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HANDBOOK

on the Classification and Definition of

MENTAL DISORDERS

FOR USE BY HOSPITALS FOR MENTAL DISEASES

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PREFACE

The revised classification adopted by the Committee on Statistics was approved by The American Psychiatric Association at its 1934 annual meeting, and adopted by The National Committee for Mental Hygiene (Canada) for use in all mental hospitals in Canada as of January 1, 1939.

For statistical purposes, the condensed form of the new classification as appearing on page 10 in this new manual, is now in effect in all mental hospitals in Canada, and annual reports published by the Bureau are based upon this classification.

There will also be found in this manual, suggestions for the preparation of statistical returns, with instructions and definitions for the filling in of cards.

S. A. CUDMORE,
DOMINION STATISTICIAN.

65705—1½

CONTENTS

I. CLASSIFICATION OF MENTAL DISORDERS*

00–1 Psychoses due to or associated with infection.

00y–147 Psychoses with syphilis of the central nervous system.
- 002–147 Meningo-encephalitic type (general paresis).
- 003–147 Meningo-vascular type (cerebral syphilis).
- 004–147 Psychoses with intracranial gumma.
- 00y–147 Other types (*to be specified*).

008–123 Psychoses with tuberculous meningitis.
008–190 Psychoses with meningitis (unspecified).
003–163 Psychoses with epidemic encephalitis.
004–196 Psychoses with acute chorea (Sydenham's).
009–1y0 Psychoses with other infectious disease (*to be specified*).
009–1xx Post-infectious psychoses (*infection to be specified*).

00–3 Psychoses due to intoxication.

001–332 Psychoses due to alcohol.
- 002–332 Pathological intoxication.
- 003–332 Delirium tremens.
- 004–332 Korsakow's psychosis.
- 007–332 Acute hallucinosis.
- 00y–332 Other types (*to be specified*).

002–300 Psychoses due to drugs or other exogenous poisons.
- 002–310 Psychoses due to metals (*to be specified*).
- 002–350 Psychoses due to gases (*to be specified*).
- 002–370 Psychoses due to opium and derivatives.
- 002–3y0 Psychoses due to other drugs (*to be specified*).

00–4 Psychoses due to trauma (traumatic psychoses).

009–42x Traumatic delirium.
009–4x9 Post-traumatic personality disorders.
003–4xx Post-traumatic mental deterioration.
003–4y0 Other types (*to be specified*).

00–5.0 Psychoses due to disturbance of circulation.

003–512 Psychoses with cerebral embolism.
003–516 Psychoses with cerebral arteriosclerosis.
009–5xx Psychoses with cardio-renal disease.
003–50y Other types (*to be specified*).

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* Wherever desired, symptomatic manifestations may be coded and named in addition to the diagnosis.

NOTE.—In this Section Y signifies an incomplete diagnosis. It is to be replaced, whenever possible, by a code digit signifying specific diagnosis.

00–5.5 **Psychoses due to convulsive disorders (epilepsy).**

003–550 Epileptic deterioration.
003–560 Epileptic clouded states.
003–55y Other epileptic types.

00–7 **Psychoses due to disturbances of metabolism, growth, nutrition or endocrine function.**

001–79x Senile psychoses.
002–79x Simple deterioration.
003–79x Presbyophrenic type.
004–79x Delirious and confused types.
005–79x Depressed and agitated types.
006–79x Paranoid types.
007–79x Alzheimer's disease.
001–796 Involutional psychoses.
002–796 Melancholia.
003–796 Paranoid types.
00y–796 Other types (*to be specified*).
00x–770 Psychoses with diseases of the endocrine glands (*to be specified*).
009–712 Exhaustion delirium.
009–766 Psychoses with pellagra.
009–yxx Psychoses with other somatic diseases (*to be specified*).

00–8 **Psychoses due to new growth.**

003–8xx Psychoses with intracranial neoplasms.
009–8xx Psychoses with other neoplasms (*to be specified*).

00–9 **Psychoses due to unknown or hereditary causes, but associated with organic changes.**

006–953 Psychoses with multiple sclerosis.
004–953 Psychoses with paralysis agitans.
004–992 Psychoses with Huntington's chorea.
004–9y0 Psychoses with other brain or nervous diseases (*to be specified*).

00–x **Disorders of psychogenic origin or without clearly defined tangible cause or structural change.**

Psychoneuroses. *Symptomatic manifestations should be coded and named in the diagnosis. (See Supplementary Classification of Manifestations of Diseases of the Nervous System in Standard Classified Nomenclature of Disease from which the symptoms with their numbers are taken).*

Hysteria.
002–x00 Anxiety hysteria.

002–x10 Conversion hysteria.

002–x11 Anesthetic type. *Indicate symptomatic manifestations, e.g.:* x12 amaurosis, x06 deafness, 55x anesthesia of ....., x41 anosmia.

002–x12 Paralytic type. *Indicate symptomatic manifestations, e.g.:* 561 monoplegia, 563 hemiplegia, x32 ophthalmoplegia, 956 aphonia.

002–x13 Hyperkinetic type. *Indicate symptomatic manifestations, eg.:* 225 tic (facial or other), 222 spasm, 228 tremor, 20x postures, 936 catalepsy, 934 convulsions, 302 stammering, 301 stuttering.

002–x14 Paresthetic type. *Indicate symptomatic manifestations, e.g.:* 506 dysesthesia, 507 paresthesia.

002–x15 Autonomic type. *Indicate symptomatic manifestations, e.g.:* 154 hyperidrosis, 153 edema, 159 ulceration.

002–x16 Amnesic type. *Indicate symptomatic manifestations,* 901 fugue, 911 amnesia, 917 somnambulism, 936 catalepsy, 902 trance, 903 dissociated personality, 931 delirium, x07 hallucination of hearing, 904 dream states, 933 stupor.

002–x1x Mixed hysterical psychoneurosis. *Indicate symptomatic combinations by using the various symptoms in the categories given above or on pages* 411-422.

Psychasthenia or compulsive states.

002–x21 Obsession. *Indicate symptomatic manifestations, e.g.:* 905 délire de toucher, 906 counting (steps, etc.), 908 urge to say words, 971 kleptomania, 974 dipsomania, 972 pyromania, 973 tricho-tillomania, 907 folie de doute.

002–x22 Compulsive tics and spasms. *Indicate symptomatic manifestations, e.g.:* 225 tremor, 227 occupation spasm or tic, 226 habit spasm or tic, 224 spasms nutans, 301 stuttering, 302 stammering.

002–x23 Phobia. *Indicate symptomatic manifestations, e.g.:* 983 claustrophobia, 984 syphilophobia, 985 agoraphobia, 986 misophobia.

002–x2x Mixed compulsive states. *Indicate symptomatic combinations by using the various symptoms in the categories given above or in Supplementary Classification.*

002–x30 Neurasthenia.

002–x31 Hypochondriasis.

002–x32 Reactive depression (simple situational reaction, others).

002–x33 Anxiety state.

002–x0x Mixed psychoneurosis. *Indicate symptomatic combinations by using the various symptoms given above or in Supplementary Classification:* 981 anxiety, 982 depression, 415 fatigue.

001–x10 Manic-depressive psychoses.
001–x11 Manic type.
001–x12 Depressive type.
001–x13 Circular type.
001–x14 Mixed type.
001–x15 Perplexed type.
001–x16 Stuporous type.
001–x1y Other types.
001–x20 Dementia præcox (schizophrenia).
001–x21 Simple type.
001–x22 Hebephrenic type.
001–x23 Catatonic type.
001–x24 Paranoid type.
001–x2y Other types.
001–x30 Paranoia.
001–x31 Paranoid conditions.
001–x40 Psychoses with psychopathic personality.
001–x50 Psychoses with mental deficiency.

00-y **Undiagnosed psychoses.**

y0–y **Without psychosis.**

NOTE.—This diagnosis is to be used only in psychiatric and psychopathic hospitals, where it is required to account for patients admitted for observation or allowed to remain in hospital for other legitimate reasons. Besides being classed as "without psychosis" the case is also recorded in positive terms as:

930–yxx Epilepsy.
000–332 Alcoholism.
000–3xx Drug addition.
000–yxx Mental deficiency.
000–163 Disorders of personality due to epidemic encephalitis.
000–x40 Psychopathic personality.
000–x41 With pathological sexuality. *Indicate symptomatic manifestations, e.g.:* 991 homosexuality, 902 erotomania, 993 sexual perversion, 994 sexual immaturity.
000–x42 With pathological emotionality. *Indicate symptomatic manifestations, e.g.:* 041 schizoid personality, 042 cyclothymic personality, 913 paranoid personality, 043 emotional instability.
000–x43 With asocial or amoral trends. *Indicate symptomatic manifestations, e.g.:* 044 antisociality, 047 pathological mendacity, 046 moral deficiency, 048 vagabondage, 987 misanthropy.
000–x4x Mixed types. *Indicate symptomatic manifestations.*

Primary behaviour disorders.

000–x61 Simple adult maladjustment.

Primary behaviour disorders in children.

000–x71 Habit disturbance. *Indicate symptomatic manifestations, e.g.:* 031 nail biting, 032 thumb sucking, 741 enuresis, 034 masturbation, 033 tantrums.

000–x72 Conduct disturbance. *Indicate symptomatic manifestations, e.g.:* 04x truancy, 050 quarrelsomeness, 051 disobedience, 059 untruthfulness, 054 stealing, 055 forgery, 056 setting fires, 053 destructiveness, 057 use of alcohol, 058 use of drugs, 052 cruelty, 995 sex offences, 049 vagrancy.

000–x73 Neurotic traits. *Indicate symptomatic manifestations, e.g.:* 223 tics, 226 habit spasm, 917 somnambulism, 302 stammering, 009 overactivity, 980 fears.

II. CONDENSED CLASSIFICATION OF MENTAL DISORDERS

As it is clearly impracticable to use the complete classification of mental disorders in statistical tables, the following condensed classification has been arranged for statistical purposes.

It is recommended that the principal groups with their subdivisions be set forth.

If these recommendations are followed the statistics prepared by use of this classification will in the main be comparable with those prepared during the past 20 years by the hospitals using the uniform statistical system.

For complete diagnosis for use in case records or for research purposes, it is recommended that the detailed classification be used.

01 Psychoses with syphilitic meningo-encephalitis (general paresis)

02 Psychoses with other forms of syphilis of the central nervous system

- 021 Meningo-vascular type (cerebral syphilis).
- 022 With intracranial gumma.
- 023 Other types (to be specified).

03 Psychoses with epidemic encephalitis

04 Psychoses with other infectious diseases

- 041 With tuberculous meningitis.
- 042 With meningitis (unspecified).
- 043 With acute chorea (Sydenham's).
- 044 With other infectious disease (to be specified).
- 045 Post-infectious psychoses (infection to be specified).

05 Alcoholic psychoses

- 051 Pathological intoxication.
- 052 Delirium tremens.
- 053 Korsakow's psychosis.
- 054 Acute hallucinosis.
- 055 Other types (to be specified).

06 Psychoses due to drugs or other exogenous poisons

- 061 Due to metals (to be specified).
- 062 Due to gases (to be specified).
- 063 Due to opium and derivatives.
- 064 Due to other drugs (to be specified).

07 Traumatic psychoses

071 Traumatic delirium.
072 Post-traumatic personality disorders.
073 Post-traumatic mental deterioration.
074 Other types (to be specified).

08 Psychoses with cerebral arteriosclerosis

09 Psychoses with other disturbances of circulation

091 With cerebral embolism.
092 With cardio-renal disease.
093 Other types (to be specified).

10 Psychoses with convulsive disorders (epilepsy)

101 Epileptic deterioration.
102 Epileptic clouded states.
103 Other epileptic types.

11 Senile psychoses

111 Simple deterioration.
112 Presbyophrenic type.
113 Delirious and confused types.
114 Depressed and agitated types.
115 Paranoid types.

12 Involutional psychoses

121 Melancholia.
122 Paranoid types.
123 Other types (to be specified).

13 Psychoses due to other metabolic, etc., diseases

131 With diseases of the endocrine glands (to be specified).
132 Exhaustion delirium.
133 Alzheimer's disease.
134 With pellagra.
135 With other somatic diseases (to be specified).

14 Psychoses due to new growth

141 With intracranial neoplasms.
142 With other neoplasms (to be specified).

15 Psychoses associated with organic changes of the nervous system

151 With multiple sclerosis.
152 With paralysis agitans.
153 With Huntington's chorea.
154 With other brain or nervous diseases (to be specified).

65705—2½

16 Psychoneuroses

161 Hysteria (anxiety hysteria, conversion hysteria and subgroups).
162 Psychasthenia or compulsive states (and subgroups).
163 Neurasthenia.
164 Hypochondriasis.
165 Reactive depression (simple situational reaction, others).
166 Anxiety state.
167 Mixed psychoneurosis.

17 Manic-depressive psychoses

171 Manic type.
172 Depressive type.
173 Circular type.
174 Mixed type.
175 Perplexed type.
176 Stuporous type.
177 Other types.

18 Dementia præcox (schizophrenia)

181 Simple type.
182 Hebephrenic type.
183 Catatonic type.
184 Paranoid type.
185 Other types.

19 Paranoia and paranoid conditions

191 Paranoia.
192 Paranoid conditions.

20 Psychoses with psychopathic personality

21 Psychoses with mental deficiency

22 Undiagnosed psychoses

23 Without psychoses

231 Epilepsy.
231a Epilepsy only.
231b Epilepsy with mental deficiency.
232 Alcoholism.
233 Drug addiction.
234 Mental deficiency.
234a Idiot.
234b Imbecile.
234c Moron.
234d Unspecified.

235 Disorders of personality due to epidemic encephalitis.
236 Psychopathic personality.
2361 With pathological sexuality.
2362 With pathological emotionality.
2363 With asocial or amoral trends.
2364 Mixed types.

24 Primary behaviour disorders

241 Simple adult maladjustment.
242 Primary behaviour disorders in children.
2421 Habit disturbance.
2422 Conduct disturbance.
2423 Neurotic traits.

III. DEFINITIONS AND EXPLANATORY NOTES

The following explanatory notes and definitions of the various clinical groups were prepared for the committee by Dr. Clarence O. Cheney, Director, Psychiatric Institute and Hospital, New York City.

*00-1 Psychoses due to or associated with infection

00y–147 Psychoses With Syphilis of the Central Nervous System

It is expected that cases shall be classified as far as possible under the sub-groups (002, 003, 004, 00y). A classification under this general heading is to be made only after failure of every reasonable effort to determine the predominating pathological process.

002–147 Meningo-encephalitic Type (general paresis)

The earlier clinically descriptive term, general paralysis, has been discarded in the present classification for the term indicating the fundamental pathological process. 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, dementia præcox 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.

003–147 Meningo-Vascular Type (cerebral syphilis)

Under this heading are to be classified cases in which the history, signs and symptoms, including serology point to a primary and predominating involvement of the meninges and blood vessels rather than of the paren-

* Code numbers are those used in "A Standard Classified Nomenclature of Disease," prepared by the National Conference on Nomenclature of Disease, published by the Commonwealth Fund, New York.

chyma of the nervous system. Indicating cerebral syphilis rather than paresis are: comparatively early onset after infection, sudden onset with confusion or delirium, focal signs, particularly cranial nerve palsies, apoplectiform seizures, very high spinal fluid cell count, positive blood Wassermann and negative spinal fluid Wassermann and the luetic type of gold curve, often prompt response to systemic antisyphilitic treatment. Under this heading are also to be classified those cases of chronic syphilitic meningitis which may show mild or severe deterioration in emotional and intellectual reactions, but which usually nevertheless show a clinical picture distinguishable from the paretic. Cases showing psychotic reactions on a basis of cerebral lesions from vascular disease determined to be of a syphilitic nature should be classified here rather than under the heading of "Psychoses due to disturbances of the circulation." The determination of the syphilitic nature of the vascular disease may be difficult in these old "burned out" cases of syphilis as the serology may be entirely negative. A history of syphilis, of its treatment, of vascular attacks earlier in life, and signs of old systemic syphilis help in the differentiation.

004–147 Psychoses With Intracranial Gumma

Under this heading are to be classified those comparatively rare cases in which the predominating pathological process is gummatous formation, either single or multiple. In most cases gummata are a part of a diffuse meningo-vascular process under which they should be classified. Occasionally solitary gumma of large size occur, giving the symptoms of intracranial pressure with or without focal signs. Serological examination helps to differentiate these from other intracranial growths. It is to be remembered that persons with systemic syphilis may have brain tumors, and that a positive blood Wasserman in the presence of signs of intracranial growth does not necessarily indicate a gumma. Spinal fluid examination is necessary. Response to antisyphilitic treatment may help in the classification.

00y–147 Other Types (to be specified)

Here should be classified the comparatively infrequent cases of psychoses with syphilis of the central nervous system not covered in the above mentioned groups,

including psychoses with tabes dorsalis, providing it is determined that such cases do not belong in the paretic group or the group of cerebral syphilis, as they frequently do. Psychoses ascribed to or associated with syphilitic meningo-myelitis may be placed here, with the same reservations.

008–123 Psychoses With Tuberculous Meningitis

Psychoses developing during the course of a demonstrated tuberculous meningitis should be reported here. Cases developing a tuberculous meningitis during the course of a psychosis should not be reported under this heading but under the primary psychoses.

008–190 Psychoses With Meningitis (unspecified)

Here are to be classified those cases developing meningitis, the type of which cannot be specified. Psychoses associated with other forms of meningitis which can be specifically determined are to be listed elsewhere under their proper headings.

003–163 Psychoses With Epidemic Encephalitis

Here are to be listed those mental disturbances associated with acute phases of epidemic encephalitis such as delirium or stupor and those chronic cases with demonstrable residual defects of the intellectual processes and emotions; these defects show themselves in a diminution of voluntary attention, of spontaneous interest, and of initiative; memory impairment is often slight. Apathy, depression, euphoria, anxiety or emotional instability may be found from case to case.

004–196 Psychoses With Acute Chorea (Sydenham's)

Here are to be classified patients showing acute and chronic mental disturbances associated with Sydenham's chorea, which may be associated with a more or less marked encephalopathy. Care should be taken to distinguish this type of chorea from the hysterical type; in differentiating, a history of rheumatism and repeated attacks of tonsillitis, presence of cardiac disease, and fever help in the establishment of the diagnosis of Sydenham's chorea.

009–1y0 Psychoses With Other Infectious Disease (to be specified)

Here are to be classified those psychoses which are primarily and predominantly to be ascribed to, or asso-

ciated with, infectious disease particularly during the febrile period. The most common clinical picture met is that of delirium with or without motor excitement or hallucinations. There are frequent shifts in the levels of consciousness; the attacks may be followed by amnesia for the period. These infectious psychoses are particularly apt to arise in association with influenza, pneumonia, typhoid fever and acute articular rheumatism. In the classification, care should be taken to distinguish between these infectious psychoses and other psychoses, particularly the manic-depressive and dementia præcox reactions, which may be made manifest by even a mild attack of infectious disease. Delirious reactions occurring in connection with childbirth are not to be looked upon as infectious psychoses unless there is clear-cut evidence of infection with toxemia, so that the infection appears to be the main etiological factor.

009–1xx—Post-infectious Psychoses (infection to be specified)

Here are to be classified those mental disturbances arising during the post-febrile period or the period of convalescence from infectious disease, frequently showing themselves as mild forms of confusion, or depressive, irritable, suspicious reactions. Here also are to be classified the occasionally-occuring states of mental enfeeblement following acute infectious disease, especially typhoid fever, acute particular rheumatism, and meningitis. Abnormal mental states arising as part of the asthenia or exhaustion following infectious disease are to be classified here rather than under the heading of exhaustion delirium.

00-3 Psychoses due to intoxication

001–332 Psychoses Due To Alcohol

Under this heading are to be grouped only those cases that have abnormal mental reactions which can reasonably be concluded to have alcohol as the main etiological factor. Excessive alcoholism may be a symptom of some other psychosis or psychopathological condition or, on the other hand, 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.

002–332 Pathological Intoxication

Under this heading belong those cases which show as a result of small or large amounts of alcohol sudden excitation or twilight states, often with a mistaking of the situation and also with illusions and hallucinations and marked emotional reactions, particularly of anxiety or rage. Such an attack may last a few minutes or a number of hours and usually there is complete amnesia for the attack. In making such a classification epileptic conditions precipitated by small amounts of alcohol, or catatonic excitation in dementia præcox or manic-depressive reactions or general paresis or arteriosclerotic episodes are to be ruled out.

003–332 Delirium Tremens

Little difficulty is usually experienced in reaching a classification in a case of delirium tremens; the delirium, often of sudden onset but frequently showing premonitory signs of nervousness and "jumpiness," with predominantly visual hallucinations and distinct clouding of the sensorium, defects of attention and physical prostration, with marked tremors, point to this classification. Cases which do not recover within two weeks may require careful consideration for differentiation from Korsakow's psychosis.

004–332 Korsakow's Psychosis

This reaction is sometimes referred to as chronic alcoholic delirium in contrast to the acute delirium of delirium tremens. The onset of the two types of reactions may be similar although in the Korsakow reaction there is noticed at times a more marked interference with the intellectual functions than in delirium tremens. The course is a protracted one, however. After the acute stages are recovered from, there is usually a striking defect of retention with confabulation. Perhaps the majority of these patients are left with a permanent defect of memory and retention but occasionally patients are seen who completely recover. Polyneuritis is frequently a part of the total reaction; it may be severe leaving physical defects of a permanent nature; in other cases it is slight and is recovered from, and in still other cases polyneuritis is not demonstrable and is not considered necessarily a criterion of the Korsakow reaction. The

Korsakow syndrome appearing in connection with other toxic conditions, i.e., toxemia in pregnancy, should not be classified under this heading.

007–332 Acute Hallucinosis

Under this heading should be grouped those cases that as a result of the excessive use of alcohol develop suddenly or gradually hallucinations, particularly of the auditory type, with a characteristic fear or anxiety reaction but with retention of clearness of the sensorium. Physical prostration and other toxic physical signs are not as outstanding as they are in delirium tremens. These cases, particularly those which do not recover within a few weeks but continue in a chronic hallucinatory state, often require careful differentiation from dementia præcox reactions and consideration has to be given to the possibility that in certain potential or actual cases of dementia præcox alcohol has precipitated a psychotic reaction which should be classified as one fundamentally of dementia præcox.

00y–332 Other Types (to be specified)

Under this heading are to be grouped psychotic reactions on an alcoholic basis not already specified in the above sub-groups. In the present sub-group there may be placed under the designation "Deterioration," those chronic alcoholics who appear to show deterioration not only in the moral and ethical senses and in their emotional blunting, but also evidence of an organic memory defect. Other chronic alcoholics who seem to develop paranoid ideas, particularly delusions of infidelity in connection with chronic drinking, may best be placed in this subgroup with the designation "Paranoid type."

002–300 Psychoses Due To Drugs or Other Exogenous Toxins

002–310 Psychoses Due To Metals (to be specified)

Here are to be grouped those psychotic cases due usually to prolonged exposure to metallic poisoning, particularly lead, arsenic and mercury. Persons so exposed, often showing earlier gastro-intestinal and peripheral nerve toxic symptoms, may develop deliria with marked prostration from which they may recover or they may be left with intellectual or emotional defects apparently

based on encephalopathy associated with these toxic conditions. The clinical picture at times resembles the Korsakow mental state.

002–350 Psychoses Due to Gases

Under this heading should be placed the cases that develop mental disturbance from exposure to poisonous gases, particularly carbon monoxide gas in illuminating gas and automobile exhaust. The preliminary period of unconsciousness may be followed by a more or less protracted delirium after which the patients may be left with increased fatigability and difficulty in concentration. It should be recalled that persons who have suffered from carbon monoxide poisoning may appear to clear up entirely from the initial disturbance and have a free interval lasting over weeks, to be followed by the appearance of symptoms of defect which may not be recovered from. These patients remain in a chronic state of mild or severe mental enfeeblement.

002–370 Psychoses Due To Opium and its Derivatives

Here should be grouped those comparatively infrequent psychotic reactions appearing in habitual users of opium and particularly its derivative morphine. Such effects appear to show themselves in mental deterioration with demonstrable memory defect as well as an ethical and social deterioration. Paranoid states may also develop. Difficulty may be experienced in differentiating the actual effects of the morphine intoxication from the underlying personality defects which seem frequently to be present and which would place these individuals for statistical purposes rather in the group of psychopathic personalities. Drug addicts who do not show definite psychotic manifestations sufficiently to justify their hospitalization or their special treatment because of their mental condition should be classified not under this sub-group but under the heading drug addiction (000–3xx).

002–3y0 Psychoses Due To Other Drugs

Here should be classified those cases which develop abnormal mental states in association with long continued or brief excessive use of other drugs such as cocaine, bromides, chloral, acetanilide, phenacetin, sulphonal, trional and proprietary combinations. Following

the use of these drugs certain individuals may become dull or apathetic, these conditions sometimes being followed by toxic delirium with confusion, hallucination of sight and hearing, flight of ideas, confabulation, misidentification and paraphasia. Cases developing a toxic reaction from the use of drugs in the treatment of another form of psychosis should be reported according to the primary psychosis and not as drug psychoses.

00-4 Psychoses due to trauma (traumatic psychoses)

Under this heading should be classified only those cases of fairly characteristic psychotic reactions which it is reasonable to conclude were brought about by head or brain injury as a result of force directly or indirectly applied to the head. Psychoses following injuries to other parts of the body are not to be classified here. Manic-depressive psychoses, general paresis, dementia præcox and psychoneuroses in which trauma may act as a contributing or precipitating cause should not be included in this group.

009–42x Traumatic Delirium

Here belong those cases of acute (concussion) delirium developing immediately following head injury and also those which show following such injury a protracted or chronic delirium which often resembles the Korsakow syndrome, with superficial alertness but marked disorientation, memory defect and confabulations.

009–4x9 Post-Traumatic Personality Disorders

This term is used in place of the former designation of post-traumatic constitution and is intended to apply to those cases showing post-traumatic changes in disposition, with vasomotor instability, headache, fatigability and explosive emotional reactions, intolerance to alcohol, and sometimes convulsive seizures. A complete history of the previous personality reactions and a careful evaluation of the present reaction are often necessary to rule out psychoneuroses.

003–4xx Post-Traumatic Mental Deterioration

Here are to be classified those cases which, following severe or apparently slight head injury with or without an acute or protracted delirium, develop a gradually increasing mental enfeeblement or dementia. Symptoms

mentioned under post-traumatic personality disorders may also be present. Psychoses to be ascribed to arteriosclerosis, complicated by head injury, may be difficult to differentiate. If the case history shows symptoms of arteriosclerosis before the injury and the mental and physical examination bears this out the case should be classified under that heading instead of under the present one. It is to be remembered that the confusion of an arteriosclerotic or a cerebral attack may have brought about the head injury.

003–4y0 Other Types (to be specified)

It appears that only occasionally will other traumatic reaction types be found to be classified under this heading.

00-5.0 Psychoses due to disturbance of circulation

003–512 Psychoses With Cerebral Embolism

Emboli interfering with the cerebral circulation, causing cerebral softening and neurological or psychotic symptoms, may arise from the pulmonary circulation, from vegetations on the heart valves or from thrombosis of the arteries of the neck and head. The incidence of such occurrences is comparatively rare, however.

003–516 Psychoses With Cerebral Arteriosclerosis

Here are classified the comparatively large group of middle-aged and old persons who show evidence of interference with the cerebral circulation in such symptoms as difficulty in sustained mental operations, 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; the pathological changes lying at the basis of the two psychotic reaction types may be associated.

The age, history, and careful survey of the symptoms often assist one in determining which is the predominant type of reaction, but where such a determination is not clearly possible, preference should continue to be given, for statistical purposes, to the arteriosclerotic classification.

009–5xx Psychoses With Cardio-renal Disease

Here are to be classified those psychotic disturbances, particularly deliria or temporary periods of confusion, often worse at night, shown by persons with cardiac disease, especially in stages of decompensation. Fearful hallucinations sometimes occur. There is difficulty in concentration and memory may be impaired. Marked fluctuations in the degree of mental clearness may be striking. Also to be classified here are the psychotic changes associated with acute and chronic kidney disease, including uremia.

003–50y Other Types (to be specified)

Rarely will there be psychoses developing because of disturbance of circulation that may not be properly classified under the headings already mentioned but if such cases arise they should be classified under this present heading.

00-5.5 Psychoses due to convulsive disorders (epilepsy)

Under this heading will be classified only cases that show psychotic disturbances in connection with epilepsy which appears to be primary, essential, or idiopathic. Cases showing convulsive manifestations symptomatic of other diseases are to be classified under the headings for these diseases rather than under the present heading.

003–550 Epileptic Deterioration

Under this heading are to be classified those epileptics who show a gradual development of mental dullness, slowness of association and thinking, impairment of memory, irritability or apathy. Various accessory symptoms, paranoid delusions and hallucinations may be added to this fundamental deterioration.

003–560 Epileptic Clouded States

Here are to be classified those epileptics who develop preceding or following convulsive attacks or, as equival-

ents of attacks, dazed reactions with deep confusion, bewilderment and anxiety or excitement, with hallucinations, fears and violent outbreaks; instead of fear there may be ecstatic moods with religious exaltation.

003–55y Other Epileptic Types

Here are to be classified the occasional epileptics who without obvious deterioration or clouded states may develop psychotic manifestations such as paranoid trends or hallucinatory states, depressions or elations.

00-7 Psychoses due to disturbances of metabolism, growth, nutrition or endocrine function

001–79x Senile Psychoses

Some feebleness of mind is characteristic of and normal for old age. It may be designated as senility or dotage. It is characterized by self-centering of interests, reminiscence, and difficulty in assimilation of new experiences so that there is forgetfulness of recent occurrences; childish emotional reactions are prominent, with irritability aroused on slight provocation. Such mental states may best be classified under a heading "Senility" in the group "Without psychoses," rather than with the senile psychoses.

002–79x Simple Deterioration

Under this heading should be classified as psychotic, those persons who show definite exaggeration of the normal senile mental change, in loss of memory for recent events particularly, defects of attention and concentration, misidentification of persons and of places and lack of appreciation of time. Such persons may require special hospital care because of restless wandering, marked irritability or assaultiveness, erotic excitement or because of delusions which may be fleeting or persistent. Deterioration of the mental processes may progress to a state of vegetative existence.

003–79x Presbyophrenic Type

Under this heading are to be classified those cases of senile psychosis showing severe memory and retention defects with complete disorientation but at the same time preservation of mental alertness and attentiveness with ability to grasp immediate impressions and conversation

quite well. Forgetfulness leads to marked contradictions and repetitions; suggestibility and free fabrication are prominent symptoms. The general picture resembles the Korsakow mental complex.

004–79x Delirious and Confused Types

Here are to be classified those cases in which the outstanding picture is one of deep confusion or of a delirious condition. This type of reaction is often precipitated by acute illness.

005–79x Depressed and Agitated Types

In certain cases of senile psychoses the outstanding picture may be one of pronounced depression and persistent agitation. Such patients are to be distinguished from cases of involution melancholia by the presence of fundamental defects of the memory and grasp of recent occurrences.

006–79x Paranoid Types

In certain cases well-marked delusional trends, chiefly of a persecutory or expansive nature may accompany the deterioration; in the early stages the diagnosis may be difficult particularly if the defect symptoms are mild or absent on superficial examination.

007–79x Alzheimer's Disease

This condition is characterized in its pathological manifestations by a very marked brain atrophy with microscopic focal necroses and neurofibral alteration. Clinically these cases present at a comparatively early age period, sometimes in the forties, a high degree of dementia, often with aphasic or apractic symptoms. In the absence of other causes for an organic dementia Alzheimer's disease is to be considered, although few cases may be classified clinically as belonging to this group.

001–796 Involutional Psychoses
002–796 Melancholia

Here are to be classified the depressions occurring in middle life and later years without evidence of organic intellectual defects, characterized mainly by agitation, uneasiness and insomnia, often with self-

condemnatory trends. For statistical purposes, cases showing such symptoms but with a history of previous attacks of depression or excitement should be classified with the manic-depressive group.

003–796 Paranoid Types

Here should be classified those cases which during the involutional period, and without previous indication of paranoid reactions, show transitory or prolonged paranoid reactions with delusions of persecution, suspiciousness and misinterpretation.

00y–796 Other Types (to be specified)

Other types of psychotic reactions occurring during the involutional period and from which organic brain disease can be excluded, may be classified under this heading.

00x–770 Psychoses With Diseases of the Endocrine Glands (to be specified)

This classification is provided for those cases which show psychoses obviously to be ascribed to diseases of the endocrine glands, separating them off for statistical purposes from psychoses occurring with other somatic diseases. Outstanding among the cases classified here are psychoses associated with disorders of the function of the thyroid gland, more specifically the hallucinatory deliria of thyroidtoxicosis and the apathy of myxodemia, the latter often accompanied by paranoid trends. Psychoses to be ascribed to diabetes, disorders of the pituitary, Addison's disease and multiglandular disorders should be classified under this heading.

009–712 Exhaustion Delirium

Under this heading should be classified only those cases which do not have infectious disease or other organic disease as a basis for the delirium. Care should also be taken to rule out manic-depressive and dementia præcox reactions of a delirious nature before classifying cases as due to exhaustion. With proper elimination of cases belonging to the other categories it appears that cases with true exhaustion delirium are rare.

009–766 Psychoses With Pellagra

Under this heading should be classified only those psychoses developing during the course of pellagra and apparently caused by this disease. The mental disturbances occurring in connection with pellagra are deliria or confused states similar to other toxic-organic reactions. Cases developing pellagra during the course of some other psychosis should not be classified under this heading but rather under the primary psychosis.

009–yxx Psychoses With Other Somatic Diseases (to be specified)

Here should be classified only those psychoses developing in connection with other somatic disease not already specified in the classification, ruling out psychoses with infectious diseases and post-infectious psychoses which are provided for elsewhere in the classification.

00-8 Psychoses due to new growth

003–8xx Psychoses With Intracranial Neoplasms

Psychoses developing during the course of intracranial neoplasms (brain tumor) should be classified here whether the brain tumor is primary or secondary.

009–8xx Psychoses With Other Neoplasms

Here should be classified those psychoses developing in connection with new growth elsewhere in the body, these growths being instrumental in bringing about psychotic reactions either by their general toxic effects or by their psychological effects on the patient. Toxic delirious conditions may be seen or depressions with hopelessness, with or without agitation.

00-9 Psychoses due to unknown or hereditary causes, but associated with organic changes

Under this heading which takes the place of the former classification designation of "Psychoses with other brain and nervous diseases," are to be classified those psychoses developing with, and as a part of, certain diseases of the nervous system not classified under foregoing headings, specifically multiple sclerosis, paralysis agitans, and Huntington's chorea. These psychoses are essentially of the organic brain disease type, with defects in the intellectual

functions and emotional deterioration, sometimes with accessory symptoms of hallucinations and delusions. Cases showing psychoses of a constitutional or functional nature prior to the development of symptoms of the organic nervous disease, and in which therefore the latter disease seems incidental, should be grouped under the heading of the primary psychosis rather than under the present heading.

00-x Disorders of psychogenic origin or without clearly defined tangible cause or structural change

This heading is so worded in the present nomenclature to imply that the disorders classified under it may or may not be of psychogenic origin, but that there is no *clearly defined tangible* cause or structural change. Reference to heredity and "constitutional psychoses" made in the previous nomenclature, is eliminated, although it would seem that the latter term served a useful purpose.

Psychoneuroses

Hysteria

002–x00 Anxiety Hysteria

There is not complete agreement on what should be covered by this designation. According to one viewpoint anxiety hysteria is conversion hysteria with anxiety added to the clinical picture. From another viewpoint anxiety hysteria includes those reactions which are indicated in the present classification under "Psychasthenia, phobia" (002-x23). From still another viewpoint, anxiety hysteria is not a desirable designation and all reactions which have been previously designated as anxiety hysteria are, according to this viewpoint, more properly classified as anxiety states (002-x33).

For statistical purposes patients showing conversion phenomena with recurring attacks of anxiety may be classified under anxiety hysteria. Other patients who present conversion symptoms or phobias but who are relatively free from recurring attacks of anxiety may be grouped under "Conversion hysteria" (002-x10) or "Psychasthenia, phobia" (002-x23). Because of the frequent combination of psychoneurotic symptoms in individual cases the classification "Mixed psychoneurosis" (002-x0x) may be the proper one in many instances.

002–x10. Conversion Hysteria

Cases should be classified according to the sub-groups under this general heading. The symptoms to be found in these various types are indicated in the classification for guidance in differentiation and are self-explanatory. It is to be recalled, however, that some of these hysterical symptoms may occur in the psychoses, and by themselves are not diagnostic; the whole clinical history and picture must be considered.

Psychasthenia or compulsive states

Under this heading are to be classified those cases showing predominantly obsessions, compulsive tics and spasms, and phobias; examples of frequent symptoms are given in the classification for guidance in differentiation.

002–x30 Neurasthenia

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 præcox or mild depressions of the manic-depressive type not infrequently have to be considered in the differential diagnosis.

002–x31 Hypochondriasis

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 involution melancholia by the absence of marked depression with agitation and self-condemnation. Hypochondriacal complaints may be a symptom of dementia præcox and this reaction type should be eliminated before classifying cases here.

002–x32 Reactive Depression

Here are to be classified those cases which show depression in reaction to obvious external causes which might naturally produce sadness, such as bereavement, sickness, and financial and other worries. The reaction, of a more marked degree and of longer duration than normal sad-

ness, may be looked upon as pathological. The deep depression, with motor and mental retardation shown in the manic-depressive depression, are not present, but these reactions may be more closely related in fact to the manic-depressive reactions than to the psychoneuroses.

002–x33 Anxiety State

Cases which show more or less continuous diffuse anxiety and apprehensive expectation, with paroxysmal exacerbations associated with physiological signs of fear, palpitation, dyspnea, nausea, diarrhoea, are to be classified here. Emotional tension is apt to be high, and irritability and intense self-preoccupation may be prominent, particularly during episodes. The diagnosis should not be made until all other more clearly defined types showing anxiety as a symptom have been excluded.

001-x10 Manic-depressive psychoses

This group comprises the essentially benign, affective psychoses, mental disorders which fundamentally are marked by emotional oscillations and a tendency to recurrence. Various accessory symptoms such as illusions and hallucinations may be added in individual cases to the fundamental affective alterations. To be distinguished are:

001–x11. Manic Type

Manic type with elevation of spirits (elation) or irritability, with overtalkativeness or flight of ideas and increased motor activity. Transitory, often momentary, swings to depression may occur but should not change the classification from the predominantly manic type of reaction.

001–x12 Depressive Type

Depressive type with outstanding depression of spirits and mental and motor retardation and inhibition; in some cases the mood is one of uneasiness and anxiety.

001–x13 Circular Type

Here should be classified cases which show a change without a free or recovered interval of one phase to the opposite, i.e., when a manic reaction passes over into depressive reaction or vice versa.

001–x14 Mixed Type

This term is not meant to apply to those cases that show transitory changes from depressive to elated moods or the reverse but is for those cases that show a combination of the cardinal symptoms of manic and depressive states. Perhaps the most frequent of these is the agitated depression, i.e., a depression of mood but with increased motor activity and at times pressure of thought. Occasionally also are seen cases of a so-called manic stupor in which there is elation and flight of ideas but with retarded motor activity amounting at times to complete immobility. Still other cases show elevation of mood and increased motor activity but without evident pressure of thought or flight of ideas, a so-called "unproductive mania."

001–x15 Perplexed Type

In this type of reaction perplexity is an outstanding symptom in a depressive setting. Patients are apparently unable to understand their surroundings or they misinterpret them. Apparently as a result of this, there may show strange symptoms and bizarre behaviour. The prognosis in general is good but the attacks may run a long course. Such patients are sometimes mistaken for cases of dementia præcox. The perplexity and general depressive reaction are differentiating features.

001–x16 Stuporous Type

This reaction is characterized by a marked reduction in activity, at times leading to immobility. The mood is essentially one of depression and mutism may be present, and this with drooling and muscular symptoms at times suggest the catatonic form of dementia præcox. Retrospectively, however, it is found that the sensorium has been clouded and that there may have been ideas of death and dream-like hallucinations.

001–x1y Other Types

The above classification covers the majority of the manic-depressive reactions but occasionally there may be found some other type to be classified under this subgroup.

001-x20 Dementia præcox (schizophrenia)

This general group is divided into the following several sub-groups because of the prominence of the various symptoms in individual cases but it is to be borne in mind that these are only relative distinctions and transitions from one clinical form to another are common.

001–x21 Simple Type

Cases to be classified under this heading show essentially defects of interest with gradual development of an apathetic state but without other strikingly peculiar behaviour and without expression of delusions or hallucinations.

001–x22 Hebephrenic Type

Cases to be classified under this heading show prominently a tendency to silliness, smiling, laughter which appears inconsistent with the ideas expressed; peculiar, often bizarre, ideas are expressed, neologisms or a coining of words or phrases not infrequently occur and hallucinations which appear pleasing to these individuals may be prominent.

001–x23 Catatonic Type

These cases show prominence of negativistic reactions or various peculiarities of conduct with phases of stupor or excitement, the latter characterized often by impulsive or stereotyped behaviour and usually hallucinations. It is found retrospectively that in the stupor the sensorium has remained clear.

001–x24 Paranoid Type

These cases are characterized by prominence of delusions, particularly ideas of persecution or grandeur and frequently with a consistent emotional reaction of aggressiveness due to persecution. There may be hallucinations in various fields to which the patients react at first consistently but later, as deterioration occurs, apathy or indifference may make an appearance. A predominately homosexual component or fixation at this level of development appears prominent in this group of cases whereas the previous groups show evidence frequently of not having reached this level or of having regressed to more infantile levels of psychosexuality.

001–x2y Other Types

Occasionally other types of reactions of dementia præcox may be met with to be classified under this present heading.

001-x30 Paranoia

From this group should be excluded the deteriorating paranoid states (dementia præcox) and paranoid states symptomatic of other mental disorders, included under the organic brain disease, toxic and other groups. In the present group are to be classified those cases showing fixed suspicions and ideas of persecution logically elaborated for the most part after a false interpretation of an actual occurrence has been made. The emotional reactions are consistent with the ideas held and such persons are prone to take action against their persecutors, rendering them dangerous. Intelligence which is often of a superior type is well preserved. In this group belong certain types of reformers, agitators, litigous persons and prophets. Hallucinations if present, are not prominent and may consist of visions, particularly in religious ecstasies.

001–x31 Paranoid Conditions

Cases in this group lie between the paranoia and paranoid dementia præcox groups in respect to the preservation of their personalities, coherence of their thinking and abnormalities in behaviour. In this group should be classified those cases showing predominantly delusions, usually of a persecutory nature, with an inclination more toward illogical thinking and misinterpretation. Hallucinations may be prominent. Such conditions may exist for many years with little, if any deterioration in general interests and with better preservation of the emotional reactions than in the paranoid form of dementia præcox.

001-x40 Psychoses with psychopathic personality

In this group are to 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. Cases of intellectual defect (feeblemindedness) are not to be included in this group.

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 perversions. 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 classed in the manic-depressive group and likewise a psychopathic personality with a schizophrenic psychosis should go in the dementia præcox group. Psychopathic personalities without episodic mental attack or psychotic symptoms should be placed in the group "Without psychosis."

001-x50 Psychoses with mental deficiency

Under this heading should be classified those mental defectives that show psychoses. These are usually of an acute transitory nature and most commonly are episodes of excitement with depression, paranoid trends or hallucinatory attacks. The degree of mental deficiency should be determined from the history and the use of the standard psychometric tests.

Mentally deficient persons may suffer from manic-depressive attacks or from dementia præcox or from the organic psychoses and they should be classified then under such respective headings instead of under the heading of mental deficiency. Cases of mental deficiency without psychotic disturbances should be placed in the group "Without Psychosis."

00-y Undiagnosed psychoses

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 a too short 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, on the other hand, may indicate a too 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 without reasonable facts.

y0-y Without psychosis

Attention is called to the note in the classification that this heading is to be used only in psychiatric hospitals. In these as well as in non-institutional practice the non-psychotic condition which the patient shows is to be reported according to the designations in the classification. Disorders not named in the classification are to be specified under the heading "Other non-psychotic diseases or conditions."

000–163 Disorders of Personality due to Epidemic Encephalitis

Here are to be classified those cases that show comparatively mild changes in their personality as a result of epidemic encephalitis. These changes are not severe enough to handicap the individual in his relations with others. Erratic disordered behaviour is not shown, intellect is not impaired and there is no marked emotional instability.

Cases showing character changes which disturb their relations with others and that show disordered erratic behaviour, intellectual defects or marked emotional instability should be classified as "Psychosis with epidemic encephalitis" (003-163).

000–x40 Psychopathic Personality

The symptoms listed in the classification are included as guides in the differentiation of the various types of psycho-

pathic personality. Cases showing combinations of these traits should be classified under "Mixed types."

Psychopathic personalities showing episodes of excitement, depression, definite paranoid trends, hallucinatory states and other marked deviations from their usual personality reaction, should be classified as "Psychoses with psychopathic personality."

000-x61 Primary behaviour disorders

SIMPLE ADULT MALADJUSTMENT

Under this heading are to be classified those cases which, without evidence of psychosis, or without a history of symptoms of psychopathic personality, appear nevertheless to be maladjusted, particularly to specific situations such as marriage, the home and occupation. Adaptability seems limited and such persons may be dependent more or less chronically on others for their support.

PRIMARY BEHAVIOUR DISORDERS IN CHILDREN

Under this heading attempt is made in the sub-groups to classify various disturbances seen in children which are primary and not secondary to disease or defect of the nervous system or other organic pathological states. One of the purposes of this classification is to separate them from the group "Without psychosis" under which they had been previously classified, particularly in institutions and clinics.

Cases showing definite clinical pictures of psychoneuroses, dementia præcox or manic-depressive reactions or other reaction types elsewhere classified, are to be placed under the appropriate headings in this classification and not under the present heading. It is expected therefore, that the group of so-called "problem children" who do not show definite symptomatology of recognized groups of mental disorders will be classified here.

It is obvious that there may be some overlapping in any one case of the symptoms of the various sub-groups but the cases should be classified according to the predominant behaviour symptoms.

IV SUGGESTIONS FOR THE PREPARATION OF STATISTICS

The Bureau wishes to recommend that care should be exercised in compiling statistics in the several hospitals and that the suggestions in this manual should be closely followed. Only by the use of uniform methods can accurate nation-wide statistics be made available to supervisory boards, managers and superintendents, and to other persons interested in hospital management and in the scientific study of mental disorders. These recommendations have an added significance now that the Dominion Statistician has been authorized to collect and publish institutional statistics annually, and it is hoped that full cooperation will be given the Bureau in the promotion of this valuable work.

The Institutional Statistics Branch (Mental Hospitals Division) will welcome, as in the past, every opportunity to be of service in connection with the use of a uniform statistical system. It is now studying together with the National Committee for Mental Hygiene (Canada) a set of new statistical cards for first admissions, readmissions, transfers, discharges and deaths. It is hoped that the use of a uniform card for every province would greatly facilitate the tabulation and improve the value of information received. Before adopting such cards, they would be submitted for study and comment to persons concerned with the filling in of cards.

Punch Card Tabulation

The increasing use of mechanical methods of tabulating statistical data, both for annual reports of institutions and for special research studies, together with the advantages of uniformity in coding, have made it advisable to assign code numbers to the larger classifications included in this manual. The numbers appearing with the detailed classification of mental disorders are those of the Standard Classified Nomenclature of Disease, while those of the condensed classification have been arbitrarily assigned.

A detailed description of punched card methods of tabulation would not be appropriate here. It is sufficient to say that the basis of such methods is a specially designed card in which holes are punched to represent the items of information pertinent to each patient. The cards for all patients are passed through a machine, where they are rapidly and accurately sorted and counted according to the information desired.

Sources of Information

The facts needed to fill out the cards are obtained from (*a*) the relatives and friends of the patient; (*b*) the patient himself; (*c*) the commitment papers; (*d*) the family physician; (*e*) official documents and records, and (*f*) mental and physical examination of the patient.

The nurse or attendant sent to bring the patient to the hospital should be provided with a history blank and should note thereon all the important facts concerning the patient and his family history that can be obtained from relatives and friends. Additional data should be secured when friends come to the hospital to visit the patient. The practice of many hospitals of employing social workers in the preparation of case histories is commended.

The data required to fill out the discharge and death cards are obtained from the hospital records. These cards should always be consistent with the admission cards.

It is advisable to have a statistical data sheet, similar to the first admission card, filled out and incorporated in the case record of the patient.

Statistical Cards

As a first step in preparing statistics of patients in an institution for mental diseases, it is necessary to have statistical data cards with the essential captions arranged in convenient form. Such cards call for the same items of information concerning every patient. If properly filled out they will furnish data that may be classified in various ways and tabulated so as to give clear summaries of important facts concerning the patients and their diseases and the results of treatment.

To facilitate tabulation and filing, it is recommended that the following statistical cards be used:

1. A *first admission card*, to be filled out for every patient admitted for the first time to any hospital, public or private, for the treatment of mental diseases, except institutions for temporary care only.

2. A *readmission card*, to be filled out for every patient admitted who has been previously under treatment in a hospital for mental diseases wherever situated, excepting transfers and those who have received treatment in institutions for temporary care only.

3. A *discharge card*, to be filled out for every patient with mental disease discharged, except transfers.

4. A *death card*, to be filled out for every patient with mental disease who dies in the hospital.

5. A *transfer card*, to be filled out for every patient sent from one hospital for mental diseases to another within the same province.

It is suggested that first admission cards be printed on *white* cardboard, readmission cards on *yellow*, discharge cards on *salmon*, death

cards on *blue*, and transfer cards on *mauve*; and that in each instance cards for male patients be printed with *black* ink and cards for female patients with *red*.

Instructions for the Filling in of Cards

Fill out every caption on each card; if full or accurate information cannot possibly be obtained, enter "U" (symbol for "facts unascertained").

If the information is negative, enter "none" or "no."

Do not use the interrogation point (?).

Do not use the dash (—) for "unascertained" or for "negative."

Do not use the term "several"; as "several" years; enter rather "less than 1 yr." "between 1 and 5 yrs." or "over 10 yrs.," if exact figures cannot be obtained.

Avoid round numbers; accept figures ending with 5 or with 0 with skepticism and only after close questioning. Avoid, *e.g.*, "1 yr." for 11 mos., 12½ mos., etc., and "1 mo." for 35 days, etc. Avoid "60 yrs.," for 59 or 61 yrs.

Use only standard abbreviations. Avoid ambiguous abbreviations; as "lob. pneu." (lobar or lobular?), "par." (paranoid or paralytic?), etc.

If the place assigned to any caption of the schedule is too limited to enter all ascertained data, mark the blank "over," and enter the data on the back of the card.

Entries on all cards should be typewritten.

Definitions for the Filling in of Schedules

The term *mental diseases* is used in a broad sense and includes all patients with psychoses who are on the books of the hospital, regardless of the method of admission, whether voluntary, committed, emergency, temporary care, for observation or otherwise. Inasmuch as the hospitals are, theoretically at least, for mental diseases only, mental defectives, epileptics, alcoholics and drug cases and others who may be classified as *without psychosis*, should be included, unless the hospital maintains a separate department for them. If a separate department is provided for mental defectives and epileptics who are without mental disease, they should be reported on the uniform tabular forms which are designed to care for statistics of such classes as well as mental cases.

1. Movement of population—

(*a*) A *first admission* is a patient admitted for the first time to any institution for mental diseases, public or private, excepting institutions for temporary care only.

(*b*) A *re-admission* is a patient admitted who has been previously under treatment in an institution for mental diseases, wherever situated, excepting transfers and patients who have received treatment in institutions for temporary care only.

(*c*) A *transfer* is a patient brought directly from one mental hospital to another within the same province.

(*d*) A *parole* or *probational leave* means a patient who is temporarily absent from an institution for mental diseases but whose name is still carried on the books of the institution. A patient who returns to the institution from probational leave or escape returns with the classification he had previous to leaving the hospital and is not a *re-admission* unless he was discharged while absent from the institution.

(*e*) A *discharged* patient is one released from the supervision of the hospital authorities and marked discharged on the books of the institution. A discharge card should be filled out for a patient who dies when on parole or escape, as it is not fair to credit the institution with a death after patient has left the hospital.

Patients handed over to the authorities for deportation are to be considered as discharged from the institution and a discharge card should be made out as from the date the patient was handed over to the authorities.

(*f*) A *death* refers only to patients who die in the hospital.

(*g*) *Official bed capacity*—As there is increasing demand by public authorities for information as to the allocation of beds in mental hospitals, the official bed capacity should be accurately ascertained. By bed capacity is meant the number of beds which could be established in the hospital based upon space intended for such use, as laid down by provincial authorities. It may happen that the number of beds installed may be either above or below the official bed capacity of the hospital, nevertheless in such cases the official bed capacity only should be given.

(*h*) *Average daily number of patients* is the number obtained by dividing the total collective days' stay of all patients during the year by 365.

2. Personnel (Medical Service)—

The term *physicians*, as used in the table, includes all physicians regularly employed in the hospital in a grade below that of superintendent and above that of medical interne. The term *clinical assistants* includes medical students who are employed temporarily or permanently in hospital work below the grade of medical interne.

Consulting and visiting physicians are not to be included. Dentists are to be reported under separate heading.

The term *graduate nurses* includes only those nurses who have graduated from a school of nursing maintained by a general hospital or a hospital for mental diseases giving a course covering at least three years.

The term *social workers* refers to persons regularly employed by the hospital to look after the interests of parole and other out-patients. Voluntary workers in this field are not to be included in the table.

3. Finance—

In reporting receipts or revenue, all federal, provincial and municipal grants or payments must be reported separately. In reporting expenditures care should be taken to distinguish clearly between expenditures for maintenance and those for additions and permanent betterments. All items of upkeep and current expense should be charged to the maintenance account.

DEFINITIONS FOR THE FILLING IN OF CARDS

4. Classification of Mental Diseases—

The official classification as adopted and amended by the American Psychiatric Association (see Statistical Manual, page 10) should be used.

Under classification of mental diseases, care should be taken to give the number, group and type clearly, such as

(*a*) Psychosis No. 18; Group—Dementia Præcox; Type 184, Paranoid.

(*b*) With psychosis 23 (without psychosis), the following additional numbers should be used:

Under 231, Epilepsy, use 231a for "Epilepsy only"
231b for "Epilepsy with mental deficiency,"

and under 234 use
234a—Mental Deficiency—Type: Idiot.
234b—Mental Deficiency—Type: Imbecile.
234c—Mental Deficiency—Type: Moron.
234d—Mental Deficiency—Type: Unspecified.

5. Conjugal Condition—

The terms denoting *conjugal condition* used in the headings are to be applied in accordance with the ordinary usage of the words. *Separated* means living apart through estrangement, whether legal or not, but not divorced.

6. Commitment—

The usual method of commitment is by *certificate,* and indicates that admission is according to the formalities prescribed by provincial laws.

A *voluntary patient* is one received in an institution upon his own application.

By warrant means that the patient is admitted on the order of the Lieutenant-Governor, a Magistrate or Justice of the Peace, and receives a mental examination by the medical board of the hospital within a limited time following his admission (the length of time varies with each province).

7. Birthplace—

(*a*) Every care should be taken to ascertain the country of birth of every first admission. If patient was born in Canada, the name of the province or territory in which patient was born should be ascertained. If born outside Canada, the name of the country in which he or she was born should be given.

(*b*) Language should not be relied upon to determine birthplace. This is especially true of the German language for three-fourths of the Swiss speak German and over one-third of the Austrians.

(*c*) If patient was born in the British Isles, the name of the particular country should be given, as England, Ireland, Scotland, Wales, Isle of Man, etc.

The following is the list of countries to be used in reporting birthplace:—

Armenia	Greece	Russia
Australia	Holland	Scotland
Austria	Hungary	South America
Belgium	Iceland	Spain
Bulgaria	India	Sweden
Canada	Ireland	Switzerland
China	Italy	Syria
Czechoslovakia	Japan	Turkey
Denmark	Jugo-Slavia	United States
England	Lithuania	Other British possessions
Finland	Norway	
France	Poland	Other countries
Germany	Roumania	Not given

8. Immigration—

(*a*) The facts regarding immigration, nationality and racial origin are closely related and information under these heads should be gathered

with the greatest care. The information is of special value in a study of the foreign-born population. It is also essential in dealing with questions relating to education, occupation and unemployment.

(*b*) For foreign-born inmates, the year of arrival in Canada and if patient is naturalized should be ascertained, as this information shows to what extent Canada is absorbing into its citizenship the immigrant population of foreign nationality.

9. Citizenship—

The term *Canadian* does not denote a racial origin but a nationality and should be used for every inmate who has the rights of citizenship. The following are citizens of Canada and should be classified as *Canadian:—*

(*a*) Every person born in Canada, unless such person has subsequently become the citizen of another country.

(*b*) Any person born in the United Kingdom or in any of the British Dominions or Dependencies, who has not subsequently become a citizen of another country and who is now permanently domiciled in Canada.

(*c*) Every British subject who has lived in Canada for five years after his entry.

(*d*) Any person born in any foreign country whose home is now in Canada, and who has become a naturalized citizen.

Alien: All other persons not included above should be classed as of the citizenship of the country to which they owe allegiance.

10. Year of arrival in Canada—

Year of arrival should be given for every person born outside Canada, whether naturalized or not.

11. Racial Origin—

The purpose of the information sought is to obtain as accurately as possible the racial origins of the inmates of mental institutions so as to link up the information with the general population.

(*a*) Racial origin is best indicated by stating the name of the stock from which derived, as English, Scotch, Irish, Welsh, French, etc. Hebrews should be so classified without regard to the country from which they come.

(*b*) In the cases of the black, yellow, red or brown races, the answer would be Negro, Japanese, Chinese, Indian, Hindu, Malayan, etc.

(*c*) In some cases the country of birth may not indicate racial origin. Very often Ukrainians come from Poland, Russia, Austria and Hungary, but they should not be classed as Poles, Germans, etc., but

as Ukrainians. A German born in France is not French by origin although he may be a citizen of France.

(*d*) A person whose father is English and whose mother is French will be recorded as of English origin, while a person whose father is French and mother is English will be recorded as of French origin, for racial origin is traced through the father.

The race of patients submitted should be designated by the terms given in the following list:

Austrian n.o.s.	Greek	Polish
Belgian	Jewish	Roumanian
Bulgarian	Hungarian	Russian
Chinese	Icelandic	Scotch
Czecho-Slovakian	Indian	Swedish
Danish	Irish	Syrian
Dutch	Italian	Turkish
English	Japanese	Ukranian
Finnish	Jugo-Slavian	Other specific races
French	Negro	Not given
German	Norwegian	

12. Religion—

The religion should be entered according as inmate professes, specifying the religious body, denomination, sect or community to which the patient adheres or belongs, such as Anglican, Presbyterian, Roman Catholic, United Church, Hebrew, etc.

13. Occupation—

In giving the occupation it will be advisable, wherever possible, to give the name of the industry or business in which the inmate was employed or engaged at commitment. If the occupation is *carpenter*, the industry might be *shipyard, sash and door factory, house*, etc.

14. Education—

The education of admissions and the degree of same should be ascertained for all admissions. Illiterate denotes persons who cannot read and write. Common school, high school and college should be interpreted as meaning graduation from such institutions, respectively, or completion of at least half of the prescribed course.

15. Environment on Admission—

For statistical purposes *urban* is written for all places with a population of 1,000 and over and *rural* when population is under 1,000.

16. Economic Condition on Admission—

Dependent means lacking the necessities of life and receiving aid from public funds or persons outside the immediate family.

Marginal means living on own earnings but accumulating little or nothing; being on the margin between self-support and dependency.

Comfortable means having accumulated resources sufficient to maintain self and family for a reasonable time (four months or more).

17. Use of Alcohol—

The term *use of alcohol* refers to the alcoholic habits of the patient previous to the onset of the psychosis.

The term *abstinent* should be applied to persons who use no alcoholic liquor whatever. *Temperate* denotes persons who use some liquor but not in sufficient quantities to be classed as intemperate. *Intemperate* use of liquor should be inferred from (*a*) repeated intoxication; (*b*) physical, mental or moral deterioration or any disease due to alcohol; (*c*) unsocial acts due to alcohol.

18. Condition on Discharge—

Recovered indicates the condition of patients who have regained their normal mental health so that they may be considered as having practically the same mental status as they had previous to the onset of the psychosis. *Improved* denotes any degree of mental gain less than recovery. *Unimproved* means that there has been no change in the mental status the patient had when admitted.

19. Length of Residence in Hospital—

The *last hospital residence* is the time spent in hospital by a patient, exclusive of probational leaves or escapes. The term *total duration of hospital life* means the total time spent by a patient in hospitals for mental diseases wherever located and exclusive of probational leaves or escapes.

20. Causes of Death—

Each institution should be provided with the International List of Causes of Death and report deaths in accordance with the directions contained therein. The primary cause of the death should be underlined in each case.