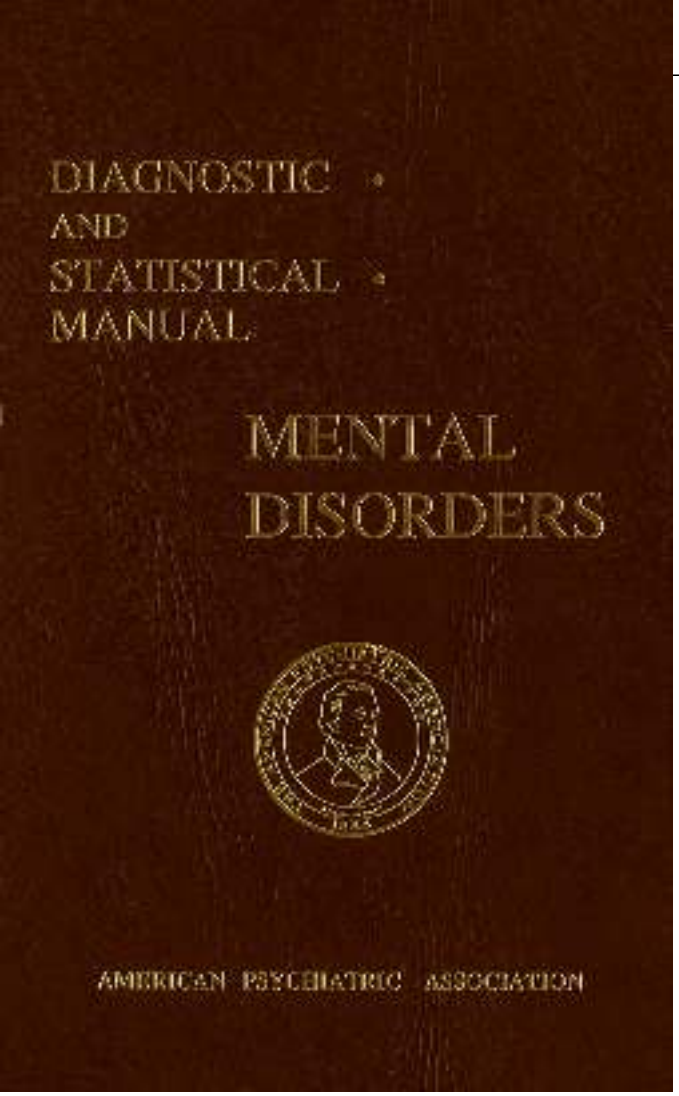
DIAGNOSTIC
AND
STATISTICAL
MANUAL
MENTAL
DISORDERS
AMERICAN PSYCHIATRIC ASSOCIATION

DIAGNOSTIC AND STATISTICAL
MANUAL

MENTAL DISORDERS

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

Published by
AMERICAN PSYCHIATRIC ASSOCIATION
MENTAL HOSPITAL SERVICE
1785 Massachusetts Ave., N. W.
Washington 6, D. C.
1952

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

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

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FOREWORD

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Washington, D. C.
November, 1951

Section I

0– DISEASES OF THE PSYCHOBIOLOGIC UNIT †

INTRODUCTION

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

Qualifying Phrases

.x1 With psychotic reaction

.x2 With neurotic reaction

.x3 With behavioral reaction

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

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

.x2 is redundant when used with Psychoneurotic Disorders

.x3 is redundant when used with Personality Disorders

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

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

DISORDERS CAUSED BY OR ASSOCIATED WITH IMPAIRMENT OF BRAIN TISSUE FUNCTION

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

ACUTE BRAIN DISORDERS

—1 DISORDERS DUE TO OR ASSOCIATED WITH INFECTION

003–100	Acute Brain Syndrome associated with intracranial infection. *Specify infection*	*(308.5)* •
000–100	Acute Brain Syndrome associated with systemic infection. *Specify infection*	*(308.3)* •

3 DISORDERS DUE TO OR ASSOCIATED WITH INTOXICATION

000–3..	Acute Brain Syndrome, drug or poison intoxication. *Specify drug or poison*	*(308.5)* •
000–3312	Acute Brain Syndrome, alcohol intoxication	*(307)* •
000–33122	Acute hallucinosis	*(307)*
000–33123	Delirium tremens	*(307)*

—4 DISORDERS DUE TO OR ASSOCIATED WITH TRAUMA

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

· 50 DISORDERS DUE TO OR ASSOCIATED WITH CIRCULATORY DISTURBANCE

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

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

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

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

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

—8 DISORDERS DUE TO OR ASSOCIATED WITH NEW GROWTH

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

—9 DISORDERS DUE TO UNKNOWN OR UNCERTAIN CAUSE

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

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

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

CHRONIC BRAIN DISORDERS [1]

— 0 DISORDERS DUE TO PRENATAL (CONSTITUTIONAL) INFLUENCE

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

— 1 DISORDERS DUE TO OR ASSOCIATED WITH INFECTION

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

— 3 DISORDERS ASSOCIATED WITH INTOXICATION

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

— 4 DISORDERS ASSOCIATED WITH TRAUMA

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

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

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

—5 DISORDERS ASSOCIATED WITH CIRCULATORY DISTURBANCES

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

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

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

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

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

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

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

—8 DISORDERS ASSOCIATED WITH NEW GROWTH

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

9 DISORDERS ASSOCIATED WITH UNKNOWN OR UNCERTAIN CAUSE

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

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

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

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

MENTAL DEFICIENCY [1]

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

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

— y DISORDERS DUE TO UNDETERMINED CAUSE

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

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

PSYCHOTIC DISORDERS

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

000–796	Involutional psychotic reaction	*(302)*

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

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

* Include intelligence quotient (I. Q.) in the diagnosis.

000–x28	Schizophrenic reaction, childhood type	*(300.8)* *
000–x29	Schizophrenic reaction, residual type	*(300.5)*
000–x30	Paranoid reactions	*(303)*
000–x31	Paranoia	*(303)*
000–x32	Paranoid state	*(303)*
000–x90	Psychotic reaction without clearly defined structural change, other than above	*(309.1)* *

PSYCHOPHYSIOLOGIC AUTONOMIC AND VISCERAL DISORDERS

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

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

PSYCHONEUROTIC DISORDERS

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

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

PERSONALITY DISORDERS

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

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

TRANSIENT SITUATIONAL PERSONALITY DISORDERS

000–x80	Transient situational personality disturbance	*(326.4)* *
000–x81	Gross stress reaction	*(325.3)* *
000–x82	Adult situational reaction	*(326.6)* *
000–x83	Adjustment reaction of infancy	*(324.0)* *
000–x84	Adjustment reaction of childhood	*(324.1)* *
000–x841	Habit disturbance	*(324.1)* *
000–x842	Conduct disturbance	*(324.1)* *
000–x843	Neurotic traits	*(324.1)* *
000–x85	Adjustment reaction of adolescence	*(324.2)* *
000–x86	Adjustment reaction of late life	*(326.5)* *

NONDIAGNOSTIC TERMS FOR HOSPITAL RECORD

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

Section II A

INTRODUCTION TO THE REVISED NOMENCLATURE

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

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

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

All mental disorders are divided into two major groups:

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

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

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

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

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

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

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

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

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

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

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

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

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

sample content of DSM I: Diagnostic and Statistical Manual Mental Disorders