Country of birth** — check the appropriate box for the patient and his natural parents, or, if these are not known, his foster parents. Persons born in Newfoundland prior to its confederation with Canada are to be considered as having been born in Canada.
6. **Year of arrival in Canada** applies to persons born elsewhere than in Canada. For Canadian-born state the age in years.
7. **Citizenship** or "nationality" refers to the country to which the patient owes allegiance. "Canadian" refers to a person who was born in Canada or who is a Canadian citizen by marriage or naturalization in accordance with the provisions of the Canadian Citizenship Act. Include as "Canadian" persons who were Newfoundland citizens prior to its confederation with Canada.
8. **Origin** refers to the people, race or ethnic group from which the patient is descended, as traced through the father. The terms "Canadian" or "American" should not be recorded as origins since they refer to citizenship. The following list suggests suitable terms for reporting origin:
 

Austrian	Esthonian	Indian (Native)	Roumanian
Belgian	Finnish	Italian	Russian
Bulgarian	German	Japanese	Swedish
Chinese	Greek	Latvian	Syrian
Czech and Slovak	Jewish	Lithuanian	Turkish
Danish	Hungarian	Negro	Ukrainian
Dutch	Icelandic	Norwegian	Welsh
Eskimo	Indian (Asia)	Polish	Yugoslavic
9. **Years of schooling** means the number of completed school years beyond Kindergarten. Where, for example, two years were spent in the same school grade they are to be counted as one completed school year. Part-time attendance and private study should count for the number of years of formal schooling to which they are equivalent.
10. **Religion** is the specific religious body, denomination, sect, or community of which the patient is a member or which he adheres to or favours. Avoid such broad terms as Christian, Protestant, or Believer. If the patient has no religious affiliation, record "none".
11. **Occupation** is the trade, profession or kind of work in which the patient was engaged as his usual occupation prior to admission, for example, carpenter, stenographer, sales clerk, office clerk, housewife, etc.
12. **Industry** means the kind of business or industry in which the patient followed his occupation, such as coal mining, retail grocery, dairy farming, textile manufacturing, etc.
13. **Method of admission** — Check the appropriate box to indicate whether the patient has been admitted on his own application, or a warrant of the Lieutenant-Governor, or on the certificate of one or more doctors in accordance with provincial law.

14. **Source of admission** — indicate, by checking the appropriate box, the agency, institution or person by whom the patient was referred for committal. In the case of transfer from another mental hospital, a training school or a psychiatric unit, state the name of the hospital. In a general hospital the movement of a patient from a general unit to a psychiatric unit should not be reported as a transfer but a first admission or re-admission as the case may be. In such a case check the space for General Hospital.

When the patient is admitted by transfer, give also the date of his last admission other than by transfer, that is, the date on which continuous hospitalization began. For example, where a patient is admitted to hospital A on January 2 and transferred to hospital B on March 11, the latter hospital will show January 2 as the date of last admission other than by transfer.

**15. Diagnosis**

- (a) State the complete diagnosis using, so far as possible, terminology of the International Statistical Classification (1948) or of the Standard Nomenclature.
- (b) Insert the International Statistical Classification number for the diagnosis.
- (c) Where mental deficiency and/or epilepsy are present, either alone or in addition to the primary diagnosis, check the appropriate boxes as applicable. For example, suppose a patient is admitted with hebephrenic schizophrenia and is also mentally defective. In 15(a), both the mental disorder and the mental deficiency would be reported; in 15(b) the International Statistical Classification number, 300.1, would be reported; and in 15(c) the box "yes" would be checked for mental deficiency.

In cases where a combination of mental deficiency and epilepsy forms the diagnosis, describe both conditions in 15(a), reporting the primary condition first; then check "yes" for both conditions in 15(c).

**Separation card**

**Discharge** refers to a patient released from the supervision of the hospital authorities. A patient on parole or boarded out is not considered as discharged until he has been officially discharged from the books of the institution.

**Death** refers to a patient who dies in the hospital or institution, or while boarding out or on parole or while otherwise on the books of the institution.

**Transfer** refers to a patient who is transferred out from the hospital to another hospital for mental diseases, wherever situated.

**Name of patient** — print or type the surname first, followed by the given names in full.

**Date of separation** — give the month, day and year of discharge, death or transfer out. If a patient is on parole do not report as a separation until the patient is actually written off the books.

3. **Date of last admission other than by transfer** — give the date on which the patient last entered a mental hospital or institution as a

☐ Discharge☐ Death☐ Transfer☐ Male☐ FemaleMental Institution  
Separation Card

Name of Patient \_\_\_\_\_ Date of Separation \_\_\_\_\_ 19\_\_\_\_ Case No. \_\_\_\_\_

1. Residence \_\_\_\_\_

(City, town, village, rural municipality) (County)

2. Age at Separation \_\_\_\_\_ Date of Birth \_\_\_\_\_

3. Date of last Admission other than by Transfer \_\_\_\_\_

4. Date of finally leaving Hospital \_\_\_\_\_

5. Final Diagnosis: (a) Describe fully \_\_\_\_\_

(b) International Statistical Classification No. \_\_\_\_\_

(c) Was the Patient { Mentally Defective ☐ Yes ☐ No  
Epileptic ☐ Yes ☐ No6. Nature of Separation { On Medical Advice ☐ Against Medical Advice ☐7. Condition on Separation { Recovered ☐ Much Improved ☐  
Improved ☐ Unimproved ☐

8. Disposition to:

☐ Home☐ Clinic Agency☐ General Hospital☐ Welfare Institution☐ Other☐ Transfer to other Mental Hospital

Name of Hospital \_\_\_\_\_

9. Cause of Death

I { Disease or Con-  
dition Directly  
leading to  
Death

{ (a) Due to (or as consequence of) \_\_\_\_\_

{ Antecedent  
Causes

{ (b) Due to (or as consequence of) \_\_\_\_\_

{ (c) \_\_\_\_\_

II { Other Signi-  
ficant ConditionsApproximate  
interval be-  
tween onset  
and death

10. Was an Autopsy Performed

☐ Yes☐ No

Findings \_\_\_\_\_

27 Hospital \_\_\_\_\_ Location \_\_\_\_\_

first admission or readmission. If the patient now being separated came in as a transfer, report the date admitted to the mental hospital from which he was transferred.

4. **Date of finally leaving hospital** — give the date on which the patient physically left the hospital prior to the recorded separation. In the majority of cases this will be the date on which probation commenced.
5. **Final diagnosis** — this will not, in most cases, differ from the diagnosis reported on the admission card. In some instances, however, additional diagnostic information may have become available after the admission card had been sent in which may amplify or alter the diagnosis originally reported. The question is **not** intended to reflect any change brought about by treatment or to give any indication of the patient's diagnosis or condition at the time of separation. The final diagnosis should be expressed in terms similar to those used to answer question 15 of the Admission Card.
6. **Nature of separation** — for patients being discharged check the appropriate space to indicate whether the discharge was on or against medical advice.
7. **Condition on separation** — for purposes of statistical comparability, use the following definitions to determine which space should be checked:

*Recovered* — a restoration to that degree of social adjustment which obtained before the illness.

*Much improved* — a near restoration to that degree of social adjustment which obtained before the illness.

*Improved* — a partial restoration to that degree of social adjustment which obtained before the illness.

*Unimproved* — no restoration to that degree of social adjustment which obtained before the illness.

8. **Disposition to:** — indicate by checking the appropriate box, the agency, institution or person to whom the patient was referred on discharge. In the case of a transfer to a mental hospital, training school or psychiatric unit, give the name of the institution. In a general hospital, the movement of a patient from a psychiatric unit to a general unit of the hospital should not be reported as a transfer but as a discharge.
9. **Cause of death** — the disease or condition directly leading to death, together with the antecedent cause and other significant conditions should be stated in the same form as on the official registration of death required by the province.

In Part I enter on line (a) the condition leading directly to death and, on lines (b) and (c), the antecedent conditions which gave rise to the direct cause, with the underlying cause being stated last. If the condition on line (a) completely describes the sequence of events no further entries are needed on lines (b) or (c).

In Part II enter any other significant condition which unfavourably influenced the course of the morbid process, and thus contributed to the fatal outcome, but which was not related to the disease or condition directly causing death.

The terms used in describing the death should correspond to those contained in the 6th Revision of the International Statistical

Classification of Diseases, Injuries and Causes of Death, 1948: Canadian physicians will find the Physicians' Pocket Reference, (Dominion Bureau of Statistics, 1950) convenient for selecting acceptable terms to be used.

**Monthly statement of patient movement**

This monthly summary of the movement of patients should accompany the monthly batch of admission and separation cards sent in by each hospital, institution or psychiatric unit. It constitutes a check on the cards actually submitted and received, since the figure for item 2 will agree with the admission cards received, and that for item 4 with the separation cards.

Where, in a smaller hospital, no patients have been admitted or separated in a particular month, a statement should nevertheless be sent with items 1, 3 and 5 completed for the number of patients in the hospital.

To: Dominion Bureau of Statistics, Institutions Section, Ottawa

**STATEMENT OF POPULATION MOVEMENT: For the Month of .....19...**

	Males	Females
1. On books at beginning of month .....	.....	.....
2. Admissions (Cards enclosed).....	.....	.....
3. Total under care (Items 1 and 2) .....	.....	.....
4. Separations (Cards enclosed).....	.....	.....
5. On books at end of month .....	.....	.....

HOSPITAL ..... 9002-16

Report submitted by ..... 30-10-53

## SECTION 4

### Classification of mental disorders

Statistics of mental illness are the facts, in numerical form, which are used to appraise the mental health conditions and needs of the people of Canada. To be used with confidence they must be built up from individual diagnostic particulars recorded and classified in a comparable manner. To be intelligible they must bring together these individual diagnoses into groupings which permit scientific generalization and deduction. These fundamental attributes of the statistics provide the basis for the employment of a uniform classification of mental disorders.

Such a classification should not be confused with a medical or psychiatric nomenclature. The function of a nomenclature is to provide a completely specific list or catalogue of approved terms for every disease entity which is clinically recognizable. On the other hand a statistical classification, while it encompasses the full range of psychiatric conditions, accommodates these within a more limited number of titles, chosen and arranged to facilitate the statistical study of mental disease phenomena.

Canada, as one of the member nations of the World Health Organization, has adopted the International Statistical Classification of Diseases, Injuries and Causes of Death (6th revision) as the basis for statistics of mortality and morbidity since 1950. The classification as a whole provides 612 numbered categories of diseases and morbid conditions, arranged in 17 main sections. One of these major groups is entitled Mental, Psychoneurotic and Personality Disorders and contains the 26 categories or rubrics which are used to classify most of the diagnoses reported by mental hospitals and psychiatric units. Each category is identified by a three-digit number, several being further broken down by decimal subdivision for greater specificity.

Since the scheme of classification followed could not be expected to include within these 26 categories all the conditions involving admission to mental hospitals, certain conditions such as *tabes dorsalis* and *puerperal psychosis* are contained in other major groups of the Classification. Syphilis, for example, is included in the section covering Infective and Parasitic Diseases.

The following pages list twice the categories of the International Statistical Classification which are used to classify the diagnostic information reported by Canadian mental hospitals and psychiatric units. The first list contains the three-digit categories in summary form for convenience of reference. The second contains fourth-digit categories where they exist, together with the diagnostic terms which are included within each category and also describes briefly the characteristics of each mental disorder as an aid in making correct assignments.

## Summary list of categories

### Psychoses

- 300 Schizophrenic disorders (dementia praecox)
- 301 Manic-depressive reaction
- 302 Involutional melancholia
- 303 Paranoia and paranoid states
- 304 Senile psychosis
- 305 Presenile psychosis
- 306 Psychosis with cerebral arteriosclerosis
- 307 Alcoholic psychosis
- 308 Psychosis of other demonstrable etiology
- 309 Other and unspecified psychoses

### Psychoneurotic disorders

- 310 Anxiety reaction without mention of somatic symptoms
- 311 Hysterical reaction without mention of anxiety reaction
- 312 Phobic reaction
- 313 Obsessive-compulsive reaction
- 314 Neurotic-depressive reaction
- 315 Psychoneurosis with somatic symptoms (somatization reaction) affecting circulatory system
- 316 Psychoneurosis with somatic symptoms (somatization reaction) affecting digestive system
- 317 Psychoneurosis with somatic symptoms (somatization reaction) affecting other systems
- 318 Psychoneurotic disorders, other, mixed, and unspecified types

### Disorders of character, behaviour, and intelligence

- 320 Pathological personality
- 321 Immature personality
- 322 Alcoholism
- 323 Other drug addiction
- 324 Primary childhood behaviour disorders
- 325 Mental deficiency
- 326 Other and unspecified character, behaviour, and intelligence disorders

### Other

- 020.1 Juvenile neurosyphilis (congenital)
- 024 Tabes dorsalis
- 025 General paralysis of insane
- 026 Other syphilis of central nervous system
- 083 Late effects of acute infectious encephalitis
- 353 Epilepsy
- 648.3 Psychosis arising from pregnancy
- 688.1 Puerperal psychosis
- 793 Observation, without need for further medical care

**Detailed list of categories, inclusions and characteristics  
of Mental, Psychoneurotic, and Personality Disorders**

**Psychoses**

In the psychotic disorders will be found varying degrees 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.

**300 SCHIZOPHRENIC DISORDERS (Dementia Praecox)**

This term is synonymous with the formerly used term dementia praecox. In this group of psychotic reactions there is disturbance in reality relationships and concept formations with affective, behavioural 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, aggressive behaviour and, in some, by a tendency to deterioration.

This group of psychoses is further subdivided because of the prominence of the various symptoms in individual cases. The distinctions are only relative and transitions from one sub group to another are common.

**300.0 Simple type**

Under this heading will be shown those reactions which display some defective interest with gradual development of an apathetic state and indifference but without other strikingly peculiar behaviour and without expression of delusions or hallucination. It manifests a type of reaction with an increasing severity of symptoms over a long period of time with some apparent mental deterioration.

*Inclusions -*

Dementia:  
primary  
simplex

Schizophrenia:  
primary  
simple

**300.1 Hebephrenic type (apathetic type)**

These reactions are characterized by a shallow effect, unpredictable, silly behaviour which appears inconsistent with the ideas expressed; neologisms; bizarre ideas; and coining of words or phrases are common. Hallucinations and delusions are quite common in this type of reaction and the regressive type of behaviour is fairly rapid.

*Inclusions -*

Dementia, paraphrenic:  
Hebephrenia  
Paraphrenia

Schizophrenia:  
hebephrenic  
paraphrenic

### 300.2 Catatonic type

These reactions are characterized by usually a conspicuous alternating state with either marked generalized inhibition (stupor, mutism, negativism and waxy flexibility) or excessive motor activity and excitement. The latter shows marked impulsiveness and belligerence. In retrospect it is usually found that the sensorium has remained clear. Regression to a vegetative state may occur.

*Inclusions —*

Catatonia

Schizophrenia, catatonic

Dementia, catatonic

### 300.3 Paranoid type

This group is characterized by prominence of delusional ideas generally of a persecutory or grandiose nature. A consistent emotional reaction of aggressiveness due to persecutory delusions is most frequent. The hallucinations occur in various fields to which the patient frequently responds. Excessive religiosity or expansive delusional system of omnipotence, genius or special ability are also found here. The systematized paranoid hypochondriacal states are included in this group.

*Inclusions —*

Dementia, paranoid

Schizophrenia, paranoid

### 300.4 Acute schizophrenic reaction (Acute undifferentiated type)

This classification is reserved for the acute undifferentiated cases of schizophrenic reaction. The symptoms usually clear in a few weeks but there is a tendency to recur. If the condition progresses it usually falls into one of the more clearly defined types.

*Inclusions —*

Schizophrenic reaction, acute

### 300.5 Latent schizophrenia

This classification is reserved for chronic undifferentiated cases, those referred to usually as "latent", "incipient", "pre-psychotic" schizophrenia, etc.

*Inclusions —*

Latent schizophrenic reaction

Schizophrenic residual

Schizophrenia, latent

state (Restzustand)

### 300.6 Schizo-affective psychosis

This group covers those cases exhibiting a mixture of schizophrenic and affective reactions. It includes those main groups of schizophrenic reactions with schizophrenic-like thinking or bizarre behaviour. It can also include those cases where the pre-psychotic personality is at variance or inconsistent with the presenting psychotic symptoms. On prolonged observation, all these usually prove to be basically schizophrenic in nature.

*Inclusions —*

Mixed schizophrenic and manic-depressive psychosis

Schizo-affective psychosis

Schizothymia

### 300.7 Other and unspecified

Occasionally other schizophrenic reactions may occur which cannot be classified in the previous groups—only such cases should be placed in this group.

#### *Inclusions —*

Dementia praecox	} Not otherwise specified, or any type not classifiable under 300.0 - 300.6
Schizophrenia	
Schizophrenic reaction	

## 301 MANIC-DEPRESSIVE REACTION

This term is synonymous with manic-depressive psychosis. These conditions are characterized by marked changes in mood and a tendency to remission and recurrence. Many other symptoms such as illusions, delusions and hallucinations may be present in addition to the marked affective changes.

### 301.0 Manic and circular (Manic type)

This group is characterized by elation or irritability with overtalkativeness or flight of ideas and increased motor activity. Occasional brief periods of depression may occur but this should not change the diagnosis from the manic type of reaction.

#### *Inclusions —*

Alternating insanity	Insanity or psychosis, manic-
Circular:	depressive:
insanity	circular
stupor	manic
Cyclothymia	Mania NOS
Hypomania	Manic-depressive reaction:
	agitated
	circular
	manic

### 301.1 Depressive

In this group will be found those cases with marked depression of mood and with mental and motor retardation. Agitation, apprehension and anxiety may also be present in this group. Perplexed and stuporous reactions should also be included in this sub-classification.

#### *Inclusions —*

Insanity or psychosis, manic-depressive, depressive  
Manic-depressive reaction, depressive  
Melancholia NOS

### 301.2 Other

Under this heading will be included those with marked mixture of 301.0 plus 301.1, where the alteration is frequent and where it is difficult to say which phase predominates. The alteration of the two phases may be rapid and constitute the circular type. In addition other manic-depressive reactions which are not in 301.0 and 301.1 should be classified here.

#### *Inclusions —*

Affective psychosis  
Insanity or psychosis, manic-depressive:  
  NOS any type except circular, depressive, or manic  
Manic-depressive reaction:  
  NOS stuporous

### 302 INVOLUTIONAL MELANCHOLIA

This group includes psychiatric reactions characterized by depression during the involutional period. Generally without previous history of manic-depressive reaction and occurring usually in individuals of the compulsive personality type. These reactions tend to have a prolonged course and may be manifested by worry, intractability, insomnia, guilt, anxiety, agitation, delusional ideas and somatic complaints. Agitation and depression are common in many of these cases while others may present a paranoid idea. Somatic pre-occupation to a delusional degree is common in this group. Manic-depressive reactions occurring in the involutional period should not be included in this group nor should other psychotic reactions which have an onset in this involutional period.

*Inclusions -*

Insanity, climacteric  
Melancholia:  
    climacteric  
    involutional  
    menopausal

Psychosis, involutional  
(any type)

### 303 PARANOIA AND PARANOID STATES

In this group will be included those cases showing characteristics of a paranoid state, paranoid condition and those more commonly known under the old classification as paranoia.

These reactions show fixed suspicions and logically elaborated ideas of persecution generally as the result of false interpretation of an actual occurrence. Emotional reactions are usually consistent with the ideas held. Hallucinations are usually not present. The patients are prone to take action against their suspected persecutors. The abnormal ideas are frequently isolated from the normal ideas of the individual and may be difficult to elicit. Intelligence is usually good. The course is prolonged and chronic but deterioration is not a marked feature.

All cases of paranoid schizophrenia and other psychotic reactions showing paranoid symptoms should be excluded from this category.

*Inclusions -*

Paranoia

Paranoid conditions, other than in dementia and schizophrenia  
Paranoid state, NOS

### 304 SENILE PSYCHOSIS

This group is to include only those who are having a psychotic reaction and exhibit such symptoms as exaggeration of normal senile mental changes, marked loss of memory for recent events, inability to concentrate, misidentification, fabrication and faulty orientation. Determination, irritability, confusion, delusions or depression or excitement may predominate.

A degree of self-centering of interests, reminiscence and difficulty in adjustment in character of old persons should be classified under 794. Deterioration may be minimal or it may progress to a state of vegetative existence.

*Inclusions —*

Cerebral atrophy or degeneration with psychosis at ages 65 and over  
Dementia of old age

*Senile:*

dementia  
imbecility  
insanity  
melancholia  
psychosis (any type)

### 305 PRESENILE PSYCHOSIS

This classification is reserved for those who show severe progressive brain syndrome in the comparatively early age period. There is a gradual loss of memory, changes in perception, changes in personal habits and disorientation. Loss of intellectual impairment appears fairly early whereas loss of sleep and often debility are later features. Deterioration is a prominent feature. Onset usually occurs between 40 and 60 years of age but earlier cases have been reported. Included in this group is Pick's disease, Alzheimer's disease and diffuse convolutional atrophy.

*Inclusions —*

Alzheimer's disease  
Circumscribed atrophy of brain  
Pick's disease of brain

*Presenile:*

dementia  
psychosis  
sclerosis

### 306 PSYCHOSIS WITH CEREBRAL ARTERIOSCLEROSIS

Here are to be classified those chronic progressive mental disturbances occurring in connection with cerebral arteriosclerosis. This will constitute a comparatively large group of middle age and old persons who show evidence of interference with cerebral circulation. Such symptoms are difficulty in sustained mental cerebration, confusion, loss of memory and general impairment of the intellectual functions in varying degrees. Preservation of the personality and insight into the defects may be present in early or mild cases but in severe circulatory disturbance with cerebral destruction, mental enfeeblement may be advanced to a high degree. In elderly persons hypertension may or may not be found in the presence of severe vascular disease. Cases with essential hypertension or with arteriosclerosis without demonstrable degenerative changes in the larger vessels, but showing psychotic symptoms of the arteriosclerotic type, should be classified here. Differentiation from the senile psychoses is sometimes difficult as the pathological changes lying at the basis of the two psychotic reaction types may be associated. The age, history, and a careful survey of the symptoms will often assist in determining which is the predominant type of reaction; where such a determination is not clearly possible, preference should continue to be given, for statistical purposes, to the arteriosclerosis classification.

*Inclusions —*

Dementia, arteriosclerotic  
Organic brain disease with psychosis  
Psychosis due to arteriosclerosis (cerebral)

### 307 ALCOHOLIC PSYCHOSIS

Under this heading will be included all degrees of permanent brain damage resulting from the use of alcohol ranging from very mild, up to and including very severe. In this group will be those cases which can be reasonably concluded to have alcohol as the main etiological factor. This includes pathological intoxication, delirium tremens, Korsakoff's Psychosis and alcoholic hallucinosis.

Excessive alcoholism may be a symptom of some other psychosis or psychopathological condition. It may aggravate and bring to notice an already existing psychosis of a non-alcoholic nature. Such cases are to be carefully distinguished by the previous history, by the symptomatology and course, and should be grouped elsewhere under their proper categories. Alcoholic addiction without psychosis should be classified under 322.

#### *Inclusions -*

Delirium tremens

Hallucinosis, alcoholic

Korsakoff's psychosis or syndrome, unless specified as non-alcoholic

Polyneuritic psychosis, alcoholic

Psychosis, alcoholic (any type)

### 308 PSYCHOSIS OF OTHER DEMONSTRABLE ETIOLOGY

The psychoses of other organic etiology constitute a class which result from relatively permanent more or less irreversible diffuse impairment of cerebral tissue function. These disorders are classified according to the cause of impairment of brain function. There may be varying degrees of progress but some disturbance of memory, judgment, orientation, comprehension and affect persist permanently.

#### 308.0 Resulting from brain tumour

Psychoses developing during the course of intracranial neoplasms (brain tumour) should be classified here whether the brain tumour is primary or secondary. Personality change with defect in judgment and deterioration may often be the presenting symptom in a brain tumour.

#### *Inclusions -*

Psychosis:

resulting from brain tumour

with intracranial neoplasm

#### 308.1 Resulting from epilepsy and other convulsive disorders

Here should be classified only cases which show psychosis in connection with idiopathic epilepsy. This includes epileptic deterioration, epileptic clouded states and epileptic confusion. Most commonly found in epilepsy with psychosis are those who show a gradual development of mental dullness, slowness of associated thinking, impairment of memory and other intellectual functions as well as apathy.

If the convulsive manifestation is symptomatic of another disease, it should be classified under the other disease heading. Epilepsy without psychosis is to be classified under 353.

*Inclusions —*

**Epileptic:**

clouded state  
deterioration

**Psychosis with:**

any condition classifiable  
under 353  
other convulsive disorders

**308.2 Secondary or due to infective or parasitic diseases**

Classify here only those psychoses due to severe general systemic infections—e.g., pneumonia, typhoid. Do not include other disorders which may be manifest during an infectious or parasitic disease.

Exclude psychosis due to tuberculosis of central nervous system (010), syphilis of the central nervous system (025, 026) and acute infectious encephalitis (083).

**308.3 Secondary or due to allergic, endocrine, metabolic and nutritional diseases**

Include only those psychoses due to such disease. Do not classify here psychoses occurring coincidental with such conditions.

**308.4 Secondary or due to diseases of the blood, blood-forming organs and circulatory system**

Here are to be classified those chronic organic mental disturbances occurring in connection with circulatory disturbance other than cerebral arteriosclerosis. In each case specify the condition such as cerebral embolism, cerebral hemorrhages, arterial hypertension and other chronic vascular disease.

Do not include here syphilis (see 020, 024, 026) or cerebral arteriosclerosis (306).

**308.5 Secondary or due to diseases of the nervous system and sense organs**

Classify here only those conditions due to diseases of the nervous system and sense organs and not those seen together with these conditions.

**308.6 Secondary or due to drugs and other exogenous poisons**

Classify here those psychoses due to drugs, noxious food-stuffs or poisoning by other substances.

**308.7 Secondary or due to accidents and violence**

Here will be classified only those cases of acute psychosis occurring immediately after injury or violence of an external nature. If an injury to another part of the body produces mental disturbance, it should not be classified here. Also psychoses in which head trauma axis is a contributing or precipitating cause should be diagnosed under proper heading and not included in this group.

**308.8 Secondary or due to other diseases**

This category is intended for those cases where there is demonstrable etiology which does not properly fit in the above groups or is not elsewhere classifiable as an organic psychosis. The disease, however, will be specified. It is also permissible to use this category for incomplete diagnoses.

## 309 OTHER AND UNSPECIFIED PSYCHOSES

Here will be classified those cases that show abnormal reactions essentially of an emotional and volitional nature apparently on the basis of constitutional defect, which are not to be classified under the groups already described.

### 309.1 Psychoses with Psychopathic Personality

Psychopathic personalities are characterized largely by emotional immaturity or childishness with marked defects of judgment and without evidence of learning by experience. They are prone to impulsive reactions without consideration of others and to emotional instability with rapid swings from elation to depression, often apparently for trivial causes. Special features in individual psychopaths are prominent criminal traits, moral deficiency, vagabondage and sexual perversion. Intelligence as shown by standard intelligence tests may be normal or superior, but on the other hand, not infrequently, a borderline intelligence may be present.

The abnormal reactions which bring psychopathic personalities into the group of psychoses are varied in form but usually of an episodic character. Most prominent are attacks of irritability, excitement, depression, paranoid episodes, transient confused states, etc. True prison psychoses belong in this group.

A psychopathic personality with a manic-depressive attack should be classified in the manic-depressive group. Likewise a psychopathic personality with a schizophrenic psychosis should go into the appropriate classification. Psychopathic personalities without episodic mental attack or psychotic symptoms should be placed in the group "Without psychosis". Cases of intellectual defect (feeble-mindedness, mental deficiency) are not to be included in this group.

### 309.2 Psychoses, other and unspecified

In this group should be placed the cases in which a satisfactory diagnosis cannot be reasonably made and in which the psychosis must therefore be regarded as an unclassified one. Most frequently this may be due to lack of history, inaccessibility of the patient, or too short a period of observation. On the other hand, the clinical picture may be so obscured and the symptoms so unusual that a reasonably accurate classification cannot be made.

The number of undiagnosed psychoses may reflect the attitude of physicians, indicating either inadequacy of careful collection of facts and insufficient observation or may indicate a rigid tendency for absolute accuracy. It may be mentioned that reasonable accuracy and not absolute accuracy is looked for in statistical classification of medical conditions. This does not mean guessing at a classification or forcing one into a group without reasonable facts to substantiate the decision.

## Psychoneurotic Disorders

These disorders usually present evidence of periodic or constant adjustment of varying degrees from early life. There is usually no gross distortion of external reality nor gross disorganization

of the personality. The chief features are anxiety and tension which may be directly felt and expressed or unconsciously and automatically controlled by the utilization of various psychological defence mechanism. The reaction to stress may bring about acute symptomatic expression of such disorders and manifest itself by varying types of reaction in the psychoneurotic group.

### 310 ANXIETY REACTION WITHOUT MENTION OF SOMATIC SYMPTOMS

This term is synonymous with the former term 'anxiety state' and 'anxiety neurosis'. These cases show more or less continuous diffuse anxiety and apprehension. Feelings of acute panic and acute tension are extremely common and emotional tension is high.

When somatic symptoms are definite the condition should be classified under 315, 316, 317 or 318.

#### *Inclusions —*

Anxiety:

neurosis NOS

reaction NOS

state NOS

Anxiety reaction with any condition in 311 without mention of somatic symptoms

### 311 HYSTERICAL REACTION WITHOUT MENTION OF SOMATIC SYMPTOMS

In these cases the anxiety is 'converted' into functional symptoms and expressed in organs or parts of the body, usually those that are mainly under voluntary control. These are to be differentiated from the psychoneuroses with somatic symptoms which should be classified under 315, 316, 317 and 318. Conversion reaction is synonymous with conversion hysteria and hysterical neurosis.

#### *Inclusions —*

Anorexia nervosa

Compensation neurosis

Dissociative reaction

(any)

Hysteria, hysterical:

NOS

amnesia

anaesthesia

anorexia

anosmia

aphonia

blindness

cataplexy

conversion

without  
mention  
of  
anxiety  
reaction

Hysteria, hysterical:

convulsions

dyskinesia

fugue

mutism

paralysis

postures

somnambulism

tic

tremor

other manifesta-

tions

Hystero-epilepsy

without  
mention  
of  
anxiety  
reaction

### 312 PHOBIC REACTION

In these cases the anxiety is usually attached to some specific fear—syphilis, dirt, high places, etc. The patient tries to avoid the specific situations in the effort to overcome his anxiety. The terms phobia and anxiety hysteria belong in this group.

#### *Inclusions —*

Fear reaction

Phobia NOS

Phobic reaction

### 313 OBSESSIVE-COMPULSIVE REACTION

In these conditions there is obsessive rumination or pre-occupation with ideas, and repetitive impulses to perform certain acts. The acts may be recognized by the patient as unreasonable but the desire cannot be controlled.

#### *Inclusions -*

##### Neurosis:

compulsive  
impulsive  
obsessional  
obsessive-compulsive

##### Obsessional:

ideas and mental images  
impulses  
phobias  
ruminations  
state

##### Obsessive-compulsive reaction

### 314 NEUROTIC-DEPRESSIVE REACTION

Here are to be classified those cases which show depression in reaction to obvious external causes such as bereavement, sickness, financial and other worries. The reaction of a more marked degree and of longer duration than normal sadness, may be looked upon as pathological. The anxiety in this reaction is replaced to some extent by depression and self-deprecation. Feelings of guilt are common.

This term is synonymous with the former term "reactive depression". Differentiation from manic-depressive reactions are on the basis of a life history and absence of such malignant symptoms as severe psychomotor retardation. Manic-depressive Reaction will be classified under 301.

#### *Inclusions -*

Neurotic-depressive reaction  
Psychogenic depression

Reactive depression

### 315 PSYCHONEUROSIS WITH SOMATIC SYMPTOMS (SOMATIZATION REACTION) AFFECTING CIRCULATORY SYSTEM

This group is different from other psychoneurotic reactions in that there is persistent attachment to the cardiovascular system.

#### 315.0 Neurocirculatory asthenia

##### *Inclusions -*

Cardiac asthenia  
Da Costa's syndrome  
Disordered action of heart,  
specified as psychogenic

Effort syndrome  
Neurocirculatory asthenia  
"Soldier's heart"

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

##### *Inclusions -*

Functional heart disease  
Paroxysmal tachycardia  
Angina

} specified as psychogenic

#### 315.2 Other circulatory manifestations of psychogenic origin

##### *Inclusions -*

Hypertension  
Vascular spasm  
Migraine

} specified as psychogenic

### **316 PSYCHONEUROSIS WITH SOMATIC SYMPTOMS (SOMATIZATION REACTION) AFFECTING DIGESTIVE SYSTEM**

This title excludes ulcer of stomach and of duodenum. It excludes functional disorders of oesophagus, of stomach and of intestines unless specified as psychogenic. The condition will be classified according to the sub-groups below:

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

*Inclusions —*

Mucous colic	}	specified as psychogenic
Mucous colitis		

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

*Inclusions —*

Functional diarrhoea	}	specified as psychogenic
Enterospasm		
Spastic colon		

#### **316.2 Gastric neuroses**

*Inclusions —*

Cyclical vomiting  
Functional dyspepsia, specified as psychogenic  
Gastric neurosis  
Functional disorders of stomach, specified as psychogenic

#### **316.3 Other digestive manifestations specified as of psychogenic origin**

*Inclusions —*

Aerophagy  
Globus

Disorders of digestive system specified as psychogenic, but not classifiable under 316.0 to 316.2.

### **317 PSYCHONEUROSIS WITH SOMATIC SYMPTOMS (SOMATIZATION REACTION) AFFECTING OTHER SYSTEMS**

#### **317.0 Psychogenic reactions affecting respiratory system**

*Inclusions —*

Disorder of respiratory system, specified as psychogenic  
Psychogenic asthma

#### **317.1 Psychogenic reactions affecting genito-urinary system**

*Inclusions —*

Disorder of:	}	specified as psychogenic
genito-urinary system		
micturition		
sexual function		

#### **317.2 Pruritus of psychogenic origin**

*Inclusions —*

Pruritus, specified as psychogenic

### 317.3 Other cutaneous neuroses

#### *Inclusions —*

Disorder of skin specified as psychogenic, excluding pruritus

### 317.4 Psychogenic reactions affecting musculoskeletal system

#### *Inclusions —*

Disorder of:

articulation (joint)  
joint  
limb  
muscle  
musculoskeletal system  
Paralysis

} specified as psychogenic

### 317.5 Psychogenic reactions affecting other systems

#### *Inclusions —*

Disorders of parts of body not classifiable under 315-317.4,  
specified as psychogenic

## 318 PSYCHONEUROTIC DISORDERS, OTHER, MIXED, AND UNSPECIFIED TYPES

### 318.0 Hypochondriacal reaction

Under this heading are to be classified those cases that show essentially an obsessive preoccupation with the state of their health or of various organs, with a variety of somatic complaints which are not relieved by demonstration of a lack of pathology. Occurring frequently in the involutional period, they are to be differentiated from involutional melancholia by the absence of marked depression with agitation and self-condemnation. Hypochondriacal complaints may be a symptom of dementia praecox and this reaction type should be eliminated before classifying cases here.

#### *Inclusions —*

Hypochondria

Hypochondriasis

### 318.1 Depersonalization

In this condition there is a loss of affective response with a feeling that everything, including the patient, is unreal. Stupor, fugues, amnesias may occur.

### 318.2 Occupational neurosis

This classification is only to be used when the occupation is a definite causative factor in the development of the neurosis.

#### *Inclusions —*

Craft neurosis

Occupational neurosis

Miners' nystagmus

### 318.3 Asthenic reaction

To be designated under this heading are those cases in whom organic disease is ruled out and who complain of motor and mental fatigability, diminished power of concentration and pressure in the

head, scalp, neck or spine. Early dementia praecox or mild depressions of the manic-depressive type not infrequently have to be considered in the differential diagnosis.

*Inclusions —*

Asthenic reaction

Nervous:

debility

exhaustion

prostration

Neurasthenia

Psychogenic:

asthenia

general fatigue

**318.4 Psychoneurotic disorders, mixed**

This group excludes mixed anxiety and hysterical reactions (310). Include only those whom it is not possible to classify according to the predominant factor.

**318.5 Other and unspecified types**

Include here only those psychoneurotic disorders which cannot be classified elsewhere.

*Inclusions —*

Nervous breakdown

Neurosis NOS

Psychasthenia

Psychoneurosis:

NOS

other specified types not classifiable under 310-318.4

**Disorders of character, behaviour and intelligence**

**320 PATHOLOGICAL PERSONALITY**

**320.0 Schizoid personality**

These cases show shyness, sensitiveness, seclusiveness, unsociability, etc., often associated with eccentricity. Exclude schizophrenia (300).

**320.1 Paranoid personality**

Frequently have schizoid personality together with suspiciousness, envy, jealousy and difficulty in maintaining interpersonal relationships.

**320.2 Cyclothymic personality**

These cases exhibit alternating moods of elation and sadness. The changes of mood seem to be precipitated from within rather than by external factors.

**320.3 Inadequate personality**

Are characterized by an inability to meet life's demands—they do not exhibit severe defeat in any field but are generally unable to adapt to specific situations such as marriage, home life, or occupation.

**320.4 Antisocial personality**

These cases are characterized largely by emotional immaturity or childishness with marked defects of judgment and without evidence of learning by experience. Impulsive reactions are common as are mood changes and rationalization. Intelligence may be normal or superior but, not infrequently, is borderline.

*Inclusions —*

Antisocial personality  
Constitutional psychopathic  
state

Psychopathic personality:  
NOS  
with antisocial trend

**320.5 Asocial personality**

These cases frequently develop in an abnormal moral environment and they disregard the usual social codes and as a result are in conflict with the environment. Other than the apparent inability to appreciate norms of behaviour they show little personality deviation.

*Inclusions —*

Asocial personality  
Moral deficiency

Pathologic liar  
Psychopathic personality with  
amoral trend

**320.6 Sexual deviation**

This diagnosis is reserved for cases where the sexual deviation is not symptomatic of some other psychiatric disorder.

*Inclusions —*

Exhibitionism  
Fetishism  
Homosexuality

Pathologic sexuality  
Sadism  
Sexual deviation

**320.7 Other and unspecified**

Include only those cases of personality pathology which cannot be classified elsewhere.

**321 IMMATURE PERSONALITY**

**321.0 Emotional instability**

These cases show undue excitement and become ineffective even when faced by very minor stress situations. Judgment under stress is usually faulty and emotional conflicts are handled poorly.

**321.1 Passive dependency**

Here the patient is dependent, with helplessness and indecisiveness being the predominant characteristic.

**321.2 Aggressiveness**

Characterized by temper tantrums, irritability, and destructive behaviour.

**321.3 Enuresis characterizing immature personality**

Classify here only those cases where enuresis is the predominant symptom of the personality disorder.

**321.4 Other symptomatic habits except speech impediments**

Classify here habits other than enuresis and speech impediments which are symptomatic of the personality disorder.

**321.5 Other and unspecified**

*Inclusions —*

Immature personality NOS

Immaturity reaction NOS

### 322 ALCOHOLISM

Do not classify here alcoholic psychosis (307), acute poisoning by alcohol or cirrhosis of the liver with alcoholism.

#### 322.0 Acute

Classify here those cases of temporary disturbance caused by excessive use of alcohol.

#### 322.1 Chronic

Those cases where there is repeated and long continued use of alcohol, i.e., addiction to alcohol without recognizable underlying disorder.

##### *Inclusions —*

Alcoholic addiction	Ethylism, chronic
Alcoholism, chronic	

#### 322.2 Unspecified

Only those cases which cannot be classified in 322.0 or 322.1.

### 323 OTHER DRUG ADDICTION

As drug addiction is usually symptomatic of some underlying disorder, this category should only be used where the underlying condition is not determined.

##### *Inclusions —*

Addiction to, or chronic poisoning by:	Addiction to, or chronic poisoning by:
amphetamine	hashish
barbituric acid (and compounds)	heroin
benzedrine	Indian hemp
bromides	morphine
cannabis indica	opium
chloral	paraldehyde
cocaine	pethedine
codeine	thebaine
demerol	other narcotic, analgesic, and soporific drugs
diacetylmorphine	Drug addiction
diamorphine	Morphinism
ethylmorphine	

### 324 PRIMARY CHILDHOOD BEHAVIOUR DISORDERS

Do not classify here behaviour disorders associated with pathological personality (320), immature personality (321), mental deficiency (325), or due to any physical illness. It is expected that the group of children with personality disorders not classifiable elsewhere will be placed in this group. These conditions are usually transient.

##### *Inclusions —*

Behaviour disorder of childhood not identified with psychopathic personality, mental deficiency, or any physical illness:

- jealousy
- masturbation
- tantrum
- Juvenile delinquency

### 325 MENTAL DEFICIENCY

Exclude cerebral spastic infantile paraplegia, birth injury, epiloia, tuberous sclerosis, gargoylism, hydrocephalus, hypertelorism, juvenile general paralysis of the insane. If there is concomitant deficiency the appropriate box for mental deficiency should be checked on the admission card.

Psychosis with mental defect should be classified under the appropriate psychosis or in "psychosis unspecified" and the appropriate box for mental deficiency checked on the admission card. If there is mental deficiency and epilepsy it should be classified under the predominant condition and the appropriate boxes for epilepsy and deficiency checked on the admission card. Here will be classified primary intellectual defect existing from birth when there is no demonstrated organic brain condition or other cause.

#### 325.0 Idiocy

Adult of mental age 0-35 months

Child with I.Q. under 20

#### 325.1 Imbecility

Adult of mental age 36-84 months

Child with I.Q. of 20-49

#### 325.2 Moron

Adult of mental age 84 months

Child with I.Q. of 50-74

#### 325.3 Borderline intelligence

Some vocational limitation; I.Q. of 74-85

#### 325.4 Mongolism

Characterized by anomalies of the skull, eyes and tongue. The eyes are oblique, narrow and slit-like, and other eye anomalies are common. Cause is obscure.

#### 325.5 Other and unspecified types

##### *Inclusions -*

Amaurotic family idiocy

Cerebromacular degeneration

Mental deficiency NOS

Mental retardation NOS

Oligophrenia

Phenylpyruvic oligophrenia

Tay-Sachs disease

### 326 OTHER AND UNSPECIFIED CHARACTER, BEHAVIOUR AND INTELLIGENCE DISORDERS

This group is to be used where the specific symptom is the outstanding feature of the case. If the specific symptom is secondary to some other condition it should be classified under the primary condition.

#### 326.0 Specific learning defects

Specific defects such as reading, mathematics, etc.

### **326.1 Stammering and stuttering of non-organic origin**

#### *Inclusions —*

Balbutio

Stammering or stuttering:

NOS

due to specified non-organic cause

### **326.2 Other speech impediments of non-organic origin**

### **326.3 Acute situational maladjustment**

To include only transient conditions directly due to stress, situational difficulties, combat or other operations. If the condition falls into any other definite psychiatric group it should be so classified.

### **326.4 Other and unspecified**

#### *Inclusions —*

Simple adult maladjustment

Primary behaviour disorders and psychoneurotic personalities not classifiable under 083, 310-318, 320-326.3

## **Other mental disorders**

### **020.1 JUVENILE NEUROSYPHILIS**

This group is to include all cases of congenital neurosyphilis whether psychotic or not, i.e., juvenile neurosyphilis, dementia paralytica juvenilis, juvenile general paresis, juvenile tabes and juvenile taboparesis.

#### *Inclusions —*

Dementia paralytica juvenilis

Juvenile:

general paralysis

tabes

taboparesis

### **024 TABES DORSALIS**

Include all such cases without psychosis. Cases with psychosis should be classified according to the primary psychosis.

#### *Inclusions —*

Arthritic syphilitica deformans      Posterior spinal sclerosis  
(Charcot)      Progressive spinal ataxia

Cerebrospinal tabes      Spastic ataxia

Charcot's joint disease      Tabes dorsalis

Locomotor ataxia (progressive)      Tabetic arthropathy

Neurosyphilis, tabes (dorsalis)

### **025 GENERAL PARALYSIS OF INSANE (SYPHILITIC MENINGO-ENCEPHALITIS)**

Under this heading are to be classified cases showing rapidly or slowly progressive organic intellectual and emotional defects with

physical signs and symptoms of parenchymatous syphilis of the nervous system and completely positive serology, including the paretic gold curve. Cases showing symptoms suggestive of manic-depressive reaction, schizophrenia or of other constitutional psychotic reactions, but showing also physical signs and symptoms of syphilis of the nervous system and positive serology, particularly the paretic gold curve, are to be listed here rather than under other headings. It is to be remembered that with the modern methods of treatment a number of paretics may be found with negative serology. Here the history, particularly that of the length and nature of treatment, must be taken into consideration in making the final classification.

## **026 OTHER SYPHILIS OF CENTRAL NERVOUS SYSTEM**

### **026.0 Without psychosis**

Include here cases of C.N.S. syphilis not classifiable in 020, 024 or 025.

### **026.1 With psychosis**

It is expected that all such cases will be as far as possible classified under 020, 025 or other primary diagnosis. A classification under this heading is only to be made after failure of every reasonable effort to determine the predominating pathological process.

## **083 LATE EFFECTS OF ACUTE INFECTIOUS ENCEPHALITIS**

### **083.1 Postencephalitic personality and character disorders**

Include here only those cases due to and occurring with or following acute infectious encephalitis.

### **083.2 Postencephalitic psychosis**

Include here only those psychoses due to and occurring with or following acute infectious encephalitis.

## **353 EPILEPSY**

This title excludes epilepsy with psychosis (380.1), focal and Jacksonian epilepsy. In cases of epilepsy and mental defect classify under the predominating diagnosis and check the other condition in the appropriate box on the admission card.

### **353.0 Petit mal**

#### *Inclusions -*

Minor epilepsy

Petit mal (idiopathic)

### **353.1 Grand mal**

#### *Inclusions -*

Grand mal (idiopathic)

Haut mal

Major epilepsy

### **353.2 Status epilepticus**

### 353.3 Other and unspecified

#### *Inclusions —*

Epilepsy (idiopathic) not specified as major or minor

Epileptic:

    automatism

    convulsions or fits, not specified as major or minor

Pykno-epilepsy

### 648.3 PSYCHOSIS ARISING FROM PREGNANCY

Include here only those cases directly attributable to the pregnancy; those occurring with pregnancy should be classified under the appropriate diagnosis.

### 688.1 PUERPERAL PSYCHOSIS

#### *Inclusions —*

Psychosis of the puerperium

Puerperal:

    dementia } after delivery

    insanity }

Puerperal:

    mania

    melancholia } after delivery

    psychosis }

### 793.0 OBSERVATION WITHOUT NEED FOR FURTHER MEDICAL (PSYCHIATRIC) CARE

This title includes cases which present some evidence of an abnormal condition which requires further study, but which after examination and observation show no need for further treatment or psychiatric care.

## SECTION 5

### Index of mental disorders

An alphabetical index is a necessary tool for the use of any statistical classification. While the index which follows has been prepared primarily for the use of clerks engaged in coding diagnostic terms appearing on medical records it is felt that the persons responsible for recording such particulars may derive benefit from its inclusion in the present Handbook.

The index has been abstracted from Volume 2, the Alphabetical Index, of the International Statistical Classification of Diseases, Injuries and Causes of Death, thus assuring uniformity with the list of categories in the preceding section and with international practice. As in the case of its international counterpart, it includes many ill-defined, colloquial and even undesirable terms in order to indicate to the coder where the case should be assigned. The presence of many terms should therefore not be taken either as sanction for their usage in good medical terminology or as inferring acceptance of their adequacy for classification purposes.

For these reasons, the index should not be used alone but as auxiliary to the list of categories, which should constitute the final authority for decisions on correct assignment.

- Aberration, mental, 318.5
- Abnormal excitability under minor stress, 326.3; late effect, acute infectious encephalitis, 083.1.
- Absence, epileptic, 353.1; with psychosis, 308.1
- Absinthemia, absinthaemia, 322.2
- Absinthe addiction, 322.1; with psychosis, 307
- Absinthism, 322.2
- Abuse, alcohol, 322.2
- Acarophobia, 313
- Accidents, psychosis secondary or due to, 308.7
- Accommodation, paralysis of, hysterical, 311; with anxiety reaction, 310
- Achlorhydria, neurogenic or psychogenic, 316.2
- Achylia gastrica, neurogenic or psychogenic, 316.2
- Acid stomach, psychogenic, 316.2
- Acidity, gastric, psychogenic, 316.2
- Acrophobia, 313
- Action, heart, irregular, psychogenic, 315.0
- Addiction, alcohol, alcoholic, 322.1; with psychosis, 307; absinthe, 322.1; with psychosis, 307; periodic, 322.1; with psychosis, 307; any of following list, 323; any of following list with psychosis, 308.6; amphetamine; barbituric acid (and compounds); benzedrine; bhang; bromides; cannabis indica; chloral; cocaine; codeine; demerol; diacetylmorphine; diamorphine; dionin; drug (analgesic) (hypnotic) (narcotic) (soporific); ether; ethylmorphine; hashish; heroin; Indian hemp; marihuana; morphine; opium; paraldehyde; pethidine; thebaine; veronal
- Adolescent insanity (see also Dementia praecox), 300.7

Adult maladjustment, simple, 326.4  
 Aerophagy, aerophagia, 316.3  
 Aggressive outburst, 321.2  
 Aggressiveness, 321.2; late effect, acute infectious encephalitis, 083.1  
 Agitated — see condition  
 Agoraphobia, 313  
 Agrammatism (nonorganic origin), 326.2; late effect, acute infectious encephalitis, 083.1  
 Agraphia (absolute) (due to specified nonorganic cause), 326.2; developmental, 326.0; late effect, acute infectious encephalitis, 083.1  
 Alcohol, alcoholic —  
   addiction, 322.1; with psychosis, 307; periodic, 322.1; delirium, acute, 322.0; chronic, 307; tremens, 307; gastritis or gastro-enteritis, 322.2; acute, 322.0; chronic, 322.1; dementia, hallucinosis, insanity, mania (acute or chronic), mental disorders, psychosis, or polyneuritic psychosis, 307; apoplexy (cerebral), brain congestion, cardiopathy, coma, convulsive disorder, edema of brain, encephalitis, epilepsy, intoxication, meningitis (serous), nephritis, neuritis (toxic) (multiple), oedema of brain, paralysis (general), polyneuritis, pseudoparesis, pseudopellagra, or wet brain, 322.2  
 Alcoholism, 322.2; with psychosis, 307; acute, 322.0; chronic, 322.1; chronic with psychosis, 307; Korsakoff's, 307; paranoid type psychosis, 307  
 Alexia, congenital, developmental, or NOS, 326.0; late effect, acute infectious encephalitis, 083.1  
 Alienation, mental, 309.2; late effect, acute infectious encephalitis, 083.1  
 Allergic reactions, psychogenic, 317.5  
 Alternating — see condition  
 Alzheimer's disease, 305  
 Amaurosis, hysterical, 311; hysterical with anxiety reaction 310; mental deficiency, 325.5  
 Amaurotic family idiocy NOS or with mental deficiency or with retinal atrophy, 325.5  
 Amblyopia, hysterical, 311; hysterical with anxiety reaction, 310  
 Amentia, 325.2; late effect, acute infectious encephalitis, 083.1  
 Amnesia, hysterical, 311; hysterical with anxiety reaction, 310  
 Amoral trends, 320.5; late effect, acute infectious encephalitis, 083.1  
 Amphetamine addiction, 323; with psychosis, 308.6  
 Anaesthesia, see Anesthesia  
 Analgesic drug addiction, 323; with psychosis, 308.6  
 Anarthria, 326.2; late effect, acute infectious encephalitis, 083.1  
 Anergasia, 309.2; late effect, acute infectious encephalitis, 083.1; senile, 304  
 Anesthesia, functional or hysterical, 311; functional or hysterical with anxiety reaction, 310; sexual psychogenic, 317.1  
 Aneurysm: any of following without psychosis, 026.0; with psychosis, 026.1; brain, syphilitic; carotid, syphilitic intracranial; central nervous system; syphilitic-brain, central nervous system, cerebral, spine, or spinal  
 Angioneurosis, 315.2  
 Anhidrosis, lid, neurogenic 317.5  
 Anomaly, cranial, developmental with mental deficiency 325.5  
 Anorexia, hysterical or nervosa, 311; hysterical or nervosa with anxiety reaction, 310  
 Anosmia, hysterical or psychic, 311; hysterical or psychic with anxiety reaction, 310  
 Antisocial personality 320.4; late effect, acute infectious encephalitis 083.1  
 Anxiety: with — aerophagy, 316.3; cardiac asthenia, 315.0; DaCosta's syndrome, 315.0; globus, 316.3; hysteria, 310; hysterio-epilepsy, 310; neurocirculatory asthenia, 315.0; soldiers' heart, 315.0; vomiting, cyclical, 316.2; anxiety neurosis, reaction or state, 310

Apepsia, psychogenic, 316.2  
 Aphasia, amnesic, atoxic, developmental, global, jargon, nominal, nonorganic, semantic, sensory, syntactic, verbal, or NOS, 326.2; nonorganic as late effect of acute infectious encephalitis, 083.1; with tertiary syphilis, 026.0  
 Asphemia, congenital, developmental, nonorganic, or NOS, 326.2; as late effect of acute infectious encephalitis, 083.1  
 Aphonia, functional, hysterical, or functional hysterical, 311; with anxiety reaction, 310  
 Apoplexy, alcoholic or alcoholic cerebral, 322.2  
 Apprehension state 310 (see also Anxiety)  
 Arachnoiditis, syphilitic 026.0; with psychosis, 026.1  
 Arrhythmia, psychogenic, 315.1  
 Arteriosclerosis: with psychosis, 306; brain, central nervous system, or cerebral, with mental disorder or psychosis, 306  
 Arteriosclerotic dementia, 306  
 Arteritis; cerebral syphilitic, 026.0; syphilitic or syphilitic general, brain or spinal, 026.0; any of these with psychosis, 026.1  
 Arthritis, arthritic: congenital syphilitic, 020.2; syphilitica deformans (Charcot) 024  
 Arthropathy, Charcot's, neuropathic, tabes dorsalis, or tabetic, 024  
 Articulation disorder, psychogenic, 317.4  
 Asocial—mental defect, 325.5; personality or trends, 320.5; any of these as late effect, acute infectious encephalitis, 083.1  
 Asphyxia, asphyxiation, alcoholic, 322.2  
 Asthenia, Asthenic: cardiac, cardiovascular, heart, or neurocirculatory, 315.0; hysterical, 311; hysterical with anxiety reaction, 310; nervous, psychogenic, or reaction NOS, 318.3  
 Asthenopia, hysterical or muscular hysterical, 311; with anxiety reaction, 310  
 Asthma, psychogenic 317.0  
 Ataxia: hysterical, 311; hysterical with anxiety reaction, 310; locomotor, progressive locomotor, partial, progressive, spastic, syphilitic spastic, progressive spinal, 024  
 Atonia, atonic, psychogenic: caecum, cecum, colon or intestine, 316.3; dyspepsia or stomach, 316.2; neurotic, stomach, 316.2  
 Atrophy, atrophic: bone, due to tabes dorsalis or neurogenic tabes dorsalis, 024; brain—with psychosis -65 yr., 309.2; brain—with psychosis specified as presenile dementia, 305; brain—with psychosis 65 + yr., 304; brain—alcoholic, 322.2; brain—circumscribed, 305; macular or dermatological macular—due to syphilis, 026.0 or with psychosis, 026.1; neurogenic, bone—tabetic, 024; optic—syphilitic, 026.0, or with psychosis, 026.1; optic—tabes dorsalis, 024  
 Attack, panic, 310  
 Auditory—see condition  
 Auricle, auricular—see condition  
 Automatism, epileptic or paroxysmal, idiopathic, 353.3; with psychosis, 308.1  
 Autonomic, hysteria seizure, 311; with anxiety reaction, 310  
 Aviators' effort syndrome, 315.0

- B -

Backwardness, 325.3  
 Balbuties or balbutio 326.1; late effect, acute infectious encephalitis 083.1  
 Barbituric acid addiction, 323; with psychosis, 308.6  
 Battle exhaustion 326.3  
 Bayle's disease 025  
 Beard's disease 318.3  
 Bedwetting child 324  
 Behaviour, behaviour-disorders, see Disorders—disturbance, 326.4; in child, 324; postencephalitic, 083.1; problem child, 324

Bell's disease or mania 301.0  
 Benzedrine addiction 323; with psychosis, 308.6  
 Bergeron's disease 311; with anxiety reaction, 310  
 Bhang addiction 323; with psychosis, 308.6  
 Bielschowsky—Jansky amaurotic familial idiocy or disease 325.5  
 Bigeminal pulse, psychogenic, 315.1  
 Blindness, hysterical or psychic, 311; with anxiety reaction, 310; word blindness, congenital or nonorganic, 326.0; word blindness, late effect, acute infectious encephalitis, 083.1  
 Block, heart or sino-auditory, psychogenic, 315.1  
 Borderline intelligence, 325.3; late effect, acute infectious encephalitis, 083.1  
 Bradycardia or vagal bradycardia, psychogenic, 315.1  
 Breakdown, nervous 318.5  
 Breath holder, child, 324  
 Bromide addiction, 323; with psychosis, 308.6  
 Bromidism, chronic, 323; with psychosis, 308.6  
 Bromidrophobia, 313  
 Bromism, chronic, 323; with psychosis, 308.6  
 Bruck—Lange disease, 325.5  
 Burning, functional 311; with anxiety reaction, 310

- C -

Cachexia, nervous 318.3  
 Camptocormia, 311; with anxiety reaction, 310  
 Cancerphobia, 313  
 Cannabis indica addiction, 323; with psychosis, 308.6  
 Carcinomaphobia, 313  
 Cardiophobia, 313  
 Cardiospasm; neurotic, psychogenic, or reflex 316.3  
 Catalepsy, 318.5; hysterical, 311; hysterical with anxiety reaction, 310  
 Cerebromacular degeneration, 325.5; late effect, acute infectious encephalitis, 083.1  
 Change(s), mental, 318.5; personality, 320.7, personality, late effect, acute infectious encephalitis, 083.1  
 Chloral addiction, 323; with psychosis, 308.6  
 Chorea with mental disorders, 308.1, chorea insaniens, 308.1  
 Choreic dementia or insanity, 308.1  
 Climacteric insanity or melancholia, 302  
 Clouded state, epileptic or paroxysmal idiopathic 308.1  
 Cluttering 326.1; late effect, acute infectious encephalitis 083.1  
 Cocaine addiction, 323; with psychosis, 308.6  
 Cocainism, 323; with psychosis, 308.6  
 Codeine addiction, 323; with psychosis, 308.6  
 Colic; hysterical, 311; hysterical with anxiety reaction, 310; psychogenic mucous, 316.0  
 Colitis, psychogenic: membranous, 316.3; mucous, 316.0; spastic, 316.1  
 Collapse, nervous, 318.5  
 Coma, epileptic, 353.3  
 Compensation neurosis or psychoneurosis, 311; with anxiety reaction, 310  
 Complaint, functional psychogenic, bowel or intestine, 316.3  
 Complex, homosexual or hypersexual, 320.6; late effect, acute infectious encephalitis, 083.1  
 Compulsion or compulsive neurosis, states, swearing, or tics and spasms, 313  
 Conduct disturbance, child 324  
 Confusional or confused insanity, psychosis or state 309.2  
 Congenital: epilepsy, 353.3; idiocy, 325.0; imbecility, 325.1; mental insufficiency, 325.5  
 Congestion, brain, alcoholic 322.2  
 Conjugal maladjustment 326.4  
 Constipation, psychogenic, atonic or spastic, 316.3

Constitutional psychopathic state, 320.4; late effect, acute infectious encephalitis, 083.1  
 Constitutionally substandard, 320.3  
 Contraction, contracture, contracted: hourglass stomach, psychogenic, 316.2; hysterical, 311; hysterical with anxiety reaction, 310; joint or muscle, hysterical, 311; joint or muscle, hysterical with anxiety reaction, 310; neck, psychogenic, 317.4; stomach, hourglass, psychogenic 316.2; stomach, psychogenic, 316.2  
 Conversion, hysterical or conversion reaction, 311; with anxiety reaction, 310  
 Convulsions: epileptic, 353.3; epileptic major, 353.1; epileptic minor, 353.0; epileptic, any type, with psychosis, 308.1; hysterical, 311; hysterical with anxiety reaction, 310; infantile epilepsy, 353.3  
 Convulsive disorders or state: with psychosis, 308.1; epileptic, 353.3  
 Craft neurosis, 318.2  
 Cramp(s): muscle, hysterical 311, with anxiety reaction 310; occupational, telegraphers', typists' or writers', 318.2  
 Crazy, 309.2; late effect, acute infectious encephalitis 083.2  
 Cribbing, 324  
 Criminalism, 320.5; late effect, acute infectious encephalitis 083.1  
 Crisis, stomach or tabetic, 024  
 Cruelty in children 324  
 Crying, forced 324  
 Cyclical vomiting, 316.2  
 Cyclothymia, 301.0; late effect, acute infectious encephalitis, 083.2  
 Cyclothymic personality, 320.2; late effect, acute infectious encephalitis, 083.1

# - D -

Da Costa's syndrome 315.0  
 Deafmutism, hysterical, 311; hysterical with anxiety reaction, 310  
 Deafness, hysterical, 311; hysterical with anxiety reaction, 310; word, developmental, 326.0  
 Defect, defective: developmental, mental 325.5; high grade, 325.2; high grade, late effect, acute infectious encephalitis, 083.1; mental, asocial, 325.5; mental, asocial, late effect, acute infectious encephalitis, 083.1; specific learning, late effect, acute infectious encephalitis, 083.1; speech NEC, 326.2; speech, nonorganic origin or due to specified non-organic cause, 326.2; speech, due to specified non-organic cause, late effect, acute infectious encephalitis, 083.1  
 Deficiency: mental: NOS, 325.5; borderline condition, 325.3; idiot, 325.0; imbecile, 325.1; late effect, acute infectious encephalitis, 083.1; mongolian, 325.4; moron, 325.2; postinfectious, 325.5; moral, 320.5; moral, late effect, acute infectious encephalitis, 083.1; psychobiological, 320.3  
 Deficientia intelligentiae, 325.3; late effect, acute infectious encephalitis, 083.1  
 Degeneration: brain: with psychosis, age 65 plus, 304; with psychosis, age less than 65, 309.2; with psychosis, age less than 65, specified as presenile dementia, 305; arteriosclerotic, with psychosis or mental disorder, 306; cerebellum or cerebral, see brain: cerebromacular, 325.5; late effect, acute infectious encephalitis, 083.1: cerebrovascular with psychosis, 306: moral, 320.5; late effect, acute infectious encephalitis, 083.1  
 Delayed conduction, psychogenic 315.1  
 Delinquency or juvenile delinquency 324  
 Delirium, delirious; alcoholic NOS, alcoholic chronic, or tremens 307; alcoholic acute, 322.0; chronic delirium, exhaustion delirium, maniacal delirium, or delirium in institution for insane, 309.2; any of these as late effect, acute infectious encephalitis, 083.2; hysterical, 311; hysterical with anxiety reaction, 310; mania, 301.0

Delusion, delusional 318.5; insanity or mental stupor, 309.2; insanity or mental stupor as late effect, acute infectious encephalitis, 083.2; persecution, 303

Dementia: NOS, agitated, apathetic, depressive or organic, 309.2; any of these as late effect, acute infectious encephalitis, 083.2; alcoholic, 307; apoplectic, old, 306; arteriosclerotic, 306; catatonic, 300.2; choreic or epileptic, 308.1; developmental or praecox, see schizophrenia; hebephrenic, 300.2; old age, senile, senile exhaustion, or senile paranoid, 304; paralytica, paralytic, 025; paralytica juvenilis, 020.1; paralytic syphilitic, 025; paralytic syphilitic with psychosis, 025; paralytic syphilitic, congenital, 020.1; paralytic, tabetic form, 025; paranoid, 300.3; paraphrenic, 300.1; parietic or progressive syphilitic, 025; pregnancy, old unknown psychosis, 309.2; presenile, 305; primary, 300.0; puerperal, 688.1; puerperal, old unknown psychosis 309.2; secondary, see Psychosis, secondary; simple type or simplex, 300.0; terminal, see Psychosis, secondary.

Demerol addiction, 323; with psychosis, 308.6

Dependency, passive or reactions, 321.1; late effect, acute infectious encephalitis, 083.1

Depersonalization, 318.1

Depression, acute, agitated, or recurrent, 301.1; acute, agitated or recurrent as late effect, acute infectious encephalitis, 083.2; psychogenic or reactive, 314

Depressive: dementia, 309.2; dementia as late effect, acute infectious encephalitis, 083.2; manic, see Manic depressive; neurotic reaction, 314

Derangement, mental 309.2; late effect, acute infectious encephalitis, 083.2

Dermatitis factitia or ficta, psychogenic, 317.3

Dermatosis, hysterical, 311; with anxiety reaction, 310

Despondency 318.5

Destructiveness 324

Deterioration: epileptic, 308.1; mental, 309.2; mental, late effect, acute infectious encephalitis, 083.2

Development, delayed speech, 325.3; tardy mental, 325.5

Deviation, sexual, 320.6; late effect, acute infectious encephalitis, 083.1

Diabetes, diabetic insanity 308.3

Diacetylmorphine addiction, 323; with psychosis, 308.6

Diamorphine addiction, 323; with psychosis, 308.6

Diarrhea, diarrhoea, diarrheal, diarrhoeal: functional psychogenic, nervous, or neurogenic 316.1; hyperperistalsis or nervous hyperperistalsis, 316.3

Dilatation, psychogenic, ileum or jejunum, 316.3; psychogenic or reflex, stomach, 316.2

Dionin addiction, 323; with psychosis, 308.6

Diplegia, brain, syphilitic, congenital, 020.1

Dipsomania, 322.1; with psychosis, 307

Dirt-eating child 324

Disability, special spelling 326.0

Disease, diseased: Alzheimer's, 305; Batten's retina, 325.5; Bayle's, 025; Beard's, 318.3; Bell's, 301.0; Bell's as late effect, acute infectious encephalitis, 083.2; Bergeron's, 311; Bergeron's with anxiety reaction, 310; Bielschowsky-Jansky, 325.5; bowel, functional, psychogenic, 316.3; brain, arterial, arteriosclerotic, or artery with mental disorder or psychosis, or organic with psychosis, 306; Bruck-Lange, 325.5; cerebrovascular with psychosis, 306; Charcot's 024; Duchenne's or Duchenne's locomotor ataxia, 024; epigastric, functional, psychogenic, 316.2; Ericksen's, 311; gastro-intestinal, functional, psychogenic, 316.2; Gilles de la Tourette's, 318.4; Grave's insanity, 308.3; heart, functional psychogenic, 315.1; infective, followed by toxic psychosis, 308.2; intestine, functional psychogenic, 316.3; Janet's 318.3; joint, Charcot's, 024; Korsakoff's, 307; Kraepelin-

Morel, 300.7; Lasegue's, 303; mental, 309.2; Morel-Kraepelin, 300.7; Pelizaeus-Merzbacher, 325.5; Pick's brain, 305; psychiatric, 309.2; retina, Batten's, 325.5; Rossbach's, psychogenic, 316.2; Sachs' 325.5; Sander's, 303; somatic psychosis, 309.2; Spillinger-Stock, 325.5; Spillmeyer-Vogt, 325.5; stomach, functional psychogenic, 316.2; Tay-Sachs, 325.5; Unverricht's, 353.3; Vogt-Spielmeyer 325.5

# Disobedience 324

Disorder (see also Disease): affective, 301.2; affective, late effect, acute infectious encephalitis, 083.2; articulation, psychogenic, 317.4; behavior or behaviour—NEC or primary (except primary childhood), 326.4—late effect, acute infectious encephalitis, 083.1—conduct or habit disturbance or neurotic traits in child, 324—primary childhood NOS, enuresis, jealousy, masturbation, or tantrum, 324; cardiac functional psychogenic, 315.1; cardiovascular system psychogenic NEC or with anxiety reaction, 315.2; character (see also Disorder, behavior or behaviour) 326.4—late effect, acute infectious encephalitis, 083.1; convulsive with psychosis, 308.1; convulsive epileptic, 353.3; digestive—psychogenic, 316.2—system, psychogenic NEC, 316.3; esophagus, functional psychogenic, 316.3; functional speech, 326.2; gastro intestinal, functional psychogenic 316.2; genitourinary system, psychogenic 317.1; heart action, psychogenic 315.0; intestinal, functional NEC, psychogenic 316.3; joint or limb, psychogenic, 317.4; mental, see Mental disorder; micturition, psychogenic, 317.4; muscle, or musculoskeletal system, psychogenic, 317.4; oesophagus, functional psychogenic, 316.3; parts of body NEC, psychogenic, 317.5; personality, see Disorder of Personality; psychoneurotic, mixed NEC, 318.4; respiration, psychogenic, 317.0; sexual function, psychogenic, 317.1; skin, psychogenic, 317.3—pruritus 317.2; stomach, functional psychogenic, 316.2; substitution, 311; substitution with anxiety reaction, 310

Disorder of Personality: NOS, 320.7; any type, as late effect, acute infectious encephalitis, 083.1; aggressiveness, 321.2; antisocial, 320.4; asocial, 320.5; characterized by—enuresis, 321.3—symptomatic habits NEC, 321.4; cyclothymic, 320.2; emotional instability, 321.0; immaturity, 321.5; inadequate, 320.3; paranoid, 320.1; passive dependency, 321.1; pathological NEC, 320.7; schizoid, 320.0; sexual deviation, 320.6

# Disorientation 318.5

Dissociated personality 320.0

Dissociation, auriculoventricular, psychogenic 315.1

Dissociative reaction 311; with anxiety reaction 310

Distress: functional psychogenic bowel, 316.3; psychogenic gastro-intestinal or functional psychogenic gastro-intestinal, 316.2

Disturbance: behavior, behaviour, 326.4—child 324—postencephalitic 083.1; conduct child 324; digestive, psychogenic 316.2; emotional 321.0; gastro-intestinal, psychogenic 316.2; habit, child 324; heart, functional psychogenic, 315.1; mental, postbifurcated 308.8; motor, stomach 316.2; personality, see Disorder of Personality; rhythm, heart, psychogenic 315.1; speech NEC 326.2—late effect, acute infectious encephalitis, 083.1; stomach, functional psychogenic 316.2

Dream state, hysterical, 311; with anxiety reaction, 310

Drug addiction, 323; with psychosis, 308.6; drug habit, 323; drug psychosis, 308.6

# Drunkenness 322.2

Duchenne's disease or Duchenne's locomotor ataxia 024

Dullness, 325.3; late effect, acute infectious encephalitis, 083.1

Dysaesthesia, hysterical, 311; with anxiety reaction, 310

Dysarthria, 326.2; late effect, acute infectious encephalitis, 083.1

Dysbasia, hysterical, 311; with anxiety reaction, 310

Dysentery, functional psychogenic or neurogenic, 316.3

Dysergasia 308.3

Dysesthesia, hysterical 311; with anxiety reaction 310

Dysfunction, colon or rectum, psychogenic, 316.3  
 Dyskinesia, hysterical 311; with anxiety reaction, 310  
 Dysmenorrhea, dysmenorrhoea, psychogenic, 317.1  
 Dysorexia, hysterical, 311; with anxiety reaction, 310  
 Dyspareunia, psychogenic, 317.1  
 Dyspepsia: atonic psychogenic 316.2; diarrhea, diarrhoea, psychogenic 316.2; functional or gastro-intestinal, psychogenic 316.2; intestinal, psychogenic 316.3; nervous, neurogenic, or neurotic, 316.2; occupational psychogenic, 316.2; psychogenic NOS or reflex, 316.2  
 Dysphagia, functional or nervous: NOS, 311; with anxiety reaction, 310  
 Dysphasia, 326.2; late effect, acute infectious encephalitis, 083.1  
 Dysphonia, functional 311  
 Dyspnea, dyspnoea, hysterical, 311; hysterical with anxiety reaction, 310; neurogenic, 317.0

# - E -

Ectopic; auricular beats, psychogenic 315.1; ventricular beats, psychogenic 315.1  
 Effort syndrome or aviators' effort syndrome 315.0  
 Embolism of brain with mental disorder 308.4  
 Emotional instability 321.0; late effect, acute infectious encephalitis 083.1  
 Emotionality, pathological 321.0; late effect, acute infectious encephalitis, 083.1  
 Encephalitis, infectious, late effects: behavior, behaviour disturbance or personality or character disorders, 083.1; psychosis, 083.2  
 Encephalomyelitis, acute or infectious—see Encephalitis, infectious  
 Encephalopathy due to alcohol 322.2  
 Endarteritis: senile, see Arteriosclerosis; syphilitic, spinal, brain, or cerebral 026.0—with psychosis 026.1  
 Enterospasm, psychogenic 316.1  
 Enuresis: childhood behavior, behaviour disorder 324; manifestation immature personality, 321.3  
 Epilepsy, epileptic: NOS, 353.3; any type listed below (except "alcoholic" or "due to syphilis") with psychosis, 308.1; absence, 353.1; affective, 353.3; akinetic psychomotor, 353.3; alcoholic, 322.2; alcoholic with psychosis, 307; automatism, 353.3; brain, cerebral, or climacteric, 353.3; clouded state, 308.1; coma, communicating, congenital (except focal), or convulsions, 353.3; dementia or deterioration, 308.1; due to syphilis, 026.0; due to syphilis, with psychosis, 026.1; fit or functional, 353.3; grand mal, 353.1; hysterical 311—with anxiety reaction 310; insanity, 308.1; Kojevnikoff's, 353.3; major, 353.1; mania, 308.1; migraine basis, 353.3; minor, 353.0; mixed, musicogenic, or myoclonus, 353.3; petit mal, 353.0; psychic equivalent, 308.1; psychomotor, 353.3; seizure, akinetic 353.3; senile, stroke, or vertigo, 353.3  
 Epileptic—see Epilepsy  
 Episcleritis, syphilitic 026.0—with psychosis, 026.1  
 Ericksen's disease 311  
 Erotomania 320.6; late effect, acute infectious encephalitis 083.1  
 Eructation, nervous 316.2  
 Essential—see condition  
 Ether addiction 323—with psychosis, 308.6  
 Etherism 323—with psychosis, 308.6  
 Ethylism: NOS 322.2; with psychosis, 307; acute, 322.0; chronic 322.1—with psychosis 307  
 Ethylmorphine addiction 323; with psychosis, 308.6  
 Excitability, abnormal, under minor stress, 326.3; late effect, acute infectious encephalitis, 083.1  
 Excitement: manic, 301.0; mental, 309.2; state, 309.2

Exhaustion, exhaustive: delirium, 309.2; mental or nervous, 318.3; psychosis, 309.2; senile dementia, 304  
Exhibitionism, 320.6; late effect, acute infectious encephalitis, 083.1  
Extrasystole, psychogenic 315.1

- F -

Fatigue: general psychogenic, 318.3; syndrome, 315.0  
Fear complex or reaction, 312  
Feeble-mindedness 325.2; late effect, acute infectious encephalitis, 083.1  
Fermentation, psychogenic. gastric, gastro-intestinal, or stomach, 316.2; intestine, 316.3  
Fetishism, 320.6; late effect, acute infectious encephalitis, 083.1  
Fibrillation, psychogenic: auricular, cardiac, heart, or ventricular, 315.1  
Fit, epileptic: NOS, 353.3; major, 353.1; minor, 353.0; any of these with psychosis, 308.1  
Flutter, psychogenic: arrhythmia, auricular or heart 315.1  
Food refusal, 65 or more years of age, 304  
Frigidity, psychic, 317.1  
Fugue, hysterical, 311 — with anxiety reaction, 310

- G -

Gallop rhythm, psychogenic 315.1  
Ganser's syndrome 309.2  
Gastralgia, psychogenic 316.2  
Gastrectasis, psychogenic 316.2  
Gastritis, alcoholic: NOS, 322.2; acute, 322.0; chronic, 322.1  
Gastrorrhea, gastrorrhoea, psychogenic 316.2  
Gastrosplasm, neurogenic, neurotic, or reflex 316.2  
Gastrosuccorhea, gastrosuccorhoea, neurotic or psychogenic 316.2  
General — see condition  
Globus, 316.3; hystericus, 311; hystericus with anxiety reaction, 310  
Grand mal, 353.1; with psychosis, 308.1  
Graphospasm 318.2  
Grave's disease with insanity, 308.3  
Gumma: brain, cauda equina, central nervous system, intracranial, leptomeninges, neurosyphilitic or spinal cord, 026.0; any of these with psychosis, 026.1

- H -

Habit: disturbance, child 324; drug 323 — with psychosis, 308.6; symptomatic, manifestation of immature personality NEC 321.4 — late effect, acute infectious encephalitis, 083.1  
Hallucinosi: NOS, 309.2; alcoholic, 307; late effect, acute infectious encephalitis, 083.2  
Hashish: addiction, 323; addiction with psychosis, 308.6; insanity, 308.6  
Haut mal, 353.1; with psychosis, 308.1  
Hebephrenia, hebephrenic dementia praecox, or hebephrenic schizophrenia 300.1  
Hemi-anesthesia or hemi-anaesthesia, hysterical 311 — with anxiety reaction 310  
Hemiparesis, hysterical 311 — with anxiety reaction 310  
Hemiplegia, hysterical 311 — with anxiety reaction 310  
Heredodegeneration, macular 325.5  
Heroin addiction 323 — with psychosis 308.6  
Heubner's disease 026.0 — with psychosis 026.1  
High grade defect 325.2 — late effect, acute infectious encephalitis 083.1  
Hobolism 320.4 — late effect, acute infectious encephalitis 083.1  
Homesickness 326.4  
Homosexuality 320.6 — late effect, acute infectious encephalitis 083.1

Hourglass contraction of stomach, psychogenic 316.2  
 Hydrocephalus, syphilitic congenital 020.1  
 Hyperacidity, gastric, psychogenic 316.2  
 Hyperactive, hyperactivity: child, 324; gastro-intestinal, psychogenic 316.2  
 Hyperaesthesia, larynx or pharynx, hysterical 311 — with anxiety reaction 310  
 Hyperchlorhydria, neurotic or psychogenic 316.2  
 Hyperchylia gastrica, psychogenic 316.2  
 Hyperemesis, psychogenic 316.2  
 Hyperesthesia, larynx or pharynx, hysterical 311 — with anxiety reaction, 310  
 Hyperkinesia, 326.4 — late effect, acute infectious encephalitis 083.1  
 Hypermobility, psychogenic: caecum, cecum, colon, or ileum, 316.1; stomach, 316.2  
 Hypermotility, intestine, psychogenic 316.1  
 Hypersecretion, gastric, psychogenic 316.2  
 Hypersensitive, hypersensitiveness: allergic, see Allergy; nonallergic — psychogenic colon, 316.1 — psychogenic stomach, 316.2  
 Hyperthymergasia, 301.0  
 Hypertonicity of stomach, psychogenic 316.2  
 Hypo-acidity, gastric, psychogenic 316.2  
 Hypochlorhydria, neurotic or psychogenic, 316.2  
 Hypochondria or hypochondriasis, 318.0  
 Hypomania or hypomanic reaction 301.0 — late effect, acute infectious encephalitis 083.2  
 Hypomotility, psychogenic: gastro-intestinal tract or intestine, 316.3; stomach, 316.2  
 Hypothymergasia, 301.1  
 Hysteria NOS 311; with anxiety reaction, 310  
 Hysterical: amnesia, anaesthesia, anesthesia, anorexia, anosmia, aphonia, blindness, catalepsy, convulsion, deafness, dyskinesia, fugue, mutism, paralysis, postures, somnambulism, tic, tremor, manifestation NEC, 311 — any of preceding with anxiety reaction, 310; conversion hysteria, NOS, amnesia, anaesthetic, anesthetic, autonomic, hyperkinetic, mixed, paralytic, paraesthetic, paresthetic, 311 — any of preceding with anxiety reaction, 310; psychosis, 309.2 — late effect, acute infectious encephalitis, 083.2; vomiting, 311 — with anxiety reaction, 310  
 Hystero-epilepsy, 311 — with anxiety reaction, 310

# - 1 -

Ideas and mental images, obsessional 313  
 Idiocy — see Idiot  
 Idioglossia not specified as organic, 326.2  
 Idiopathic — see condition  
 Idiot, idiocy: NOS, 325.0; adult, mental age to 2 yr., 325.0 — late effect, acute infectious encephalitis, 083.1; amaurotic, family 325.5; child, I.Q. — 20, 325.0 — late effect, acute infectious encephalitis, 083.1, microcephalic, 325.5; mongolian, 325.4; oxycephalic, 325.5  
 Illusions 309.2  
 Imbecile, imbecility: NOS, 325.1; adult, mental age 3 yr.-7 yr., 325.1 — late effect, acute infectious encephalitis, 083.1; child, I.Q. 20-49, 325.1 — late effect, acute infectious encephalitis, 083.1; congenital, 325.1; infantile, 325.1 — late effect acute infectious encephalitis, 083.1; old age, 304; moral, 320.5; senile, 304  
 Immature personality (see also Immaturity reaction): NOS, 321.5; late effect, acute infectious encephalitis 083.1; characterized by — enuresis, 321.3 — symptomatic habits NEC, 321.4  
 Immaturity reaction: NOS, 321.5; late effect, acute infectious encephalitis, 083.1  
 Impediment, speech, not specified as organic, 326.2; late effect, acute infectious encephalitis, 083.1

Impotence 317.1  
 Impulses, obsessional 313  
 Impulsive, neurosis 313  
 Inadequate, inadequacy: biologic, constitutional, functional, or social, 083.1; mental, 325.5; personality, 320.3; any of these as late effect, acute infectious encephalitis, 083.1  
 Incontinence: faeces—due to hysteria, 311—with anxiety reaction, 310; hysterical, 311: hysterical with anxiety reaction, 310; urine, neurogenic, 317.1  
 Indian hemp addiction, 323; with psychosis, 308.6  
 Indigestion, nervous or psychogenic, 316.2  
 Inebriety 322.2  
 Inertia, stomach, psychogenic 316.2  
 Infantile degeneration of macula 325.5  
 Inferiority, 320.3; late effect, acute infectious encephalitis, 083.1  
 Insanity, insane: NOS, 309.2; adolescent (see also Dementia Praecox) 300.7; affective, 301.2; alcoholic, 307; alternating, 301.0; chorea, 308.5; circular, 301.0; climacteric, 302; confusional, 309.2—late effect acute infectious encephalitis 083.2; delusional, 309.2—late effect, acute infectious encephalitis, 083.2; diabetic, 308.3; due to alcohol, 307; due to chronic poisoning, 308.6; due to habit forming drug, 308.6; due to hashish, 308.6; due to lead, 308.6; epileptic, 308.1; Grave's disease, 308.3; impulsive, 309.2—late effect, acute infectious encephalitis, 083.2; late effect, acute infectious encephalitis, 083.2; lead, 308.6; manic depressive—see Insanity, manic depressive; menopausal, 302; mercurial, 308.6; myxedema or myxoedema, 308.3; obsessive, 309.2—late effect, acute infectious encephalitis, 083.2; paralysis, general or progressive, 025; paresis, general 025; partial, 309.2—late effect, acute infectious encephalitis, 083.2; pellagra, 308.3; postfebrile, 308.8; puerperal, 688.1—old, unknown type 309.2; senile, 304; total, 309.2—late effect, acute infectious encephalitis, 083.2; toxic, 308.6  
 Insanity, manic depressive: NOS, 301.2; with schizophrenic, 300.6; agitated, 301.0; circular, 301.0; depressive, 301.1; manic, 301.0; mixed NEC, 301.2; perplexed, 301.2; stuporous, 301.2  
 Instability; biological, emotional, nervous, or personality, 321.0; any of these as late effect, acute infectious encephalitis, 083.2  
 Insufficiency, mental, 325.5; congenital mental, 325.5  
 Intelligence, borderline, 325.3  
 Intemperance 322.2  
 Intoxication: NOS or alcoholic, 322.2; acute, 322.0; psychosis, alcoholic, 307  
 Involutional; melancholia or psychosis, 302  
 Irritability, colon or stomach, psychogenic, 316.1  
 Irritation, gastric, gastro-intestinal, or stomach, 316.2

- J -

Janet's disease 318.3  
 Jansky-Bielschowsky amaurotic familial idiocy 325.5  
 Jealousy 324

- K -

Katatonia (see also Catatonia) 300.2  
 Kleptomania 313  
 Kojevnikoff's epilepsy 353.3  
 Korsakoff's disease, psychosis, or syndrome 307  
 Korsakow's—see Korsakoff's  
 Kraepelin-Morel disease 300.7

- L -

Lalling (non-organic origin) 326.1—late effect, acute infectious encephalitis 083.1  
 Lasègue's disease 303  
 Lead insanity 308.6  
 Learning defect, specific 326.0—late effect, acute infectious encephalitis 083.1  
 Leptomenigitis, syphilitic, 026.0— with psychosis, 026.1  
 Liar, pathologic 320.5—late effect, acute infectious encephalitis 083.1  
 Lichenification, psychogenic 317.3  
 Lispering 326.2  
 Loss of mind 309.2—late effect, acute infectious encephalitis 083.2  
 Lunacy 309.2—late effect, acute infectious encephalitis 083.2  
 Lycanthropy 309.2—late effect, acute infectious encephalitis 083.2  
 Lypemania 301.1

- M -

Madness 309.2—late effect, acute infectious encephalitis 083.2  
 Mal cerebral (see also Epilepsy) 353.3  
 Mal comitial (see also Epilepsy) 353.3  
 Maladjustment—conjugal, 326.4; simple, adult 326.4—late effect, acute infectious encephalitis, 083.2; situational acute, 326.3—late effect, acute infectious encephalitis, 083.2  
 Mania: NOS, 301.0; alcoholic or alcoholic acute, 307; Bell's, 301.0; compulsive, 313; delirious, 301.0; epileptic, 308.1; hysterical, 311; hysterical with anxiety reaction, 310; puerperal, 688.1; puerperal, old 301.0; recurrent, 301.0; senile, 304  
 Manic depression 301.2  
 Manic psychosis 301.0  
 Manic-depressive insanity, psychosis, or reaction 301.2; with schizophrenia, 300.6; agitated, 301.0; mixed NEC, 301.2; perplexed, 301.2; stuporous, 301.2  
 Marihuana addiction or chronic poisoning, 323; with psychosis, 308.6  
 Masochism, 320.6;—late effect, acute infectious encephalitis, 083.1  
 Masturbation, 317.1;—behaviour disorder of childhood, 324  
 Megalomania, 309.2;—late effect, acute infectious encephalitis, 083.2  
 Melancholia—NOS, agitated, intermittent, old puerperal, recurrent, or stuporous, 301.1; climacteric, involutional, or menopausal, 302; hypochondriac, 318.0; puerperal, 688.1; senile, 304  
 Mendacity, pathologic, 320.5;—late effect, acute infectious encephalitis, 083.1  
 Meningitis—alcoholic, 322.2; psychotic, 308.5; syphilitic, 026.1; congenital syphilitic, 020.1  
 Meningomyelocoele, syphilitic 026.0; congenital syphilitic, 020.1  
 Menopausal—insanity, melancholia, or psychosis, 302  
 Mental age—0-2 yr., in adult 325.0; 3-7 yr., in adult 325.1; 8-12 yr., in adult 325.2  
 Mental changes with senility 304  
 Mental deficiency—NOS, 325.5; late effect, acute infectious encephalitis 083.1  
 Mental deterioration or disorder—NOS, 309.2; late effect, acute infectious encephalitis 083.2; with acute chorea, 308.5; with cerebral arteriosclerosis, embolism, haemorrhage, or thrombosis, 306; with syphilis of the central nervous system, 025; due to alcohol, 308; presbyophrenic type or senile, 304  
 Mental excitement 309.2  
 Mental exhaustion 318.3  
 Mental images and obsessional ideas 313  
 Mental insufficiency 325.5  
 Mental observation without need for further medical care 793.0

Mental retardation 325.5; late effect, acute infectious encephalitis 083.1  
 Mercurial insanity 308.6  
 Merergasia 318.5  
 Metrorrhagia, psychogenic 317.1  
 Microcephalic idiocy 325.5  
 Micturition disorder, psychogenic 317.1  
 Miners' nystagmus 318.2  
 Misanthropy 320.4; late effect, acute infectious encephalitis 083.1  
 Mongolian idiocy, mongolianism, mongolism, mongoloid infant 325.4  
 Monomania 309.2; late effect, acute infectious encephalitis, 083.2  
 Monoplegia, hysterical 311; with anxiety reaction, 310  
 Moral deficiency or imbecility, 320.5; late effect, acute infectious encephalitis, 083.1  
 Morbus caducus or morbus comitalis, 353.3; see also Epilepsy  
 Morel-Kraepelin disease, 300.7  
 Moria 309.2; late effect, acute infectious encephalitis 083.2  
 Moron 325.2; adult, mental age 8-12 yr., 325.2; child I.Q. 50-69 325.2  
 Morphine addiction 323; with psychosis, 308.6  
 Morphinism 323; with psychosis, 308.6  
 Morphinomania 323  
 Mutism NOS, 326; hysterical, 311; hysterical with anxiety reaction 310  
 Myasthenic stomach, psychogenic 316.2  
 Myelitis, syphilitic 026.0; with psychosis, 026.1  
 Myxedema or myxoedema, insanity 308.3

#### - N -

Nail biting, child 324  
 Narcissism, 320.6; late effect, acute infectious encephalitis 083.1  
 Narcotic drug addiction, 323; with psychosis, 308.6  
 Narcotism, 323; with psychosis, 308.6  
 Necrophilia 320.6  
 Negativism, 320.4; late effect, acute infectious encephalitis 083.1  
 Neoplasm of brain, with psychosis 308.0  
 Nephritis, alcoholic, 322.2; with psychosis, 307  
 Nervous—heart, 315.0; stomach, 316.2  
 Neuralgia, writers' 318.2  
 Neurasthenia—NOS, 318.3; cardiac, 315.0; gastric, 316.2; heart, 315.0; postfebrile, 318.3  
 Neuritis, acoustic nerve, syphilitic 026.0  
 Neurocirculatory asthenia 315.0  
 Neurosis—NOS, 318.5; anxiety, 310; bladder, 317.1; cancerphobia, 313; cardiac, or cardiovascular, 315.0; compensation, 311—with anxiety reaction, 310; compulsive, 313; craft, 318.2; cutaneous, 317.3; environmental, 318.5; functional, 311—with anxiety reaction, 310; gastric or gastro-intestinal, 316.2; heart, 315.0; impulsive, 313; inco-ordination of larynx or vocal cords, 317.0; intestine, 316.3; larynx, 317.0; larynx, hysterical, 311—with anxiety reaction, 310; larynx, sensory, 317.0; musculoskeletal, 317.4; obsessional or obsessive-compulsive, 313.0; ocular, 317.5; occupational, 318.2; pharynx, 317.0; railroad, 311—with anxiety reaction, 310; rectum, 316.3; respiratory, 317.0; rumination, 316.3; senile, 318.5; sexual, 317.1; situational, 326.3—late effect, acute infectious encephalitis, 083.1; stomach, 316.2; vasomotor, 315.2; war, 326.3  
 Neurosyphilis—NOS, 026.0; with psychosis, 026.1; with ataxia, 024; any condition below coded to 026.0, if described as "with psychosis", code to 026.1; acute meningitis, aneurysm, arachnoid, arteritis, asymptomatic, 026.0; congenital, 020.1; leptomeninges, meninges, meningovascular, 026.0; optic atrophy, 026.0; parenchymatous or paresis, 025; psychosis, 026.1; relapse, 026.0; remission in, 026.0; serological, 026.0; tabes, 024—juvenile, 020.1; taboparesis, 025—juvenile, 020.1; thrombosis or vascular, 026.0

Neurotic—NOS, 318.5; atony of stomach, 316.2; depressive reaction, 314; psychogenic excoriation, 317.3; traits, child 324  
 New growth, brain, with psychosis, 308.0  
 Night terrors, child 324  
 Nodal rhythm, auriculoventricular, psychogenic 315.1  
 Nomadism, 320.5—late effect, acute infectious encephalitis 083.1  
 Nosomania 309.2—late effect, acute infectious encephalitis, 083.2  
 Nosophobia 313  
 Nostalgia 326.4  
 Nymphomania 320.6—late effect, acute infectious encephalitis 083.1  
 Nystagmus, miners' 318.2

- O -

Observation without need for further care for mental disease 793.0  
 Obsession, obsessional ideas and mental images, obsessional—neurosis, phobias, psychasthenia, ruminations, or state 313; obsessional insanity, 309.2—late effect, acute infectious encephalitis, 083.2  
 Obsessive—compulsive neurosis or reaction, 313  
 Obstipation, psychogenic, 316.3  
 Obstructed intestine, reflex or neurogenic, 316.3  
 Oedema of brain, alcoholic, 322.2  
 Offences, sex, in children, 324  
 Old age, dementia 304  
 Oligergasia 325.5  
 Oligophrenia 325.5; late effect, acute infectious encephalitis, 083.1  
 Onanism 317.1; child problem, 324  
 Onychophagy, 326.4; child problem, 324; manifestation of immature personality, 321.4  
 Operational fatigue 326.3  
 Opium—addiction, intoxication chronic, opiumism, 323; any of these with psychosis, 308.6  
 Outburst, aggressive, 321.2  
 Overeating, psychogenic 316.2  
 Oxycephalic idiocy 325.5

- P -

Pachymeningitis, syphilitic, 026.0; with psychosis, 026.1  
 Palilalia 326.2—late effect, acute infectious encephalitis 083.1  
 Palsy of brain, syphilitic;—NOS, 026.0; with psychosis, 026.1; congenital, 020.1  
 Panic 310  
 Paraesthesia, larynx or pharynx, hysterical, 311; with anxiety reaction, 310  
 Paraldehyde addiction, 323; with psychosis, 308.6  
 Paralysis, accommodation, hysterical, 311; with anxiety reaction, 310  
 Paralysis, alcoholic 322.2; ataxic general, 025; cranial syphilitic, 026.0—with psychosis 026.1; dementia paralytic 025; general—NOS 025; alcoholic 322.2; ataxic or insane 025; juvenile 020.1; progressive or tabetic 025; hysterical—NOS 311, with anxiety reaction 310; ileus, neurogenic 316.3; juvenile general 020.1; progressive general 025; psychogenic 317.4; spastic spinal syphilitic 024; tabetic general 025; uvula hysterical 311; uvula, hysterical, with anxiety reaction, 310  
 Paranoia 303  
 Paranoid—dementia 300.3; dementia, senile, 304; personality 320.1, personality, late effect, acute infectious encephalitis, 083.1; psychosis, 303; psychosis, senile 304; reaction, 303; schizophrenia, 300.3; state, 303; type, psychopathic personality 320.1—as late effect, acute infectious encephalitis 083.1  
 Paraphasia 326.2  
 Paraphrenia, paraphrenic dementia or paraphrenic schizophrenia 300.1  
 Paraplegia—functional or hysterical, 311, with anxiety reaction 310; syphilitic 326.0, with psychosis 326.1

Parergasia 309.2, late effect, acute infectious encephalitis 083.2  
 Paresis—reported from institution for insane, 025; bladder, tabetic 024;  
 general—NOS, arrested, brain, cerebral, insane, progressive, remission  
 or tabetic 025, juvenile or juvenile remission 020.1; insane, 025;  
 juvenile 020.1; syphilitic 025; syphilitic juvenile 020.1  
 Paresthesia of larynx or pharynx, hysterical 311—with anxiety reaction  
 310  
 Paretic convulsions or dementia 025  
 Parorexia 326.4  
 Paroxysmal tachycardia, psychogenic 315.1  
 Pathologic, pathological—any of following as late effect, acute in-  
 fectious encephalitis 083.1—emotionality 321.0; liar 320.5; mendacity  
 320.5; personality, 320.7; sexuality 320.6  
 Pedophilia 320.6  
 Pelizaeus—Merzbacher disease 325.5  
 Pellagra followed by psychosis 308.3  
 Pel's crisis 024  
 Persecution delusion 303  
 Personality—any of following as late effect, acute infectious en-  
 cephalitis 083.1—antisocial 320.4; asocial 320.5; change or disorder  
 320.7; cyclothymic 320.2; eccentric 320.7; immature—NOS 321.5,  
 characterized by enuresis 321.3, symptomatic habits NEC 321.4; in-  
 adequate 320.3; paranoia 320.1; pathologic 320.7; psychoneurotic  
 NEC 326.4; psychopathic, see Personality, psychopathic, below;  
 schizoid 320.0; transient reactions due to acute or special stress NEC  
 326.3; unstable 321.0  
 Personality, psychopathic—NOS, 320.4; with amoral trend 320.5; with  
 amoral trend or NOS as late effect, acute infectious encephalitis  
 083.1; mixed types 320.4; pathologic emotionality 321.0; pathologic  
 sexuality 320.6  
 Perversion, sexual 320.6; as late effect, acute infectious encephalitis  
 083.1  
 Pethidine addiction 323; with psychosis, 308.6  
 Petit mal 353.0; with psychosis, 308.1  
 Phenylketonuria with mental deficiency 325.5  
 Phobia, phobic reaction 312; phobia, obsessional 313  
 Pica 326.4  
 Pick's brain disease 305  
 Pithiatism 311; with anxiety reaction 310  
 Pneumophagia 316.3  
 Poisoning—absinthe addiction 322.1; chronic poisoning with any of  
 following list without mention of psychosis, code to 323; with  
 psychosis, code to 308.6—acetanilid, acetophenetidin, adalin, amido-  
 pyrine, amylene hydrate, amytal, analgesic drug NEC, antipyrine,  
 apomorphine, barbital, barbitone, barbiturate, barbituric acid, bang,  
 bromal, bromide, bromine liquid, bromoseltzer, bromural, butyl chloral,  
 cannabis, carbomalum, chloroform, cocaine, codeine, croton, demerol,  
 diacetylmorphine, dial, diamorphine, diethyl, dionin, drug analgesic,  
 drug hypnotic, drug narcotic, drug sedative, drug soporific, duboisine,  
 ether liquid, ethidine chloride liquid, ethyl bromide, ethyl chloride  
 liquid, ethyl morphine, ethylene dichloride liquid, evipal, evipan,  
 gardenal, gelsemine, gelseminine, gelsemium, hashish, headache  
 powder, hedonal, heroin, hypnotic drug, indian hemp, ipral, lactuca  
 virosa, laudanum, lettuce strong scented, luminal, marihuana, medinal,  
 methyl bromide, methyl sulphonol, methylene chloride liquid, methy-  
 lene dichloride liquid, morphine, narcotic, narcotism, nembutal, neo-  
 nal, novocaine, nupercaine, opiate, opium, paraldehyde, paregoric,  
 percaine, pernorton, pethidine, phanodorm, phanodorn, phenacetin,  
 phenobarbital, Pitkin's solution, pontocaine hydrochloride, potassium  
 bromide, procaine hydrochloride, propanal, pyramidon, seconal,  
 sedative drug, sedormid, sodium amytal, sodium bromide, sodium  
 soporific, somnifaine, soneryi, soothing syrup, soporific drug, stovaine,  
 sulfonal, sulfonmethane, tetronal, thebaine, tribromethanol, trional,  
 urethane, veganin, veronal, yellow jasmine

Polyneuritis, alcoholic 322.2  
 Polyneuritic psychosis, alcoholic 307  
 Polyphagia, psychogenic 316.2  
 Postures, hysterical 311; with anxiety reaction, 310  
 Potatorium, chronic 322.1  
 Premature beats, auricular or ventricular, psychogenic 315.1  
 Premature contraction, auricular, auriculoventricular, heart, junctional, or ventricular, 315.1  
 Problem—mental hygiene, adult 318.5; personality not child, 320.7; personality as late effect, acute infectious encephalitis 083.1; psychiatric not child, 318.5; any of following list in child, code 324—anger reaction, behaviour, delinquency, child problem NOS, enuresis, fear reaction, jealousy, masturbation, nail biting, neglected dependent, personality, sleep disorder, spite reaction, spoiled child, tantrum, thumb sucking, tic  
 Proctalgia, spasmodic psychogenic, 316.3  
 Proctospasm, psychogenic 316.3  
 Prurigo, psychogenic 317.3  
 Pruritus, pruritic—ani, psychogenic 317.2; conditions NEC, psychogenic, 317.2; genital organ, psychogenic, 317.2; neurogenic, 317.2; scrotum, neurogenic, 317.2; vulval, neurogenic, 317.2  
 Psychasthenia—NOS, 318.5; compulsive, 313; mixed compulsive states, 313; obsession, 313  
 Psychic epileptic, idiopathic or paroxysmal equivalents, 308.1  
 Psychogenic—see condition  
 Psychoneurosis, psychoneurotic—NOS, 318.5; otherwise see under remainder of diagnosis  
 Psychopathic—see condition; see also Personality, psychopathic  
 Psychopathy, sexual 320.6  
 Psychosis—NOS, 309.2; psychosis with psychopathic personality, 309.1; otherwise see nature of psychosis  
 Ptyalism—hysterical 311; with anxiety reaction 310  
 Puerperal dementia, insanity, mania or melancholia, 688.1; old, unknown type 309.2  
 Pulsus alternans, psychogenic 315.1  
 Pycno-epilepsy, pycnolepsy, 353.3; with psychosis, 308.1  
 Pykno—see pycno

## - Q -

Quarrelsomeness 321.2

## - R -

Railroad neurosis, 311; with anxiety reaction, 310  
 Railway spine, 311; with anxiety reaction, 310  
 Raymond-Cestan syndrome with psychosis, 306  
 Reaction—psychogenic NEC, 317.5; psychotic NOS, 309.2; psychotic with psychopathic personality, 309.1; otherwise see remainder of diagnosis  
 Relaxation of anus due to hysteria, 311; with anxiety reaction, 310  
 Respiration, disorder of, psychogenic 317.0  
 Retained urine, psychogenic 317.1  
 Retardation, mental 325.5; late effect, acute infectious encephalitis, 083.1  
 Retention, psychogenic 317.1  
 Risk, suicidal 318.5  
 Rossbach's disease, psychogenic 316.2  
 Rumination—neurotic, 316.3; obsessional, 313  
 Ruptured brain or spinal cord, syphilitic or syphilitic aneurysm, 026.0; with psychosis, 026.1

- S -

- Sachs' amaurotic familial idiocy or Sachs' disease, 325.5  
 Sadism 320.6; late effect, acute infectious encephalitis, 083.1  
 Sander's disease 303 (distinguish from Sanders' disease, 900)  
 Satyriasis 320.6; late effect, acute infectious encephalitis, 083.1  
 Scar, psychic 318.5  
 Schizo-affective psychosis 300.6  
 Schizoid personality 320.0; late effect, acute infectious encephalitis, 083.1  
 Schizophrenia—NOS, 300.7; with manic-depressive psychosis 300.6; acute 300.4; catatonic 300.2; hebephrenic 300.1; latent 300.5; paranoid 300.3; paraphrenic 300.1; primary 300.0; residual state, 300.5; simple, simplex 300.0  
 Schizothymia 300.6  
 Sclerosis, sclerotic—Alzheimer's, 305; brain, arterial or senile with psychosis, 306; cerebrovascular with psychosis, 306; presenile, 305; spinal combined syphilitic—NOS, 026.0; with psychosis, 026.1; spinal posterior, 024  
 Seizure—autonomic 311, autonomic with anxiety reaction 310, cortical focal sensory idiopathic 353.3; cortical idiopathic 353.3; epilepsy 353.3; epilepsy akinetic 353.3  
 Self-mutilation 318.5  
 Senility—with mental changes or psychosis, 304; arteriosclerotic, see Arteriosclerosis  
 Sexual—deviation, 320.6; deviation as late effect, acute infectious encephalitis, 083.1; function, disorder of 317.1; impotence, 317.1; sadism, 320.6; sadism as late effect, acute infectious encephalitis 083.1  
 Sexuality, pathologic 320.6; late effect, acute infectious encephalitis 083.1  
 Shell shock 326.3  
 Shock, nervous or psychic, 318.5  
 Silophobia 313  
 Situational maladjustment, acute 326.3; late effect, acute infectious encephalitis 083.1  
 Sleep disorder, child 324  
 Sodomy 320.6; late effect, acute infectious encephalitis 083.1  
 "Soldier's heart" 315.0  
 Somnambulism, hysterical 311; with anxiety reaction 310  
 Soporific drugs, addiction 323; with psychosis, 308.6  
 Spasm, spastic, spasticity—anus or ani, psychogenic or reflex, 316.3; bowel or caecum, psychogenic, 316.1; cardia, psychogenic, 316.3; cecum or colon, psychogenic 316.1; diaphragm or esophagus, psychogenic, 316.3; glottis, hysterical 311; glottis, hysterical with anxiety reaction, 310; hysterical, 311; hysterical with anxiety reaction 310; intestinal, psychogenic 316.1; larynx, hysterical, 311; larynx, hysterical, with anxiety reaction 310; occupation 318.2; oesophagus, psychogenic, 316.3; pharynx, hysterical, 311; pharynx, hysterical with anxiety reaction 310; pylorus, psychogenic, 316.3; rectum, psychogenic, 316.3; sigmoid, psychogenic, 316.1; stomach, neurotic, 316.2; throat, hysterical, 311; throat, hysterical, with anxiety reaction, 310  
 Speech defect or impediment NEC, 326.2; late effect, acute infectious encephalitis, 083.1  
 Spielmeyer—Stock disease 325.5  
 Spielmeyer—Vogt disease 325.5  
 Spoiled child reaction 324  
 Stammering 326.1; late effect, acute infectious encephalitis, 083.1  
 Starvation, voluntary, — 65 yrs., 309.2; 65 yr. +, 304  
 State—anxiety, see Anxiety; apprehension, 310; clouded epileptic or clouded paroxysmal idiopathic, 308.1; compulsive, 313; confusional, 309.2; confusional as late effect, acute infectious encephalitis 083.2; constitutional psychopathic, 320.4; constitutional psychopathic as late effect, acute infectious encephalitis, 083.1; convulsive, 313;

excitement, 309.2; excitement as late effect, acute infectious encephalitis, 083.2; obsessional, 313; paranoid, 303; tension, 318.5  
 Status convulsivus idiopathicus 353.2  
 Status epilepticus 353.2; with psychosis, 308.1  
 Stealing, child problem 324  
 Strephosymbolia 326.0  
 Stroke, epileptic 353.3  
 Stupor—circular, 301.0; mental, 309.2; mental, as late effect, acute infectious encephalitis, 083.1  
 Stuttering 326.1; late effect, acute infectious encephalitis, 083.1  
 Subacidity, gastric, psychogenic, 316.2  
 Substitution disorder 311; with anxiety reaction 310  
 Sucking thumb, child 324  
 Suicidal risk or tendencies 318.5  
 Syndrome—Da Costa's, effort, exhaustion, fatigue, 315.0; Ganser's, 309.2; irritable heart, 315.0; irritable weakness, 326.4; Korsakoff's, 307; Korsakoff's nonalcoholic, 309.2; Korsakoff's nonalcoholic as late effect, acute infectious encephalitis, 083.2; migraine epilepsy, 353.3; migraine epilepsy with psychosis, 308.1; multiple operations, 318.5; Raymond-Cestan with psychosis, 306  
 Syphilis, syphilitic—any condition here coded to 026.0, if with psychosis, takes code 026.1—acoustic nerve, 026.0; agraphia, 026.0; alexia, 026.0; aneurysm of central nervous system, cerebral, or spinal, 026.0; aphasia, 026.0; arachnoid or arachnoiditis, 026.0; artery, cerebral or artery, spinal 026.0; ataxia, 024; Bell's palsy, 026.0; brain or brain tumour, 026.0; central nervous system, see Syphilis of central nervous system, below; cerebral—NOS, Meningovascular, nerves, sclerosis or thrombosis, 026.0; cerebrospinal—NOS 024, tabetic type 026.0; cerebrovascular, 026.0; Charcot's joint, 024; choked disc, 026.0; chorioretinitis, choroid, or choroidoretinitis, 026.0; combined sclerosis, 026.0; congenital with paresis, tabes, or taboparesis, 020.1; congenital juvenile neurosyphilis 020.1; conjugal tabes 024; cord bladder 024; cranial nerve 026.0; dactylitis, 026.0; deafness, 026.0; degeneration, spinal cord, 026.0; dementia—NOS, 026.1; paralytica 025, paralytica juvenilis 020.1; dura mater, 026.0; ear—inner NOS or inner neurorecurrence, 026.0; early central nervous system—NOS 026.0; paresis, 025; tabes, 024; early paresis, 025; early tabes, 024; eighth nerve, 026.0; encephalitis, encephalomyelitis, encephalopathy, 026.0; epilepsy, 026.0; episcleritis, 026.0; eyelid ptosis, 026.0; gastric crisis, 024; general paralysis—NOS 025; juvenile 020.1; glaucoma, 026.0; gumma, central nervous system, 026.0; hemianopsia, hemiparesis, hemiplegia, hyalitis, 026.0; laryngeal paralysis 026.0; late—central nervous system, 026.0; paresis, 025; tabes, 024; latent central nervous system, 026.0; latent positive spinal fluid, 026.0; lens, 026.0; leptomeningitis, 026.0; Lissauer's paralysis, 025; locomotor ataxia 024; meninges or meningitis, 026.0; meningo-encephalitis, 025; meningovascular, 026.0; mental changes or deterioration, 026.1; mesarteritis, brain or spine, 026.0; monoplegia or myelitis, 026.0; nerve palsy or nervous system, 026.0; neuritis of acoustic nerve, 026.0; neurorecidive of retina, 026.0; neuroretinitis, ophthalmic, or ophthalmoplegia, 026.0; optic nerve 026.0; pachymeningitis, 026.0; paralysis—NOS, 026.0; general, 025, juvenile 020.1; paranoia, paraplegia, 026.0; paresis—NOS or general 025, juvenile, 020.1; paresthesia, 026.0; Parkinson's disease or syndrome, 026.0; poliomyelitis, 026.0; pontine lesion, 026.0; psychosis, 026.1; ptosis, 026.0; radiculitis, 026.0; retina—NOS, late, or neurorecidive, 026.0; retinitis, NOS, late or central recurrent, 026.0; retrobulbar neuritis, 026.0; sclera, 026.0; sclerosis, cerebral, multiple or subacute, 026.0; scotoma, 026.0; secondary, of central nervous system, 026.0; seventh nerve, 026.0; spastic spinal paralysis, 024; spinal—NOS, 026.0; with paresis, 025, with tabes 024; tabes dorsalis or tabetic type—NOS, 024, juvenile, 020.1; taboparesis, 025; taboparesis juvenile, 020.1; tertiary central nervous system, 026.0; tumor of brain, 026.0; vascular, brain or cerebral, 026.0; vein, cerebral, 026.0

Syphilis of central nervous system—with—ataxia, 024, mental disorder NEC, 026.0; mental disorder psychotic, 026.1; paralysis general, 025; paralysis general juvenile, 020.1; paranoia, 026.0; paranoia psychotic, 026.1; paresis, 025, paresis juvenile, 020.1; psychosis, 026.1; psychosis general, paralysis of insane, 025; psychosis general paralysis of insane juvenile 020.1; tabes 024; tabes juvenile, 020.1; taboparesis, 025; taboparesis juvenile 020.1—aneurysm, 026.0; aneurysm with psychosis, 026.1; congenital 020.1; remission in 026.0; remission in, with psychosis, 026.1; scotoma, 026.0; scotoma with psychosis, 026.1; serology doubtful negative, or positive with psychoschisis, 026.1; vascular, 026.0; vascular with psychosis, 026.1  
 Syphiloma of central nervous system, 026.0; with psychosis, 026.1; see also Syphilis of central nervous system  
 Syphilophobia 313

## - T -

Tabes, tabetic—with—central nervous system syphilis, 024; Charcot's joint, 024; cord bladder, 024; crisis, viscera, 024; paralysis, general, 025; paresis, 025; perforating ulcer, 024—arthropathy, bone, bladder, or cerebrospinal, 024; congenital, 020.1; conjugal, dorsalis NOS, dorsalis neurosyphilis, early, 024; juvenile, 020.1; latent, 024; paralysis insane, general, 025; spasmodic or syphilis, 024  
 Taboparalysis, 025  
 Taboparesis—NOS, 025; juvenile, 020.1; with Charcot's joint, cord bladder, or perforating ulcer, 025  
 Tachycardia, arrhythmia, paroxysmal, sino-auricular or sinus, psychogenic, 315.1  
 Tantrum 324  
 Tay-Sachs disease or amaurotic family idiocy 325.5  
 Tendency, homosexual, 320.6; late effect, acute infectious encephalitis, 083.1  
 Tendency, suicide, 318.5  
 Tension state, 318.5  
 Terrors, night 324  
 Tetany, functional 311; with anxiety reaction 310  
 Thebaine addiction, 323; with psychosis, 308.6  
 Thrombosis of brain—with mental disorder, 306; due to syphilis, 026.0; due to syphilis, with psychosis, 026.1  
 Thrombosis of spinal cord due to syphilis, 026.0; with psychosis, 026.1  
 Thumb sucking 324  
 Thymergasia 300.2  
 Thyrogenous psychosis, 308.3  
 Tic—child problem 324; compulsive, 313; hysterical 311; hysterical with anxiety reaction, 310; occupational, 318.2  
 Tics and spasms, compulsive, 313  
 Torticollis—hysterical, 311; hysterical with anxiety reaction, 310; psychogenic, 317.4  
 Trance—hysterical 311; hysterical with anxiety reaction, 310  
 Transvestism, 320.6; late effect, acute infectious encephalitis, 083.1  
 Trauma, mental deterioration or psychosis due to, 308.7  
 Tremor—hysterical 311; hysterical with anxiety reaction, 310  
 Tumor, phantom, 318.5

## - U -

Unsoundness of mind, 309.2; late effect, acute infectious encephalitis, 083.2  
 Untruthfulness 324  
 Unverricht's disease, 353.3; with psychosis, 308.1  
 Upset, psychogenic—NOS, 316.3; intestinal, 316.3; stomach, 316.2

- V -

Vagabondage, 320.5; late effect, acute infectious encephalitis, 083.1  
Vaginismus, hysterical 311; with anxiety reaction, 310  
Vasovagal attack, psychogenic, 315.1  
Ventricular escape, psychogenic, 315.1  
Veronal addiction, 323; with psychosis, 308.6  
Vesania 309.2  
Vogt - Spielmeyer disease or amaurotic familial idiocy 325.5  
Voluntary starvation: - 65 yr., 309.2; 65 yr. +, 304  
Vomiting - cyclical, or functional psychogenic, 316.2; hysterical, 311;  
hysterical with anxiety reaction, 310; nervous, neurotic, pernicious  
psychogenic, persistent psychogenic, psychic, uncontrollable psycho-  
genic, 316.2

- W -

Wandering, pacemaker, psychogenic, 315.1  
Wet brain 322.2  
Witzelsucht 326.4  
Word-blindness - NOS, 326.0; congenital, 326.0; late effect, acute  
infectious encephalitis, 083.1; non-organic, 326.0 - deafness, develop-  
mental, 326.0  
Wry neck - hysterical, 311; hysterical with anxiety reaction, 310, psycho-  
genic, 317.4

**Note:**

The following groups are abbreviated, being served by cross refer-  
ences:

Psychoneurosis, psychoneurotic  
Psychopathic  
Psychosis  
Reaction

## SECTION 6

### Commonly used statistical terms and rates

**Average or mean.** The sum of the values recorded in a series of observations divided by the number of observations.

**Median.** The centre value in a series of observations when the observations are ranged from lowest to highest. With an even number of observations the mean of the two central observations is usually taken. The median is a useful form of average when the arithmetic mean is unduly affected by very large or very small outlying observations. It is an average of position, being affected by the number of observations rather than by the size of extreme values of observations.

**Mode.** The value which occurs most frequently in a series of observations. It is the maximum point on the curve which most closely describes an observed frequency distribution. While it is not possible to make an exact mathematical determination of the mode it can be calculated approximately from the formula  $\text{Mode} = \text{Mean} - 3 (\text{Mean} - \text{Median})$ .

**Range.** The distance between the lowest and highest values observed.

**Frequency distribution.** An arrangement of a number of observations to show the frequency with which each observation occurs, for example, the number of individuals in each age group of a population.

**Mean deviation.** The arithmetic average of all the differences between the observations and their mean, the differences being added without regard to whether they are difference above or below the mean.

**Standard deviation.** A special form of average deviation from the mean. It is computed by taking the square root of the arithmetic average of the squares of the differences between the observations and their mean.

**Coefficient of variation.** The standard deviation expressed as a percentage of the mean, or —

$$\frac{\text{Standard deviation} \times 100}{\text{mean}}$$

**Standard error.** A measure of the variability which a statistical value, such as a percentage or a mean, would show if repeated samples were taken from the same series of observations. In other words it shows how much variation might be expected to occur merely by chance in the various characteristics of samples drawn equally randomly from one and the same population.

**Significance.** If two averages (or two proportions) differ by more than twice the value of the standard error of the difference, the difference is said to be "significant", or more than is easily likely to have arisen by chance.

**Probable error.** The probable error of a value is 0.6745 times (or about two-thirds) its standard error. If twice the standard error is taken as the level of "significance", then three times the probable error must be taken to reach the same level.

**Correlation coefficient.** A measure of the degree of association or interdependence between two characteristics. Its value must be between plus 1 and minus 1. Either plus or minus 1 indicates complete dependence of one characteristic on the other; zero denotes no association whatever between them. A plus sign shows that an upward movement of one characteristic is accompanied by an upward movement in the other. A minus sign indicates that an upward movement of one is accompanied by a downward movement of the other.

**Chi-square test.** A test as to whether a series of values differs, between themselves or from an expected series, to a greater extent than might be expected to occur by chance.

**Scatter diagram.** A graphic method of ascertaining the correlation between two characteristics of a number of individuals. Each individual is entered as a point or dot on a graph, the position of each point being determined by the associated value of the two characteristics measured in that individual, for example the height of children plotted against their weight. The relationship is shown by the form of the path made by the points across the face of the diagram.

### **Rates and ratios**

**Admission rate.** The total number of admissions (excluding transfers) to mental hospitals during a calendar year per 100,000 general population at the middle of the year.

$$\frac{\text{Number of admissions} \times 100,000}{\text{Population}}$$

**First admission rate.** The number of first admissions during a calendar year per 100,000 general population at the middle of the year.

$$\frac{\text{Number of first admissions} \times 100,000}{\text{Population}}$$

**Re-admission rate.** The number of re-admissions during a calendar year per 100,000 general population at the middle of the year.

$$\frac{\text{Number of re-admissions} \times 100,000}{\text{Population}}$$

**Age-specific admission rate.** The number of admissions in a specified age-group during a calendar year per 100,000 population in that age group at the middle of the year.

$$\frac{\text{Number of admissions at a specified age} \times 100,000}{\text{Total population at the same age}}$$

Note: Admission rates may be specific for other characteristics than age, or for combinations of characteristics, for example, sex, marital status, occupation, age-sex, etc. Similarly admission rates may be calculated for individual diagnoses either for the whole population or specific for age and other characteristics.

**Hospitalization rate.** The number of persons on the books of mental hospitals at a given date per 100,000 general population at the same date.

$$\frac{\text{Patients at end of year} \times 100,000}{\text{Population at end of year}}$$

**Patients under care.** The total number of persons receiving care at any time during the year, i.e. the sum of the number of patients on books at the beginning of the year and the number of admissions during the year.

**Discharge rate.** The number of patients discharged alive during a calendar year per 1,000 patients under care during the year.

$$\frac{\text{Discharges} \times 1,000}{\text{Patients under care during year}}$$

**Death rate.** The number of patients who died before discharge during a calendar year per 1,000 patients under care during the year.

$$\frac{\text{Number of patients died} \times 1,000}{\text{Patients under care during year}}$$

**General death rate.** The number of deaths in the general population during a calendar year per 1,000 population at the middle of the year.

$$\frac{\text{Number of deaths} \times 1,000}{\text{Population}}$$

Note: Death rates (either general or institutional) may be specific for age, sex, diagnosis or other characteristics subject to the proviso that both the numerator and denominator used in calculating the rate must refer to the same population characteristic.

**Average daily population.** The number of patients under care on an average day during the calendar year.

$$\frac{\text{Total patient days of care during the year}}{\text{Number of days in the year}}$$

**Percentage occupancy.** A measure of "patient turnover" which relates the average daily population to the beds available. It may be calculated either for bed capacity or the average number of beds set up.

$$(a) \frac{\text{Average daily population} \times 100}{\text{Standard bed capacity}}$$

$$(b) \frac{\text{Average daily population} \times 100}{\text{Average beds set up}}$$

**Average stay.** The average duration of stay, in days, weeks or months of all patients who died in, or were discharged from the hospital during the year.

$$\frac{\text{Total duration of stay of separated patients}}{\text{Number of separated patients}}$$

**Personnel ratio.** The ratio between the number of patients in hospital at the end of a calendar year and the number of staff, either for all personnel or for those in a particular category, at the same date, e.g.

$$\frac{\text{Patients in hospital at end of year}}{\text{Nursing staff}}$$

**Average cost per patient day.** The average operating cost of maintaining a patient in the hospital for one day.

$$\frac{\text{Total maintenance expenditure for the year}}{\text{Total patient days during the year}}$$

## SECTION 7

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