The ICD-10 Classification of Mental and Behavioural Disorders

Diagnostic criteria for research

World Health Organization

Geneva

The World Health Organization is a specialized agency of the United Nations with primary responsibility for international health matters and public health. Through this organization, which was created in 1948, the health professions of some 180 countries exchange their knowledge and experience with the aim of making possible the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

By means of direct technical cooperation with its Member States, and by stimulating such cooperation among them, WHO promotes the development of comprehensive health services, the prevention and control of diseases, the improvement of environmental conditions, the development of human resources for health, the coordination and development of biomedical and health services research, and the planning and implementation of health programmes.

These broad fields of endeavour encompass a wide variety of activities, such as developing systems of primary health care that reach the whole population of Member countries; promoting the health of mothers and children; combating malnutrition; controlling malaria and other communicable diseases including tuberculosis and leprosy; coordinating the global strategy for the prevention and control of AIDS; having achieved the eradication of smallpox, promoting mass immunization against a number of other preventable diseases; improving mental health; providing safe water supplies; and training health personnel of all categories.

Progress towards better health throughout the world also demands international cooperation in such matters as establishing standards for biological substances, pesticides and pharmaceuticals; formulating environmental health criteria; recommending international nonproprietary names for drugs; administering the International Health Regulation; revising the International Statistical Classification of Diseases and Related Heath Problems; and collecting and disseminating health statistical information.

Reflecting the concerns and priorities of the Organization and its Member States, WHO publications provide authoritative information and guidance aimed at promoting and protecting health and preventing and controlling disease.

The ICD-10 Classification of Mental and Behavioural Disorders

Diagnostic criteria for research

World Health Organization

Geneva

1993

Contents

Preface

Acknowledgements

Notes for users

ICD-10 Chapter V(F) and associated diagnostic instruments

List of categories

Diagnostic criteria for research

Annex 1. Provisional criteria for selected disorders

Annex 2. Culture-specific disorders

List of individual experts

List of field trial coordinating centres, field trial centres reporting to them, and directors

Index

INTRODUCTION

In the early 1960s, the Mental Health Programme of the World Health Organization (WHO) became actively engaged in a programme aiming to improve the diagnosis and classification of mental disorders. At that time, WHO convened a series of meetings to review knowledge, actively involving representatives of different disciplines, various schools of thought in psychiatry, and all parts of the world in the programme. It stimulated and conducted research on criteria for classification and for reliability of diagnosis, and produced and promulgated procedures for joint rating of videotaped interviews and other useful research methods. Numerous proposals to improve the classification of mental disorders resulted from the extensive consultation process, and these were used in drafting the Eighth Revision of the International Classification of Diseases (ICD-8). A glossary defining each category of mental disorder in ICD-8 was also developed. The programme activities also resulted in the establishment of a network of individuals and centres who continued to work on issues related to the improvement of psychiatric classification (1,2).

The 1970s saw further growth of interest in improving psychiatric classification worldwide. Expansion of international contacts, the undertaking of several international collaborative studies, and the availability of new treatments all contributed to this trend. Several national psychiatric bodies encouraged the development of specific criteria for classification in order to improve diagnostic reliability. In particular, the American Psychiatric Association developed and promulgated its Third Revision of the Diagnostic and Statistical Manual, which incorporated operational criteria into its classification system.

In 1978, WHO entered into along-term collaborative project with the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) in the USA, aiming to facilitate further improvements in the classification and diagnosis of mental disorders, and alcohol- and drug-related problems (3). A series of workshops brought together scientists from a number of different psychiatric traditions and cultures, reviewed knowledge in specified areas, and developed recommendations for future research. A major international conference on classification and diagnosis was held in Copenhagen, Denmark, in 1982 to review the recommendations that emerged from these workshops and to outline a research agenda and guidelines for future work (4).

Several major research efforts were undertaken to implement the recommendations of the Copenhagen conference. One of them, involving centres in 17 countries, had as its aim the development of the Composite International Diagnostic Interview, an instrument suitable for conducting epidemiological studies of mental disorders in general population groups in different countries (5). Another major project focused on developing an assessment instrument suitable for use by clinicians (Schedules for Clinical Assessment in Neuropsychiatry) (6). Still another study was initiated to develop an instrument for the assessment of personality disorders in different countries (the International Personality Disorder Examination) (7).

In addition, several lexicons have been, or are being, prepared to provide clear definitions of terms (8). A mutually beneficial relationship evolved between these projects and the work on definitions of mental and behavioral disorders in the Tenth Revision of the International Classification of Diseases and Related Health Problems (ICD-10) (9). Converting diagnostic criteria into

diagnostic algorithms incorporated in the assessment instruments was useful in uncovering inconsistencies, ambiguities and overlap and allowing their removal. The work on refining the ICD-10 also helped to shape the assessment instruments. The final result was a clear set of criteria for ICD-10 and assessment instruments which can produce data necessary for the classification of disorders according to the criteria included in Chapter V (F) of ICD-10.

The Copenhagen conference also recommended that the viewpoints of the different psychiatric traditions be presented in publications describing the origins of the classification in the ICD-10. This resulted in several major publications, including a volume that contains a series of presentations highlighting the origins of classification in contemporary psychiatry (10).

The *Clinical descriptions and diagnostic guidelines* was the first of a series of publications developed from Chapter V (F) of ICD-10 (11). This publication was the culmination of the efforts of numerous people who have contributed to it over many years. The work has gone through several major drafts, each prepared after extensive consultation with panels of experts, national and international psychiatric societies, and individual consultants. The draft in use in 1987 was the basis of field trials conducted in some 40 countries, which constituted the largest ever research effort of its type designed to improve psychiatric diagnosis (12,13). The results of the trials were used in finalizing the clinical guidelines.

The text presented here has also been extensively tested (14), involving researchers and clinicians in 32 countries. A list of these is given at the end of the book together with a list of people who helped in drafting texts or

commented on them. Further texts will follow: they include a version for use by general health care workers, a multiaxial presentation of the classification, a series of 'fascicles' dealing in more detail with special problems (e.g. a fascicle on the assessment and classification of mental retardation) and "crosswalks" - allowing cross-reference between corresponding terms in ICD-10, ICD-9 and ICD-8.

Use of this publication is described in the Notes for Users. The Appendix provides suggestions for diagnostic criteria which could be useful in research on several conditions which do not appear as such in the ICD-10 (except as index terms) and crosswalks allowing the translation of ICD-10 into ICD-9 and ICD-8 terms. The Acknowledgements section is of particular significance since it bears witness to the vast number of individual experts and institutions, all over the world, who actively participated in the production of the classification and the various texts that accompany it. All the major traditions and schools of psychiatry are represented, which gives this work its uniquely international character. The classification and the guidelines were produced and tested in many languages; the arduous process of ensuring equivalence of translations has resulted in improvements in the clarity, simplicity and logical structure of the texts in English and in other languages.

The ICD-10 proposals are thus a product of collaboration, in the true sense of the word, between very many individuals and agencies in numerous countries. They were produced in the hope that they will serve as a strong support to the work of the many who are concerned with caring for the mentally ill and their families, worldwide.

No classification is ever perfect: further improvements and simplifications should become possible with increases in our knowledge and as experience with the classification accumulates. The task of collecting and digesting comments and reasults of tests of the classification will remain largely on the shoulders of the centres that collaborated with WHO in the development of the classification. Their addresses are listed below because it is hoped that they will continue to be involved in the improvement of the WHO classifications and associated materials in the future and to assist the Organization in this work as generously as they have so far.

Numerous publications have arisen from Field Trial Centers describing results of their studies in connection with ICD-10. A full list of these publications and reprints of the articles can be obtained from WHO, Division of Mental Health, Geneva.

A classification is a way of seeing the world at a point in time. There is no doubt that scientific progress and experience with the use of these guidelines will require their revision and updating. I hope that such revisions will be the product of the same cordial and productive worldwide scientific collaboration as that which has produced the current text.

Norman Sartorius,
Director, Division of Mental Health
World Health Organization

References

1. Kramer M et al. The ICD-9 classification of mental disorders: a review of its development and contents. *Acta psychiatrica scandinavica*, 1979, **59**: 241-262.

2. Sartorius N. Classification: an international perspective. *Psychiatric annals*, 1976, **6**: 22-35.

3. Jablensky A et al. Diagnosis and classification of mental disorders and alcohol- and drug-related problems: a research agenda for the 1980s. *Psychological medicine*, 1983, **13**: 907-921.

4. *Mental disorders, alcohol- and drug-related problems: international perspectives on their diagnosis and classification.* Amsterdam, Excerpta Medica, 1985 (International Congress Series, No. 669).

5. Robins L et al. The composite international diagnostic interview. *Archives of general psychiatry*, 1989, **45**: 1069-1077.

6. Wing JK et al. SCAN: Schedules for clinical assessment in neuropsychiatry. *Archives of general psychiatry*, 1990, **47**: 589-593.

7. Loranger AW et al. The WHO/ADAMHA International Pilot Study of Personality Disorders. *Archives of general psychiatry* (in press).

8. Loranger AW et al. The WHO/ADAMHA International Pilot Study of Personality Disorders: background and purpose. *Journal of personality disorders*, 1991, **5**: 296-306.

9. *Lexicon of psychiatric and mental health terms. Vol. I.* Geneva, World Health Organization, 1989.

10. *International Statistical Classification of Diseases and Related Health Problems. Tenth Revision. Vol. 1: Tabular list. Vol. 2: Instruction manual. Vol. 3: Index.* Geneva, World Health Organization, 1992.

11. Sartorius N et al., eds. *Sources and traditions in classification in psychiatry*. Toronto, Hegrefe and Huber, 1990.

12. *The ICD-10 Classification of Mental and Behavioural Disorders. Clinical descriptions and diagnostic guidelines.* Geneva, World Health Organization, 1992.

13. Sartorius N et al., eds. *Psychiatric classification in an international perspective*. *British journal of psychiatry*, 1988, **152** (Suppl.).

14. Sartorius N et al. Progress towards achieving a common language in psychiatry: results from the field trials of the clinical guidelines accompanying the WHO Classification of Mental and Behavioural Disorders in ICD-10. *Archives of general psychiatry*, 1993, **50**: 115-124.

15. Sartorius N et al. Progress towards achieving a common language in psychiatry. II: Diagnostic criteria for research for ICD-10 Mental and Behavioural Disorders. Results from the international field trials. *American journal of psychiatry* (in press).

Acknowledgements

Many individuals and organizations have contributed to the production of the classification of mental and behavioural disorders in ICD-10 and to the development of the texts that accompany it. The Acknowledgements section of the ICD-10 *Clinical descriptions and diagnostic guidelines*[1] contains a list of researchers and clinicians in some 40 countries who participated in the trials of that document. A similar list is provided on pages xx-xx of this work. It is clearly impossible to list all those who have helped in the production of the texts and in their testing, but every effort has been made to include at least all those whose contributions were central to the creation of the documents that make up the ICD-10 "family" of classifications and guidelines.

Dr A. Jablensky, then Senior Medical Officer in the Division of Mental Health of WHO in Geneva, coordinated the first part of the programme, and thus made a major contribution to the development of the proposals for the text of the criteria. After the proposals for the classification had been assembled and circulated for comment to WHO expert panels and many other individuals, an amended version of the classification was produced for field tests. Tests were conducted according to a protocol produced by WHO staff with the help of Dr J.E. Cooper and other consultants mentioned below, and involved a large number of centres (listed on pages xx-xx) whose work was coordinated by Field Trial Coordinating Centres. The Coordinating Centres, listed below and on pages xx-xx, also undertook the task of producing equivalent versions of *Diagnostic criteria for research* in the languages used in their countries.

---

[1] *The ICD-10 Classification of Mental and Behavioural Disorders. Clinical descriptions and diagnostic guidelines.* Geneval, World Health Organization, 1992.

Dr N. Sartorius had overall responsiblity for the work on classification of mental and behavioural disorders in ICD-10 and for the production of accompanying documents.

Throughout the work on the ICD-10 documents, Dr J. E. Cooper acted as a chief consultant to the project and provided invaluable guidance and help to the WHO coordinating team. Among the team members were Dr J. van Drimmelen, who has worked with WHO from the beginning of the process of developing ICD-10 proposals, Dr B. Üstün who has made particularly valuable contributions during the field trials of the criteria and the analysis of the data they produced. Mr A. L'Hours, technical officer, Strengthening of Epidemiological and Statistical Services, provided generous support, ensuring compliance between the ICD-10 development in general and the production of this classification. Mrs J. Wilson conscientiously and efficiently handled the innumerable administrative tasks linked to the field tests and other activities related to the project. Mrs Ruthbeth Finerman, associated professor in anthropology, provided the information upon which Appendix 2: Culture-specific disorders, is based.

A number of other consultants, including Dr A. Bertelsen, Dr H. Dilling, Dr J. Lopez-Ibor, Dr C. Pull, Dr D. Regier, Dr M. Rutter and Dr N. Wig, were also closely involved in this work, functioning not only as heads of FTCCs for the field trials but also providing advice and guidance about issues in their area of expertise and relevant to the psychiatric traditions of the groups of countries about which they were particularly knowledgeable.

Among the agencies whose help was of vital importance were the Alcohol, Drug Abuse and Mental Health Administration in the USA, which provided generous support to the activities preparatory to the drafting of ICD-10, and which ensured effective and productive consultation between groups working on ICD-10 and those working on the fourth revision of the American Psychiatric Association's Diagnostic Statistical Manual (DSM-IV) classification. Close direct collaboration with the chairmen and the work groups of the APA task force in DSMIV chaired by Dr A. Frances allowed an extensive exchange of views and helped in ensuring compatibility between the texts. Invaluable help was also provided by the WHO Advisory Committee on ICD-10, chaired by Dr E. Strömgren; the World Psychiatric Association and its special committee on classification, the World Federation for Mental Health, the World Association for Psychosocial Rehabilitation, the World Association of Social Psychiatry, the World Federation of Neurology, the International Union of Psychological Societies, and the WHO Collaborating Centres for Research and Training in Mental Health, located in some 40 countries, were particularly useful in the collection of commments and suggestions from their parts of the world.

Governments of WHO Member States, including in particular Belgium, Germany, the Netherlands, Spain and the USA, also provided direct support to the process of developing the classification of mental and behavioural disorders, both through their designated contributions to WHO and through contributions and financial support to the centres that participated in this work.

Field Trial Coordinating Centres and Directors:

Dr A. Bertelsen, Institute of Psychiatric Demography, Psychiatric Hospital, University of Aarhus, 8240 Risskov, Denmark

Dr D. Caetano, Department of Psychiatry, Universidade Estadual de Campinas

Caixa Postal 1170, 13100 Campinas, S.P., Brazil

Dr S. Channabasavanna, National Institute of Mental Health and Neuro Sciences, P.O. Box 2979, Bangalore 560029, India

Dr H.Dilling, Klinik für Psychiatrie der Medizinischen Hochschule, Ratzeburger Allee 160, 2400 Lübeck, Germany

Dr M. Gelder, Department of Psychiatry, Oxford University Hospital,

Warneford Hospital, Old Road, Headington, Oxford, United Kingdom

Dr D. Kemali, Istituto di Psichiatria, Prima Facoltà Medica, Università di Napoli, Largo Madonna della Grazie, 80138 Napoli, Italy

Dr J.J. Lopez Ibor Jr., Clinica Lopez Ibor, Av. Nueva Zelanda 44

Puerto de Hierro, Madrid 35, Spain

Dr G. Mellsop, The Wellington Clinical School, Wellington Hospital, Wellington 2, New Zealand

Dr Y. Nakane, Department of Neuropsychiatry, Nagasaki University, School of Medicine, 7-1 Sakamoto-Machi, Nagasaki 852, Japan

Dr A. Okasha, Department of Psychiatry, Ain Shams University, 3 Shawarby Street, Kasr-El-Nil, Cairo, Egypt

Dr Ch. Pull, Service de Neuropsychiatrie, Centre Hospitalier de Luxembourg, 4, rue Barblé, Luxembourg, Luxembourg

Dr D. Regier, Director, Division of Clinical Research, Room 10-105, National Institute of Mental Health, 5600 Fishers Lane, Rockville, Md. 20857, USA

Dr S. Tzirkin, All Union Research Centre of Mental Health, Institute of Psychiatry, Academy of Medical Sciences, Zagorodnoye Shosse d.2, Moscow 113152
USSR

Dr Xu Tao-Yuan, Department of Psychiatry, Shanghai Psychiatric Hospital, 600 Wan Ping Nan Lu, Shanghai, People's Republic of China

Former Directors of FTCCs:

Dr J. Cooper, Department of Psychiatry, Queen's Medical Centre, Clifton Boulevard, Nottingham NG7 2UH, United Kingdom

Dr R. Takahashi, Department of Psychiatry, Tokyo Medical and Dental University, 5-45 Yushima, 1-Chome, Bunkyo-ku, Tokyo, Japan

Dr N. Wig, Regional Adviser for Mental Health, World Health Organization Regional

Office for the Eastern Mediterranean, P.O. Box 1517, Alexandria 21511, Egypt

Dr Young Derson, Hunan Medical College, Changsha, Hunan, China

NOTES FOR USERS

1. The *Diagnostic Criteria for Research* accompanying the ICD-10 (DCR-10) are designed for use in research; their content is derived from the Glossary to the chapter on Mental and Behavioural Disorders in the ICD-10 (Chapter V(F)). They provide specific criteria for diagnoses contained in the "*Clinical Descriptions and Diagnostic Guidelines*" (CDDG) that have been produced for general clinical and educational use by psychiatrists and other mental health professionals (WHO 1992).

2. Although completely compatible with the Glossary in ICD-10 and the CDDG, the DCR-10 have a different style and lay-out. Researchers using the DCR-10 should first make themselves familiar with the CDDG, since the DCR-10 are not designed to be used alone. The DCR-10 do not contain the descriptions of the clinical concepts upon which the research criteria are based, nor any comments on commonly associated features which, although not essential for diagnosis, may well be relevant for both clinicians and researchers. These are to be found, for each disorder in turn, in the CDDG. The introductory chapters of the CDDG also contain information and comments that are relevant for both clinical and research uses of the ICD-10. It is presumed that anyone using the DCR-10 will have a copy of the CDDG.

3. In addition to the obvious differences in lay-out and detail between the DCR-10 and the CDDG, there are some other differences between them that need to be appreciated before the DCR-10 can be used satisfactorily.

a) The DCR-10, like other published diagnostic criteria for research, are purposefully restrictive in that their use allows the selection

of groups of subjects whose symptoms and other characteristics resemble each other in clearly stated ways. This increases the likelihood of obtaining homogenous groups of patients but limits the generalizations that can be made. Researchers wishing to study the overlap of disorders or the best way to define boundaries between them may therefore need to supplement the criteria so as to allow the inclusion of atypical cases depending upon the purposes of the study.

b) With a few exceptions, it is not appropriate to provide detailed criteria for the "other" (.8) categories in the overall classification of Chapter V F, and by definition it is never appropriate for "unspecified" (.9). Appendix 1 (pxx) contains suggestions for criteria for some of these exceptions; their placement in an Appendix implies that although their present status is somewhat controversial or tentative, further research on them is to be encouraged.

c) Similarly, there is no requirement for extensive rules on mutual exclusions and co-morbidity in a set of diagnostic criteria for research, since different research projects have varied requirements for these, depending upon their aims. Some of the more frequently used and obvious exclusion clauses have been included in the DCR-10 as a reminder and for the convenience of users, and if required more can be found in the CDDG.

4. The general ICD rule of not using interference with social role performance as a diagnostic criterion has been followed in the DCR-10 as far as possible. There are a few unavoidable exceptions, the most obvious being Dementia, Simple Schizophrenia and Dissocial Personality Disorder. Once the decision had been made to include these somewhat controversial disorders in the classification, it was considered best to do so without modifying the concepts. Experience and further research

should show whether these decisions were justified.

For many of the disorders of childhood and adolescence, some form of interference with social behaviour and relationships is included amongst the diagnostic criteria. At first sight this appears to go against the general ICD rule that interference with the performance of social roles should not be used as defining characteristics of disorders or diseases. But a close examination of the disturbances that are being classified in F8 and F9 shows that social criteria are needed because of the more complicated and interactive nature of the subject matter. Children often show general misery and frustration, but rarely produce specific complaints and symptoms equivalent to those that characterise the more individually conceptualised disorders of adults. Many of the disorders in F8 and F9 are joint disturbances which can only be described by indicating how roles within the family, school or peer group are affected.

The problem is apparent rather than real, and is caused by the use of the term "disorder" for all the sections of Chapter V(F). The term is used to cover many varieties of disturbance, and different types of disturbance need different types of information to describe them.

5. For the same reasons as given in 3c), definitions of remission, relapse, and duration of episodes have been provided in the DCR-10 in only a limited number of instances. Further suggestions will be found in the Lexicon of terms to Chapter V (F) of ICD-10.

6. The criteria are labelled with letters or numbers to indicate their place in a hierarchy of generality and importance. General criteria that must be fulfilled by all members of a group of disorders (such as the general criteria for all varieties of dementia, or for the main types of schizophrenia) are labelled with a capital G, plus a number. Obligatory

criteria for individual disorders are labelled by capitals only (A,B,C, etc.). Ordinary numbers (1,2,3, etc.) and lower case letters (a,b, etc.) are used to identify further groups and sub-groups of characteristics, of which only some are required for the diagnosis. To avoid the use of "and/or", when it is specified that either of two criteria is required, then it is always assumed that the presence of both criteria also satisfies the requirement.

7. When the DCR-10 are used in research on patients who also suffer from neurological disorders, researchers may wish to use the Neurological Adaptation of the ICD-10 (ICD-10NA (in press)) and the accompanying glossary (in preparation).

8. The two Appendices to this volume deal with disorders of uncertain or provisional status. Appendix 1 contains some affective disorders that have been the subject of recent research, and some personality disorders that although regarded as clinically useful in some countries, are of uncertain status from an international viewpoint. It is hoped that their inclusion here will encourage research concerning their usefulness.

Appendix 2 contains provisional descriptions of a number of disorders that are often referred to as "culture specific". There are grounds for supposing that they might be better regarded as cultural variants of disorders already present in ICD-10 Chapter V(F), but reliable and detailed clinical information is still too scanty to allow definite conclusions to be drawn about them. The considerable practical difficulties involved in doing field studies of persons with these disorders are recognised, but the provision of these descriptions may act as a stimulus to research by those with a knowledge of the languages and cultures concerned.

ICD-10 CHAPTER V(F) AND ASSOCIATED DIAGNOSTIC INSTRUMENTS

The Schedule for Clinical Assessment in Neuropsychiatry (SCAN), the Composite International Diagnostic Interview (CIDI), and the International Personality Disorder Examination (IPDE) have been developed in the framework of the WHO/ADAMHA Joint Project on Diagnosis and Classification of Mental Disorders, Alcohol- and Drug- related Problems. More information about these instruments, can be obtained through the Division of Mental Health, WHO Headquarters in Geneva.

Training in the use of these instruments can at present be obtained in the following languages: Chinese, Danish, Dutch, English, French, German, Greek, Hindi, Kannada, Portuguese, Spanish, Tamil and Turkish.

List of categories

F00-F09
Organic, including symptomatic, mental disorders

F00 Dementia in Alzheimer's disease

F00.0 Dementia in Alzheimer's disease with early onset

F00.1 Dementia in Alzheimer's disease with late onset

F00.2 Dementia in Alzheimer's disease, atypical or mixed type

F00.8 Dementia in Alzheimer's disease, unspecified

F01 Vascular dementia

F01.0 Vascular dementia of acute onset

F01.1 Multi-infarct dementia

F01.2 Subcortical vascular dementia

F01.3 Mixed cortical and subcortical vascular dementia

F01.8 Other vascular dementia

F01.9 Vascular dementia, unspecified

F02 Dementia in other diseases classified elsewhere

F02.0 Dementia in Pick's disease

F02.1 Dementia in Creutzfeldt-Jakob disease

F02.2 Dementia in Huntington's disease

F02.3 Dementia in Parkinson's disease

F02.4 Dementia in human immunodeficiency virus [HIV] disease

F02.8 Dementia in other specified diseases classified elsewhere

F03 Unspecified dementia

A fifth character may be used to specify dementia in F00-F03, as follows:

.*x*0 Without additional symptoms

.*x*1 With other symptoms, predominantly delusional

.*x*2 With other symptoms, predominantly hallucinatory

.*x*3 With other symptoms, predominantly depressive

.*x*4 With other mixed symptoms

A sixth character may be used to indicate the severity of the dementia:

.*xx*0 Mild

.*xx*1 Moderate

.*xx*2 Severe

F04 Organic amnesic syndrome, not induced by alcohol and other psychoactive substances

F05 Delirium, not induced by alcohol and other psychoactive substances

F05.0 Delirium, not superimposed on dementia, so described

F05.1 Delirium, superimposed on dementia

F05.8 Other delirium

F05.9 Delirium, unspecified

F06 Other mental disorders due to brain damage and dysfunction and to physical disease

F06.0 Organic hallucinosis

F06.1 Organic catatonic disorder

F06.2 Organic delusional [schizophrenia-like] disorder

F06.3 Organic mood [affective] disorder

.30 Organic manic disorder

.31 Organic bipolar disorder

.32 Organic depressive disorder

.33 Organic mixed affective disorder

F06.4 Organic anxiety disorder

F06.5 Organic dissociative disorder

F06.6 Organic emotionally labile [asthenic] disorder

F06.7 Mild cognitive disorder

.70 Not associated with a physical disorder

.71 Associated with a physical disorder

F06.8 Other specified mental disorders due to brain damage and dysfunction and to physical disease

F06.9 Unspecified mental disorder due to brain damage and dysfunction and to physical disease

F07 Personality and behavioural disorders due to brain disease, damage and dysfunction

F07.0 Organic personality disorder

F07.1 Postencephalitic syndrome

F07.2 Postconcussional syndrome

F07.8 Other organic personality and behavioural disorders due to brain disease, damage and dysfunction

F07.9 Unspecified mental disorder due to brain disease, damage and dysfunction

F09 Unspecified organic or symptomatic mental disorder

F10-F19
Mental and behavioural disorders due to psychoactive substance use

F10.- Mental and behavioural disorders due to use of alcohol

F11.- Mental and behavioural disorders due to use of opioids

F12.- Mental and behavioural disorders due to use of cannabinoids

F13.- Mental and behavioural disorders due to use of sedatives or hypnotics

F14.- Mental and behavioural disorders due to use of cocaine

F15.- Mental and behavioural disorders due to use of other stimulants, including caffeine

F16.- Mental and behavioural disorders due to use of hallucinogens

F17.- Mental and behavioural disorders due to use of tobacco

F18.- Mental and behavioural disorders due to use to volatile solvents

F19.- Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances

Four-, five- and six-character categories are used to specify the clinical conditions as follows, and diagnostic criteria particular to each psychoactive substance are provided where appropriate for acute intoxication and withdrawal state:

F1*x*.0 Acute intoxication
- .00 Uncomplicated
- .01 With trauma or other bodily injury
- .02 With other medical complications
- .03 With delirium
- .04 With perceptual distortions
- .05 With coma
- .06 With convulsions
- .07 Pathological intoxication

F1*x*.1 Harmful use

F1*x*.2 Dependence syndrome

.20 Currently abstinent

.200 Early remission

.201 Partial remission

.202 Full remission

.21 Currently abstinent, but in a protected environment

.22 Currently on a clinically supervised or replacement regime [controlled dependence]

.23 Currently abstinent, but receiving treatment with aversive or blocking drugs

.24 Currently using the substance [active dependence]

.240 Without physical features

.241 With physical features

.25 Continuous use

.26 Episodic use [dipsomania]

F1*x*.3 Withdrawal state

.30 Uncomplicated

.31 With convulsions

F1*x*.4 Withdrawal state with delirium

.40 Without convulsions

.41 With convulsions

F1*x*.5 Psychotic disorder

.50 Schizophrenia-like

.51 Predominantly delusional

.52 Predominantly hallucinatory

.53 Predominantly polymorphic

.54 Predominantly depressive psychotic symptoms

.55 Predominantly manic psychotic symptoms

.56 Mixed

F1*x*.6 Amnesic syndrome

F1*x*.7 Residual disorders and late-onset psychotic disorder

.70 Flashbacks

.71 Personality or behaviour disorder

.72 Residual affective disorder

.73 Dementia

.74 Other persisting cognitive disorder

.75 Late-onset psychotic disorder

F1*x*.8 Other mental and behavioural disorders

F1*x*.9 Unspecified mental and behavioural disorder

F20-F29
Schizophrenia, schizotypal and delusional disorders

F20 Schizophrenia

- F20.0 Paranoid schizophrenia
- F20.1 Hebephrenic schizophrenia
- F20.2 Catatonic schizophrenia
- F20.3 Undifferentiated schizophrenia
- F20.4 Post-schizophrenic depression
- F20.5 Residual schizophrenia
- F20.6 Simple schizophrenia
- F20.8 Other schizophrenia
- F20.9 Schizophrenia, unspecified

A fifth character may be used to classify course:

- .*x*0 Continuous
- .*x*1 Episodic with progressive deficit
- .*x*2 Episodic with stable deficit
- .*x*3 Episodic remittent
- .*x*4 Incomplete remission
- .*x*5 Complete remission
- .*x*8 Other
- .*x*9 Course uncertain, period of observation too short

F21 Schizotypal disorder

F22 Persistent delusional disorders

- F22.0 Delusional disorder
- F22.8 Other persistent delusional disorders
- F22.9 Persistent delusional disorder, unspecified

F23 Acute and transient psychotic disorders

- F23.0 Acute polymorphic psychotic disorder without symptoms of schizophrenia
- F23.1 Acute polymorphic psychotic disorder with symptoms of schizophrenia
- F23.2 Acute schizophrenia-like psychotic disorder
- F23.3 Other acute predominantly delusional psychotic disorder
- F23.8 Other acute and transient psychotic disorders
- F23.9 Acute and transient psychotic disorder, unspecified

A fifth character may be used to identify the present or absence of associated acute stress:

.*x*0 Without associated acute stress

.*x*1 With associated acute stress

F24 Induced delusional disorder

F25 Schizoaffective disorders

F25.0 Schizoaffective disorder, manic type

F25.1 Schizoaffective disorder, depressive type

F25.2 Schizoaffective disorder, mixed type

F25.8 Other schizoaffective disorders

F25.9 Schizoaffective disorder, unspecified

A fifth character may be used to classify the following subtypes:

.*x*0 Concurrent affective and schizophrenic symptoms only

.*x*1 Concurrent affective and schizophrenic symptoms, plus persistence of the schizophrenic symptoms beyond the duration of the affective symptoms

F28 Other nonorganic psychotic disorders

F29 Unspecified nonorganic psychosis

F30-F39
Mood [affective] disorders

F30 Manic episode

- F30.0 Hypomania
- F30.1 Mania without psychotic symptoms
- F30.2 Mania with psychotic symptoms
  - .20 With mood-congruent psychotic symptoms
  - .21 With mood-incongruent psychotic symptoms
- F30.8 Other manic episodes
- F30.9 Manic episode, unspecified

F31 Bipolar affective disorder

- F31.0 Bipolar affective disorder, current episode hypomanic
- F31.1 Bipolar affective disorder, current episode manic without psychotic symptoms
- F31.2 Bipolar affective disorder, current episode manic with psychotic symptoms
  - .20 With mood-congruent psychotic symptoms
  - .21 With mood-incongruent psychotic symptoms
- F31.3 Bipolar affective disorder, current episode mild or moderate depression
  - .30 Without somatic syndrome
  - .31 With somatic syndrome
- F31.4 Bipolar affective disorder, current episode severe depression without psychotic symptoms
- F31.5 Bipolar affective disorder, current episode severe depression with psychotic symptoms
  - .50 With mood-congruent psychotic symptoms
  - .51 With mood-incongruent psychotic symptoms
- F31.6 Bipolar affective disorder, current episode mixed
- F31.7 Bipolar affective disorder, currently in remission
- F31.8 Other bipolar affective disorders
- F31.9 Bipolar affective disorder, unspecified

F32 Depressive episode

- F32.0 Mild depressive episode
  - .00 Without somatic syndrome
  - .01 With somatic syndrome

F32.1 Moderate depressive episode

.10 Without somatic syndrome

.11 With somatic syndrome

F32.2 Severe depressive episode without psychotic symptoms

F32.3 Severe depressive episode with psychotic symptoms

.30 With mood-congruent psychotic symptoms

.31 With mood-incongruent psychotic symptoms

F32.8 Other depressive episodes

F32.9 Depressive episode, unspecified

F33 Recurrent depressive disorder

F33.0 Recurrent depressive disorder, current episode mild

.00 Without somatic syndrome

.01 With somatic syndrome

F33.1 Recurrent depressive disorder, current episode moderate

.10 Without somatic syndrome

.11 With somatic syndrome

F33.2 Recurrent depressive disorder, current episode severe without psychotic symptoms

F33.3 Recurrent depressive disorder, current episode severe with psychotic symptoms

.30 With mood-congruent psychotic symptoms

.31 With mood-incongruent psychotic symptoms

F33.4 Recurrent depressive disorder, currently in remission

F33.8 Other recurrent depressive disorders

F33.9 Recurrent depressive disorder, unspecified

F34 Persistent mood [affective] disorders

F34.0 Cyclothymia

F34.1 Dysthymia

F34.8 Other persistent mood [affective] disorders

F34.9 Persistent mood [affective] disorder, unspecified

F38 Other mood [affective] disorders

F38.0 Other single mood [affective] disorders

.00 Mixed affective episode

F38.1 Other recurrent mood [affective] disorders

.10 Recurrent brief depressive disorder

F38.8 Other specified mood [affective] disorders

F39 Unspecified mood [affective] disorder

F40-F48
Neurotic, stress-related and somatoform disorders

F40 Phobic anxiety disorders

- F40.0 Agoraphobia
  - .00 Without panic disorder
  - .01 With panic disorder
- F40.1 Social phobias
- F40.2 Specific (isolated) phobias
- F40.8 Other phobic anxiety disorders
- F40.9 Phobic anxiety disorder, unspecified

F41 Other anxiety disorders

- F41.0 Panic disorder [episodic paroxysmal anxiety]
  - .00 Moderate
  - .01 Severe
- F41.1 Generalized anxiety disorder
- F41.2 Mixed anxiety and depressive disorder
- F41.3 Other mixed anxiety disorders
- F41.8 Other specified anxiety disorders
- F41.9 Anxiety disorder, unspecified

F42 Obsessive-compulsive disorder

- F42.0 Predominantly obsessional thoughts or ruminations
- F42.1 Predominantly compulsive acts [obsessional rituals]
- F42.2 Mixed obsessional thoughts and acts
- F42.8 Other obsessive-compulsive disorders
- F42.9 Obsessive-compulsive disorder, unspecified

F43 Reaction to severe stress, and adjustment disorders

- F43.0 Acute stress reaction
  - .00 Mild
  - .01 Moderate
  - .02 Severe
- F43.1 Post-traumatic stress disorder
- F43.2 Adjustment disorders
  - .20 Brief depressive reaction
  - .21 Prolonged depressive reaction
  - .22 Mixed anxiety and depressive reaction
  - .23 With predominant disturbance of other emotions
  - .24 With predominant disturbance of conduct

.25 With mixed disturbance of emotions and conduct

.28 With other specified predominant symptoms

F43.8 Other reactions to severe stress

F43.9 Reaction to severe stress, unspecified

F44 Dissociative [conversion] disorders

F44.0 Dissociative amnesia

F44.1 Dissociative fugue

F44.2 Dissociative stupor

F44.3 Trance and possession disorders

F44.4 Dissociate motor disorders

F44.5 Dissociative convulsions

F44.6 Dissociate anaesthesia and sensory loss

F44.7 Mixed dissociative [conversion] disorders

F44.8 Other dissociative [conversion] disorders

.80 Ganser's syndrome

.81 Multiple personality disorder

.82 Transient dissociative [conversion] disorders occurring in childhood and adolescence

.88 Other specified dissociative [conversion] disorders

F44.9 Dissociative [conversion] disorder, unspecified

F45 Somatoform disorders

F45.0 Somatization disorder

F45.1 Undifferentiated somatoform disorder

F45.2 Hypochondriacal disorders

F45.3 Somatoform autonomic dysfunction

.30 Heart and cardiovascular system

.31 Upper gastrointestinal tract

.32 Lower gastrointestinal tract

.34 Genitourinary system

.38 Other organ or system

F45.4 Persistent somatoform pain disorder

F45.8 Other somatoform disorders

F45.9 Somatoform disorder, unspecified

F48 Other neurotic disorders

F48.0 Neurasthenia

F48.1 Depersonalization-derealization syndrome

F48.8 Other specified neurotic disorders

F48.9 Neurotic disorder, unspecified

F50-F59
Behavioural syndromes associated with physiological disturbances and physical factors

F50 Eating disorders

- F50.0 Anorexia nervosa
- F50.1 Atypical anorexia nervosa
- F50.2 Bulimia nervosa
- F50.3 Atypical bulimia nervosa
- F50.4 Overeating associated with other psychological disturbances
- F50.5 Vomiting associated with other psychological disturbances
- F50.8 Other eating disorders
- F50.9 Eating disorder, unspecified

F51 Nonorganic sleep disorders

- F51.0 Nonorganic insomnia
- F51.1 Nonorganic hypersomnia
- F51.2 Nonorganic disorder of the sleep-wake schedule
- F51.3 Sleepwalking [somnambulism]
- F51.4 Sleep terrors [night terrors]
- F51.5 Nightmares
- F51.8 Other nonorganic sleep disorders
- F51.9 Nonorganic sleep disorder, unspecified

F52 Sexual dysfunction, not caused by organic disorder or disease

- F52.0 Lack or loss of sexual desire
- F52.1 Sexual aversion and lack of sexual enjoyment
  - .10 Sexual aversion
  - .11 Lack of sexual enjoyment
- F52.2 Failure of genital response
- F52.3 Orgasmic dysfunction
- F52.4 Premature ejaculation
- F52.5 Nonorganic vaginismus
- F52.6 Nonorganic dyspareunia
- F52.7 Excessive sexual drive
- F52.8 Other sexual dysfunction, not caused by organic disorder or disease
- F52.9 Unspecified sexual dysfunction, not caused by organic disorder or disease

F53 Mental and behavioural disorders associated with the puerperium, not elsewhere classified

F53.0 Mild mental and behavioural disorders associated with the puerperium, not elsewhere classified

F53.1 Severe mental and behavioural disorders associated with the puerperium, not elsewhere classified

F53.8 Other mental and behavioural disorders associated with the puerperium, not elsewhere classified

F53.9 Puerperal mental disorder, unspecified

F54 Psychological and behavioural factors associated with disorders or diseases classified elsewhere

F55 Abuse of non-dependence-producing substances

F55.0 Antidepressants

F55.1 Laxatives

F55.2 Analgesics

F55.3 Antacids

F55.4 Vitamins

F55.5 Steroids or hormones

F55.6 Specific herbal or folk remedies

F55.8 Other substances that do not produce dependence

F55.9 Unspecified

F59 Unspecified behavioural syndromes associated with physiological disturbances and physical factors

F60-F69
Disorders of adult personality and behaviour

F60 Specific personality disorders

- F60.0 Paranoid personality disorder
- F60.1 Schizoid personality disorder
- F60.2 Dissocial personality disorder
- F60.3 Emotionally unstable personality disorder
  - .30 Impulsive type
  - .31 Borderline type
- F60.4 Histrionic personality disorder
- F60.5 Anankastic personality disorder
- F60.6 Anxious [avoidant] personality disorder
- F60.8 Other specific personality disorders
- F60.9 Personality disorder, unspecified

F61 Mixed and other personality disorders

- F61.0 Mixed personality disorder
- F61.1 Troublesome personality changes

F62 Enduring personality changes, not attributable to brain damage and disease

- F62.0 Enduring personality change after catastrophic experience
- F62.1 Enduring personality change after psychiatric illness
- F62.8 Other enduring personality changes
- F62.9 Enduring personality change, unspecified

F63 Habit and impulse disorders

- F63.0 Pathological gambling
- F63.1 Pathological fire-setting [pyromania]
- F63.2 Pathological stealing [kleptomania]
- F63.3 Trichotillomania
- F63.8 Other habit and impulse disorders
- F63.9 Habit and impulse disorder, unspecified

F64 Gender identity disorders

- F64.0 Transsexualism
- F64.1 Dual-role transvestism
- F64.2 Gender identity disorder of childhood
- F64.8 Other gender identity disorders
- F64.9 Gender identity disorder, unspecified

F65 Disorders of sexual preference

F65.0 Fetishism

F65.1 Fetishistic transvestism

F65.2 Exhibitionism

F65.3 Voyeurism

F65.4 Paedophilia

F65.5 Sadomasochism

F65.6 Multiple disorders of sexual preference

F65.8 Other disorders of sexual preference

F65.9 Disorder of sexual preference, unspecified

F66 Psychological and behavioural disorders associated with sexual development and orientation

F66.0 Sexual maturation disorder

F66.1 Egodystonic sexual orientation

F66.2 Sexual relationship disorder

F66.8 Other psychosexual development disorders

F66.9 Psychosexual development disorder, unspecified

F68 Other disorders of adult personality and behaviour

F68.0 Elaboration of physical symptoms for psychological reasons

F68.1 Intentional production or feigning of symptoms or disabilities, either physical or psychological [factitious disorder]

F68.8 Other specified disorders of adult personality and behaviour

F69 Unspecified disorder of adult personality and behaviour

F70-F79
Mental retardation

F70 Mild mental retardation

F71 Moderate mental retardation

F72 Severe mental retardation

F73 Profound mental retardation

F78 Other mental retardation

F79 Unspecified mental retardation

A fourth character may be used to specify the extent of associated impairment of behaviour:

F7*x*.0 No, or minimal, impairment of behaviour

F7*x*.1 Significant impairment of behaviour requiring attention or treatment

F7*x*.2 Other impairments of behaviour

F7*x*.3 Without mention of impairment of behaviour

F80-F89
Disorders of psychological development

F80 Specific developmental disorders of speech and language

- F80.0 Specific speech articulation disorder
- F80.1 Expressive language disorder
- F80.2 Receptive language disorder
- F80.3 Acquire aphasia with epilepsy [Landau-Kleffner syndrome]
- F80.8 Other developmental disorders of speech and language
- F80.9 Developmental disorder of speech and language, unspecified

F81 Specific developmental disorders of scholastic skills

- F81.0 Specific reading disorder
- F81.1 Specific spelling disorder
- F81.2 Specific disorder of arithmetical skills
- F81.3 Mixed disorder of scholastic skills
- F81.8 Other developmental disorders of scholastic skills
- F81.9 Developmental disorder of scholastic skills, unspecified

F82 Specific developmental disorder of motor function

F83 Mixed specific developmental disorder

F84 Pervasive developmental disorders

- F84.0 Childhood autism
- F84.1 Atypical autism
  - .10 Atypicality in age of onset
  - .11 Atypicality in symptomatology
  - .12 Atypicality in both age of onset and symptomatology
- F84.2 Rett's syndrome
- F84.3 Other childhood disintegrative disorder

F84.4 Overactive disorder associated with mental retardation and stereotyped movements

- F84.5 Asperger's syndrome
- F84.8 Other pervasive developmental disorders
- F84.9 Pervasive developmental disorder, unspecified

F88 Other disorders of psychological development

F89 Unspecified disorder of psychological development

F90-F98
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence

F90 Hyperkinetic disorder

- F90.0 Disturbance of activity and attention
- F90.1 Hyperkinetic conduct disorder
- F90.8 Other hyperkinetic disorders
- F90.9 Hyperkinetic disorder, unspecified

F91 Conduct disorders

- F91.0 Conduct disorder confined to the family context
- F91.1 Unsocialized conduct disorder
- F91.2 Socialized conduct disorder
- F91.3 Oppositional defiant disorder
- F91.8 Other conduct disorders
- F91.9 Conduct disorder, unspecified

F92 Mixed disorders of conduct and emotions

- F92.0 Depressive conduct disorder
- F92.8 Other mixed disorders of conduct and emotions
- F92.9 Mixed disorder of conduct and emotions, unspecified

F93 Emotional disorders with onset specific to childhood

- F93.0 Separation anxiety disorder of childhood
- F93.1 Phobic anxiety disorder of childhood
- F93.2 Social anxiety disorder of childhood
- F93.3 Sibling rivalry disorder
- F93.8 Other childhood emotional disorders
- F93.9 Childhood emotional disorder, unspecified

F94 Disorders of social functioning with onset specific to childhood and adolescence

- F94.0 Elective mutism
- F94.1 Reactive attachment disorder of childhood
- F94.2 Disinhibited attachment disorder of childhood
- F94.8 Other childhood disorders of social functioning
- F94.9 Childhood disorder of social functioning, unspecified

F95 Tic disorders

F95.0 Transient tic disorders

F95.1 Chronic motor or vocal tic disorder

F95.2 Combined motor and vocal tic disorder [de la Tourette's syndrome]

F95.8 Other tic disorders

F95.9 Tic disorder, unspecified

F98 Other behavioural and emotional disorders with onset usually occurring in childhood and adolescence

F98.0 Nonorganic enuresis

.00 Nocturnal enuresis only

.01 Diurnal enuresis only

.02 Nocturnal and diurnal enureses

F98.1 Nonorganic encopresis

.10 Failure to acquire physiological bowel control

.11 Adequate bowel control with normal faeces deposited in inappropriate places

.12 Soiling that is associated with excessively fluid faeces such as with retention with overflow

F98.2 Feeding disorder of infancy and childhood

F98.3 Pica of infancy and childhood

F98.4 Stereotyped movement disorders

.40 Non-self-injurious

.41 Self-injurious

.42 Mixed

F98.5 Stuttering [stammering]

F98.6 Cluttering

F98.8 Other specified behavioural and emotional disorders with onset usually occurring in childhood and adolescence

F98.9 Unspecified behavioural and emotional disorders with onset usually occurring in childhood and adolescence

F99
Unspecified mental disorder

F99 Mental disorder, not otherwise specified

Diagnostic criteria

for research

F00 - F09 ORGANIC, INCLUDING SYMPTOMATIC, MENTAL DISORDERS

DEMENTIA

G1. Evidence of each of the following:

(1) A decline in memory, which is most evident in the learning of new information, although in more severe cases, the recall of previously learned information may be also affected. The impairment applies to both verbal and non-verbal material. The decline should be objectively verified by obtaining a reliable history from an informant, supplemented, if possible, by neuropsychological tests or quantified cognitive assessments. The severity of the decline, with mild impairment as the threshold for diagnosis, should be assessed as follows:

Mild: a degree of memory loss sufficient to interfere with everyday activities, though not so severe as to be incompatible with independent living (see comment on cultural aspects of "independent living" on page 24). The main function affected is the learning of new material. For example, the individual has difficulty in registering, storing and recalling elements in daily living, such as where belongings have been put, social arrangements, or information recently imparted by family members.

Moderate: A degree of memory loss which represents a serious handicap to independent living. Only highly learned or very familiar material is retained. New information is retained only occasionally and very briefly. The individual is unable to recall basic information about where he lives, what he has recently been doing, or the names of familiar persons.

Severe: a degree of memory loss characterized by the complete inability to retain new information. Only fragments of previously learned information remain. The subject fails to recognize even close relatives.

(2) A decline in other cognitive abilities characterized by deterioration in judgement and thinking, such as planning and organizing, and in the general processing of information. Evidence for this should be obtained when possible from interviewing an informant, supplemented, if possible, by neuropsychological tests or quantified objective assessments. Deterioration from a previously higher level of performance should be established. The severity of the decline, with mild impairment as the threshold for diagnosis, should be assessed as follows:

Mild. The decline in cognitive abilities causes impaired performance in daily living, but not to a degree making the individual dependent on others. More complicated daily tasks or recreational activities cannot be undertaken.

Moderate. The decline in cognitive abilities makes the individual unable to function without the assistance of another in daily living, including shopping and handling money. Within the home, only simple chores are preserved.

Activities are increasingly restricted and poorly sustained.

Severe. The decline is characterized by an absence, or virtual absence, of intelligible ideation.

The overall severity of the dementia is best expressed as the level of decline in memory or other cognitive abilities, whichever is the more severe (e.g. mild decline in memory and moderate decline in cognitive abilities indicate a dementia of moderate severity).

G2. Preserved awarenenss of the environment (i.e. absence of clouding of consciousness (as defined in F05, criterion A)) during a period of time long enough to enable the unequivocal demonstration of G1. When there are superimposed episodes of delirium the diagnosis of dementia should be deferred.

G3. A decline in emotional control or motivation, or a change in social behaviour, manifest as at least one of the following:

(1) emotional lability;

(2) irritability;

(3) apathy;

(4) coarsening of social behaviour.

G4. For a confident clinical diagnosis, G1 should have been present for at least six months; if the period since the manifest onset is shorter, the diagnosis can only be tentative.

Comments: The diagnosis is further supported by evidence of damage to other higher cortical functions, such as aphasia, agnosia, apraxia.

Judgment about independent living or the development of dependence (upon others) need to take account of the cultural expectation and context.

Dementia is specified here as having a minimum duration of six months to avoid confusion with reversible states with identical behavioural syndromes, such as traumatic subdural haemorrhage (S06.5), normal pressure hydrocephalus (G91.2) and diffuse or focal brain injury (S06.2 and S06.3).

A fifth character may be used to indicate the presence of additional symptoms, in the categories F00-F03 (F00 Dementia in Alzheimer's disease; F01 Vascular dementia; F02 Dementia in diseases classified elsewhere; and F03 Unspecified dementia), as follows:

.x0 without additional symptoms

.x1 with other symptoms, predominantly delusional

.x2 with other symptoms, predominantly hallucinatory

.x3 with other symptoms, predominantly depressive

.x4 with other mixed symptoms

A sixth character may be used to indicate the severity of the dementia:

.xx0 mild

.xx1 moderate

.xx2 severe

As mentioned above on page ?? the overall severity of the dementia depends on the level of memory or intellectual impairment, whichever is the more severe.

F00 DEMENTIA IN ALZHEIMER'S DISEASE

A. The general criteria for dementia (G1 to G4) must be met.

B. There is no evidence from the history, physical examination or special investigations for any other possible cause of dementia (e.g. cerebrovascular disease, Parkinson's disease, Huntington's disease, normal pressure hydrocephalus), a sysytemic disorder (e.g. hypothyroidism, vit. B_{12} or folic acid deficiency, hypercalcaemia), or alcohol- or drug-abuse.

Comments: The diagnosis is confirmed by post mortem evidence of neurofibrillary tangles and neuritic plaques in excess of those found in normal ageing of the brain.

The following features support the diagnosis, but are not necessary elements: Involvement of cortical functions as evidenced by aphasia, agnosia or apraxia; decrease of motivation and drive, leading to apathy and lack of spontaneity; irritability and disinhibition of social behaviour; evidence from special investigations that there is cerebral atrophy, particularly if this can be shown to be increasing over time. In severe cases there may be Parkinson-like extrapyramidal changes, logoclonia, and epileptic fits.

Specification of features for possible subtypes. Because of the possibility that subtypes exist, it is recommended that the following characteristics be ascertained as a basis for a further classification: age at onset; rate of progression; the configuration of the clinical features, particularly the relative prominence (or lack) of temporal, parietal or frontal lobe signs; any neuropathological or neurochemical abnormalities, and their pattern.

The division of AD into subtypes can at present be accomplished in two ways: first by taking only the age of onset and labeling AD as either early or late, with an approximate cut-off point at 65 years; or secondly, by assessing how well the individual conforms to one of the two putative syndromes, early or late onset type.

It should be noted that it is unlikely that a sharp distinction exists between early and late onset type. Early onset type may occur in late life, just as late onset type may occasionally have an onset under the age of 65. The following criteria may be used to differentiate F00.0 from F00.1, but it should be remembered that the status of this subdivision is still controversial.

F00.0 Dementia in Alzheimer's disease with early onset

1. The criteria for dementia in Alzheimer's disease (F00) must be met, and the age at onset being under 65 years.

2. In addition, at least one of the following requirements must be met:

(a) evidence of a relatively rapid onset and progression;

(b) in addition to memory impairment, there is aphasia (amnesic or sensory), agraphia, alexia, acalculia, or apraxia (indicating the presence of temporal, parietal and/or frontal lobe involvement).

F00.1 Dementia in Alzheimer's disease with late onset

1. The criteria for dementia in Alzheimer's disease (F00) must be met and the age at onset must be 65 or more.

2. In addition, at least one of the following requirements must be met:

(a) evidence of a very slow, gradual onset and progression (the rate of the latter may be known only retrospectively after a course of 3 years or more);

(b) predominance of memory impairment G1.1, over intellectual impairment G1.2 (see general criteria for dementia).

F00.2 Dementia in Alzheimer's disease, atypical or mixed type

Use this term and code for dementias that have important atypical features or that fulfil criteria for both early and late onset type of Alzheimer's disease. Mixed Alzheimer's and vascular dementia is also included here.

F00.9 Dementia in Alzheimer's disease, unspecified

F01 VASCULAR DEMENTIA

G1. The general criteria for dementia (G1 to G4) must be met.

G2. Unequal distribution of deficits in higher cognitive functions, with some affected and others relatively spared. Thus memory may be quite markedly affected while thinking, reasoning and information processing may show only mild decline.

G3. There is clinical evidence of focal brain damage, manifest as at least one of the following:

(1) unilateral spastic weakness of the limbs;

(2) unilaterally increased tendon reflexes;

(3) an extensor plantar response;

(4) pseudobulbar palsy.

G4. There is evidence from the history, examination, or tests, of a significant cerebrovascular disease, which may reasonably be judged to be etiologically related to the dementia (e.g. a history of stroke; evidence of cerebral infarction).

The following criteria may be used to differentiate subtypes of vascular dementia, but it should be remembered that the usefulness of this subdivision may not be generally accepted.

F01.0 Vascular dementia of acute onset

A. The general criteria for vascular dementia (F01) must be met.

B. The dementia develops rapidly (i.e. usually within one month, but within no longer than three months) after a succession of strokes, or (rarely) after a single large infarction.

F01.1 Multi-infarct dementia

A. The general criteria for vascular dementia (F01) must be met.

B. The onset of the dementia is gradual (i.e. within three to six months), following a number of minor ischaemic episodes.

Comments: It is presumed that there is an accumulation of infarcts in the cerebral parenchym. Between the ischaemic episodes there may be periods of actual clinical improvement.

F01.2 Subcortical vascular dementia

A. The general criteria for vascular dementia (F01) must be met.

B. A history of hypertension.

C. Evidence from clinical examination and special investigations of vascular disease located in the deep white matter of the cerebral hemispheres, with preservation of the cerebral cortex.

F01.3 Mixed cortical and subcortical vascular dementia

Mixed cortical and subcortical components of the vascular dementia may be suspected from the clinical features, the results of investigations (including autopsy), or both.

F01.8 Other vascular dementia

F01.9 Vascular dementia, unspecified

F02 DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE

F02.0 Dementia in Pick's disease

A. The general criteria for dementia (G1 to G4) must be met.

B. Slow onset with steady deterioration.

C. Predominance of frontal lobe involvement evidenced by two or more of the following:

(1) emotional blunting;

(2) coarsening of social behaviour;

(3) disinhibition;

(4) apathy or restlessness;

(5) aphasia.

D. Relative preservation, in the early stages, of memory and parietal lobe functions.

F02.1 Dementia in Creutzfeldt-Jakob disease

A. The general criteria for dementia (G1 to G4) must be met.

B. Very rapid progression of the dementia, with disintegration of virtually all higher cerebral functions.

C. The emergence, usually after or simultaneously with the dementia, of one or more of the following types of neurological symptoms and signs:

(1) pyramidal symptoms;

(2) extrapyramidal symptoms;

(3) cerebellar symptoms;

(4) aphasia;

(5) visual impairment.

Comments: An akinetic and mute state is the typical terminal stage. An amyotrophic variant may be seen, where the neurological signs precede the onset of the dementia. A characteristic electroencephalogram (periodic spikes against a slow and low voltage background), if present in association with the above clinical signs, will increase the probability of the diagnosis. However, the diagnosis can be confirmed only by neuropathological examination (neuronal loss, astrocytosis, and spongiform changes). Because of the risk of infection, this should be carried out only under special protective conditions.

F02.2 Dementia in Huntington's disease

A. The general criteria for dementia (G1 to G4) must be met.

B. Subcortical functions are affected first and dominate the picture of dementia throughout; manifest as slowness of thinking or movement and personality alteration with apathy or depression.

C. Presence of involuntary choreiform movements, typically of the face, hands or shoulders, or in the gait. The patient may attempt to conceal them by converting them into a voluntary action.

D. A history of Huntington's disease in one parent or a sibling; or a family history which suggests the disorder.

E. The absence of clinical features otherwise accounting for the abnormal movements.

Comments: In addition to involuntary choreiform movements there may be development of extrapyramidal rigidity, or spasticity with pyramidal signs.

F02.3 Dementia in Parkinson's disease

A. The general criteria for dementia (G1 to G4) must be met.

B. Diagnosis of Parkinson's disease.

C. Absence of cognitive impairment attributable to anti-parkinsonian medication.

D. There is no evidence from the history, physical examination or special investigations for any other possible cause of dementia, including other forms of brain disease, damage or dysfunction (e.g. cerebrovascular disease, HIV disease, Huntington's disease, normal pressure hydrocephalis), a systemic disorder (e.g. hypothyroidism, vit. B_{12} or folic acid deficiency, hypercalcaemia), or alcohol or drug abuse.

If criteria are also fulfilled for dementia in Alzheimer's disease with late onset (F00.1), this category F00.1 should be used in combination with Parkinson's disease G20.

F02.4 Dementia in human immunodeficiency (HIV) disease

A. The general criteria for dementia (G1 to G4) must be met.

B. Diagnosis of HIV infection.

C. There is no evidence from the history, physical examination or special investigations for any other possible cause of dementia, including other forms of brain disease, damage or dysfunction (e.g. Alzheimer's disease, cerebrovascular disease, Parkinson's disease, Huntington's disease, normal pressure hydrocephalis), a systemic disorder (e.g. hypothyroidism, vit. B_{12} or folic acid deficiency, hypercalcaemia), or alcohol or drug abuse.

F02.8 Dementia in other specified diseases classified elsewhere

Dementia can occur as a manifestation or consequence of a variety of cerebral and somatic conditions. To specify the etiology, the ICD-10 code for the underlying condition should be added.

F03 UNSPECIFIED DEMENTIA

This category should be used when the general criteria for dementia are met, but when it is not possible to identify one of the specific types (F00.0-F02.9).

FO4 ORGANIC AMNESIC SYNDROME, NOT INDUCED BY ALCOHOL AND OTHER PSYCHOACTIVE SUBSTANCES

A. Memory impairment, manifest in both:

(1) a defect of recent memory (impaired learning of new material), to a degree sufficient to interfere with daily living; and

(2) a reduced ability to recall past experiences.

B. Absence of:

(1) a defect in immediate recall (as tested, for example, by the digit span);

(2) clouding of consciousness and disturbance of attention, as defined in FO5, criterion A;

(3) global intellectual decline (dementia).

C. Objective evidence (physical & neurological examination, laboratory tests) and/or history of an insult to or a disease of the brain (especially involving bilaterally the diencephalic and medial temporal structures but other than alcoholic encephalopathy) that can reasonably be presumed to be responsible for the clinical manifestations described under A.

Comments: Associated features, including confabulations, emotional changes (apathy, lack of initiative), and lack of insight, are useful additional pointers to the diagnosis but are not invariably present.

FO5 DELIRIUM, NOT INDUCED BY ALCOHOL AND OTHER PSYCHOACTIVE SUBSTANCES

A. Clouding of consciousness, i.e. reduced clarity of awareness of the environment, with reduced ability to focus, sustain, or shift attention.

B. Disturbance of cognition, manifest by both:

(1) impairment of immediate recall and recent memory, with relatively intact remote memory;

(2) disorientation in time, place or person.

C. At least one of the following psychomotor disturbances:

(1) rapid, unpredictable shifts from hypo-activity to hyper-activity;

(2) increased reaction time;

(3) increased or decreased flow of speech;

(4) enhanced startle reaction.

D. Disturbance of sleep or the sleep-wake cycle, manifest by at least one of the following:

(1) insomnia, which in severe cases may involve total sleep loss, with or without daytime drowsiness, or reversal of the sleep-wake cycle;

(2) nocturnal worsening of symptoms;

(3) disturbing dreams and nightmares which may continue as hallucinations or illusions after awakening.

E. Rapid onset and fluctuations of the symptoms over the course of the day.

F. Objective evidence from history, physical and neurological examination or laboratory tests of an underlying cerebral or systemic disease (other than psychoactive substance-related) that can be presumed to be responsible for the clinical manifestations in A-D.

Comments: Emotional disturbances such as depression, anxiety or fear, irritability, euphoria, apathy or wondering perplexity, disturbances of perception (illusions or hallucinations, often visual) and transient delusions are typical but are not specific indications for the diagnosis.

Use the fourth character to indicate whether the delirium is superimposed on dementia or not:

F05.0 Delirium, not superimposed on dementia

F05.1 Delirium, superimposed on dementia

F05.8 Other delirium

F05.9 Delirium, unspecified

FO6 OTHER MENTAL DISORDERS DUE TO BRAIN DAMAGE AND DYSFUNCTION AND TO PHYSICAL DISEASE

G1. Objective evidence (from physical and neurological examination and laboratory tests) and/or history of cerebral disease, damage or dysfunction, or of systemic physical disorder known to cause cerebral dysfunction, including hormonal disturbances (other than alcohol or other psychoactive substance-related)

and non-psychoactive drug effects.

G2. A presumed relationship between the development (or marked exacerbation) of the underlying disease, damage or dysfunction, and the mental disorder, the symptoms of which may have immediate onset or may be delayed.

G3. Recovery or significant improvement of the mental disorder following removal or improvement of the underlying presumed cause.

G4. Absence of sufficient or suggestive evidence for an alternative causation of the mental disorder, e.g. a highly loaded family history for a clinically similar or related disorder.

If criteria G1, G2, and G4 are met, a provisional diagnosis is justified; if, in addition, there is evidence of G3, the diagnosis can be regarded as certain.

FO6.0 Organic hallucinosis

A. The general criteria for F06 must be met.

B. The clinical picture is dominated by persistent or recurrent hallucinations (usually visual or auditory).

C. Occurrence of hallucinations in clear consciousness.

Comments: Delusional elaboration of the hallucinations, as well as full or partial insight, may or may not be present: these features are not essential for the diagnosis.

FO6.1 Organic catatonic disorder

A. The general criteria for F06 must be met.

B. One of the following must be present:

(1) Stupor i.e. profound diminution or absence of voluntary movements and speech, and of normal responsiveness to light, noise and touch, but in the presence of maintenance of normal muscle tone, static posture and breathing (with often limited coordinated eye movements).

(2) Negativism (positive resistance to passive movement of limbs or body or rigid posturing).

C. Catatonic excitement (gross hypermotility of a chaotic quality with or without a tendency to assaultiveness).

D. Rapid and unpredictable alternation of stupor and excitement.

Comments: The confidence in the diagnosis will be increased if additional catatonic phenomena are present, e.g. stereotypies, waxy flexibility, and impulsive acts. Care should be taken to exclude delirium; however, it is not known at present whether an organic catatonic state always occurs in clear consciousness, or it represents an atypical manifestation of a delirium in which criteria A, B and D are only marginally met while criterion C is prominent.

F06.2 Organic delusional [schizophrenia-like] disorder

A. The general criteria for F06 must be met.

B. The clinical picture is dominated by delusions (of persecution, bodily change, disease, death, jealousy) which may exhibit varying degree of systematization.

C. Consciousness is clear and memory is intact.

Comments: Further features which complete the clinical picture but are not invariably present include: hallucinations (in any modality); schizophrenic-type thought disorder; isolated catatonic phenomena such as stereotypies, negativism, or impulsive acts.

The clinical picture may meet the symptomatic criteria for schizophrenia (F20.0 - F20.3), persistent delusional disorder (F22), or acute and transient psychotic disorders (F23). However, if the state also meets the general criteria for a presumptive organic aetiology laid down in the introduction to F06, it should be classified here. It should be noted that marginal or non-specific findings such as enlarged cerebral ventricles or "soft" neurological signs do not qualify as evidence for criterion G1 in the introduction.

FO6.3 Organic mood [affective] disorder

A. The general criteria for F06 must be met.

B. The condition must meet the criteria for one of the affective disorders, laid down in F30-F32.

The diagnosis of the affective disorder may be specified by using a fifth character:

F06.30 Organic manic disorder
F06.31 Organic bipolar disorder
F06.32 Organic depressive disorder
F06.33 Organic mixed affective disorder

FO6.4 Organic anxiety disorder

A. The general criteria for F06 must be met.

B. The condition must meet the criteria for either F41.0 or F41.1.

F06.5 Organic dissociative disorder

A. The general criteria for F06 must be met.

B. The condition must meet the criteria for one of the subcategories F44.0-F44.8.

FO6.6 Organic emotionally labile [asthenic] disorder

A. The general criteria for F06 must be met.

B. The clinical picture is dominated by emotional lability (uncontrolled, unstable, and fluctuating expression of emotions).

C. There is a variety of unpleasant physical sensations such as dizziness or pains and aches.

Comments: Fatiguability and listlessness (asthenia) are often present but are not essential for the diagnosis.

F06.7 Mild cognitive disorder

Note: The status of this construct is being examined. Specific research criteria must be viewed as tentative. A main reason for its inclusion is to obtain further evidence allowing its differentiation from disorders such as dementia (F00), delirium (F05), amnesic disorders (F04) and several disorders in F07.

A. The general criteria for F06 must be met.

B. The presence of a disorder in cognitive function for most of the time for at least two weeks, as reported by the individual or a reliable informant. The disorder is exemplified by difficulties in any of the following areas:

(1) New learning

(2) Memory (e.g. recall)

(3) Concentration

(4) Thinking (e.g. slowing)

(5) Language (e.g. comprehension, word finding, etc.)

C. Abnormality or decline in performance on neuropsychological tests (or quantified cognitive assessments).

D. None of B (1)-(5) are such that a diagnosis can be made of dementia (F00-F03), amnesic disorders (F04), delirium (F05), postencephalitic syndrome (F07.1), postconcussional syndrome (F07.2), or other persisting cognitive impairment due to psychoactive substance use (F1x.74).

Comments: If general criterion G1 is met because of the presence of CNS dysfunction, it is usually presumed that this is the cause of the mild cognitive disorder. If criterion G1 is met because of the presence of a systemic physical disorder, it is often unjustified to assume that there is a direct causative relationship. Nevertheless, it may be useful in such instances to record the presence of the systemic physical disorder as "associated" without implying a necessary causation. An additional 5th character may be used for this:

F06.70 not associated with a systemic physical disorder
F06.71 associated with a systemic physical disorder.

The systemic physical disorder should be recorded separately by its proper ICD-10 code.

F06.8 Other specified mental disorders due to brain damage and dysfunction and to physical disease

Examples are transient or mild abnormal mood states not meeting the criteria for organic mood disorder (F06.3), occurring during treatment with steroids or antidepressants.

F06.9 Unspecified mental disorder due to brain damage and dysfunction and to physical disease

FO7 PERSONALITY AND BEHAVIOURAL DISORDERS DUE TO BRAIN DISEASE, DAMAGE AND DYSFUNCTION

G1. Objective evidence (from physical and neurological examination and laboratory tests) and/or history, of cerebral disease, damage, or dysfunction.

G2. Absence of clouding of consciousness and of significant memory deficit.

G3. Absence of sufficient or suggestive evidence for an alternative causation of the personality or behaviour disorder that would justify its placement in section F6.

FO7.0 Organic personality disorder

A. The general criteria for F07 must be met.

B. At least three of the following features must be present over a period of six or more months:

(1) Consistently reduced ability to persevere with goal-directed activities, especially ones involving longer periods of time and postponed gratification.

(2) One or more of the following emotional changes: (a) emotional lability (uncontrolled, unstable, and fluctuating expression of emotions); (b) euphoria and shallow, inappropriate jocularity, unwarranted by the circumstances; (c) irritability and/or outbursts of anger and aggression; (d) apathy.

(3) Disinhibited expression of needs or impulses without consideration of consequences or of social conventions (the subject may engage in antisocial acts such as stealing, inappropriate sexual advances, ravenous eating, or exhibit extreme disregard for personal hygiene).

(4) Cognitive disturbances, typically in the form of: (a) excessive suspiciousness and paranoid ideas; (b) excessive preoccupation with a single theme such as religion, or rigid categorization of other people's behaviour in terms of "right" and "wrong".

(5) Marked alteration of the rate and flow of language production, with features such as circumstantiality, over-inclusiveness, viscosity, and hypergraphia.

(6) Altered sexual behaviour (hyposexuality or change in sexual preference).

Specification of features for possible subtypes

Option 1: A marked predominance of (1) and (2d) is thought to define a pseudoretarded or apathetic type; a predominance of (1), (2c) and (3) a pseudopsychopathic type; and the combination of (4), (5) and (6) is regarded as characteristic of the limbic epilepsy personality syndrome. None of these entities has yet been sufficiently validated to warrant a separate description.

Option 2: If desired, the following types may be specified: labile type, disinhibited type, aggressive type, apathetic type, paranoid type, mixed or other.

FO7.1 Postencephalitic syndrome

A. The general criteria for F07 must be met.

B. Residual neurological signs; manifest in at least one of the following:

(1) paralysis;

(2) deafness;

(3) aphasia;

(4) constructional apraxia;

(5) acalculia.

C. The syndrome is reversible, and its duration rarely exceeds 24 months.

Comments: Criterion C constitutes the main differentiating feature from organic personality disorder (FO7.0).

Residual symptoms and behavioural change following either viral or bacterial encephalitis are non-specific and do not provide a sufficient basis for a clinical diagnosis. They may include: general malaise, apathy or irritability; some lowering of cognitive functioning (learning difficulties); disturbances in the sleep-wake pattern; or altered sexual behaviour.

FO7.2 Postconcussional syndrome

Note: The nosological status of this syndrome is uncertain, and criterion A of the introduction to this rubric is not always ascertainable. However, for those undertaking research into this condition, the following criteria are recommended:

A. The general criteria of F07 must be met.

B. History of head trauma with loss of consciousness, preceding the onset of symptoms by a period of up to four weeks (objective EEG, brain imaging, or oculonystagmographic evidence for brain damage may be lacking).

C. At least three of the following:

(1) Complaints of unpleasant sensations and pains, such as headache, dizziness (usually lacking the features of true vertigo), general malaise and excessive fatigue. or noise intolerance.

(2) Emotional changes, such as irritability, emotional lability, both easily provoked or exacerbated by emotional excitement or stress, or some degree of depression and/or anxiety.

(3) Subjective complaints of difficulty in concentration and in performing mental tasks, and

of memory complaints, without clear objective evidence (e.g. psychological tests) of marked impairment.

(4) Insomnia.

(5) Reduced tolerance to alcohol.

(6) Preoccupation with the above symptoms and fear of permanent brain damage, to the extent of hypochondriacal over-valued ideas and adoption of a sick role.

F07.8 Other organic personality and behavioural disorders due to brain disease, damage and dysfunction

Brain disease, damage, or dysfunction may produce a variety of cognitive, emotional, personality, and behavioural disorders, some of which may not be classifiable under the preceding rubric. However, since the nosological status of the tentative syndromes in this area is uncertain, they should be coded as "other". A fifth character may be added, if necessary, to identify presumptive individual entities.

F07.9 Unspecified organic personality and behavioural disorder, due to brain disease, damage and dysfunction

F09 UNSPECIFIED ORGANIC OR SYMPTOMATIC MENTAL DISORDER

F10 - F19 MENTAL AND BEHAVIOURAL DISORDERS DUE TO PSYCHOACTIVE SUBSTANCE USE

F10.- DISORDERS DUE TO USE OF ALCOHOL

F11.- DISORDERS DUE TO USE OF OPIOIDS

F12.- DISORDERS DUE TO USE OF CANNABINOIDS

F13.- DISORDERS DUE TO USE OF SEDATIVES OR HYPNOTICS

F14.- DISORDERS DUE TO USE OF COCAINE

F15.- DISORDERS DUE TO USE OF OTHER STIMULANTS, INCLUDING CAFFEINE

F16.- DISORDERS DUE TO USE OF HALLUCINOGENS

F17.- DISORDERS DUE TO USE OF TOBACCO

F18.- DISORDERS DUE TO USE OF VOLATILE SOLVENTS

F19.- DISORDERS DUE TO MULTIPLE DRUG USE AND USE OF OTHER PSYCHOACTIVE SUBSTANCES

F1x.0 Acute intoxication

G1. Clear evidence of recent use of a psychoactive substance (or substances) at sufficiently high dose levels to be consistent with intoxication.

G2. Symptoms or signs of intoxication compatible with the known actions of the particular substance (or substances), as specified below, and of sufficient severity to produce disturbances in the level of consciousness, cognition, perception, affect or behaviour which are of clinical importance.

G3. Not accounted for by a medical disorder unrelated to substance use, and not better accounted for by another mental or behavioural disorder.

Acute intoxication frequently occurs in persons who have more persistent alcohol- or drug-related problems in addition. Where there are such problems, e.g. harmful use (F1x.1), dependence syndrome (F1x.2), or psychotic disorder (F1x.5), they should also be recorded too.

The following fifth character codes may be used to indicate whether the acute intoxication was associated with any complications:

F1x.00 Uncomplicated

Symptoms of varying severity, usually dose-dependent.

F1x.01 With trauma or other bodily injury.

F1x.02 With other medical complications.

Examples are haematemesis, inhalation of vomit.

F1x.03 With delirium.

F1x.04 With perceptual distortions.

F1x.05 With coma.

F1x.06 With convulsions.

F1x.07 Pathological intoxication (applies only to alcohol).

F10.0 Acute alcohol intoxication

A. The general criteria for acute intoxication (F1x.0) are met.

B. Dysfunctional behaviour, as evidenced by at least one of the following:

(1) disinhibition;
(2) argumentativeness;
(3) aggression;
(4) lability of mood;
(5) impaired attention;
(6) impaired judgement;
(7) interference with personal functioning.

C. At least one of the following signs:

(1) unsteady gait;
(2) difficulty standing;
(3) slurred speech;
(4) nystagmus;
(5) decreased level of consciousness (e.g. stupor, coma);
(6) flushed face,
(7) conjunctival injection.

Comment: Acute alcohol intoxication when severe may be accompanied by hypotension, hypothermia, and depression of the gag reflex.

If desired, the blood alcohol level may be specified by using codes Y90.0 - Y90.8. Code Y91 may be used to specify the clinical severity of intoxication, where the blood alcohol level is not available.

F10.07 Pathological alcohol intoxication

Note: The status of this condition is being examined. These research criteria must be regarded as tentative.

A. The general criteria for acute intoxication (F1x.0) are met, with the exception that pathological intoxication occurs after drinking amounts of alcohol not sufficient to cause intoxication in most people.

B. Verbally aggressive or physically violent behaviour that is not typical of the person when sober.

C. Occurs very soon (usually a few minutes) after consumption of alcohol.

D. No evidence of organic cerebral disorder or other mental disorders.

Comment: This is an uncommon condition. If blood alcohol levels are available, the levels found in this disorder are lower than those which would cause acute intoxication in most people, i.e. below 40mg/100ml.

F11.0 Acute opioid intoxication

A. The general criteria for acute intoxication (F1x.0) are met.

B. Dysfunctional behaviour as evidenced by at least one of the following:

(1) apathy and sedation;
(2) disinhibition;
(3) psychomotor retardation;
(4) impaired attention;
(5) impaired judgement;
(6) interference with personal functioning.

C. At least one of the following signs:

(1) drowsiness;
(2) slurred speech;
(3) pupillary constriction (except in anoxia from severe overdose when pupillary dilatation occurs)
(4) decreased level of consciousness (e.g. stupor, coma);

Comment: Acute opioid intoxication when severe may be accompanied by respiratory depression (and hypoxia), hypotension and hypothermia.

F12.0 Acute cannabis intoxication

A. The general criteria for acute intoxication (F1x.0) are met.

B. Dysfunctional behaviour or perceptual disturbances which include at least one of the following:

(1) euphoria and disinhibition;
(2) anxiety or agitation;
(3) suspiciousness or paranoid ideation;
(4) temporal slowing (a sense that time is passing very slowly, and/or the person is experiencing a rapid flow of ideas);
(5) impaired judgement;
(6) impaired attention;
(7) impaired reaction time;
(8) auditory, visual or tactile illusions;
(9) hallucinations with preserved orientation;
(10) depersonalisation;
(11) derealization;
(12) interference with personal functioning.

C. At least one of the following signs:

(1) increased appetite;
(2) dry mouth;
(3) conjunctival injection;
(4) tachycardia.

F13.0 Acute intoxication from sedative-hypnotic drugs

A. The general criteria for acute intoxication (F1x.0) are met.

B. Dysfunctional behaviour, as evidenced by at least one of the following:

(1) euphoria and disinhibition;
(2) apathy and sedation;
(3) abusiveness or aggression;
(4) lability of mood;
(5) impaired attention;
(6) anterograde amnesia;
(7) impaired psychomotor performance;
(8) interference with personal functioning.

C. At least one of the following signs:

(1) unsteady gait;
(2) difficulty standing;
(3) slurred speech;
(4) nystagmus;
(5) decreased level of consciousness (e.g. stupor, coma);
(6) erythematous skin lesion or blisters.

Comment: Acute intoxication from sedative-hypnotic drugs when severe may be accompanied by hypotension, hypothermia, and depression of the gag reflex.

F14.0 Acute cocaine intoxication

A. The general criteria for acute intoxication (F1x.0) are met.

B. Dysfunctional behaviour or perceptual abnormalities, as evidenced by at least one of the following:

(1) euphoria and sensation of increased energy;
(2) hypervigilance;
(3) grandiose beliefs or actions;
(4) abusiveness or aggression;
(5) argumentativeness;
(6) lability of mood;
(7) repetitive stereotyped behaviours;
(8) auditory, visual or tactile illusions;
(9) hallucinations usually with intact orientation;
(10) paranoid ideation;
(11) interference with personal functioning.

C. At least two of the following signs:

(1) tachycardia (sometimes bradycardia);
(2) cardiac arrhythmias;
(3) hypertension (sometimes hypotension);
(4) sweating and chills;
(5) nausea or vomiting;
(6) evidence of weight loss;
(7) pupillary dilatation;
(8) psychomotor agitation (sometimes retardation);
(9) muscular weakness;

(10 chest pain;
(11) convulsions.

Comment: Interference with personal functioning is most readily apparent from the social interactions of the users, which range from extreme gregariousness to social withdrawal.

F15.0 Acute intoxication from stimulants other than cocaine

A. The general criteria for acute intoxication (F1x.0) are met.

B. Dysfunctional behaviour or perceptual abnormalities, as evidenced by at least one of the following:

(1) euphoria and sensation of increased energy;
(2) hypervigilance;
(3) grandiose beliefs or actions;
(4) abusiveness or aggression;
(5) argumentativeness;
(6) lability of mood;
(7) repetitive stereotyped behaviours;
(8) auditory, visual or tactile illusions;
(9) hallucinations usually with intact orientation;
(10) paranoid ideation;
(11) interference with personal functioning.

C. At least two of the following signs:

(1) tachycardia (sometimes bradycardia);
(2) cardiac arrhythmias;
(3) hypertension (sometimes hypotension);
(4) sweating and chills;
(5) nausea or vomiting;
(6) evidence of weight loss;
(7) pupillary dilatation;
(8) psychomotor agitation (sometimes retardation);
(9) muscular weakness;
(10 chest pain;
(11) convulsions.

Comment: Interference with personal functioning is most readily apparent from the social interactions of the users, which range from extreme gregariousness to social withdrawal.

F16.0 Acute hallucinogen intoxication

A. The general criteria for acute intoxication (F1x.0) are met.

B. Dysfunctional behaviour or perceptual abnormalities, as evidenced by at least one of the following:

(1) anxiety and fearfulness;
(2) auditory, visual or tactile illusions or hallucinations occurring in a state of full wakefulness and alertness;
(3) depersonalisation;
(4) derealisation;
(5) paranoid ideation;
(6) ideas of reference;
(7) lability of mood;
(8) hyperactivity;
(9) impulsive acts;
(10) impaired attention;
(11) interference with personal functioning.

C. At least two of the following signs:

(1) tachycardia;
(2) palpitations;
(3) sweating and chills;
(4) tremor;
(5) blurring of vision;
(6) pupillary dilatation;
(7) incoordination.

F17.0 Acute nicotine intoxication

A. The general criteria for acute intoxication (F1x.0) are met.

B. Dysfunctional behaviour or perceptual abnormalities, as evidenced by at least one of the following:

(1) insomnia;
(2) bizarre dreams;
(3) lability of mood;
(4) derealisation;
(5) interference with personal functioning.

C. At least one of the following signs:

(1) nausea or vomiting;
(2) sweating;
(3) tachycardia;
(4) cardiac arrhythmias.

F18.0 Acute intoxication from volatile solvents

A. The general criteria for acute intoxication (F1x.0) are met.

B. Behavioural changes which include at least one of the following:

(1) apathy and lethargy;
(2) argumentativeness;
(3) abusiveness or aggression;
(4) lability of mood;
(5) impaired judgement;
(6) impaired attention and memory;
(7) psychomotor retardation;
(8) interference with personal functioning.

C. At least one of the following signs:

(1) unsteady gait;
(2) difficulty standing;
(3) slurred speech;
(4) nystagmus;
(5) decreased level of consciousness (e.g. stupor, coma);
(6) muscle weakness;
(7) blurred vision or diplopia.

Comment: Acute intoxication from inhalants other than solvents should also be coded here.

Acute intoxication from volatile solvents when severe may be accompanied by hypotension, hypothermia, and depression of the gag reflex.

F19.0 Acute intoxication due to multiple drug use and use of other psychoactive substances

This category should be used when there is evidence of intoxication caused by recent use of other psychoactive substances (e.g. phencyclidine) or of multiple psychoactive substances where it is uncertain which substance has predominated.

F1x.1 Harmful use

A. Clear evidence that the substance use was responsible for (or substantially contributed to) physical or psychological harm, including impaired judgement or dysfunctional behaviour.

B. The nature of the harm should be clearly identifiable (and specified).

C. The pattern of use has persisted for at least one month or has occurred repeatedly within a twelve-month period.

D. The disorder does not meet the criteria for any other mental or behavioural disorder related to the same drug in the same time period (except for acute intoxication F1x.0).

F1x.2 Dependence syndrome

A. Three or more of the following manifestations should have occurred together for at least one month or if persisting for periods of less than one month then they have occurred together repeatedly within a twelve-month period.

(1) A strong desire or sense of compulsion to take the substance.

(2) Impaired capacity to control substance-taking behaviour in terms of onset, termination or level of use, as evidenced by: the substance being often taken in larger amounts or over a longer period than intended, or any unsuccessful effort or persistent desire to cut down or control substance use.

(3) A physiological withdrawal state (see F1x.3 and F1x.4) when substance use is reduced or ceased, as evidenced by the characteristic withdrawal syndrome for the substance, or use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms.

(4) Evidence of tolerance to the effects of the substance, such that there is a need for markedly increased amounts of the substance to achieve intoxication or desired effect, or that there is a markedly diminished effect with continued use of the same amount of the substance.

(5) Preoccupation with substance use, as manifested by: important alternative pleasures or interests being given up or reduced because of substance use; or a great deal of time being spent in activities necessary to obtain the substance, take the substance, or recover from its effects.

(6) Persisting with substance use despite clear evidence of harmful consequences, (see

F1x.1), as evidenced by continued use when the person was actually aware of, or could be expected to have been aware of the nature and extent of harm.

The diagnosis of the dependence syndrome may be further specified by the following five character codes:

F1x.20 Currently abstinent

F1x.200 early remission

F1x.201 partial remission

F1x.202 full remission

F1x.21 Currently abstinent but in a protected environment (e.g. in hospital, in a therapeutic community, in prison, etc.)

F1x.22 Currently on a clinically supervised maintenance or replacement regime [controlled dependence]

Flx.23 Currently abstinent, but receiving treatment with aversive or blocking drugs (e.g. naltrexone or disulfiram)

Flx.24 Currently using the substance [active dependence]

F1x.240 without physical features

F1x.241 with physical features

The course of the dependence may be further specified, if desired, as follows:

Flx.25 Continuous use

F1x.26 Episodic use [dipsomania]

F1x.3 Withdrawal state

G1. Clear evidence of recent cessation or reduction of substance use after repeated, and usually prolonged and/or high-dose use of that substance.

G2. Symptoms and signs compatible with the known features of a withdrawal state from the particular substance or substances (see below).

G3. Not accounted for by a medical disorder unrelated to substance use, and not better accounted for by another mental or behavioural disorder.

The diagnosis of withdrawal state may be further specified by using the following fifth character codes:

F1x.30 Uncomplicated

F1x.31 With convulsions

F10.3 Alcohol withdrawal state

A. The general criteria for withdrawal state (F1x.3) are met.

B. Any three of the following:

(1) tremor of the outstretched hands, tongue or eyelids;
(2) sweating;
(3) nausea, retching or vomiting;
(4) tachycardia or hypertension;
(5) psychomotor agitation;
(6) headache;
(7) insomnia;
(8) malaise or weakness;
(9) transient visual, tactile or auditory hallucinations or illusions;
(10) grand mal convulsions.

Comment: If delirium is present, the diagnosis of alcohol withdrawal state with delirium ("delirium tremens") (F10.4) should be made.

F11.3 Opioid withdrawal state

A. The general criteria for withdrawal state (F1x.3) are met. (Note that an opioid withdrawal state may also be induced by administration of an opioid antagonist after a brief period of opioid use.)

B. Any three of the following:

(1) craving for an opioid drug;
(2) rhinorrhoea or sneezing;
(3) lacrimation;
(4) muscle aches or cramps;
(5) abdominal cramps;
(6) nausea or vomiting;
(7) diarrhoea;
(8) pupillary dilatation;
(9) piloerection, or recurrent chills;
(10) tachycardia or hypertension;
(11) yawning;
(12) restless sleep.

F12.3 Cannabis withdrawal state

Note: This is an ill-defined syndrome for which definitive diagnostic criteria cannot be established at the present time. It occurs following cessation of prolonged high-dose use of cannabis. It has been reported variously as lasting from several hours to up to seven days.

Symptoms and signs include anxiety, irritability, tremor of the outstretched hands, sweating, and muscle aches.

F13.3 Sedative-hypnotic withdrawal state

A. The general criteria for withdrawal state (F1x.3) are met.

B. Any three of the following:

(1) tremor of the outstretched hands, tongue or eyelids;
(2) nausea or vomiting;
(3) tachycardia;
(4) postural hypotension;
(5) psychomotor agitation;
(6) headache;
(7) insomnia;
(8) malaise or weakness;
(9) transient visual, tactile or auditory hallucinations or illusions;
(10) paranoid ideation;
(11) grand mal convulsions.

If delirium is present, the diagnosis of sedative-hypnotic withdrawal state with delirium (F13.4) should be made.

F14.3 Cocaine withdrawal state

A. The general criteria for withdrawal state (F1x.3) are met.

B. Dysphoric mood (for instance sadness or anhedonia).

C. Any two of the following symptoms and signs:

(1) lethargy and fatigue;
(2) psychomotor retardation or agitation;
(3) craving for cocaine;
(4) increased appetite;

(5) insomnia or hypersomnia;

(6) bizarre or unpleasant dreams.

F15.3 Withdrawal state from stimulants other than cocaine

A. The general criteria for withdrawal state (F1x.3) are met.

B. Dysphoric mood (for instance sadness or anhedonia).

C. Any two of the following symptoms and signs:

(1) lethargy and fatigue;

(2) psychomotor retardation or agitation;

(3) craving for stimulant drugs;

(4) increased appetite;

(5) insomnia or hypersomnia;

(6) bizarre or unpleasant dreams.

F17.3 Nicotine withdrawal state

A. The general criteria for withdrawal state (F1x.3) are met.

B. Any two of the following symptoms and signs:

(1) craving for tobacco (or other nicotine-containing products);

(2) malaise or weakness;

(3) anxiety;

(4) dysphoric mood;

(5) irritability or restlessness;

(6) insomnia;

(7) increased appetite;

(8) increased cough;

(9) mouth ulceration;

(10) difficulty concentrating.

F1x.4 Withdrawal state with delirium

A. The general criteria for withdrawal state (F1x.3) are met.

B. The criteria for delirium (F05) are met.

The diagnosis of withdrawal state with delirium may be further specified by using the following fifth character codes:

F1x.40 Without convulsions
F1x.41 With convulsions

F1x.5 Psychotic disorder

A. Onset of psychotic symptoms during or within two weeks of substance use.

B. Persistence of the psychotic symptoms for more than 48 hours.

C. Duration of the disorder not exceeding six months.

The diagnosis of psychotic disorder may be further specified by using the following fifth character codes:

F1x.50 Schizophrenia-like
F1x.51 Predominantly delusional
F1x.52 Predominantly hallucinatory
Flx.53 Predominantly polymorphic
F1x.54 Predominantly depressive psychotic symptoms
F1x.55 Predominantly manic psychotic symptoms
F1x.56 Mixed

For research purposes it is recommended to further specify the onset of the disorder from a non-psychotic to a clearly psychotic state as either:

abrupt (onset within 48 hours) or
acute (onset in more than 48 hours but less than two weeks).

F1x.6 Amnesic syndrome

A. Memory impairment manifest in both:

(1) a defect of recent memory (impaired learning of new material) to a degree sufficient to interfere with daily living; and

(2) a reduced ability to recall past experiences.

B. Absence (or relative absence) of all the following:

(1) a defect in immediate recall (as tested, for example, by the digit span);

(2) clouding of consciousness and disturbance of attention, as defined in F05, criterion A;

(3) global intellectual decline (dementia).

C. No objective evidence on physical and neurological examination, laboratory tests or history of a disorder or disease of the brain (especially involving bilaterally the diencephalic and medial temporal structures) other than that related to substance use, that can reasonably be presumed to be responsible for the clinical manifestations described under A.

F1x.7 Residual disorders and late-onset psychotic disorder

A. Conditions and disorders meeting the criteria for the individual syndromes listed below should be clearly related to substance use. Where onset of the condition or disorder occurs subsequent to use of psychoactive substances strong evidence should be provided to demonstrate a link.

Comments: In view of the considerable variation in this category, the characteristics of such residual states or conditions should be clearly documented in terms of their type, severity and duration. For research purposes full descriptive details should be specified.

A fifth character may be used, if required, as follows:

F1x.70 Flashbacks

F1x.71 Personality or behaviour disorder

B. The general criteria for F07 (Personality and behaviour disorder due to brain disease, damage, and dysfunction), must be met.

F1x.72 Residual affective disorder

B. The criteria for F06.3 Organic affective disorder must be met.

F1x.73 Dementia

B. The general criteria for dementia must be met (F0).

F1x.74 Other persisting cognitive impairment

B. The criteria for F06.7 Mild cognitive disorder must be met, except for the exclusion of psychoactive substance use in criterion D.

F1x.75 Late-onset psychotic disorder

B. The general criteria of F1x.5 must be met, except with regard to the onset of the disorder which is more than two weeks but not more than six weeks after substance use.

Flx.8 Other mental and behavioural disorders

F1x.9 Unspecified mental and behavioural disorder

F20 - F29 SCHIZOPHRENIA, SCHIZOTYPAL AND DELUSIONAL DISORDERS

F20 SCHIZOPHRENIA

This overall category includes the common varieties of schizophrenia, together with some less common varieties and closely related disorders.

F20.0 - F20.3

General criteria for Paranoid, Hebephrenic, Catatonic and Undifferentiated type of Schizophrenia:

G1. Either at least one of the syndromes, symptoms and signs listed below under (1), or at least two of the symptoms and signs listed under (2), should be present for most of the time during an episode of psychotic illness lasting for at least one month (or at some time during most of the days).

(1) At least one of the following:

a) Thought echo, thought insertion or withdrawal, or thought broadcasting.

b) Delusions of control, influence or passivity, clearly referred to body or limb movements or specific thoughts, actions, or sensations; delusional perception.

c) Hallucinatory voices giving a running commentary on the patient's behaviour, or discussing him between themselves, or other types of hallucinatory voices coming from some part of the body.

d) Persistent delusions of other kinds that are culturally inappropriate and completely impossible (e.g. being able to control the weather, or being in communication with aliens from another world).

(2) or at least two of the following:

e) Persistent hallucinations in any modality, when occurring every day for at least one month, when accompanied by delusions (which may be fleeting or half-formed) without clear affective content, or when accompanied by persistent over-valued ideas.

f) Neologisms, breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech.

g) Catatonic behaviour, such as excitement, posturing or waxy flexibility, negativism, mutism and stupor.

h) "Negative" symptoms such as marked apathy, paucity of speech, and blunting or incongruity of emotional responses (it must be clear that these are not due to depression or to neuroleptic medication).

G2. Most commonly used exclusion criteria: If the patient also meets criteria for manic episode (F30) or depressive episode (F32), the criteria listed under G1.1 and G1.2 above must have been met before the disturbance of mood developed.

G3. The disorder is not attributable to organic brain disease (in the sense of F0), or to alcohol- or drug-related intoxication, dependence or withdrawal.

Comments: In evaluating the presence of the these abnormal subjective experiences and behaviour, special care should be taken to avoid false-positive assessments, especially where culturally or sub-culturally influenced modes of expression and behaviour, or a subnormal level of intelligence, are involved.

In view of the considerable variation of the course of schizophrenic disorders it may be desirable (especially for research) to specify the pattern of course by using a fifth character. Course should not usually be coded unless there has been a period of observation of at least one year (For remission, see note X in Introduction).

Pattern of course

F20.x0 Continuous (no remission of psychotic symptoms throughout the period of observation);
F20.x1 Episodic, with a progressive development of 'negative' symptoms in the intervals between psychotic episodes;
F20.x2 Episodic, with persistent but non-progressive 'negative' symptoms in the intervals between psychotic episodes;
F20.x3 Episodic (remittent) with complete or virtually complete remissions between psychotic episodes;
F20.x4 Incomplete remission;
F20.x5 Complete or virtually complete remission;
F20.x8 Other pattern of course.
F20.x9 Course uncertain, period of observation too short.

F20.0 Paranoid schizophrenia

A. The general criteria for Schizophrenia (F20.0 - F20.3 above) must be met.

B. Delusions or hallucinations must be prominent (such as delusions of persecution, reference, exalted birth, special mission, bodily change or jealousy; threatening or commanding voices, hallucinations of smell or taste, sexual or other bodily sensations).

C. Flattening or incongruity of affect, catatonic symptoms, or incoherent speech must not dominate the clinical picture, although they may be present to a mild degree.

F20.1 Hebephrenic schizophrenia

A. The general criteria for Schizophrenia (F20.0 - F20.3) above must be met.

B. Either (1) or (2):

(1) Definite and sustained flattening or shallowness of affect;

(2) Definite and sustained incongruity or inappropriateness of affect.

C. Either (1) or (2):

(1) Behaviour which is aimless and disjointed rather than goal-directed;

(2) Definite thought disorder, manifesting as speech which is disjointed, rambling or incoherent.

D. Hallucinations or delusions must not dominate the clinical picture, although they may be present to a mild degree.

F20.2 Catatonic schizophrenia

A. The general criteria for Schizophrenia (F20.0 - F20.3 above) must eventually be met, though this may not be possible initially if the patient is uncommunicative.

B. For a period of at least two weeks one or more of the following catatonic behaviours must be prominent:

(1) Stupor (marked decrease in reactivity to the environment and reduction of spontaneous movements and activity) or mutism;

(2) Excitement (apparently purposeless motor activity, not influenced by external stimuli);

(3) Posturing (voluntary assumption and maintenance of inappropriate or bizarre postures);

(4) Negativism (an apparently motiveless resistance to all instructions or attempts to be moved, or movement in the opposite direction);

(5) Rigidity (maintenance of a rigid posture against efforts to be moved);

(6) Waxy flexibility (maintenance of limbs and body in externally imposed positions);

(7) Command automatism (automatic compliance with instructions).

C. Other possible precipitants of catatonic behaviour, including brain disease and metabolic disturbances, have been excluded.

F20.3 Undifferentiated schizophrenia

A. The general criteria for Schizophrenia (F20.0 - F20.3) above must be met.

B. Either (1) or (2):

(1) There are insufficient symptoms to meet the criteria of any of the sub-types F20.0, .1, .4, or .5;

(2) There are so many symptoms that the criteria for more than one of the subtypes listed in B(1) above are met.

F20.4 Post-schizophrenic depression

A. The general criteria for schizophrenia (F20.0 - F20.3 above) must have been met within the past twelve months, but are not met at the present time.

B. One of F20 G1.2 e, f, g or h must still be present.

C. The depressive symptoms must be sufficiently prolonged, severe and extensive to meet criteria for at least a mild depressive episode (F32.0).

F20.5 Residual schizophrenia

A. The general criteria for Schizophrenia (F20.0 - F20.3 above) must have been met at some time in the past, but are not met at the present time.

B. At least four of the following 'negative' symptoms have been present throughout the previous twelve months:

(1) Psychomotor slowing or underactivity;

(2) Definite blunting of affect;

(3) Passivity and lack of initiative;

(4) Poverty of either the quantity or the content of speech;

(5) Poor non-verbal communication by facial expression, eye contact, voice modulation or posture;

(6) Poor social performance or self-care.

F20.6 Simple schizophrenia

A. Slowly progressive development over a period of at least one year, of all three of the following:

(1) A significant and consistent change in the overall quality of some aspects of personal behaviour, manifest as loss of drive and interests, aimlessness, idleness, a self-absorbed attitude, and social withdrawal.

(2) Gradual appearance and deepening of "negative" symptoms such as marked apathy, paucity of speech, under-activity, blunting of affect, passivity and lack of initiative, and poor non-verbal communication (by facial expression, eye contact, voice modulation and posture).

(3) Marked decline in social, scholastic, or occupational performance.

B. Absence, at any time, of any symptoms referred to in G1 in F20.0 - F20.3, and of hallucinations or well-formed delusions of any kind, i.e. the subject must never have met the criteria for any other type of schizophrenia, or any other psychotic disorder.

C. Absence of evidence of dementia or any other organic mental disorder listed in section F0.

F20.8 Other schizophrenia

F20.9 Schizophrenia, unspecified

F21 SCHIZOTYPAL DISORDER

A. The subject must have manifested, over a period of at least two years, at least four of the following, either continuously or repeatedly:

(1) Inappropriate or constricted affect, subject appears cold and aloof;

(2) Behaviour or appearance which is odd, eccentric or peculiar;

(3) Poor rapport with others and a tendency to social withdrawal;

(4) Odd beliefs or magical thinking influencing behaviour and inconsistent with subcultural norms;

(5) Suspiciousness or paranoid ideas;

(6) Ruminations without inner resistance, often with dysmorphophobic, sexual or aggressive contents;

(7) Unusual perceptual experiences including somatosensory (bodily) or other illusions, depersonalization or derealization;

(8) Vague, circumstantial, metaphorical, over-elaborate or often stereotyped thinking, manifested by odd speech or in other ways, without gross incoherence;

(9) Occasional transient quasi-psychotic episodes with intense illusions, auditory or other hallucinations and delusion-like ideas, usually occurring without external provocation.

B. The subject must never have met the criteria for any disorder in F20 (Schizophrenia).

F22 PERSISTENT DELUSIONAL DISORDERS

F22.0 Delusional disorder

A. The presence of a delusion or a set of related delusions other than those listed as typical schizophrenic under F20 G1.1b or d (i.e. other than completely impossible or culturally inappropriate). The commonest examples are persecutory, grandiose, hypochondriacal, jealous (zelotypic)) or erotic delusions.

B. The delusion(s) in A must be present for at least three months.

C. The general criteria for schizophrenia (F20.0 - F20.3) are not fulfilled.

D. Persistent hallucinations in any modality must not be present (but transitory or occasional auditory hallucinations that are not in the third person or giving a running commentary, may be present).

E. Depressive symptoms (or even a depressive episode (F32.-)) may be present intermittently, provided that the delusions persist at times when there is no disturbance of mood.

F. Most commonly used exclusion criteria: There must be no evidence of primary or secondary brain disease as listed under F0, or a psychotic disorder due to psychoactive substance use (F1x.5).

Specification for possible subtypes: The following types may be specified, if desired: persecutory type; litiginous type; self-referential type; grandiose type; hypochondriacal (somatic) type; jealous type; erotomanic type.

F22.8 Other persistent delusional disorders

This is a residual category for persistent delusional disorders that do not meet the criteria for delusional disorder (F22.0). Disorders in which delusions are accompanied by persistent hallucinatory voices or by schizophrenic symptoms that are insufficient to meet criteria for schizophrenia (F20.-) should be coded here. Delusional disorders that have lasted for less than three months should, however, be coded, at least temporarily, under F23.-.

F22.9 Persistent delusional disorder, unspecified

F23 ACUTE AND TRANSIENT PSYCHOTIC DISORDERS

G1. An acute onset of delusions, hallucinations, incomprehensible or incoherent speech, or any combination of these. The time interval between the first appearance of any psychotic symptoms and the presentation of the fully developed disorder should not exceed two weeks.

G2. If transient states of perplexity, misidentification, or impairment of attention and concentration are present, they do not fulfill the criteria for organically caused clouding of consciousness as specified in F05 A.

G3. The disorder does not meet the symptomatic criteria for manic episode (F30), depressive episode (F32), or recurrent depressive disorder (F33).

G4. No evidence of recent psychoactive substance use sufficient to fulfil the criteria of intoxication (F1x.0), harmful use, (F1x.1), dependence (F1x.2) or withdrawal states (F1x.3 and F1x.4). The continued moderate and largely unchanged use of alcohol or drugs in amounts or frequencies to which the subject is accustomed does not necessarily rule out the use of F23; this must be decided by clinical judgement and the requirements of the research project in question.

G5. Most commonly used exclusion criteria: absence of organic brain disease (F0) or serious metabolic disturbances affecting the central nervous system (this does not include childbirth).

A fifth character should be used to specify whether the acute onset of the disorder is associated with acute stress (occurring within two weeks prior to evidence of first psychotic symptoms).

F23.x0 without associated acute stress
F23.x1 with associated acute stress

For research purposes it is recommended to further specify the onset of the disorder from a non-psychotic to a clearly psychotic state as either:

abrupt (onset within 48 hours), or
acute (onset in more than 48 hours but less than two weeks).

F23.0 Acute polymorphic psychotic disorder without symptoms of schizophrenia

A. The general criteria for acute and transient psychotic disorders (F23) must be met.

B. The symptomatology is rapidly changing in both type and intensity from day to day or within the same day.

C. The presence of any type of either hallucinations or delusions, for at least several hours, at any time since the onset of the disorder.

D. Symptoms from at least two of the following categories, occurring at the same time:

(1) Emotional turmoil, characterized by intense feelings of happiness or ecstasy, or overwhelming anxiety or marked irritability;

(2) Perplexity, or misidentification of people or places;

(3) Increased or decreased motility, to a marked degree.

E. Any of the symptoms listed in Schizophrenia F20, G1.1 and G1.2 that are present, are only present for a minority of the time since the onset, i.e. criterion B of F23.1 is not fulfilled.

F. The total duration of the disorder does not exceed three months.

F23.1 Acute polymorphic psychotic disorder with symptoms of schizophrenia

A. Criteria A, B, C, and D of acute polymorphic psychotic disorder (F23.0) must be met.

B. Some of the symptoms specified for schizophrenia (F20.0 - F20.3) must have been present for the majority of the time since the onset of the disorder, but not necessarily meeting these criteria completely, i.e. at least any one of the symptoms in F20, G1.1a to G1.2g.

C. The symptoms of schizophrenia in B above do not persist for more than one month.

F23.2 Acute schizophrenia-like psychotic disorder

A. The general criteria for acute and transient psychotic disorders (F23) must be met.

B. The criteria for schizophrenia (F20.0 - F20.3) are met, with exception of the duration criterium.

C. The disorder does not meet the criteria B, C and D for acute polymorphic psychotic disorder (F23.0).

D. The total duration of the disorder does not exceed one month.

F23.3 Other acute predominantly delusional psychotic disorder

A. The general criteria for acute and transient psychotic disorders (F23) must be met.

B. Relatively stable delusions and/or hallucinations are present, but they do not fulfil the symptomatic criteria for schizophrenia (F20.0 - F20.3).

C. The disorder does not meet the criteria for acute polymorphic psychotic disorder (F23.0).

D. The total duration of the disorder does not exceed three months.

F23.8 Other acute and transient psychotic disorders

Any other acute psychotic disorders that are unclassifiable under any other category in F23 (such as acute psychotic states in which definite delusions or hallucinations occur but persist for only small proportions of the time) should be coded here. States of undifferentiated excitement should also be coded here if more detailed information about the patient's mental state is not available, provided that there is no evidence of an organic cause.

F23.9 Acute and transient psychotic disorder, unspecified

F24 INDUCED DELUSIONAL DISORDER

A. The subject must develop a delusion or delusional system originally held by someone else with a disorder classified in F20-F23.

B. The two people must have an unusually close relationship with one another, and be relatively isolated from other people.

C. The subject must not have held the belief in question prior to contact with the other person, and must not have suffered from any other disorder classified in F20-F23 in the past.

F25 SCHIZOAFFECTIVE DISORDERS

Note: This diagnosis depends upon an approximate "balance" between the number, severity and duration of the

schizophrenic and affective symptoms.

G1. The disorder meets the criteria of one of the affective disorders of moderate or severe degree, as specified for each sub-type.

G2. Symptoms from at least one of the symptom groups listed below, clearly present for most of the time during a period of at least two weeks (these groups are almost the same as for schizophrenia (F20.0 - F20.3)):

(1) Thought echo, thought insertion or withdrawal, thought broadcasting (F20 G1.1a)

(2) Delusions of control, influence or passivity, clearly referred to body or limb movements or specific thoughts, actions or sensations (F20 G1.1b)

(3) Hallucinatory voices giving a running commentary on the patient's behaviour, or discussing him between themselves; or other types of hallucinatory voices coming from some part of the body (F20 G1.1c)

(4) Persistent delusions of other kinds that are culturally inappropriate and completely impossible, but not merely grandiose or persecutory (F20 G1.1d), e.g. has visited other worlds; can control the clouds by breathing in and out; can communicate with plants or animals without speaking, etc.

(5) Grossly irrelevant or incoherent speech, or frequent use of neologisms (a marked form of F20 G1.2f)

(6) The intermittent but frequent appearance of some forms of catatonic behaviour, such as posturing, waxy flexibility and negativism (F20 G1.2g)

G3. Criteria G1 and G2 must be met within the same episode of the disorder, and concurrently for at least some time of the episode. Symptoms from both criteria G1 and G2 must be prominent in the clinical picture.

G4. Most commonly used exclusion criteria: the disorder is not attributable to organic brain disease (in the sense of F0), or to psychoactive substance-related intoxication, dependence or withdrawal (F1).

F25.0 Schizoaffective disorder, manic type

A. The general criteria for schizoaffective disorder (F25) must be met.

B. Criteria of a manic disorder must be met (F30.1 or F31.1).

F25.1 Schizoaffective disorder, depressive type

A. The general criteria schizoaffective disorder (F25) must be met.

B. The criteria for depressive disorder, at least moderate severity must be met (F32.1, F32.2, F31.3 or F31.4).

F25.2 Schizoaffective disorder, mixed type

A. The general criteria for schizoaffective disorder (F25) must be met.

B. The criteria for mixed bipolar affective disorder must be met (F31.6).

F25.8 Other schizoaffective disorders

F25.9 Schizoaffective disorder, unspecified

Comments: If desired, further subtypes of schizo-affective disorder may be specified, according to the longitudinal development of the disorder, as follows:

F25.x0 Concurrent affective and schizophrenic symptoms (as defined in G2 above) only.

F25.x1 Concurrent affective and schizophrenic symptoms, plus persistence of the schizophrenic symptoms beyond the duration of the affective symptoms.

F28 OTHER NONORGANIC PSYCHOTIC DISORDERS

Psychotic disorders that do not meet the criteria for schizophrenia (F20.-) or for psychotic types of mood [affective] disorders (F30-F39), and psychotic disorders that do not meet the symptomatic criteria for persistent delusional disorder (F22.-) should be coded here (such as persistent hallucinatory disorder). Include here also combinations of symptoms not covered by the previous categories of F20, such as delusions other than those listed as typical schizophrenic under F20 G1.1.b or d (i.e. other than completely impossible or culturally inappropriate) plus catatonia.

F29 UNSPECIFIED NONORGANIC PSYCHOSIS

F30 - F39 MOOD [AFFECTIVE] DISORDERS

F30 MANIC EPISODE

F30.0 Hypomania

A. The mood is elevated or irritable to a degree that is definitely abnormal for the individual concerned and sustained for at least four consecutive days.

B. At least three of the following must be present, leading to some interference with personal functioning in daily living:

(1) increased activity or physical restlessness;

(2) increased talkativeness;

(3) difficulty in concentration or distractibility;

(4) decreased need for sleep;

(5) increased sexual energy;

(6) mild spending sprees, or other types of reckless or irresponsible behaviour;

(7) increased sociability or over-familiarity.

C. The episode does not meet the criteria for mania (F30.1 and F30.2), bipolar affective disorder (F31.-), depressive episode (F32.-), cyclothymia (F34.0) or anorexia nervosa (F50.0).

D. Most commonly used exclusion criteria: the episode is not attributable to psychoactive substance use (F1) or any organic mental disorder, in the sense of F0.

F30.1 Mania without psychotic symptoms

A. A mood which is predominantly elevated, expansive or irritable and definitely abnormal for the individual concerned. This mood change must be prominent and sustained for at least a week (unless it is severe enough to require hospital admission).

B. At least three of the following must be present (four if the mood is merely irritable), leading to severe interference with personal functioning in daily living:

(1) Increased activity or physical restlessness;

(2) Increased talkativeness ('pressure of speech');

(3) Flight of ideas or the subjective experience of thoughts racing;

(4) Loss of normal social inhibitions resulting in behaviour which is inappropriate to the circumstances;

(5) Decreased need for sleep;

(6) Inflated self-esteem or grandiosity;

(7) Distractibility or constant changes in activity or plans;

(8) Behaviour which is foolhardy or reckless and whose risks the subject does not recognize e.g. spending sprees, foolish enterprises, reckless driving;

(9) Marked sexual energy or sexual indiscretions.

C. The absence of hallucinations or delusions, although perceptual disorders may occur (e.g. subjective hyperacusis, appreciation of colours as specially vivid, etc.).

D. Mot commonly used exclusion criteria: the episode is not attributable to psychoactive substance use (F1) or any organic mental disorder, in the sense of F0.

F30.2 Mania with psychotic symptoms

A. The episode meets the criteria for mania without psychotic symptoms (F30.1) with exception of criterion C.

B. The episode does not simultaneously meet the criteria for schizophrenia (F20) or schizo-affective disorder, manic type (F25.0).

C. Delusions or hallucinations are present, other than those listed as typical schizophrenic in F20 G1.1b, c and d (i.e. delusions other than those that are completely impossible or culturally inappropriate and hallucinations, that are not in the third person or giving a running commentary). The commonest examples are those with grandiose, self-referential, erotic or persecutory content.

D. Mot commonly used exclusion criteria: the episode is not attributable to psychoactive substance use (F1) or any organic mental disorder, in the sense of F0.

A fifth character may be used to specify whether the hallucinations or delusions are congruent or incongruent with the mood:

F30.20 mania with mood congruent psychotic symptoms (such as grandiose delusions or voices telling the subject that he has superhuman powers)

F30.21 mania with mood incongruent psychotic symptoms (such as voices speaking to the subject about affectively neutral topics, or delusions of reference or persecution).

F30.8 Other manic episodes

F30.9 Manic episode, unspecified

F31 BIPOLAR AFFECTIVE DISORDER

Note: Episodes are demarcated by a switch to an episode of opposite or mixed polarity or by a remission.

F31.0 Bipolar affective disorder, current episode hypomanic

A. The current episode meets the criteria for hypomania (F30.0).

B. There has been at least one other affective episode in the past, meeting the criteria for hypomanic or manic episode (F30.-), depressive episode (F32.-) or mixed affective episode (F38.00).

F31.1 Bipolar affective disorder, current episode manic without psychotic symptoms

A. The current episode meets the criteria for mania without psychotic symptoms (F30.1).

B. There has been at least one other affective episiode in the past, meeting the criteria for hypomanic or manic episode (F30.-), depressive episode (F32.-) or mixed affective episode (F38.00).

F31.2 Bipolar affective disorder, current episode manic with psychotic symptoms

A. The current episode meets the criteria for mania with psychotic symptoms (F30.2).

B. There has been at least one other affective episode in the past, meeting the criteria for hypomanic or manic episode (F30.-), depressive episode (F32.-) or mixed affective episode (F38.00).

A fifth character may be used to specify whether the psychotic symptoms are congruent or incongruent with the mood:

F31.20 with mood congruent psychotic symptoms

F31.21 with mood incongruent psychotic symptoms

F31.3 Bipolar affective disorder, current episode moderate or mild depression

A. The current episode meets the criteria for a depressive episode of either mild (F32.0) or moderate severity (F32.1).

B. There has been at least one other affective episode in the past, meeting the criteria for hypomanic or manic episode (F30.-), or mixed affective episode (F38.00).

A fifth character may be used to specify the presence of the somatic syndrome as defined in F32, in the current episode of depression:

F31.30 without somatic syndrome

F31.31 with somatic syndrome

F31.4 Bipolar affective disorder, current episode severe depression without psychotic symptoms

A. The current episode meets the criteria for a severe depressive episode without psychotic symptoms (F32.2).

B. There has been at least one well authenticated hypomanic or manic episode (F30.-) or mixed affective episode (F38.00) in the past.

F31.5 Bipolar affective disorder, current episode severe depression with psychotic symptoms

A. The current episode meets the criteria for a severe depressive episode with psychotic symptoms (F32.3).

B. There has been at least one well authenticated hypomanic or manic episode (F30.-) or mixed affective episode (F38.00) in the past.

A fifth character may be used to specify whether the psychotic symptoms are congruent or incongruent with the mood.

F31.50 with mood congruent psychotic symptoms

F31.51 with mood incongruent psychotic symptoms

F31.6 Bipolar affective disorder, current episode mixed

A. The current episode is characterized by either a mixture or a rapid alternation (i.e. within a few hours) of hypomanic, manic and depressive symptoms.

B. Both manic and depressive symptoms must be prominent most of the time during a period of at least two weeks.

C. There has been at least one well authenticated hypomanic or manic episode (F30.-), depressive (F32.-) or mixed affective episode (F38.00) in the past.

F31.7 Bipolar affective disorder, currently in remission

A. The current state does not meet the criteria for depressive or manic episode in any severity, or for any other mood disorder in F3 (possibly because of treatment to reduce the risk of future episodes).

B. There has been at least one well authenticated hypomanic or manic episode

(F30.-) in the past and in addition at least one other affective episode (hypomanic or manic (F30.-), depressive (F32.-), or mixed (F38.00)).

F31.8 Other bipolar affective disorders

F31.9 Bipolar affective disorders, unspecified

F32 Depressive episode

G1. The depressive episode should last for at least 2 weeks.

G2. There have been no hypomanic or manic symptoms sufficient to meet the criteria for hypomanic or manic episode (F30.-) at any time in the individual's life.

G3. Most commonly used exclusion clause. The episode is not attributable to psychoactive substance use (F10-F19) or to any organic mental disorder (in the sense of F00-F09).

Somatic syndrome

Some depressive symptoms are widely regarded as having special clinical significance and are here called "somatic". (Terms such as biological, vital, melancholic, or endogenomorphic are used for this syndrome in other classification.)

A fifth character (as indicated in F31.3; F32.0 and F32.1; F33.0 and F33.1) may be used to specify the presence or absence of the somatic

syndrome. To qualify for the somatic syndrome, four of the following symptoms should be present:

(1) marked loss of interest or pleasure in activities that are normally pleasurable;

(2) lack of emotional reactions to events or activities that normally produce an emotional response;

(3) waking in the morning 2 hours or more before the usual time;

(4) depression worse in the morning;

(5) objective evidence of marked psychomotor retardation or agitation (remarked on or reported by other people);

(6) marked loss of appetite;

(7) weight loss (5% or more of body weight in the past month);

(8) marked loss of libido.

In *The ICD-10 Classification of Mental and Behavioural Disorders: Clnical descriptions and diagnostic guidelines*, the presence or absence of the somatic syndrome is not specified for severe depressive episode, since it is presumed to be present in most cases. For research purposes, however, it may be advisable to allow for the coding of the absence of the somatic syndrome in severe depressive episode.

F32.0 Mild depressive episode

A. The general criteria for depressive episode (F32) must be met.

B. At least two of the following three symptoms must be present:

(1) depressed mood to a degree that is definitely abnormal for the individual, present for most of the day and almost every day, largely uninfluenced by circumstances, and sustained for at least 2 weeks.

(2) loss of interest or pleasure in activities that are normally pleasurable;

(3) decreased energy or increased fatiguability.

C. An additional symptom or symptoms from the following list should be present, to give a total of at least four:

(1) loss of confidence and self-esteem;

(2) unreasonable feelings of self-reproach or excessive and inappropriate guilt;

(3) recurrent thoughts of death or suicide, or any suicidal behaviour;

(4) complaints or evidence of diminished ability to think or concentrate, such as indecisiveness or vacillation;

(5) change in psychomotor activity, with agitation or retardation (either subjective or objective);

(6) sleep disturbance of any type;

(7) change in appetite (decrease or increase) with corresponding weight change).

A fifth character may be used to specify the presence or absence of the "somatic syndrome" (defined on page xx):

F32.00 Without somatic syndrome

F32.01 With somatic syndrome

F32.1 Moderate depressive episode

A. The general criteria for depressive episode (F32) must be met.

B. At least two of the three symptoms listed for F32.0, criterion B, must be present.

C. Additional symptoms from F32.0, criterion C, must be present, to give a total of at least six .

A fifth character may be used to specify the presence or absence of the "somatic syndrome" as defined on page xx:

F32.10 Without somatic syndrome

F32.11 With somatic syndrome

F32.2 Severe depressive episode without psychotic symptoms

Note: If important symptoms such as agitation or retardation are marked,

the patient may be unwilling or unable to describe many symptoms in detail. An overall grading of severe episode may still be justified in such a case.

A. The general criteria for depressive episode (F32) must be met.

B. All three of the symptoms in criterion B, F32.0, must be present.

C. Additional symptoms from F32.0, criterion C, must be present, to give a total of at least eight.

D. There must be no hallucinations, delusions, or depressive stupor.

F32.3 Severe depressive episode with psychotic symptoms

A. The general criteria for depressive episode (F32) must be met.

B. The criteria for severe depressive episode without psychotic symptoms (F32.2) must be met with the exception of criterion D.

C. The criteria for schizophrenia (F20.-) or schizoaffective disorder, depressive type (F25.1) are not met.

D. Either of the following must be present:

(1) delusions or hallucinations, other than those listed as typically schizophrenic in F20, criterion G1(1)b, c, and d (i.e. delusions other than those that completely impossible or culturally

inappropriate and hallucinations that are not in the third person or giving a running commentary); the commonest examples are those with depressive, guilty, hypochondriacal, nihilistic, self-referential, or persecutory content;

(2) depressive stupor.

A fifth character may be used to specify whether the psychotic symptoms are congruent or incongruent with mood:

F32.30 With mood-congruent psychotic symptoms

(i.e. delusions of guilt, worthlessness, bodily disease, or impending disaster, derisive or condemnatory auditory hallucinations)

F32.31 With mood-incongruent psychotic symptoms

(i.e. persecutory or self-referential delusions and hallucinations without an affective content)

F32.8 Other depressive episodes

Episodes should be included here which do not fit the descriptions given for depressive episodes in F32.0-F32.3, but for which the overall diagnostic impression indicates that they are depressive in nature. Examples include fluctuating mixtures of depressive symptoms (particularly those of the somatic syndrome) with non-diagnostic symptoms such as tension, worry, and distress, and mixtures of somatic depressive symptoms with persistent pain or fatigue not due to organic causes (as sometimes seen in general hospital services).

F32.9 Depressive episode, unspecified

F33 Recurrent depressive disorder

G1. There has been at least one previous episode, mild (F32.0), moderate (F32.1), or severe (F32.2 or F32.3), lasting a minimum of 2 weeks and separated from the current episode by at least 2 months free from any significant mood symptoms.

G2. At no time in the past has there been an episode meeting the criteria

for hypomanic or manic episode (F30.-).

G3. Most commonly used exclusion criteria: the episode is not attibutable to psychoactive substance use (F1) or any organic mental disorder, in the sense of F0.

It is recommended to specify the predominant type of previous episodes (mild, moderate, severe, uncertain).

F33.0 Recurrent depressive disorder, current episode mild

A. The general criteria for recurrent depressive disorder (F33) are met.

B. The current episode meets the criteria for depressive episode, mild severity (F32.0).

A fifth character may be used to specify the presence of the somatic syndrome, as defined in F32, in the current episode:

F33.00 without somatic syndrome

F33.01 with somatic syndrome

F33.1 Recurrent depressive disorder, current episode moderate

A. The general criteria for recurrent depressive disorders (F33) are met.

B. The current episode meets the criteria for depressive episode, moderate severity (F32.1).

A fifth character may be used to specify the presence of the somatic syndrome, as defined in F32, in the current episode:

F33.10 without somatic syndrome

F33.11 with somatic syndrome

F33.2 Recurrent depressive disorder, current episode severe without psychotic symptoms

A. The general criteria for recurrent depressive disorders (F33) are met.

B. The current episode meets the criteria for severe depressive episode without psychotic symptoms (F32.2).

F33.3 Recurrent depressive disorder, current episode severe with psychotic symptoms

A. The general criteria for recurrent depressive disorders (F33) are met.

B. The current episode meets the criteria for severe depressive episode with psychotic symptoms (F32.3).

A fifth character may be used to specify whether the psychotic symptoms are congruent or incongruent with the mood:

F33.30 with mood congruent psychotic symptoms

F33.31 with mood incongruent psychotic symptoms

F33.4 Recurrent depressive disorder, currently in remission

A. The general criteria for recurrent depressive disorder (F33) have been met in the past.

B. The current state does not meet the criteria for a depressive episode (F32.-) of any severity, or for any other disorder in F3 (the patient may receive treatment to reduce the risk of further episodes).

F33.8 Other recurrent depressive disorders

F33.9 Recurrent depressive disorder, unspecified

F34 PERSISTENT MOOD [AFFECTIVE] DISORDERS

F34.0 Cyclothymia

A. A period of at least two years of instability of mood involving several periods of both depression and hypomania, with or without intervening periods of normal mood.

B. None of the manifestations of depression or hypomania during such a two-year period should be sufficiently severe or long lasting to meet criteria for manic episode or depressive episode (moderate or severe); however, manic or depressive episode(s) may have occurred before, or may develop after, such a period of persistent mood instability.

C. During at least some of the periods of depression at least three of the following should be present:

(1) A reduction in energy or activity;

(2) Insomnia;

(3) Loss of self confidence or feelings of inadequacy;

(4) Difficulty concentrating;

(5) Social withdrawal;

(6) Loss of interest or enjoyment in sex and other pleasurable activities;

(7) Less talkative than normal;

(8) Pessimistic about the future or brooding over the past.

D. During at least some of the periods of mood elevation at least three of the following should be present:

(1) Increased energy or activity;

(2) Decreased need for sleep;

(3) Inflated self esteem;

(4) Sharpened or unusually creative thinking;

(5) More gregarious than normal;

(6) More talkative or witty than normal;

(7) Increased interest and involvement in sexual and other pleasurable activities;

(8) Over-optimism or exaggeration of past achievements.

Note: If desired, specify whether onset is early (in late teenage or the twenties) or late (usually between age 30 to 50 subsequent to an affective episode).

F34.1 Dysthymia

A. A period of at least two years of constant or constantly recurring depressed mood.

Intervening periods of normal mood rarely last for longer than a few weeks and there are no episodes of hypomania.

B. None, or very few, of the individual episodes of depression within such a two-year period are severe enough, or last long enough, to meet the criteria for recurrent mild depressive disorder (F33.0).

C. During at least some of the periods of depression at least three of the following should be present:

(1) A reduction in energy or activity;

(2) Insomnia;

(3) Loss of self-confidence or feelings of inadequacy;

(4) Difficulty concentrating;

(5) Often in tears;

(6) Loss of interest or enjoyment in sex and other pleasurable activities;

(7) Feeling of hopelessness or despair;

(8) A perceived inability to cope with the routine responsibilities of everyday life;

(9) Pessimistic about the future or brooding over the past;

(10) Social withdrawal;

(11) Less talkative than normal.

Note: If desired, specify whether onset is early (in late teenage or the twenties) or late (usually between age 30 to 50 subsequent to an affective episode).

F34.8 Other persistent mood [affective] disorders

A residual category for persistent affective disorders that are not sufficiently severe or long-lasting to fulfil the criteria for cyclothymia (F34.0) or dysthymia (F34.1) but that are nevertheless clinically significant. Some types of depression previously called "neurotic" are included here, provided that they do not meet the criteria for either cyclothymia (F34.0) or dysthymia (F34.1) or for depressive episode of mild (F32.0) or moderate (F32.1) severity.

F34.9 Persistent mood [affective] disorder, unspecified

F38 OTHER MOOD [AFFECTIVE] DISORDERS

There are so many possible disorders that could be listed under F38 that no attempt has been made to specify criteria, except for mixed affective episode (F38.00). Investigators requiring criteria more exact than the Diagnostic Guidelines should construct them according to the requirements of their study.

F38.0 Other single mood [affective] disorders

F38.00 Mixed affective episode

A. The episode is characterized by either a mixture or a rapid alternation (i.e. within a few hours) of hypomanic, manic and depressive symptoms.

B. Both manic and depressive symptoms must be prominent most of the time during a period of at least two weeks.

C. No previous hypomanic, depressive or mixed episodes.

F38.1 Other recurrent mood [affective] disorders

F38.10 Recurrent brief depressive disorder

A. The disorder meets the symptomatic criteria of either mild (F32.0), moderate (F32.1) or severe depressive episode (F32.2)

B. The depressive episodes occur about once a month over the past year.

C. The individual episodes last less than two weeks (typically two to three days).

D. The episodes do not occur solely in relation to the menstrual cycle.

F38.8 Other specified mood [affective] disorders

This is a residual category for affective disorders that do not meet the criteria for any other categories F30-F38 above.

F39 Unspecified mood [affective] disorder

F40 - F48 NEUROTIC, STRESS-RELATED AND SOMATOFORM DISORDERS

F40 PHOBIC ANXIETY DISORDERS

F40.0 Agoraphobia

A. Marked and consistently manifest fear in or avoidance of at least two of the following situations:

(1) crowds;

(2) public places;

(3) travelling alone;

(4) travelling away from home.

B. Symptoms of anxiety in the feared situation at some time since the onset of the disorder, with at least two symptoms present together, on at least one occasion, from the list below, one of which must have been from items (1) to (4):

Autonomic arousal symptoms

(1) Palpitations or pounding heart, or accelerated heart rate.

(2) Sweating.

(3) Trembling or shaking.

(4) Dry mouth (not due to medication or dehydration).

Symptoms concerning chest and abdomen

(5) Difficulty breathing.

(6) Feeling of choking.

(7) Chest pain or discomfort.

(8) Nausea or abdominal distress (e.g. churning in stomach).

Symptoms concerning brain and mind

(9) Feeling dizzy, unsteady, faint or light-headed.

(10) Feelings that objects are unreal (derealization), or that one's self is distant or "not really here" (depersonalization).

(11) Fear of losing control, going crazy, or passing out.

(12) Fear of dying.

General symptoms

(13) Hot flushes or cold chills.

(14) Numbness or tingling sensations.

C. Significant emotional distress due to the avoidance or the anxiety symptoms, and a recognition that these are excessive or unreasonable.

D. Symptoms are restricted to or predominate in the feared situations or when thinking about them.

E. Most commonly used exclusion criteria: criterion A is not due to delusions, hallucinations, or other symptoms of disorders such as organic mental disorders (F0), schizophrenia and related disorders (F20-F29), affective disorders (F30-F39), or obsessive compulsive disorder (F42), and are not secondary to cultural beliefs.

The presence or absence of panic disorder (F41.0) on a majority of occasions when in the agoraphobic situation may be specified by using a fifth character:

F40.00 Agoraphobia without panic disorder

F40.01 Agoraphobia with panic disorder

Options for the rating of severity: Severity in F40.00 may be rated by indicating the degree of avoidance, taking into account the specific cultural setting. Severity in F40.01 may be rated by counting the number of panic attacks.

F40.1 Social phobias

A. Either (1) or (2):

(1) marked fear of being the focus of attention, or fear of behaving in a way that will be embarrassing or humiliating;

(2) marked avoidance of being the focus of attention or situations in which there is fear of behaving in an embarrassing or humiliating way.

These fears are manifested in social situations, such as eating or speaking in public; encountering known individuals in public; or entering or enduring small group situations, such as parties, meetings and classrooms.

B. At least two symptoms of anxiety in the feared situation at some time since the onset of the disorder, as defined in criterion B for F40.0 (Agoraphobia) and in addition one of the following symptoms:

(1) Blushing.

(2) Fear of vomiting.

(3) Urgency or fear of micturition or defecation.

C. Significant emotional distress due to the symptoms or to the avoidance.

D. Recognition that the symptoms or the avoidance are excessive or unreasonable.

E. Symptoms are restricted to or predominate in the feared situation or when thinking about it.

F. Most commonly used exclusion criteria: Criteria A and B are not due to delusions, hallucinations, or other symptoms of disorders such as organic mental disorders (F0), schizophrenia and related disorders (F20-F29), affective disorders (F30-F39), or obsessive compulsive disorder (F42), and are not secondary to cultural beliefs.

F40.2 Specific (isolated) phobias

A. Either (1) or (2):

(1) marked fear of a specific object or situation not included in agoraphobia (F40.0) or social phobia (F40.1);

(2) marked avoidance of such objects or situations.

Among the most common objects or situations are animals, birds, insects, heights, thunder, flying, small enclosed spaces, sight of blood or injury, injections, dentists and hospitals.

B. Symptoms of anxiety in the feared situation at some time since the onset of the disorder, as defined in criterion B for F40.0 (Agoraphobia).

C. Significant emotional distress due to the symptoms or the avoidance, and a recognition that these are excessive or unreasonable.

D. Symptoms are restricted to the feared situation, or when thinking about it.

If desired, the specific phobias may be subdivided as follows:

- animal type (e.g. insects, dogs)
- nature-forces type (e.g. storms, water)
- blood, injection and injury type
- situational type (e.g. elevators, tunnels)
- other type

F40.8 Other phobic anxiety disorders

F40.9 Phobic anxiety disorder, unspecified

F41 OTHER ANXIETY DISORDERS

F41.0 Panic disorder [episodic paroxysmal anxiety]

A. Recurrent panic attacks, that are not consistently associated with a specific situation or object, and often occurring spontaneously (i.e. the episodes are unpredictable). The panic attacks are not associated with marked exertion or with exposure to dangerous or life-threatening situations.

B. A panic attack is characterized by all of the following:

(a) it is a discrete episode of intense fear or discomfort;

(b) it starts abruptly;

(c) it reaches a crescendo within a few minutes and lasts at least some minutes;

(d) at least four symptoms must be present from the list below, one of which must be from items (1) to (4):

Autonomic arousal symptoms

(1) Palpitations or pounding heart, or accelerated heart rate.

(2) Sweating.

(3) Trembling or shaking.

(4) Dry mouth (not due to medication or dehydration).

Symptoms concerning chest and abdomen

(5) Difficulty breathing.

(6) Feeling of choking.

(7) Chest pain or discomfort.

(8) Nausea or abdominal distress (e.g. churning in stomach).

Symptoms concerning brain and mind

(9) Feeling dizzy, unsteady, faint or light-headed.

(10) Feelings that objects are unreal (derealization), or that one's self is distant or "not really here" (depersonalization).

(11) Fear of losing control, going crazy, or passing out.

(12) Fear of dying.

General symptoms

(13) Hot flushes or cold chills.

(14) Numbness or tingling sensations.

C. Most commonly used exclusion criteria: not due to a physical disorder, organic mental disorder (F0), or other mental disorders such as schizophrenia and related disorders, (F20-29), affective disorders (F30-39), or somatoform disorders (F45).

The range of individual variation of both content and severity is so great that two grades, moderate and severe, may be specified, if desired, with a fifth character:

F41.00 Panic disorder - moderate: at least four panic attacks in a four week period.

F41.01 Panic disorder - severe: at least four panic attacks per week over a four-week period.

F41.1 Generalized anxiety disorder

Note: For children different criteria may be applied (see F93.80).

A. A period of at least six months with prominent tension, worry and feelings of apprehension, about every-day events and problems.

B. At least four symptoms out of the following list of items must be present, of which at least one from items (1) to (4).

Autonomic arousal symptoms

(1) Palpitations or pounding heart, or accelerated heart rate.

(2) Sweating.

(3) Trembling or shaking.

(4) Dry mouth (not due to medication or dehydration).

Symptoms concerning chest and abdomen

(5) Difficulty breathing.

(6) Feeling of choking.

(7) Chest pain or discomfort.

(8) Nausea or abdominal distress (e.g. churning in stomach).

Symptoms concerning brain and mind

(9) Feeling dizzy, unsteady, faint or light-headed.

(10) Feelings that objects are unreal (derealization), or that one's self is distant or "not really here" (depersonalization).

(11) Fear of losing control, going crazy, or passing out.

(12) Fear of dying.

General symptoms

(13) Hot flushes or cold chills.

(14) Numbness or tingling sensations.

Symptoms of tension

(15) Muscle tension or aches and pains.

(16) Restlessness and inability to relax.

(17) Feeling keyed up, or on edge, or of mental tension.

(18) A sensation of a lump in the throat, or difficulty with swallowing.

Other non-specific symptoms

(19) Exaggerated response to minor surprises or being startled.

(20) Difficulty in concentrating, or mind going blank, because of worrying or anxiety.

(21) Persistent irritability.

(22) Difficulty getting to sleep because of worrying.

C. The disorder does not meet the criteria for panic disorder (F41.0), phobic anxiety disorders (F40.-), obsessive-compulsive disorder (F42.-) or hypochondriacal disorder (F45.2).

D. Most commonly used exclusion criteria: not sustained by a physical disorder, such as hyperthyroidism, an organic mental disorder (F0) or psychoactive substance-related disorder (F1), such as excess consumption of amphetamine-like substances, or withdrawal from benzodiazepines.

F41.2 Mixed anxiety and depressive disorder

There are so many possible combinations of comparatively mild symptoms for these disorders that specific criteria are not given, other than those already in the diagnostic guidelines. It is suggested that researchers wishing to study patients with these disorders should arrive at their own criteria within the guidelines, depending upon the setting and purpose of their study.

F41.3 Other mixed anxiety disorders

F41.8 Other specified anxiety disorders

F41.9 Anxiety disorder, unspecified

F42 OBSESSIVE-COMPULSIVE DISORDER

A. Either obsessions or compulsions (or both), present on most days for a period of at least two weeks.

B. Obsessions (thoughts, ideas or images) and compulsions (acts) share the following features, all of which must be present:

(1) They are acknowledged as originating in the mind of the patient, and are not imposed by outside persons or influences.

(2) They are repetitive and unpleasant, and at least one obsession or compulsion must be present that is acknowledged as excessive or unreasonable.

(3) The subject tries to resist them (but if very long-standing, resistance to some obsessions or compulsions may be minimal). At least one obsession or compulsion must be present which is unsuccessfully resisted.

(4) Carrying out the obsessive thought or compulsive act is not in itself pleasurable. (This should be distinguished from the temporary relief of tension or anxiety).

C. The obsessions or compulsions cause distress or interfere with the subject's social or individual functioning, usually by wasting time.

D. Most commonly used exclusion criteria: not due to other mental disorders, such as schizophrenia and related disorders (F2), or mood [affective] disorders (F3).

The diagnosis may be specified by the following four character codes:

F42.0 Predominantly obsessional thoughts and ruminations

F42.1 Predominantly compulsive acts

F42.2 Mixed obsessional thoughts and acts

F42.8 Other obsessive-compulsive disorders

F42.9 Obsessive-compulsive disorder, unspecified

F43 REACTION TO SEVERE STRESS, AND ADJUSTMENT DISORDERS

F43.0 Acute stress reaction

A. Exposure to an exceptional mental or physical stressor.

B. Criterion A is followed by an immediate onset of symptoms (within one hour).

C. Two groups of symptoms are given; the acute stress reaction is graded as:

F43.00 Mild if only (1) is fulfilled;

F43.01 Moderate for (1) plus any two symptoms of (2), and

F43.02 Severe for either - (1) plus any four from (2)

or

- dissociative stupor.

(1) The criteria B, C and D for generalized anxiety disorder (F41.1).

(2) a) withdrawal from expected social interaction;

b) narrowing of attention;

c) apparent disorientation;

d) anger or verbal aggression;

e) despair or hopelessness;

f) inappropriate or purposeless over-activity;

g) uncontrollable and excessive grief (judged by local cultural standards).

D. If the stressor is transient or can be relieved, the symptoms must begin to diminish after not more than eight hours. If the stressor continues, the symptoms must begin to diminish after not more than 48 hours.

E. Most commonly used exclusion criteria: without the current presence of any other mental or behavioural disorder in ICD-10, (except for F41.1 (generalized anxiety disorder), and F60 (personality disorders)), and not within three months of the end of an episode of any other mental or behavioural disorder.

F43.1 Post-traumatic stress disorder

A. Exposure to a stressful event or situation (either short or long lasting) of exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone.

B. Persistent remembering or "reliving" the stressor by intrusive flash backs, vivid memories, recurring dreams, or by experiencing distress when exposed to circumstances resembling or associated with the stressor.

C. Actual or preferred avoidance of circumstances resembling or associated with the stressor (not present before exposure to the stressor).

D. Either (1) or (2):

(1) Inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor

(2) Persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor) shown by any two of the following:

a) difficulty in falling or staying asleep;

b) irritability or outbursts of anger;

c) difficulty in concentrating;

d) hyper-vigilance;

e) exaggerated startle response.

E. Criteria B, C and D all occurred within six months of the stressful event, or the end of a period of stress. (For some purposes, onset delayed more than six months may be included but this should be clearly specified separately.)

F43.2 Adjustment disorders

A. Experience of an identifiable psycho-social stressor, not of an unusual or catastrophic type, within one month of the onset of symptoms.

B. Symptoms or behaviour disturbance of types found in any of the affective disorders (except for delusions and hallucinations), any disorders in F4 (neurotic, stress related and somatoform disorders) and conduct disorders, so long as the criteria of an individual disorder are not fulfilled. Symptoms may be variable in both form and severity.

The predominant feature of the symptoms may be further specified by the use of a fifth character:

F43.20 Brief depressive reaction. A transient mild depressive state of a duration not exceeding one month.

F43.21 Prolonged depressive reaction. A mild depressive state occurring in response to a prolonged exposure to a stressful situation but of a duration not exceeding two years.

F43.22 Mixed anxiety and depressive reaction. Both anxiety and depressive symptoms are prominent, but at levels no greater than specified in mixed anxiety and depressive disorder (F41.2) or other mixed anxiety disorders (F41.3).

F43.23 With predominant disturbance of other emotions. The symptoms are usually of several types of emotion, such as anxiety, depression, worry, tensions and anger. Symptoms of anxiety and depression may meet the criteria for mixed anxiety and depressive disorder (F41.2) or other mixed anxiety disorders (F41.3), but they are not so predominant that other more specific depressive or anxiety disorders can be diagnosed. This category should also be used for reactions in children in which regressive behaviour such as bed-wetting or thumb-sucking are also present.

F43.24 With predominant disturbance of conduct. The main disturbance is one involving conduct, e.g. an adolescent grief reaction resulting in aggressive or dissocial behaviour.

F43.25 With mixed disturbance of emotions and conduct. Both emotional symptoms and disturbances of conduct are prominent features.

F43.28 With other specified predominant symptoms.

C. The symptoms do not persist for more than six months, except F43.21 prolonged depressive reaction, after the cessation of the stress or its consequences (but this criterion should not prevent a provisional diagnosis being made if it is not yet fulfilled).

F43.8 Other reactions to severe stress

F43.9 Reaction to severe stress, unspecified

F44 DISSOCIATIVE [CONVERSION] DISORDERS

G1. No evidence of a physical disorder that can explain the symptoms that characterize the disorder (but physical disorders may be present that give rise to other symptoms).

G2. Convincing associations in time between the symptoms of the disorder and stressful events, problems or needs.

F44.0 Dissociative amnesia

A. The general criteria for dissociative disorder (F44) must be met.

B. Amnesia, either partial or complete, for recent events or problems that were or still are traumatic or stressful.

C. The amnesia is too extensive and persistent to be explained by ordinary forgetfulness, (although its depth and extent may vary from one assessment to the next), or by intentional simulation.

F44.1 Dissociative fugue

A. The general criteria for dissociative disorder (F44) must be met.

B. An unexpected yet normally organized journey away from home or the ordinary places of work and social activities, during which self-care is largely maintained.

C. Amnesia, either partial or complete, for the journey, also meeting criterion C as for dissociative amnesia (F44.0).

F44.2 Dissociative stupor

A. The general criteria for dissociative disorder (F44) must be met.

B. Profound diminution or absence of voluntary movements and speech, and of normal responsiveness to light, noise and touch.

C. Maintenance of normal muscle tone, static posture, and breathing (and often limited coordinated eye movements).

F44.3 Trance and possession disorders

A. The general criteria for dissociative disorder (F44) must be met.

B. Either (1) or (2):

(1) Trance: Temporary alteration of the state of consciousness, shown by any two of:

a) Loss of the usual sense of personal identity.

b) Narrowing of awareness of immediate surroundings, or unusually narrow and selective focussing on environmental stimuli.

c) Limitation of movements, postures, and speech to repetition of a small repertoire.

(2) Possession disorder: Conviction that the individual has been taken over by a spirit, power, deity or other person.

C. Both criterion B.1 and B.2 must be unwanted and troublesome, occurring outside or being a prolongation of similar states in religious or other culturally accepted situations.

D. Most commonly used exclusion criteria: not occurring at the same time as schizophrenia or related disorders (F20- F29), or mood [affective] disorders with hallucinations or delusions (F30- F39).

F44.4 Dissociative motor disorders

A. The general criteria for dissociative disorder (F44) must be met.

B. Either (1) or (2):

(1) Complete of partial loss of the ability to perform movements that are normally under voluntary control (including speech).

(2) Various or variable degrees of incoordination or ataxia or inability to stand unaided.

F44.5 Dissociative convulsions

A. The general criteria for dissociative disorder (F44) must be met.

B. Sudden and unexpected spasmodic movements, closely resembling any of the varieties of epileptic seizures, but not followed by loss of consciousness.

C. Criterion B is not accompanied by tongue-biting, serious bruising or laceration due to falling, or incontinence of urine.

F44.6 Dissociative anaesthesia and sensory loss

A. The general criteria for dissociative disorder (F44) must be met.

B. Either (1) or (2):

(1) Partial or complete loss of any or all of the normal cutaneous sensations over part or all of the body (specify: touch, pin prick, vibration, heat, cold).

(2) Partial or complete loss of vision, hearing or smell (specify).

F44.7 Mixed dissociative [conversion] disorders

F44.8 Other dissociative [conversion] disorders

This residual code may be used to indicate other dissociative and conversion states that meet criteria A and B for F44, but do not meet the criteria for F44.0 - F44.8 listed above.

F44.80 Ganser's syndrome (approximate answers)

F44.81 Multiple personality disorder

A. The existence of two or more distinct personalities within the the individual, only one being evident at a time.

B. Each personality has its own memories, preferences and behaviour patterns, and at some time (and recurrently) takes full control of the individuals behaviour.

C. Inability to recall important personal information, too extensive to be explained by ordinary forgetfulness.

D. Not due to organic mental disorders (F0) (e.g. in epileptic disorders) or psychoactive substance-related disorders (F1) (e.g. intoxication or withdrawal).

F44.82 Transient dissociative [conversion] disorders occurring in childhood and adolescence

F44.88 Other specified dissociative [conversion] disorders

Specific research criteria are not given for all disorders mentioned above, since these other dissociative states are rare and not well described. Research workers studying these conditions in detail will wish to specify their own criteria according to the purposes of their study.

F44.9 Dissociative [conversion] disorder, unspecified

F45 SOMATOFORM DISORDERS

F45.0 Somatization disorder

A. A history of at least two years complaints of multiple and variable physical symptoms that cannot be explained by any detectable physical disorders. (Any physical disorders that are known to be present do not explain the severity, extent, variety and persistence of the physical complaints, or the associated social disability). If some symptoms clearly due to autonomic arousal are present, they are not a major feature of the disorder, in that they are not particularly persistent or distressing.

B. Preoccupation with the symptoms causes persistent distress and leads the patient to seek repeated (three or more) consultations or sets of investigations with either primary care or specialist doctors. In the absence of medical services within either the financial or physical reach of the patient, persistent self-medication or multiple consultations with local healers must be present.

C. Persistent refusal to accept medical advice that there is no adequate physical cause for the physical symptoms, except for short periods of up to a few weeks at a time during or immediately after medical investigations.

D. A total of six or more symptoms from the following list, with symptoms occurring in at least two separate groups:

Gastro-intestinal symptoms

(1) abdominal pain;

(2) nausea;

(3) feeling bloated or full of gas;

(4) bad taste in mouth, or excessively coated tongue;

(5) complaints of vomiting or regurgitation of food;

(6) complaints of frequent and loose bowel motions or discharge of fluids from anus;

Cardio-vascular symptoms

(7) breathlessness without exertion;

(8) chest pains;

Genito-urinary symptoms

(9) dysuria or complaints of frequency of micturition;

(10) unpleasant sensations in or around the genitals;

(11) complaints of unusual or copious vaginal discharge;

Skin and pain symptoms

(12) complaints of blotchiness or discolouration of the skin;

(13) pain in the limbs, extremities or joints;

(14) unpleasant numbness or tingling sensations.

E. Most commonly used exclusion criteria: not occurring only during any of the schizophrenic or related disorders (F20-F29), any of the mood (affective) disorders (F30-F39), or panic disorder (see F41.0).

F45.1 Undifferentiated somatoform disorder

A. Criteria A, C and E for somatization disorder (F45.0) are met, except that the duration of the disorder is at least six months.

B. One or both of criterium B and D for somatization disorder are incompletely fulfilled.

F45.2 Hypochondriacal disorder

A. Either (1) or (2):

(1) A persistent belief, of at least six months duration, of the presence of a maximum of two serious physical diseases (of which at least one must be specifically named by the patient).

(2) A persistent preoccupation with a presumed deformity or disfigurement (bodydysmorphic disorder).

B. Preoccupation with the belief and the symptoms causes persistent distress or interference with personal functioning in daily living, and leads the patient to seek medical treatment or investigations (or equivalent help from local healers).

C. Persistent refusal to accept medical advice that there is no adequate physical cause for the symptoms or physical abnormality, except for short periods of up to a few weeks at a time immediately after or during medical investigations.

D. Most commonly used exclusion criteria: not occurring only during any of the schizophrenic and related disorders (F20-F29, particularly F22) or any of the mood [affective] disorders (F30-F39).

F45.3 Somatoform autonomic dysfunction

A. Symptoms of autonomic arousal that are attributed by the patient to a physical disorder of one or more of the following systems or organs:

(1) heart and cardiovascular system;

(2) upper gastrointestinal tract (oesophagus and stomach);

(3) lower gastrointestinal tract;

(4) respiratory system;

(5) genitourinary system.

B. Two or more of the following autonomic symptoms:

(1) palpitations;

(2) sweating (hot or cold);

(3) dry mouth;

(4) flushing or blushing;

(5) epigastric discomfort or "butterflies" or churning in the stomach.

C. One or more of the following symptoms:

(1) chest pains or discomfort in and around the precordium;

(2) dyspnoea or hyperventilation;

(3) excessive tiredness on mild exertion;

(4) aerophagy, or hiccough, or burning sensations in chest or epigastrium;

(5) reported frequent bowel movements;

(6) increased frequency of micturition or dysuria;

(7) feeling of being bloated, distended or heavy.

D. No evidence of a disturbance of structure or function in the organs or systems about which patient is concerned.

E. Not only in the presence of phobic disorders (F40.0-F40.3) or panic disorder (F41.0).

The fifth character is to be used to classify the individual disorders in this group, indicating the organ or system regarded by the patient as the origin of the symptoms:

F45.30 Heart and cardiovascular system (includes: cardiac neurosis, neurocirculatory asthenia, Da Costa syndrome).

F45.31 Upper gastro-intestinal tract (includes: psychogenic aerophagy, hiccough, gastric neurosis).

F45.32 Lower gastro-intestinal tract (includes: psychogenic irritable bowel syndrome, psychogenic diarrhoea, gas syndrome).

F45.33 Respiratory system (includes: hyperventilation).

F45.34 Genitourinary system (includes: psychogenic increase of frequency of micturition and dysuria).

F45.38 Other organ or system

F45.4 Persistent somatoform pain disorder

A. Persistent (at least six months, continuously on most days) severe and distressing pain, in any part of the

body, which cannot be explained adequately by evidence of a physiological process or a physical disorder, and which is consistently the main focus of the patient's attention.

B. Most commonly used exclusion criteria: not occurring in the presence of schizophrenia or related disorders (F20-F29), or only during any of mood [affective] disorders (F30-F39), somatization disorder (F45.0), undifferentiated somatoform disorder (F45.1) or hypochondriacal disorder (F45.2).

F45.8 Other somatoform disorders

In these disorders the presenting complaints are not mediated through the autonomic nervous system, and are limited to specific systems or parts of the body, such as skin. This is in contrast to the multiple and often changing complaints of the origin of symptoms and distress found in somatization disorder (F45.0) and undifferentiated somatoform disorder (F45.1). Tissue damage is not involved.

Any other disorders of sensation not due to physical disorders, which are closely associated in time with stressful events or problems, or which result in significantly increased attention for the patient, either personal or medical, should also be classified here.

F45.9 Somatoform disorder, unspecified

F48 OTHER NEUROTIC DISORDERS

F48.0 Neurasthenia

A. Either (1) or (2):

(1) Persistent and distressing complaints of feelings of exhaustion after minor mental effort (such as performing or attempting to perform every-day tasks that do not require unusual mental effort).

(2) Persistent and distressing complaints of feelings of fatigue and bodily weakness after minor physical effort.

B. Irritability, and at least one of the following:

(1) feelings of muscular aches and pains;

(2) dizziness;

(3) tension headaches;

(4) sleep disturbance;

(5) inability to relax.

C. Inability to recover from A.1 or A.2 by normal periods of rest, relaxation or entertainment.

D. The duration of the disorder is at least 6 months.

E. Most commonly used exclusion criteria: not occurring in the presence of organic emotionally labile disorder (F06.6), postencephalitic syndrome (F07.1), postconcussional syndrome (F07.2), mood [affective] disorders (F30-F39), panic disorder (F41.0), or generalized anxiety disorder (F41.1).

F48.1 Depersonalization - derealization syndrome

A. Either (1) or (2):

(1) Depersonalization. The patient complains of a feeling of being distant, "not really here" (for example he may complain that his emotions, or feelings, or experience of his inner self are detached, strange, not his own, or unpleasantly lost, or that his emotions or movements feel as if they belong to someone else, or that he feels as if acting in a play).

(2) Derealization. The patient complains of a feeling of unreality (for example he may complain that the surroundings or specific objects look strange, distorted, flat, colourless, lifeless, dreary, uninteresting, or like a stage upon which everyone is acting).

B. Retention of insight, in that the patient realizes that the change is within himself, and is not imposed from outside by other persons or forces.

Comments: This diagnosis should not be used as a main or single diagnosis when occurring in the presence of other mental disorders, such as organic confusional or delusional states (F05; F06), or intoxication by alcohol or drugs (F1x.0), schizophrenia and related disorders (F2), mood [affective] disorders (F3), anxiety disorders (F40.-, F41.-), or other conditions (such as marked fatigue, hypoglycemia, or immediately preceding or following epileptic seizures). However these syndromes often occur during the course of many other psychiatric disorders, and are appropriately recorded as a secondary or additional diagnosis to a different main diagnosis. Their occurrence as an isolated syndrome is much less common.

F48.8 Other specified neurotic disorders

This category includes mixed disorders of behaviour, beliefs, and emotions which are of uncertain etiology and nosological status and which occur with particular frequency in certain cultures; examples include Dhat syndrome (undue concern about the debilitating effects of the passage of semen), koro (anxiety and fear that the penis will retract into the abdomen and cause death), and latah (imitative and automatic response behaviour). The strong association of these syndromes with locally accepted cultural beliefs and patterns of behaviour indicates that they are probably best regarded as not delusional.

F48.9 Neurotic disorder, unspecified

F50 - F59 BEHAVIOURAL SYNDROMES ASSOCIATED WITH PHYSIOLOGICAL DISTURBANCES AND PHYSICAL FACTORS

F50 EATING DISORDERS

F50.0 Anorexia nervosa

A. Weight loss, or in children a lack of weight gain, leading to a body weight of at least 15% below the normal or expected weight for age and height.

B. The weight loss is self-induced by avoidance of "fattening foods".

C. A self-perception of being too fat, with an intrusive dread of fatness, which leads to a self-imposed low weight threshold.

D. A widespread endocrine disorder involving the hypothalamic-pituitary-gonadal axis, manifest in the female as amenorrhoea, and in the male as a loss of sexual interest and potency (an apparent exception is the persistence of vaginal bleeds in anorexic women who are on replacement hormonal therapy, most commonly taken as a contraceptive pill).

E. Does not meet criteria A and B of Bulimia nervosa (F50.2).

Comments: The following features support the diagnosis, but are not necessary elements: self-induced vomiting; self-induced purging; excessive exercise; use of appetite suppressants and/or diuretics.

If onset is pre-pubertal, the sequence of pubertal events is delayed or even arrested (growth ceases; in girls the breasts do not develop and there is a primary amenorrhoea; in boys the genitals remain juvenile). With recovery, puberty is often completed normally, but the menarche is late.

F50.1 Atypical anorexia nervosa

Researchers studying atypical forms of anorexia nervosa are recommended to make their own decision about the number and type of criteria to be fulfilled.

F50.2 Bulimia nervosa

A. Recurrent episodes of overeating (at least two times per week over a period of three months) in which large amounts of food are consumed in short periods of time.

B. Persistent preoccupation with eating and a strong desire or a sense of compulsion to eat (craving).

C. The patient attempts to counteract the fattening effects of food by one or more of the following:

(1) self-induced vomiting;

(2) self-induced purging;

(3) alternating periods of starvation;

(4) use of drugs such as appetite suppressants, thyroid preparations or diuretics. When bulimia occurs in diabetic patients they may choose to neglect their insulin treatment.

D. A self-perception of being too fat, with an intrusive dread of fatness (usually leading to underweight).

F50.3 Atypical bulimia nervosa

Researchers studying atypical forms of bulimia nervosa, such as those involving normal or excessive body weight, are recommended to make their own decision about the number and type of criteria to be fulfilled.

F50.8 Other eating disorders

F50.9 Eating disorder, unspecified

F51 NONORGANIC SLEEP DISORDERS

Comments: a more comprehensive classification of sleep disorders is available (International Classification of Sleep Disorders[1]) but it should be noted that this is organized on a different basis than ICD-10. For some research purposes, where particularly homogenous groups of sleep disorders are required, a specification of 4 or more within a one-year period should be considered for categories F51.3, F51.4 and F51.5.

F51.0 Nonorganic insomnia

A. A complaint of difficulty falling asleep, maintaining sleep, or non refreshing sleep.

B. The sleep disturbance occurs at least three times per week for at least one month.

C. The sleep disturbance results in marked personal distress or interference with personal functioning in daily living.

D. Absence of any known causative organic factor, such as a neurological or other medical condition, psychoactive substance use disorder or a medication.

F51.1 Nonorganic hypersomnia

A. A complaint of excessive daytime sleepiness or sleep attacks or prolonged transition to the fully aroused state upon awakening (sleep drunkenness) (not accounted for by an inadequate amount of sleep).

---

[1] Diagnostic Classification Steering Committee, Thorpy M.J., Chairman. International classification of sleep disorders: Diagnostic and coding manual. Rochester, Minnesota. American Sleep Disorders Association, 1990.

B. This sleep disturbance occurs nearly every day for at least one month or recurrently for shorter periods of time and causes either marked distress or interference with personal functioning in daily living .

C. Absence of auxiliary symptoms of narcolepsy (cataplexy, sleep paralysis, hypnagogic hallucinations) or of clinical evidence for sleep apnoea (nocturnal breath cessation, typical intermittent snorting sounds, etc.).

D. Absence of any known causative organic factor, such as a neurological or other medical condition, psychoactive substance use disorder or a medication.

F51.2 Nonorganic disorder of the sleep-wake schedule

A. The individual's sleep-wake pattern is out of synchrony with the desired sleep-wake schedule, as imposed by societal demands and shared by most people in the individual's environment.

B. As a result of this disturbance the individual experiences insomnia during the major sleep period or hypersomnia during the waking period, nearly every day for at least one month or recurrently for shorter periods of time.

C. The unsatisfactory quantity, quality and timing of sleep either causes marked personal distress or interferes with personal functioning in daily living.

D. Absence of any known causative organic factor, such as a neurological or other medical condition, psychoactive substance use disorder or a medication.

F51.3 Sleepwalking [somnambulism]

A. The predominant symptom is repeated (two or more) episodes of rising from bed during sleep and walking about for several minutes to one half hour, usually occurring during the first third of nocturnal sleep.

B. During an episode, the individual has a blank staring face, is relatively unresponsive to the efforts of others to influence the event or to communicate with him or her and can be awakened only with considerable difficulty.

C. Upon awakening (either from an episode or the next morning), the individual has amnesia for the episode.

D. Within several minutes of awakening from the episode, there is no impairment of mental activity or behaviour, although there may initially be a short period of some confusion and disorientation.

E. Absence of any evidence of an organic mental disorder, such as dementia, or a physical disorder, such as epilepsy.

F51.4 Sleep terrors [night terrors]

A. Repeated (two or more) episodes in which the individual gets up from sleep with a panicky scream and intense anxiety, body motility and autonomic hyperactivity, (such as tachycardia, heart pounding, rapid breathing and sweating).

B. The episodes occur mainly during the first third of sleep.

C. The duration of the episode is less than ten minutes.

D. If others try to comfort the individual during the episode there is lack of response followed by disorientation and perseverative movements.

E. Limited recall of the event.

F. Absence of any known causative organic factor, such as a neurological or other medical condition, psychoactive substance use disorder or a medication.

F51.5 Nightmares

A. Awakening from nocturnal sleep or naps with detailed and vivid recall of intensely frightening dreams, usually involving threats to survival, security or self-esteem. The awakening may occur during any time of the sleep period, although they typically occur during the second half.

B. Upon awakening from the frightening dreams, the individual rapidly becomes oriented and alert.

C. The dream experience itself and the disturbance of sleep resulting from the awakenings associated with the episodes cause marked distress to the individual.

D. Absence of any known causative organic factor, such as a neurological or other medical condition, psychoactive substance use disorder or a medication.

F51.8 Other nonorganic sleep disorders

F51.9 Nonorganic sleep disorders, unspecified

F52 SEXUAL DYSFUNCTION, NOT CAUSED BY ORGANIC DISORDER OR DISEASE

G1. The subject is unable to participate in a sexual relationship as he or she should wish.

G2. The dysfunction occurs frequently, but may be absent on some occasions.

G3. The dysfunction has been present for at least six months.

G4. Not entirely attributable to any of the other mental and behavioural disorders in ICD-10, physical disorders (such as endocrine disorder) or drug treatment.

Comments: Measurement of each form of dysfunction can be based on rating scales which assess severity as well as frequency of the problem. More than one type of dysfunction can coexist.

F52.0 Lack or loss of sexual desire

A. The general criteria for sexual dysfunction (F52) must be met.

B. Lack or loss of sexual desire, manifest by diminution of seeking out sexual cues; thinking about sex with associated feelings of desire or appetite; or sexual fantasies.

C. Lack of interest in initiating sexual activity either with partner or as solitary masturbation, at a frequency clearly lower than expected, taking into account age and context, or at a frequency very clearly reduced from previous much higher levels.

F52.1 Sexual aversion and lack of sexual enjoyment

F52.10 Sexual aversion

A. The general criteria for sexual dysfunction (F52) must be met.

B. The prospect of sexual interaction with a partner produces sufficient aversion, fear or anxiety that sexual activity is avoided, or, if it occurs, is associated with strong negative feelings and an inability to experience any pleasure.

C. Not due to performance anxiety (reaction to previous failure of sexual response).

F52.11 Lack of sexual enjoyment

A. The general criteria for sexual dysfunction (F52) must be met.

B. Genital response (orgasm and/or ejaculation) all occur during sexual stimulation, but are not accompanied by pleasurable sensations or feelings of pleasant excitement.

C. Absence of manifest and persistent fear or anxiety during sexual activity (see F52.10 Sexual aversion).

F52.2 Failure of genital response

A. The general criteria for sexual dysfunction (F52) must be met.

In addition for men:

B. Erection sufficient for intercourse fails to occur when intercourse is attempted.

The dysfunction appears as one of the following:

(1) Full erection occurs during the early stages of lovemaking but disappears or declines when intercourse is attempted (before ejaculation if it occurs).

(2) Erection does occur but only at times when intercourse is not being considered.

(3) Partial erection, insufficient for intercourse, occurs, but not full erection.

(4) No penile tumescence occurs at all.

In addition for women:

B. Failure of genital response, experienced as failure of vaginal lubrication, together with inadequate tumescence of the labia.

The dysfunction appears as one of the following:

(1) General: lubrication fails in all relevant circumstances.

(2) Lubrication may occur initially but fails to persist for long enough to allow comfortable penile entry.

(3) Situational: lubrication occurs only in some situations (e.g. with one partner but not another, or during masturbation, or when vaginal intercourse is not being contemplated).

F52.3 Orgasmic dysfunction

A. The general criteria for sexual dysfunction (F52) must be met.

B. Orgasmic dysfunction (either absence or marked delay) appearing as one of the following:

(1) Orgasm has never been experienced in any situation.

(2) Orgasmic dysfunction has developed after a period of relatively normal response:

a) general: orgasmic dysfunction occurs in all situations and with any partner

b) situational:

for women: Orgasm does occur in certain situations (e.g. when masturbating or with certain partners);

for men, one of the following can be applied:

i) only during sleep, never during the waking state;

ii) never in the presence of the partner;

iii) in the presence of the partner but not within her vagina.

F52.4 Premature ejaculation

A. The general criteria for sexual dysfunction (F52) must be met.

B. Inability to delay ejaculation sufficiently to enjoy love making, manifest as either

(1) Occurrence of ejaculation before or very soon after vaginal entry (if a time limit is required: before or within 15 seconds of vaginal entry), or

(2) Ejaculation in absence of sufficient erection to make vaginal entry possible.

C. Not due to prolonged abstinence of sexual activity.

F52.5 Nonorganic vaginismus

A. The general criteria for sexual dysfunction (F52) must be met.

B. Spasm of the perivaginal muscles sufficient to prevent penile entry or make it uncomfortable.

The dysfunction appears as one of the following:

(1) Normal response has never been experienced.

(2) Vaginismus has developed after a period of relatively normal response:

a) When vaginal entry is not attempted, a normal sexual response may occur.

b) Any attempt at sexual contact leads to generalized fear, and attempts to avoid vaginal entry (e.g. spasm of

the adductor muscles of the thighs).

F52.6 Nonorganic dyspareunia

A. The general criteria for F52 must be met.

In addition for women:

B. Pain during sexual intercourse, experienced at the entry of the vagina, throughout or only when deep thrusting of the penis occurs.

C. Not attributable to vaginismus or failure of lubrication; dyspareunia due to organic pathology should be classified according to the underlying disorder.

In addition for men:

B. Pain or discomfort during sexual response. Careful recording should be established of the timing of the pain and the exact localization.

C. Absence of local physical factors. If found, the dysfunction should be classified elsewhere.

F52.7 Excessive sexual drive

No research criteria are attempted for this category. Researchers studying this category are recommended to design their own criteria.

F52.8 Other sexual dysfunction, not caused by organic disorder or disease

F52.9 Unspecified sexual dysfunction, not caused by organic disorder or disease

F53 MENTAL AND BEHAVIOURAL DISORDERS ASSOCIATED WITH THE PUERPERIUM, NOT ELSEWHERE CLASSIFIED

This category should only be used in research work in exceptional circumstances. Mental disorders associated with the puerperium should be coded according to the presenting psychiatric disorder while a second code (O99.3) will indicate the association with the puerperium.

F53.0 Mild mental and behavioural disorders associated with the puerperium, not elsewhere classified

F53.1 Severe mental and behavioural disorders associated with the puerperium, not elsewhere classified

F53.8 Other mental and behavioural disorders associated with the puerperium, not elsewhere classified

F53.9 Puerperal mental disorder, unspecified

F54 PSYCHOLOGICAL OR BEHAVIOURAL FACTORS ASSOCIATED WITH DISORDERS OR DISEASES CLASSIFIED ELSEWHERE

This category should be used to record the presence of psychological or behavioural factors thought to have influenced the manifestation, or affected the course of physical disorders which can be classified to other chapters. Any resulting mental disturbances are usually mild, and often prolonged (such as worry, emotional conflict, apprehension) and do not of themselves justify the use of any of the categories described in the rest of this book. An additional code should be used to identify the physical disorder. (In the rare instances in which an overt psychiatric disorder is thought to have caused a physical disorder, a second additional code should be used to record the psychiatric disorder).

F55 ABUSE OF NON-DEPENDENCE-PRODUCING SUBSTANCES

A wide variety of medicaments and folk remedies may be involved, but the particularly important groups are: (a) psychotropic drugs that do not produce dependence, such as antidepressants; (b) laxatives, and (c) analgesics that may be purchased without medical prescription, such as aspirin and paracetamol. Although the medication may have been medically prescribed or recommended in the first instance, prolonged, unnecessary, and often excessive dosage develops, which is facilitated by the availability of the substances without medical prescription.

Persistent and unjustified use of these substances is usually associated with unnecessary expense, often involves unnecessary contacts with medical professionals or supporting staff, and is sometimes marked by the harmful physical effects of the substances. Attempts to discourage, or forbid the use of the substance are often met with resistance; for laxatives and analgesics this may be in spite of warnings about (or even the development of) physical harm such as renal dysfunction or electrolyte disturbances. Although it is usually clear that the patient has a strong motivation to take the substance, dependence or withdrawal symptoms do not develop as in the case of the psychoactive substances specified in F10-F19.

A fourth character may be used to identify the type of substance involved:

F55.0 Anti-depressants (such as tricyclic and tetracyclic antidepressants and monamine oxidase inhibitors)

F55.1 Laxatives

F55.2 Analgesics (not specified as psychoactive in F10-F19, such as aspirin, paracetamol, phenacetin)

F55.3 Antacids

F55.4 Vitamins

F55.5 Steroids or hormones

F55.6 Specific herbal or folk remedies

F55.8 Other substances which do not produce dependence (such as diuretics)

F55.9 Unspecified

F59 UNSPECIFIED BEHAVIOURAL SYNDROMES ASSOCIATED WITH PHYSIOLOGICAL DISTURBANCES AND PHYSICAL FACTORS

F60 - F69 DISORDERS OF ADULT PERSONALITY AND BEHAVIOUR

F60 SPECIFIC PERSONALITY DISORDERS

G1. Evidence that the individual's characteristic and enduring patterns of inner experience and behaviour deviate markedly as a whole from the culturally expected and accepted range (or 'norm'). Such deviation must be manifest in more than one of the following areas:

(1) cognition (i.e. ways of perceiving and interpreting things, people and events; forming attitudes and images of self and others);

(2) affectivity (range, intensity and appropriateness of emotional arousaland response);

(3) control over impulses and need gratification;

(4) relating to others and manner of handling interpersonal situations.

G2. The deviation must manifest itself pervasively as behaviour that is inflexible, maladaptive, or otherwise dysfunctional across a broad range of personal and social situations (i.e. not being limited to one specific 'triggering' stimulus or situation).

G3. There is personal distress, or adverse impact on the social environment, or both, clearly attributable to the behaviour referred to under G2.

G4. There must be evidence that the deviation is stable and of long duration, having its onset in late childhood or adolescence.

G5. The deviation cannot be explained as a manifestation or consequence of other adult mental disorders, although episodic or chronic conditions from sections F0 to F7 of this classification may co-exist, or be

superimposed on it.

G6. Organic brain disease, injury, or dysfunction must be excluded as possible cause of the deviation (if such organic causation is demonstrable, use category F07).

Comments: The assessment of G1 to G6 above should be based on as many sources of information as possible. Although sometimes it is possible to obtain sufficient evidence from a single interview with the subject, as a general rule it is recommended to have more than one interview with the person and to collect history data from informants or past records.

It is suggested that sub-criteria should be developed to operationalize behaviour patterns specific to different cultural settings concerning social norms, rules and obligations where needed (such as examples of unresponsibility and disregard of social norms in dissocial personality disorder).

The diagnosis of personality disorder for research purposes requires the identification of a subtype (more than one subtype can be coded if there is compelling evidence that the subject meets multiple sets of criteria).

F60.0 Paranoid personality disorder

A. The general criteria of personality disorder (F60) must be met.

B. At least four of the following must be present:

(1) Excessive sensitivity to setbacks and rebuffs.

(2) Tendency to bear grudges persistently, e.g. unforgiveness of insults, injuries or slights.

(3) Suspiciousness and a pervasive tendency to distort experience by misconstruing the neutral or friendly actions of others as hostile or contemptuous.

(4) A combative and tenacious sense of personal rights out of keeping with the actual situation.

(5) Recurrent suspicions, without justification, regarding sexual fidelity of spouse or sexual partner.

(6) Persistent self-referential attitude, associated particularly with excessive self-importance.

(7) Preoccupation with unsubstantiated "conspiratorial" explanations of events around the subject or in the world at large.

F60.1 Schizoid personality disorder

A. The general criteria of personality disorder (F60) must be met.

B. At least four of the following criteria must be present:

(1) Few, if any, activities provide pleasure.

(2) Displays emotional coldness, detachment, or flattened affectivity.

(3) Limited capacity to express warm, tender feelings for others as well as anger.

(4) Appears indifferent to either praise or criticism of others.

(5) Little interest in having sexual experiences with another person (taking into account age).

(6) Almost always chooses solitary activities.

(7) Excessive preoccupation with fantasy and introspection.

(8) Neither desires, nor has, any close friends or confiding relationships (or only one).

(9) Marked insensitivity to prevailing social norms and conventions; if these are not followed this is unintentional.

F60.2 Dissocial personality disorder

A. The general criteria of personality disorder (F60) must be met.

B. At least three of the following must be present:

(1) Callous unconcern for the feelings of others.

(2) Gross and persistent attitude of irresponsibility and disregard for social norms, rules, and obligations.

(3) Incapacity to maintain enduring relationships, though having no difficulty to establish them.

(4) Very low tolerance to frustration and a low threshold for discharge of aggression, including violence.

(5) Incapacity to experience guilt, or to profit from adverse experience, particularly punishment.

(6) Marked proneness to blame others, or to offer plausible rationalizations for the behaviour bringing the subject into conflict with society.

Comments: Persistent irritability and the presence of conduct disorder during childhood and adolescence, complete the clinical picture but are not required for the diagnosis.

It is suggested that sub-crtieria should be developed to operationalize behaviour patterns specific to different cultural settings concerning social norms, rules and obligations where needed (such as examples of unresponsibility and disregard of social norms).

F60.3 Emotionally unstable personality disorder

F60.30 Impulsive type

A. The general criteria of personality disorder (F60) must be met.

B. At least three of the following must be present, one of which is (2):

(1) A marked tendency to act unexpectedly and without consideration of the consequences.

(2) A marked tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or criticized.

(3) Liability to outbursts of anger or violence, with inability to control the resulting behavioural explosions.

(4) Difficulty in maintaining any course of action that offers no immediate reward.

(5) Unstable and capricious mood.

F60.31 Borderline type

A. The general criteria of personality disorder (F60) must be met.

B. At least three of the symptoms mentioned above in criterion B (F60.30) must be present, and in addition at least two of the following:

(6) Disturbances in and uncertainty about self-image, aims and internal preferences (including sexual).

(7) Liability to become involved in intense and unstable relationships, often leading to emotional crises.

(8) Excessive efforts to avoid abandonment.

(9) Recurrent threats or acts of self-harm.

(10) Chronic feelings of emptiness.

F60.4 Histrionic personality disorder

A. The general criteria of personality disorder (F60) must be met.

B. At least four of the following must be present:

(1) Self-dramatization, theatricality, or exaggerated expression of emotions.

(2) Suggestibility, easily influenced by others or by circumstances.

(3) Shallow and labile affectivity.

(4) Continually seeks excitement and activities in which the subject is the centre of attention.

(5) Inappropriately seductive in appearance or behaviour.

(6) Overly concerned with physical attractiveness.

Comments: Egocentricity, self-indulgence, continuous longing for appreciation, lack of consideration for others, feelings that are easily hurt, and persistent manipulative behaviour complete the clinical picture, but are not required for the diagnosis.

F60.5 Anankastic personality disorder

Note: Often referred to as obsessive-compulsive personality disorder.

A. The general criteria of personality disorder (F60) must be met.

B. At least four of the following must be present:

(1) Feelings of excessive doubt and caution.

(2) Preoccupation with details, rules, lists, order, organization or schedule.

(3) Perfectionism that interferes with task completion.

(4) Excessive conscientiousness and scrupulousness.

(5) Undue preoccupation with productivity to the exclusion of pleasure and interpersonal relationships.

(6) Excessive pedantry and adherence to social conventions.

(7) Rigidity and stubbornness.

(8) Unreasonable insistence that others submit to exactly his or her way of doing things, or unreasonable reluctance to allow others to do things.

F60.6 Anxious [avoidant] personality disorder

A. The general criteria of personality disorder (F60) must be met.

B. At least four of the following must be present:

(1) Persistent and pervasive feelings of tension and apprehension.

(2) Belief that oneself is socially inept, personally unappealing, or inferior to others.

(3) Excessive preoccupation about being criticized or rejected in social situations.

(4) Unwillingness to get involved with people unless certain of being liked.

(5) Restrictions in lifestyle because of need of security.

(6) Avoidance of social or occupational activities that involve significant interpersonal contact, because of fear of criticism, disapproval or rejection.

F60.7 Dependent personality disorder

A. The general criteria of personality disorder (F60) must be met.

B. At least four of the following must be present:

(1) Encouraging or allowing others to make most of one's important life decisions.

(2) Subordination of one's own needs to those of others on whom one is dependent, and undue compliance with their wishes.

(3) Unwillingness to make even reasonable demands on the people one depends on.

(4) Feeling uncomfortable or helpless when alone, because of exaggerated fears of inability to care for oneself.

(5) Preoccupation with fears of being left to take care of oneself.

(6) Limited capacity to make everyday decisions without an excessive amount of advice and reassurance from

others.

F60.8 Other specified personality disorders

If none of the preceding rubrics is fitting, but a condition meeting the general criteria for personality disorder listed under F60 is nevertheless present, use this code. An extra character may be added for identifying specific personality disorders not currently in ICD-10. In using code F60.8, it is recommended always to record a vignette description of the specific disorder.

F60.9 Personality disorder, unspecified

F61 MIXED AND OTHER PERSONALITY DISORDERS

It has not been attempted to provide standard sets of criteria for these mixed disorders, since those doing research in this field will prefer to state their own criteria depending upon the purpose of the study.

F61.0 Mixed personality disorders

Features of several of the disorders in F60.- are present, but not to the extent that the criteria for any of the specified personality disorders in F60 are met.

F61.1 Troublesome personality changes, not classifiable in F60 or F62

Not classifiable in F60.- or F62.- and regarded as secondary to a main diagnosis of a coexisting affective or anxiety disorder.

F62 ENDURING PERSONALITY CHANGES, NOT ATTRIBUTABLE TO BRAIN DAMAGE AND DISEASE

F62.0 Enduring personality change after catastrophic experience

A. Evidence, (from the personal history or from key informants), of a definite and persistent change in a person's pattern of perceiving, relating to and thinking about the environment and one self, following exposure to catastrophic stress (i.e. concentration camp experience; torture; disaster; prolonged exposure to life-threatening situations).

B. The personality change should be significant and represent inflexible and maladaptive features as indicated by the presence of at least two of the following:

(1) A permanent hostile or distrustful attitude toward the world in a person who previously was not showing any such traits.

(2) Social withdrawal (avoidance of contacts with persons other than a few close relatives with whom he/she lives with) which is not due to another current mental disorder like a mood disorder.

(3) A constant feeling of emptiness and/or hopelessness, not limited to a discrete episode of mood disorder, and which was not present before the catastrophic stress experience; this may be associated with an increased dependency on others; inability to express negative or aggressive feelings; and prolonged depressive mood without any evidence of depressive disorder before the catastrophic stress exposure.

(4) An enduring feeling of "being on edge" or being threatened without any external cause, as evidenced by an increased vigilance and irritability in a person who previously showed no such traits or hyper-alertness. This chronic state of inner tension and feeling threatened may be associated with a tendency to excessive drinking or use of drugs.

(5) A permanent feeling of being changed or being different from the others (estrangement). This feeling may be associated with an experience of emotional numbness.

C. The change should cause either significant interference with personal functioning in daily living, personal distress or adverse impact on the social environment.

D. The personality change should have developed after the catastrophic experience and there should be no history of a pre-existing adult personality disorder or trait accentuation, or personality or developmental disorders during childhood or adolescence, that could explain the current personality traits.

E. The personality change must have been present for at least three years. It is not related to episodes of other mental disorder, (except post-traumatic stress disorder) and cannot be explained by brain damage or disease.

F. The personality change meeting the above criteria is often preceded by a post-traumatic stress disorder (F43.1). The symptoms of the two conditions can overlap and the personality change may be a chronic outcome of a post-traumatic stress disorder. However, an enduring personality change should not be assumed in such cases unless, in addition to at least two years of post-traumatic stress disorder there has been a further period of no less than two years during which the above criteria have been met.

<u>F62.1 Enduring personality change after psychiatric illness</u>

A. Evidence of a definite and enduring change in the person's pattern of perceiving, relating to and thinking about the environment and one self, following the experience of suffering from one or several episodes of psychiatric illness from which the person has recovered clinically without residual symptoms.

B. The personality change should be significant and represent inflexible and maladaptive features as indicated by the presence of at least two of the following:

(1) Dependency on others (passively assumes, or demands, that others take responsibility for his/her own life;

unwilling to decide on important issues related to own actions or future).

(2) Social withdrawal or isolation secondary to a conviction (not delusional) or feeling of being "changed" or stigmatized as a result of the illness. This conviction or feeling may be strengthened by societal attitudes but cannot be completely explained by the objective social circumstances. Feeling vulnerable to others' moral opprobrium (narcissistic injury) may also be a factor but such feeling should be ego-syntonic if it is to be considered an enduring personality trait.

(3) Passivity, reduced interests and diminished involvement in previously entertained leisure activities (which may reinforce the social isolation).

(4) A change in the person's perception of self leading to a frequent or constant claim of being ill. This feature may be associated with hypochondriacal behaviour and an increased utilization of psychiatric or other medical services.

(5) A demanding attitude toward other persons in which the subject expects special favours or consider himself/herself deserving special attention or treatment.

(6) Dysphoric or labile mood, not due to a current mental disorder or antecedent mental disorder with residual affective symptoms.

C. The personality change following the psychiatric illness must be understandable in terms of the person's subjective emotional experience of the situation; his/her previous adjustment and vulnerabilities, and life-situation including the significant others' attitudes or reactions following the illness.

D. The personality change should cause either significant interference with personal functioning in daily living, personal distress, or adverse impact on the social environment.

E. There should be no history of a pre-existing previous adult personality disorder or trait accentuation or personality or developmental disorders during childhood or adolescence that could explain the current

personality traits.

F. The personality change has been present for at least two years and is not a manifestation of another mental disorder or secondary to brain damage or disease.

F62.8 Other enduring personality changes

F62.9 Enduring personality change, unspecified

F63 HABIT AND IMPULSE DISORDERS

F63.0 Pathological gambling

A. Repeated (two or more) episodes of gambling over a period of at least one year.

B. These episodes do not have a profitable outcome for the person, but are continued despite personal distress and interference with personal functioning in daily living.

C. The person describes an intense urge to gamble which is difficult to control, and reports that he or she is unable to stop gambling by an effort of will.

D. The person is preoccupied with thoughts or mental images of the act of gambling or the circumstances surrounding the act.

F63.1 Pathological fire-setting [pyromania]

A. Repeated (two or more) acts of, fire-setting without apparent motive.

B. The person describes an intense urge to set fire to objects, with a feeling of tension before the act and relief

afterwards.

C. The person is pre-occupied with thoughts or mental images of fire-setting or of the circumstances surrounding the act (e.g. with fire engines, or with calling out the fire brigade).

F63.2 Pathological stealing [kleptomania]

A. Repeated (two or more) acts in which the person steals without any apparent motive of gain to the individual or another person.

B. The person describes an intense urge to steal with a feeling of tension before the act with relief afterwards.

F63.3 Trichotillomania

A. Noticeable hair-loss due to a persistent and recurrent failure to resist impulses to pull out hairs.

B. The person describes an intense urge to pull out hairs with a mounting tension before and a sense of relief afterwards.

C. Absence of a pre-existing inflammation of the skin; not in response to a delusion or hallucination.

F63.8 Other habit and impulse disorders

This category should be used for other kinds of persistently repeated maladaptive behaviour that are not secondary to a recognized psychiatric syndrome, and in which it appears that there is repeated failure to resist impulses to carry out the behaviour. There is a prodromal period of tension with a feeling of release at the time of the act.

F63.9 Habit and impulse disorder, unspecified

F64 GENDER IDENTITY DISORDERS

F64.0 Transsexualism

A. Desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make one's body as congruent as possible with one's preferred sex through surgery and hormonal treatment.

B. Presence of the transsexual identity for at least two years persistently.

C. Not a symptom of another mental disorder, such as schizophrenia, or associated with chromosome abnormality.

F64.1 Dual-role transvestism

A. Wearing clothes of the opposite sex in order to experience temporarily membership of the opposite sex.

B. Absence of any sexual motivation for the cross-dressing.

C. Absence of any desire to change permanently into the opposite sex.

F64.2 Gender identity disorder of childhood

For females:

A. Persistent and intense distress about being a girl, and a stated desire to be a boy (not merely a desire for any perceived cultural advantages from being a boy), or insistence that she is a boy.

B. Either (1) or (2):

(1) Persistent marked aversion to normative feminine clothing and insistence on wearing stereotypical masculine clothing, e.g. boys' underwear and other accessories.

(2) Persistent repudiation of female anatomic structures, as evidenced by at least one of the following:

(a) an assertion that she has, or will grow, a penis

(b) rejection of urinating in a sitting position

(c) assertion that she does not want to grow breasts or menstruate

C. The girl has not yet reached puberty.

D. The disorder must have been present for at least six months.

For males:

A. Persistent and intense distress about being a boy and an intense desire to be a girl or, more rarely, insistence that he is a girl.

B. Either (1) or (2):

(1) Preoccupation with female stereotypical activities, as shown by a preference for either cross-dressing or simulating female attire, or by an intense desire to participate in the games and pastimes of girls and rejection of male stereotypic toys, games and activities.

(2) Persistent repudiation of male anatomic structures, as indicated by at least one of the following repeated assertions:

(a) that he will grow up to become a woman (not merely in role)

(b) that his penis or testes are disgusting or will disappear

(c) that it would be better not to have a penis or testes.

C. The boy has not yet reached puberty.

D. The disorder must have been present for at least six months.

F64.8 Other gender identity disorders

F64.9 Gender identity disorder, unspecified

F65 DISORDERS OF SEXUAL PREFERENCE

G1. Recurrent intense sexual urges and fantasies involving unusual objects or activities.

G2. Acts on the urges or is markedly distressed by them.

G3. The preference has been present for at least six months.

F65.0 Fetishism

A. The general criteria for F65 Disorders of sexual preference must be met.

B. The fetish (some non-living object) is the most important source of sexual stimulation; or is essential for satisfactory sexual response.

F65.1 Fetishistic transvestism

A. The general criteria for F65 Disorders of sexual preference must be met.

B. The wearing of articles or clothing of the opposite set in order to create the appearance and feeling of being

a member of the opposite sex.

C. The cross-dressing is closely associated with sexual arousal. Once orgasm occurs and sexual arousal declines, there is a strong desire to remove the clothing.

F65.2 Exhibitionism

A. The general criteria for F65 Disorders of sexual preference must be met.

B. Either a recurrent or a persistent tendency to expose one's genitalia to unsuspecting strangers (usually of the opposite sex), almost invariably associated with sexual arousal and masturbation.

C. There is no intention or invitation to sexual intercourse with the "witness(es)".

F65.3 Voyeurism

A. The general criteria for F65 Disorders of sexual preference must be met.

B. Either a recurrent or a persistent tendency to look at people engaging in sexual or intimate behaviour such as undressing, associated with sexual excitement and masturbation.

C. There is no intention to reveal one's presence.

D. There is no intention to have a sexual involvement with the person(s) observed.

F65.4 Paedophilia

A. The general criteria for F65 Disorders of sexual preference must be met.

B. A persistent or a predominant preference for sexual activity with a prepubescent child or children.

C. The person is at least 16 years old and at least five years older than the child or children in B.

F65.5 Sado-masochism

A. The general criteria for F65 Disorders of sexual preference must be met.

B. A preference for sexual activity, either as recipient (masochism), or as provider (sadism), or both, which involves at least one of the following:

(1) pain;

(2) humiliation;

(3) bondage.

C. The sado-masochistic activity is the most important source of stimulation or necessary for sexual gratification.

F65.6 Multiple disorders of sexual preference

The likelihood of more than one abnormal sexual preference occurring in one individual is greater than would be expected by chance. For research purposes the different types of preference, and their relative importance to the individual, should be listed. The most common combination is fetishism, transvestism and sado-masochism.

F65.8 Other disorders of sexual preference

A variety of other patterns of sexual preference and activity may occur, each being relatively uncommon. These include such activities as making obscene telephone calls, rubbing up against people for sexual stimulation in crowded public places (frotteurism), sexual activity with animals, use of strangulation or anoxia for intensifying sexual excitement, and a preference for partners with some particular anatomical abnormality such as an amputated

limb.

Erotic practices are too diverse and many too rare or idiosyncratic to justify a separate term for each. Swallowing urine, smearing faeces, or piercing foreskin or nipples may be part of the behavioural repertoire in sadomasochism. Masturbatory rituals of various kinds are common, but the more extreme practices, such as the insertion of objects into the rectum or penile urethra, or partial self-strangulation, when they take the place of ordinary sexual contacts, amounts to abnormalities. Necrophilia should also be coded here.

F65.9 Disorder of sexual preference, unspecified

F66 PSYCHOLOGICAL AND BEHAVIOURAL DISORDERS ASSOCIATED WITH SEXUAL DEVELOPMENT AND ORIENTATION

This section is intended to cover those types of problems which derive from variations of sexual development or orientation, when the sexual preference per se is not necessarily problematic or abnormal.

F66.0 Sexual maturation disorder

The patient is suffering from uncertainty about his gender identity or sexual orientation, causing anxiety or depression.

F66.1 Egodystonic sexual orientation

The gender identity or sexual preference is not in doubt, but the individual wishes it were different.

F66.2 Sexual relationship disorder

The gender identity or sexual preference abnormality is responsible for difficulties in forming or maintaining a relationship with a sexual partner.

F66.8 Other psychosexual development disorders

F66.9 Psychosexual development disorder, unspecified

F68 OTHER DISORDERS OF ADULT PERSONALITY AND BEHAVIOUR

F68.0 Elaboration of physical symptoms for psychological reasons

A. Physical symptoms originally due to a confirmed physical disorder, disease or disabilty become exaggerated or prolonged in excess of what can be explained by the physical disorder itself.

B. There is evidence for a psychological causation for the excess symptoms (such as evident fear of disability or death; possible financial compensation; disappointment at the standard of care experienced, etc.).

F68.1 Intentional production or feigning of symptoms or disabilities, either physical or psychological [factitious disorder]

A. A persistent pattern of intentional production or feigning of symptoms and/or self-infliction of wounds in order to produce symptoms.

B. No evidence can be found for an external motivation (such as financial compensations, escape from danger, more medical care, etc.). If such evidence can be found category Z76.5 should be used (malingering).

C. Most commonly used exclusion criteria: absence of a confirmed physical or mental disorder, which could explain the symptoms.

F68.8 Other specified disorders of adult personality and behaviour

This category should be used for coding any specified disorder of adult personality and behaviour that cannot be classified under any one of the preceding headings.

F69 UNSPECIFIED DISORDER OF ADULT PERSONALITY AND DISORDER

This code should be used only as a last resort, if the presence of a disorder of adult personality and behaviour can be assumed, but information to allow its diagnosis and allocation to a specific category is lacking.

F70 - F79 MENTAL RETARDATION

Detailed clinical diagnostic criteria that can be used internationally for research cannot be specified for mental retardation in the same way as they can for most of the other disorders in Chapter V (F). This is because the two main components of mental retardation, namely low cognitive ability and diminished social competence, are both profoundly affected by social and cultural influences in the way that they become manifest. Only general guidance can be given here about the most appropriate methods of assessment to use.

1. Level of cognitive abilities

Depending upon the cultural norms and expectations of the subjects, research workers must make their own judgements as to how best to estimate Intelligence Quotient or Mental Age according to the bands given in F7, as below viz:

Category	Mental retardation	I.Q. range	Mental age
F70	Mild	50-69	9 - under 12 years
F71	Moderate	35-49	6 - under 9 years
F72	Severe	20-34	3 - under 6 years
F73	Profound	under 20	below 3 years

2. Level of social competence

Within most European and American cultures the Vineland Social Maturity Scale is recommended for use,

if it is judged to be appropriate (modified versions or equivalent scales need to be developed for use in other cultures).

A fourth character may be used to specify the extent of associated impairment of behaviour.

F7x.0 No, or minimal, impairment of behaviour

F7x.1 Significant impairment of behaviour requiring attention or treatment

F7x.8 Other impairments of behaviour

F7x.9 Without mention of impairment of behaviour

Comments: A specially designed multi-axial system is required to do justice to the variety of personal, clinical and social statements needed for the comprehensive assessment of the causes and consequences of mental retardation. One such system is now in preparation for this section of Chapter V (F) of ICD-10.

F80 - F89 DISORDERS OF PSYCHOLOGICAL DEVELOPMENTAL

F80 SPECIFIC DEVELOPMENTAL DISORDERS OF SPEECH AND LANGUAGE

F80.0 Specific speech articulation disorder

Note: Also referred to as Specific speech phonological disorder.

A. Articulation (phonological) skills, as assessed on standardized tests, below the 2 standard deviations limit for the child's age.

B. Articulation (phonological) skills at least 1 standard deviation below nonverbal IQ as assessed on a standardizerd test.

C. Language expression and comprehension, as assessed on a standardized test, within the 2 standard deviation limit for the child's age.

D. Absence of neurological, sensory or physical impairments that directly affect speech sound production, or a pervasive developmental disorder (F84.-).

E. Most commonly used exclusion criterion: Nonverbal IQ below 70 on a standardized test.

F80.1 Expressive language disorder

A. Expressive language skills, as assessed on standardized tests, below the 2 standard deviation limit for the child's age.

B. Expressive language skills at least 1 standard deviation below nonverbal IQ as assessed on a standardized test.

C. Receptive language skills, as assessed on standardized tests, within the 2 standard deviation limit for the child's age.

D. Use and understanding of non-verbal communication and imaginative language functions within the normal range.

E. Absence of neurological, sensory or physical impairments that directly affect use of spoken language, or of a pervasive developmental disorder

(F84.-).

F. Most commonly used exclusion criterion: Nonverbal IQ below 70 on a standardized test.

F80.2 Receptive language disorder

Note: Also referred to as Mixed receptive/expressive disorder.

A. Language comprehension, as assessed on standardized tests, below the 2 standard deviations limit for the child's age.

B. Receptive language skills at least 1 standard deviation below non-verbal IQ as assessed on a standardized test.

C. Absence of neurological, sensory, or physical impairments that directly affect receptive language, or of a pervasive developmental disorder

(F84.-).

D. Most commonly used exclusion criterion: Nonverbal IQ below 70 on a standardized test.

F80.5 Acquired aphasia with epilepsy [Landau-Kleffner syndrome]

A. Severe loss of expressive and receptive language skills over the course of a time period not exceeding six months.

B. Normal language development prior to the loss of language.

C. Paroxysmal EEG abnormalities affecting one or both temporal lobes that become apparent within a time span extending from two years before to two years after the initial loss of language.

D. Hearing within the normal range.

E. Retention of a level of non-verbal intelligence within the normal range.

F. Absence of any diagnosable neurological condition other than that implicit in the abnormal EEG and presence of epileptic seizures (when they occur).

G. Does not meet the criteria for a pervasive developmental disorder (F84.-).

F80.8 Other developmental disorders of speech and language

F80.9 Developmental disorder of speech and language, unspecified

This category should be avoided as far as possible and should be used only for unspecified disorders in which there is significant impairment in the development of speech or language that cannot be accounted for by mental retardation, or by neurological, sensory or physical impairments that directly affect speech or language.

F81 SPECIFIC DEVELOPMENTAL DISORDERS OF SCHOLASTIC SKILLS

F81.0 Specific reading disorder

A. Either (1) or (2):

(1) A score on reading accuracy and/or comprehension that is at least 2 standard errors of prediction below the level expected on the basis of the child's chronological age and general intelligence; with both reading skills and IQ assessed on an individually administered test standardized for the child's culture and educational system.

(2) A history of serious reading difficulties, or test scores that met criteria A (1) at an earlier age, plus a score on a spelling test that is at least 2 standard errors of prediction below the level expected on the basis of the child's chronological age and IQ.

B. The disturbance in A significantly interferes with academic achievement or activities of daily living that require reading skills.

C. Not directly due to a defect in visual or hearing acuity, or to a neurological disorder.

D. School experiences within the average expectable range (i.e. there have been no extreme inadequacies in educational experiences).

E. Most commonly used exclusion criterion: IQ below 70 on an individually administered standardized test.

Possible additional inclusion criterion: For some research purposes investigators may wish to specify: "A history of some level of impairment during the preschool years in speech, language, sound categorization, motor coordination, visual processing, attention or activity control or modulation."

Comments: The above criteria would not include general reading backwardness of a type that would fall within the clinical guidelines. The research diagnostic criteria for general reading backwardness would be the same as for specific reading disorder except that criterium A1 would specify reading skills 2 standard error of prediction below

the level expected on the basis of chronological age (i.e. not taking IQ into account), and criterium A2 would follow the same principle for spelling. The validity of the differentiation between these two varieties of reading problems is not unequivocally established but it seems that the specific type has a more specific association with language retardation (whereas general reading backwardness is associated with a wider range of developmental disabilities), and shows a stronger male preponderance.

There are also further research differentiations that are based on analyses of the types of spelling errors.

F81.1 Specific spelling disorder

A. A score on a standardized spelling test that is at least 2 standard errors of prediction below the level expected on the basis of the child's chronological age and general intelligence.

B. Scores on reading accuracy and comprehension, and on arithmetic, that are within the normal range (± 2 standard deviations from the mean).

C. No history of significant reading difficulties.

D. School experience within the average expectable range (i.e. there have been no extreme inadequacies in educational experiences).

E. Spelling difficulties present from the early stages of learning to spell.

F. The disturbance in A significantly interferes with academic achievement or activities of daily living that require spelling skills.

G. Most commonly used exclusion criterion: IQ below 70 on an individually administered standardized test.

F81.2 Specific disorder of arithmetical skills

A. A score on a standardized arithmetic test that is at least 2 standard errors of prediction below the level expected on the basis of the child's chronological age and general intelligence.

B. Scores on reading accuracy and comprehension, and on spelling that are within the normal range (± 2 standard deviations from the mean).

C. No history of significant reading or spelling difficulties.

D. School experience within the average expectable range (i.e. there have been no extreme inadequacies in educational experience).

E. Arithmetic difficulties present from the early stages of learning arithmetic.

F. The disturbance in A significantly interferes with academic achievement or activities of daily living that require mathematical skills.

G. Most commonly used exclusion criterion: IQ below 70 on an individually administered standardized test.

F81.3 Mixed disorder of scholastic skills

This is an ill-defined, inadequately conceptualized (but necessary) residual category of disorders in which both arithmetical and reading or spelling skills are significantly impaired, but in which the disorder is not solely explicable in terms of general mental retardation or inadequate schooling. It should be used for disorders meeting the criteria for F81.2 and either F81.0 or F81.1.

F81.8 Other developmental disorders of scholastic skills

F81.9 Developmental disorder of scholastic skills, unspecified

This category should be avoided as far as possible and should be used only for unspecified disorders in

which there is a significant disability of learning that cannot be solely accounted for by mental retardation, visual acuity problems, or inadequate schooling.

F82 SPECIFIC DEVELOPMENTAL DISORDER OF MOTOR FUNCTION

A. A score on a standardized test of fine or gross motor coordination that is at least two standard deviations below the level expected for the child's chronological age.

B. The disturbance in A significantly interferes with academic achievement or activities of daily living.

C. No diagnosable neurological disorder.

D. Most commonly used exclusion criterion: IQ below 70 on an individually administered standardized test.

F83 MIXED SPECIFIC DEVELOPMENTAL DISORDERS

This is an ill-defined, inadequately conceptualized (but necessary) residual category of disorders in which there is some admixture of specific developmental disorders of speech and language, of scholastic skills, or of motor function, but in which none predominates sufficiently to constitute the prime diagnosis. It is common for each of these specific developmental disorders to be associated with some degree of general impairment of cognitive functions, and this mixed category should be used only when there is a major overlap. Thus, the category should be used when there are dysfunctions meeting the criteria for two or more of F80.-, F81.-, and F82.

F84 PERVASIVE DEVELOPMENTAL DISORDERS

F84.0 Childhood autism

A. Presence of abnormal or impaired development before the age of three years, in at least one out of the following areas:

(1) receptive or expressive language as used in social communication;

(2) the development of selective social attachments or of reciprocal social interaction;

(3) functional or symbolic play.

B. Qualitative abnormalities in reciprocal social interaction, manifest in at least one of the following areas:

(1) failure adequately to use eye-to-eye gaze, facial expression, body posture and gesture to regulate social interaction;

(2) failure to develop (in a manner appropriate to mental age, and despite ample opportunities) peer relationships that involve a mutual sharing of interests, activities and emotions;

(3) A lack of socio-emotional reciprocity as shown by an impaired or deviant response to other people's emotions; or lack of modulation of behaviour according to social context, or a weak integration of social, emotional and communicative behaviours.

C. Qualitative abnormalities in communication, manifest in at least two of the following areas:

(1) a delay in, or total lack of development of spoken language that is <u>not</u> accompanied by an attempt to compensate through the use of gesture or mime as alternative modes of communication (often preceded by a lack of communicative babbling);

(2) relative failure to initiate or sustain conversational interchange (at whatever level of language skills are present) in which there is reciprocal to and from responsiveness to the communications of the other person;

(3) stereotyped and repetitive use of language or idiosyncratic use of words or phrases;

(4) abnormalities in pitch, stress, rate, rhythm and intonation of speech;

D. Restricted, repetitive, and stereotyped patterns of behaviour, interests and activities, manifest in at least two of the following areas:

(1) an encompassing preoccupation with one or more stereotyped and restricted patterns of interest that are abnormal in content or focus; or one or more interests that are abnormal in their intensity and circumscribed nature although not abnormal in their content or focus.

(2) apparently compulsive adherence to specific, non-functional, routines or rituals;

(3) stereotyped and repetitive motor mannerisms that involve either hand or finger flapping or twisting, or complex whole body movements;

(4) preoccupations with part-objects or non-functional elements of play materials (such as their odour, the feel of their surface, or the noise or vibration that they generate);

(5) distress over changes in small, non-functional, details of the environment.

E. The clinical picture is not attributable to the other varieties of pervasive developmental disorder; specific developmental disorder of receptive language (F80.2) with secondary socio-emotional problems; reactive attachment disorder (F94.1) or disinhibited attachment disorder (F94.2); mental retardation (F70-F72) with some associated emotional or behavioural disorder; schizophrenia (F20) of unusually early onset; and Rett's syndrome (F84.2).

F84.1 Atypical autism

A. Presence of abnormal or impaired development at or after age three years (criteria as for autism except for age of manifestation).

B. Qualitative abnormalities in reciprocal social interaction or in communication, or restricted, repetitive and stereotyped patterns of behaviour, interests and activities (criteria as for autism except that it is not necessary to meet the criteria in terms of number of areas of abnormality).

C. The disorder does not meet the diagnostic criteria for autism (F84.0).

Autism may be atypical in either age of onset (F84.11) or phenomenology (84.12), these two types being differentiated with a fifth character for research purposes. Syndromes that are atypical in both respects should be coded F84.12.

F84.10 Atypicality in age of onset

A. Does not meet criterion A for autism. That is, abnormal or impaired development is evident only at or after age three years.

B. Meets criteria B, C, D and E for autism (F84.0).

F84.11 Atypicality in symptomatology

A. Meets criterion A for autism (i.e. presence of abnormal or impaired development before the age of three years).

B. Qualitative abnormalities in reciprocal social interactions or in communication, or restricted, repetitive and stereotyped patterns of behaviour, interests and activities (criteria as for autism except that it is not necessary to meet the criteria in terms of number of areas of abnormality).

C. Meets criterion E for autism.

D. Does not meet the full criteria B, C and D for autism (F84.0).

F84.12 Atypicality in both age of onset and symptomatology

A. Does not meet criterion A for autism. That is abnormal or impaired development is evident only at or after the age of three years.

B. Qualitative abnormalities in reciprocal social interactions or in communication, or restricted, repetitive and stereotyped patterns of behaviour, interests and activities (criteria as for autism except that it is not necessary to meet the criteria in terms of number of areas of abnormality).

C. Meets criterion E for autism.

D. Does not meet the full criteria B, C and D for autism (F84.0).

F84.2 Rett's syndrome

A. Apparently normal prenatal and perinatal period and apparently normal psychomotor development through the first six months and normal head circumference at birth.

B. Deceleration of head growth between five months and four years and loss of acquired purposeful hand skills between six and 30 months of age that is associated with concurrent communication dysfunction and impaired social interactions and appearance of poorly coordinated/unstable gait and/or trunk movements.

C. Development of severely impaired expressive and receptive language, together with severe psychomotor retardation.

D. Stereotyped midline hand movements (such as hand wringing or washing) with an onset at or after the time that purposeful hand movements are lost.

F84.3 Other childhood disintegrative disorder

A. An apparently normal development up to the age of at least two years. The presence of normal age-appropriate skills in communication, social relationships, play, and adaptive behaviour at age two years or later is required for diagnosis.

B. A definite loss of previously acquired skills at about the time of onset of the disorder. The diagnosis requires a clinically significant loss of skills (and not just a failure to use them in certain situations) in at least two out of the following areas:

(1) expressive or receptive language;

(2) play;

(3) social skills or adaptive behaviour;

(4) bowel or bladder control;

(5) motor skills.

C. Qualitatively abnormal social functioning, manifest in at least two of the following areas:

(1) qualitative abnormalities in reciprocal social interaction (of the type defined for autism);

(2) qualitative abnormalities in communication (of the type defined for autism);

(3) restricted, repetitive and stereotyped patterns of behaviour, interests and activities including motor stereotypies and mannerisms;

(4) a general loss of interest in objects and in the environment.

D. The disorder is not attributable to the other varieties of pervasive developmental disorder; acquired aphasia with epilepsy (F80.6); elective mutism (F94.0);

schizophrenia (F20-F29); Rett's syndrome (F84.2).

F84.4 Overactive disorder associated with mental retardation and stereotyped movements

A. Severe motor hyperactivity manifest by at least two of the following problems in activity and attention:

(1) continuous motor restlessness, manifest in running, jumping and other movements of the whole body.

(2) marked difficulty in remaining seated: will ordinarily remain seated for a few seconds at most except when engaged in a stereotypic activity (see criterion B).

(3) grossly excessive activity in situations expecting relative stillness.

(4) very rapid changes of activity, so that in general activities last for less than a minute on end (occasional longer periods on highly favoured activities do not exclude this; and very long periods spent in stereotypic activities can also be compatible with this problem being present at other times).

B. Repetitive and stereotyped patterns of behaviour and activity manifest by at least one of the following:

(1) fixed and frequently repeated motor mannerisms: these may involve either complex movements of the whole body or partial movements such as hand-flapping.

(2) the excessive and non-functional repetition of activities that are constant in form: this may be play with a single object (e.g. running water) or a ritual of activities (either alone or involving other people).

(3) repetitive self-injury.

C. IQ less than 50.

D. An absence of the autistic type of social impairment, i.e. the child must show at least three of the following:

(1) developmentally appropriate use of eye gaze, expression, and posture to regulate social interaction.

(2) developmentally appropriate peer relationships that include sharing of interests, activities, etc.

(3) at least sometimes approaches other people for comfort and affection.

(4) can sometimes share other people's enjoyment. Other forms of social impairment, e.g. a disinhibited approach to strangers, are compatible with the diagnosis.

E. Does not meet diagnostic criteria for autism (F84.0 and F84.1), childhood disintegrative disorder (F84.3) or hyperkinetic disorders (F90.-).

F84.5 Asperger's syndrome

A. A lack of any clinically significant general delay in spoken or receptive language or cognitive development. Diagnosis requires that single words should have developed by two years of age or earlier and that communicative phrases be used by three years of age or earlier. Self-help skills, adaptive behaviour and curiosity about the environment during the first three years should be at a level consistent with normal intellectual development. However, motor milestones may be somewhat delayed and motor clumsiness is usual (although not a necessary diagnostic feature). Isolated special skills, often related to abnormal preoccupations, are common, but are not required for diagnosis.

B. Qualitative abnormalities in reciprocal social interaction (criteria as for autism).

C. An unusually intense circumscribed interest or restricted, repetitive, and stereotyped patterns of behaviour, interests and activities (criteria as for autism; however it would be less usual for these to include either motor mannerisms or preoccupations with part- objects or non-functional elements of play materials).

D. The disorder is not attributable to the other varieties of pervasive developmental disorder; schizotypal disorder (F21); simple schizophrenia (F20.6); reactive and disinhibited attachment disorder of childhood (F94.1 and .2); obsessional personality disorder (F60.5); obsessive-compulsive disorder (F42).

F84.8 Other pervasive developmental disorders

F84.9 Pervasive developmental disorder, unspecified

This is a residual diagnostic category that should be used for disorders which fit the general description for pervasive developmental disorders but in which a lack of adequate information, or contradictory findings, means that the criteria for any of the other F84 codes cannot be met.

F88 OTHER DISORDERS OF PSYCHOLOGICAL DEVELOPMENT

F89 UNSPECIFIED DISORDER OF PSYCHOLOGICAL DEVELOPMENT

F90 - F98 BEHAVIOURAL AND EMOTIONAL DISORDERS WITH ONSET USUALLY OCCURRING IN CHILDHOOD AND ADOLESCENCE

F90 HYPERKINETIC DISORDERS

Note: The research diagnosis of hyperkinetic disorder requires the definite presence of abnormal levels of inattention and restlessness that are pervasive across situations and persistent over time, that can be demonstrated by direct observation, and that are not caused by other disorders such as autism or affective disorders.

Eventually, assessment instruments should develop to the point where it is possible to take a quantitative cut-off score on reliable valid and standardised measures of hyperactive behaviour in the home and classroom, corresponding to the 95th percentile on both measures. Such criteria would then replace G1 and G2 below.

G1. Demonstrable abnormality of attention, activity and impulsivity at home, for the age and developmental level of the child, as evidenced by (1), (2) and (3):

(1) at least three of the following attention problems:

(a) short duration of spontaneous activities;

(b) often leaving play activities unfinished;

(c) over-frequent changes between activities;

(d) undue lack of persistence at tasks set by adults;

(e) unduly high distractibility during study e.g. homework or reading assignment;

(2) plus at least three of the following activity problems:

(a) very often runs about or climbs excessively in situations where it is inappropriate; seems unable to remain still;

(b) markedly excessive fidgeting & wriggling during spontaneous activities;

(c) markedly excessive activity in situations expecting relative stillness (e.g. mealtimes, travel, visiting, church);

(d) often leaves seat in classroom or other situations when remaining seated is expected;

(e) often has difficulty playing quietly.

(3) plus at least one of the following impulsivity problems:

(a) often has difficulty awaiting turns in games or group situations;

(b) often interrupts or intrudes on others (e.g. butts in to others' conversations or games);

(c) often blurts out answers to questions before questions have been completed.

G2. Demonstrable abnormality of attention and activity at school or nursery (if applicable), for the age and developmental level of the child, as evidenced by both (1) and (2):

(1) at least two of the following attention problems:

(a) undue lack of persistence at tasks;

(b) unduly high distractibility, i.e. often orienting towards extrinsic stimuli;

(c) over-frequent changes between activities when choice is allowed;

(d) excessively short duration of play activities;

(2) and by at least three of the following activity problems:

(a) continuous (or almost continuous) and excessive motor restlessness (running, jumping, etc.) in situations allowing free activity;

(b) markedly excessive fidgeting and wriggling in structured situations;

(c) excessive levels of off-task activity during tasks;

(d) unduly often out of seat when required to be sitting;

(e) often has difficulty playing quietly.

G3. Directly observed abnormality of attention or activity. This must be excessive for the child's age and developmental level. The evidence may be any of the following:

(1) direct observation of the criteria in G1 or G2 above, i.e. not solely the report of parent or teacher;

(2) observation of abnormal levels of motor activity, or off-task behaviour, or lack of persistence in activities, in a setting outside home or school (e.g. clinic or laboratory);

(3) significant impairment of performance on psychometric tests of attention.

G4. Does not meet criteria for pervasive developmental disorder (F84), mania (F30), depressive (F32) or anxiety disorder (F41).

G5. Onset before the age of seven years.

G6. Duration of at least six months.

G7. IQ above 50.

F90.0 Disturbance of activity and attention

The general criteria for hyperkinetic disorder (F90) must be met, but not those for conduct disorders (F91).

F90.1 Hyperkinetic conduct disorder

Both the general criteria for hyperkinetic disorder (F90) and conduct disorder (F91) must be met.

F90.8 Other hyperkinetic disorders

F90.9 Hyperkinetic disorder, unspecified

This residual category is not recommended and should be used only when there is a lack of differentiation between F90.0 and F90.1 but the overall criteria for F90.- are fulfilled.

F91 CONDUCT DISORDER

G. Does not meet the criteria for dissocial personality disorder (F60.2), schizophrenia (F20.-), mania (F30.-), depression (F32.-), pervasive developmental disorder (F84.-), or hyperkinetic disorder (F90.-). (If criteria for emotional disorder (F93) are met, diagnose "mixed" disorder of conduct and emotions F92).

The criterion list below apply to all subcategories of F91:

(1) Unusually frequent or severe temper tantrums for the child's developmental level.

(2) Often argues with adults.

(3) Often actively defies or refuses adults' requests or rules.

(4) Often, apparently deliberately, does things that annoy other people.

(5) Often blames others for one's own mistakes or misbehaviour.

(6) Often touchy or easily annoyed by others.

(7) Often angry or resentful.

(8) Often spiteful or vindictive.

(9) Frequent and marked lying (except to avoid abusive treatment).

(10) Excessive fighting with other children, with frequent initiation of fights (not including fights with siblings).

(11) Uses a weapon that can cause serious physical harm to others (e.g. a bat, brick, broken bottle, knife, gun).

(12) Often stays out after dark without permission (beginning before 13 years of age).

(13) Physical cruelty to other people (e.g. ties up, cuts or burns a victim).

(14) Physical cruelty to animals.

(15) Deliberate destruction of others' property (other than by fire-setting).

(16) Deliberate fire-setting with a risk or intention of causing serious damage.

(17) At least two episodes of stealing of objects of value (e.g. money) from home (excluding taking of food).

(18) At least two episodes of stealing outside the home without confrontation with the victim (e.g. shoplifting, burglary or forgery).

(19) Frequent truancy from school beginning before 13 years of age.

(20) Running away from home (unless this was to avoid physical or sexual abuse).

(21) Any episode of crime involving confrontation with a victim (including purse snatching, extortion, mugging).

(22) Forcing another person into sexual activity against their wishes.

(23) Frequent bullying of others (i.e. deliberate infliction of pain or hurt including persistent intimidation, tormenting, or molestation).

(24) Breaks into someone else's house, building or car.

Specification for possible subdivisions

Authorities differ on the best way of subdividing the conduct disorders, though most agree that they are heterogeneous. For determining prognosis, the severity (indexed by number of symptoms) is a better guide than the precise type of symptomatology. The best-validated distinction is that between socialized and unsocialized disorders,

defined by the presence or absence of lasting peer friendships. However, it seems that disorders confined to the home may also constitute a meaningful subvariety and a category is provided for this purpose. It is clear that further research is needed to test the validity of all proposed subdivisions of conduct disorder.

However, in addition to these categorizations it is recommended that cases be described in dimensional terms according to their scores on three dimensions of disturbance:

(1) hyperactivity (inattentive, restless behaviour);

(2) emotional disturbance (anxiety, depression, obsessionality, hypochondriasis); and

(3) severity of conduct disorder (indexed by number of items from G1 above).

F91.0 Conduct disorder confined to the family context

A. The general criterion for conduct disorder (F91) must be met.

B. Presence of three of more symptoms from the criterion list above, of which at least three must be from items 9-24.

C. At least one of the symptoms from items 9-24 must have been present for at least six months.

D. Conduct disturbance is limited to the family context.

F91.1 Unsocialized conduct disorder

A. The general criterion for conduct disorder (F91) must be met.

B. Presence of three of more symptoms from the criterion list above, of which at least three must be from items 9-24.

C. At least one of the symptoms from items 9-24 must have been present for at least six months.

D. Definitely poor relationships with peer group as shown by isolation, rejection or unpopularity and by a lack of lasting close reciprocal friendships.

F91.2 Socialized conduct disorder

A. The general criterion for conduct disorder (F91) must be met.

B. Presence of three of more symptoms from the criterion list above, of which at least three must be from items 9-24.

C. At least one of the symptoms from items 9-24 must have been present for at least six months.

D. Conduct disturbance includes settings outside the home or family context.

E. Peer relationships within normal limits.

F91.3 Oppositional defiant disorder

A. The general criterion for conduct disorder (F91) must be met.

B. Presence of four or more symptoms from the criterion list above, of which no more than two from items 9-24.

C. The symptoms in B must be maladaptive and inconsistent with the developmental level.

D. At least four of the symptoms must have been present for at least six months.

F91.8 Other conduct disorders

F91.9 Conduct disorder, unspecified

This residual category is not recommended and should be used only for disorders that meet the general criteria for F91 but that have not been specified as to subtype or that do not fulfil the criteria for any of the specified subtypes.

F92 MIXED DISORDERS OF CONDUCT AND EMOTIONS

F92.0 Depressive conduct disorder

A. The general criteria for conduct disorder (F9l) or oppositional defiant disorder (F91.3) must be met.

B. Criteria for one of the mood [affective] disorders (F30-39) must be met.

F92.8 Other mixed disorders of conduct and emotions

A. The general criteria for conduct disorder (F91) or oppositional defiant disorder (F91.3) must be met.

B. Criteria for one of the neurotic, stress-related and somatoform disorders (F40-49) or childhood emotional disorder (F93) must be met.

F92.9 Mixed disorder of conduct and emotions, unspecified

F93 EMOTIONAL DISORDERS WITH ONSET SPECIFIC TO CHILDHOOD

Note: Phobic anxiety disorder of childhood (F93.1), social anxiety disorder of childhood (F93.2) and general anxiety

disorder of childhood (F93.80) have obvious similarities to some of the disorders in F4, but current evidence and opinion suggest that there are sufficient differences in the ways that anxiety disorders present in children for additional categories to be provided. Further studies should show whether descriptions and definitions can be developed that can be used satisfactorily for both adults and children, or whether the present separation should continue.

F93.0 Separation anxiety disorder of childhood

A. At least three of the following:

(1) Unrealistic and persistent worry about possible harm befalling major attachment figures or the loss of such figures (e.g. fear that they will leave and not return or that the child will not see them again) or persistent concerns about death of attachment figures.

(2) Unrealistic and persistent worry that some untoward event will separate the child from a major attachment figure (e.g. as by the child getting lost, kidnapped, admitted to the hospital, or killed).

(3) Persistent reluctance or refusal to go to school because of fear over separation from a major attachment figure or in order to stay at home (rather than for other reasons such as fear over happenings at school).

(4) Difficulty separating at night as manifested by any of the following:

(a) persistent reluctance or refusal to go to sleep without being near an attachment figure;

(b) often getting up during the night to check on, or to sleep near an attachment figure;

(c) persistent reluctance or refusal to sleep away from home.

(5) Persistent inappropriate fear of being alone, or otherwise without the major attachment figure at home during the day.

(6) Repeated nightmares about separation.

(7) Repeated occurrence of physical symptoms (such as nausea, stomachache, headache, or vomiting) on occasions that involve separation from a major attachment figure, such as leaving home to go to school or on other occasions where anticipating a separation (holiday, camps, etc.).

(8) Excessive, recurrent distress in anticipation of, or during, or immediately following, separation from a major attachment figure (as shown by: anxiety, crying, tantrums; persistent reluctance to go away from home; excessive need to talk with parents or desire to return home; misery, apathy or social withdrawal).

B. Absence of generalized anxiety disorder of childhood (F93.80).

C. Onset before the age of six.

D. The disorder does not occur as part of a broader disturbance of emotions, conduct, personality, or of a pervasive developmental disorder, psychotic disorder, psychoactive or substance use disorder.

E. Duration of at least four weeks.

F93.1 Phobic anxiety disorder of childhood

A. A persistent or recurrent fear (phobia) that is developmentally phase- appropriate (or was so at the time of onset) but which is abnormal in degree and which is associated with significant social impairment.

B. Absence of generalized anxiety disorder of childhood (F93.80).

C. The disorder does not occur as part of a broader disturbance of emotions, conduct, personality or of a pervasive developmental disorder, psychotic disorder or psychoactive substance use disorder.

D. Duration of at least four weeks.

F93.2 Social anxiety disorder of childhood

A. Persistent anxiety in social situations in which the child is exposed to unfamiliar people, including peers, as manifested by socially avoidant behaviour.

B. Self-consciousness, embarrassment, or overconcern about the appropriateness of his or her behaviour when interacting with unfamiliar figures.

C. Significant interference with social (including peer) relationships that are restricted; when new or forced social situations are experienced, they cause marked distress and discomfort as manifested by crying, lack of spontaneous speech, or withdrawal from the social situation.

D. Has satisfying social relationships with familiar figures (family members or peers the subject knows well).

E. Onset generally coincides with a developmental phase where these anxiety reactions are considered appropriate. The abnormal degree, persistence over time and associated impairment must be manifest before the age of six.

F. Absence of generalized anxiety disorder of childhood (F93.80).

G. The disorder does not occur as part of broader disturbances of emotions, conduct, personality, or of a pervasive developmental disorder, psychotic disorder or psychoactive substance use disorder.

H. Duration of at least four weeks.

F93.3 Sibling rivalry disorder

A. Abnormally intense negative feelings towards an immediately younger sibling.

B. Emotional disturbance as shown by regression, tantrums, dysphoria, sleep difficulties, oppositional behaviour or attention-seeking behaviour with one or both parents (two or more of these must be present).

C. Onset within six months of the birth of an immediately younger sibling.

D. Duration of at least four weeks.

F93.8 Other childhood emotional disorders

F93.80 Generalized anxiety disorder of childhood

A. A period of at least one month with recurrence of excessive, disproportionate and intrusive anxieties or worries, as indicated by at least three of the following:

(1) Excessive concerns about the quality of one's performance in areas such as schoolwork, sports, and other regular activities.

(2) Excessive concerns about physical health (despite an evident good health, or, if hurt or sick, concerns that go beyond a normal apprehension) or about being injured.

(3) Excessive concerns or anticipatory worries in relation to particular non-health themes (money or financial well-being, punctuality, appearance, catastrophes, disasters, etc.).

(4) Free floating anxiety unrelated to specific situations.

(5) A frequent need for reassurance that persists in spite of several appropriate attempts to reassure the child.

(6) Marked feelings of tension, inability to relax or to concentrate, nervousness, difficulty getting to sleep, autonomic symptoms (such as palpitations, sweating, dry mouth, etc.).

(7) Recurrent somatic complaints (headaches, stomachaches, etc.) for which no physical basis can be demonstrated.

B. The multiple anxieties and worries occur across at least two situations, activities, contexts or circumstances. Generalized anxiety does not present as discrete paroxysmal episodes (as in panic disorder), nor are the main worries confined to single, major thoughts (as in separation anxiety disorder) or situations (as in social anxiety disorder or phobic disorder in childhood). When more focused anxiety is identified in the broader context of a generalized anxiety, generalized anxiety disorder takes precedence over other anxiety disorders.

C. Onset in childhood or adolescence (below age 18).

D. The symptoms in A interfere daily in a significant way with the child's activities.

E. The disorder does not occur as part of a broader disturbance of emotions, conduct, personality, or of a pervasive developmental disorder, psychotic disorder or psychoactive substance use disorder.

F93.9 Childhood emotional disorder, unspecified

F94 DISORDERS OF SOCIAL FUNCTIONING WITH ONSET SPECIFIC TO CHILDHOOD AND ADOLESCENCE

F94.0 Elective mutism

Note: Also referred to as Selective mutism.

A. Language expression and comprehension, as assessed on individually administered standardized tests, within the 2 standard deviation limit for the child's age.

B. Demonstrable evidence of a consistent failure to speak in specific social situations in which there is an expectation that the child would speak (e.g. in school), despite speaking in other situations.

C. Duration of selective mutism that exceeds four weeks.

D. Absence of a pervasive developmental disorder (F84.-), or a specific speech or language disorder (F80.-) and absence of a lack of fluency in the language that is expected to be spoken in the situation (e.g. because it is a second language for the child).

F94.1 Reactive attachment disorder of childhood

A. Onset before the age of five years.

B. Strongly contradictory or ambivalent social responses that extend across social situations (but which may show variability from relationship to relationship).

C. Emotional disturbance as shown by lack of emotional responsiveness, withdrawal reactions, aggressive responses to one's own or other's distress and/or fearful hypervigilance.

D. Evidence of capacity for social reciprocity and responsiveness as shown by elements of normal social relatedness in interactions with appropriately responsive non-deviant adults.

E. Does not meet criteria for pervasive developmental disorders (F84).

F94.2 Disinhibited attachment disorder of childhood

A. Diffuse attachments as a persistent feature during the first five years of life (but not necessarily persisting into middle childhood). Diagnosis requires a relative failure to show selective social attachments manifest by

(1) a normal tendency to seek comfort from others when distressed and

(2) an abnormal (relative) lack of selectivity in the persons from whom comfort is sought.

B. Poorly modulated social interactions with unfamiliar persons. Diagnosis requires at least one of the following: generally clinging behaviour in infancy; or attention-seeking and indiscriminately friendly behaviour in early or middle childhood.

C. The general lack of situation-specificity in the above features must be clear. Diagnosis requires that A and B above are manifest across the range of social contacts experienced by the child.

F94.8 Other childhood disorders of social functioning

F94.9 Childhood disorder of social functioning, unspecified

F95 TIC DISORDERS

F95.0 Transient tic disorder

A. Single or multiple motor or vocal tic(s) or both, that occur many times a day, most days over a period of at least four weeks.

B. Duration twelve months or less.

C. No history of Tourette syndrome, and not due to physical conditions or side effect of medication.

D. Onset before age 18 years.

F95.1 Chronic motor or vocal tic disorder

A. Motor or vocal tics, but not both, that occur many times per day, most days over a period of at least twelve months.

B. No period of remission during that year lasting longer than two months.

C. No history of Tourette syndrome, and not due to physical conditions or side effect of medication.

D. Onset before age 18 years.

F95.2 Combined vocal and multiple motor tic disorder [de la Tourette's syndrome]

A. Multiple motor tics and one or more vocal tics that have been present at some time during the disorder, but not necessarily concurrently.

B. The frequency of tics must be many times a day, nearly every day for more that one year, with no period of remission during that year lasting longer than two months.

C. Onset before 18 years of age.

F95.8 Other tic disorders

F95.9 Tic disorder, unspecified

A non-recommended residual category for a disorder that fulfils the general criteria for a tic disorder but in which the specific subcategory is not specified or in which the features do not fulfil the criteria for F95.0, F95.1 or F95.2.

F98 OTHER EMOTIONAL AND BEHAVIOURAL DISORDERS WITH ONSET USUALLY OCCURRING IN CHILDHOOD

F98.0 Nonorganic enuresis

A. Child aged at least five years, with a mental age of at least four years.

B. Involuntary voiding of urine that occurs at a frequency of at least twice a month in children aged under seven years, and at least once per month in children aged seven or above.

C. Enuresis not a consequence of epileptic attacks, or of neurological incontinence, and not a direct consequence of structural abnormalities of the urinary tract or any other nonpsychiatric medical condition.

D. No other psychiatric disorder that meets the criteria for other ICD-10 categories.

E. Duration of at least three months.

A fifth character may be used, if desired, for further specification:

F98.00 Nocturnal enuresis only

F98.01 Diurnal enuresis only

F98.02 Nocturnal and diurnal enuresis

F98.1 Nonorganic encopresis

A. Repeated passage of faeces in places that are not appropriate for that purpose (e.g. clothing, floor), whether involuntary or intentional. (The disorder may involve overflow incontinence secondary to functional faecal retention).

B. A chronological and mental age of at least four years.

C. At least one encopretic event per month.

D. Duration of at least six months.

E. Absence of an organic condition that constitutes a sufficient cause for the encopretic events.

A fifth character may be used, if desired, for further specification:

F98.10 Failure to acquire physiological bowel control.

F98.11 Adequate bowel control by normal faeces deposited in inappropriate places.

F98.12 Soiling that is associated with excessively fluid faeces, such as with retention with overflow.

F98.2 Feeding disorder of infancy and childhood

A. Persistent failure to eat adequately, or persistent rumination or regurgitation of food.

B. Failure to gain weight or loss of weight or other significant health problem over a period of at least one month (in view of the frequency of transient eating difficulties, researchers may prefer a minimum duration of three months for some purposes).

C. Onset of the disorder before age six.

D. Absence of other mental and behavioural disorders in ICD-10 (other than mental retardation (F7)).

E. No organic disease sufficient to account for the failure to eat.

F98.3 Pica of infancy and childhood

A. Persistent or recurrent eating of non-nutritive substances, at a frequency of at least twice per week.

B. Duration of at least one month (for some purposes researchers may prefer a minimum period of three months).

C. Absence of any other mental and behavioural disorders in ICD-10 (other than mental retardation (F7)).

D. A chronological and mental age of at least two years.

F98.4 Stereotyped movement disorders

A. Stereotyped movements that occur to an extent that either causes physical injury or markedly interferes with normal activities.

B. Duration of at least one month.

C. Absence of any other mental and behavioural disorders in ICD-10 (other than mental retardation (F7)).

A fifth character may be used, if desired, for further specification:

F98.40 Non self-injurious

F98.4l Self-injurious

F98.42 Mixed

F98.5 Stuttering [stammering]

A. Stuttering (i.e. speech, characterized by frequent repetition or prolongation of sounds or syllables or words, or by frequent hesitations or pauses) that is persistent or recurrent and of severity sufficient to markedly disrupt the fluency of speech.

B. Duration of at least three months.

F98.6 Cluttering

A. Cluttering (i.e. a rapid rate of speech with breakdown in fluency, but no repetitions or hesitations) that is persistent or recurrent and of a severity sufficient to give rise to significantly reduced speech intelligibility.

B. Duration of at least three months.

F98.8 Other specified behavioural and emotional disorders with onset usually occurring in childhood and adolescence

F98.9 Unspecified behavioural and emotional disorders with onset usually occurring in childhood and adolescence

F99 MENTAL DISORDER, NOT OTHERWISE SPECIFIED

Non-recommended residual category, when no other code from F00-F98 can be used.

APPENDIX 1: PROVISIONAL CRITERIA FOR SELECTED DISORDERS

This Appendix contains criteria for a number of disorders whose clinical or scientific status is still best regarded as uncertain. They all have been suggested for inclusion by interested research groups, but it was considered that further research is indicated before they could be regarded as having sufficient international acceptance to merit inclusion in Chapter V(F) of ICD-10. It is hoped that their presence in this Appendix, with provisional criteria, will stimulate research that will clarify their nature and status.

Seasonal affective disorder (Could be applied to Mood [Affective] Disorder, categories F30.-, F31-, F32.- and F33.-)

A. Three or more episodes of Affective Disorder occurring with onset within the same 90-day period of the year for 3 or more consecutive years.

B. Remissions also occur within a particular 90-day period of the year.

C. Seasonal episodes substantially outnumber non-seasonal episodes that may have occurred.

Bipolar II disorder (Could be applied to Bipolar Affective Disorder subcategories F31.0, F31.3-5, F31.7)

A. One or more episodes of depression (F32.-)

B. One or more episodes of hypomania (F30.0)

C. Absence of episodes of mania (F30.1-2)

Rapid cycling bipolar disorder (Could be applied to Bipolar Affective Disorder subcategories F31.0-7)

A. Criteria for Bipolar Affective Disorder F31.0-2 must be fulfilled

B. At least 4 episodes of Bipolar Disorder within a 12-month period

Note: Episodes are demarcated by a switch to an episode of opposite or mixed polarity or by a remission.

Narcissistic personality disorder

A. The general criteria of personality disorder (F60) must be met.

B. At least five of the following must be present:

(1) has a grandiose sense of self-importance (e.g. exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements);

(2) is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love;

(3) believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions);

(4) requires excessive admiration;

(5) has a sense of entitlement; unreasonable expectations of especially favourable treatment or automatic compliance with his or her expectations;

(6) is interpersonally exploitative, takes advantage of others to achieve his or her own ends;

(7) lack of empathy; unwilling to recognize or identify with the feelings and needs of others;

(8) is often envious of others or believe that others are envious of him or her.

(9) arrogant, haughty behaviours or attitudes.

Passive-aggressive (negativistic) personality disorder

A. The general criteria of personality disorder (F60) must be met.

B. At least five of the following must be present:

(1) procrastinates and postpones completing routine tasks that need to be done, especially those that others seek to have completed;

(2) protests, without justification, that others make unreasonable demands of him or her;

(3) becomes sulky, irritable, or argumentative when asked to do something he or she does not want to do;

(4) unreasonably criticizes or scorns people in positions of authority;

(5) works deliberately slowly or does a bad job on tasks that he or she really does not want to do;

(6) obstructs the efforts of others by failing to do his or her share of the work;

(7) avoids obligations by claiming to have forgotten.

ANNEX 2

Culture-specific disorders[1]

Culture-specific disorders have diverse characteristics but share two principal features:

(1) they are not easily accommodated by the categories in established and internationally used psychiatric classifications;
(2) they were first described in, and subsequently closely or exclusively associated with, a particular population or cultural area.

These syndromes have also been referred to as culture-bound or culture-reactive, and as ethnic or exotic psychoses. Some are rare and some may be comparatively common; many are acute and transient, which makes their systematic study particularly difficult.

The status of these disorders is controversial: many researchers argue that they differ only in degree from disorders already included in existing psychiatric classifications, such as anxiety disorders and reactions to stress, and that they are therefore best regarded as local variations of disorders that have long been recognized. Their exclusive occurrence in specific population or cultural areas has also been questioned.

There is a clear need for research that will help to establish reliable clinical descriptions of these disorders and clarify their distribution, frequency, and course. In the hope of stimulating and facilitating such research, WHO has undertaken the development of a glossary containing lexical definitions of terms used in cross-cultural and anthropological psychiatric research. It is expected that this glossary will become available in 1994. In the meantime, 12 frequently described "culture-specific" disorders have been included in this annex by way of example, together with their clinical characteristics - extracted from anthropological and medical literature - and suggestions concerning their placement in ICD categories.

---

[1]By Dr Ruthbeth Finerman, Associate Professor, Department of Anthropology,
Memphis State University, Memphis, TN, USA.

No attempt has been made to list detailed diagnostic criteria for these disorders: it is hoped that this will become possible when more reliable clinical, anthropological, epidemiological, and biological information is available.

Assigment of the disorders to categories in ICD-10, Chapter V(F) must be regarded as tentative. In certain instances, when available descriptions suggest that there is considerable variation in the clinical states covered by the term, more than one code has been given.

References

Lebra WP, ed. *Culture-bound syndromes, ethnopsychiatry, and alternate therapies.* Honolulu, University of Hawaii, 1976.

Simons RC, Hughes CC, eds. *The culture-bound syndromes.* Dordrecht, Reidel, 1985.

Yap Pow-Meng. Mental diseases peculiar to certain cultures: a survey of comparative psychiatry. *Journal of mental science*, 1951, **97**: 313-327.

Amok (Indonesia; Malaysia)

An indiscriminate, seemingly unprovoked episode of homicidal or highly destructive behaviour, followed by amnesia or fatigue. Many episodes culminate in suicide. Most events occur without warning, although some are precipitated by a period of intense anxiety or hostility. Some studies suggest that cases may derive traditional values placed on extreme aggression and suicidal attacks in warfare.

Suggested ICD-10 code

F68.8 Other specified disorders of adult personality and behaviour

Potentially related syndromes

ahade idzi be (the island of New Guinea)
benzi mazurazura (southern Africa (among Shona and affiliated groups))
berserkergang (Scandinavia)
cafard (Polynesia)
colerina (the Andes of Bolivia, Colombia, Ecuador, and Peru)
hwa-byung (Korean peninsula)
iich'aa (indigenous peoples of south-western America)

References

Lin Keh-Ming. Hwa-byung: a Korean culture-bound syndrome? *American journal of psychiatry*, 1983, **140**(1): 105-107.

Newman P. 'Wild man' behavior in a New Guinea Highlands community. *American anthropologist*, 1964, **66**: 1-19.

Simons RC, Hughes CC, eds. *The culture-bound syndromes.* Dordrecht, Reidel, 1985: 197-264.

Spores J. *Running amok: an historical inquiry*. Athens, OH, Ohio University Center for International Studies, 1988 (Southeast Asia Series, No. 82).

Yap Pow-Meng. The culture-bound reactive syndromes. In: Caudill W, Tsung-yi Lin, eds. *Mental health research in Asia and the Pacific*. Honolulu, East-West Center Press, 1969: 33-53.

Dhat, dhatu, jiryan, shen-k'uei (India; Taiwan (Province of China))

Acute anxiety and somatic complaints such as fatigue and muscle pain, related to a fear of semen loss in men or women (also thought to secrete semen). Precursors are said to include excess coitus, urinary disorders, imbalances in body humours, and diet. The main symptom is a whitish discharge in urine, interpreted as semen loss. Traditional remedies focus on herbal tonics to restore semen or humoral balance.

Suggested ICD-10 codes

F48.8 Other specified neurotic disorders
F45.34 Somatoform autonomic dysfunction of the genitourinary system
(may be used if autonomic anxiety symptoms are prominent)

Potentially related syndromes

koro (China)
rabt (Egypt)

References

Bhatia MS, Malik SC. Dhat syndrome - a useful diagnostic entity in Indian culture. *British journal of psychiatry*, 1991, **159**: 691-695.

Malhotra M, Wig N. Dhat syndrome: a culture-bound sex neurosis of the Orient. *Archives of sexual behavior*, 1975, **4**: 519-528.

Singh SP. Is Dhat culture bound? *British journal of psychiatry*, 1992, **160**: 280-281.

Wen Jung-Kwang, Wang Ching-Lun. Shen-k'uei syndrome: a culture-specific sexual neurosis in Taiwan. In: Kleinman A, Lin Tsung-yi, eds. *Normal and abnormal behavior in Chinese cultures*. Dordrecht, Reidel, 1981: 357-369.

Koro, jinjin bemar, suk yeong (various spellings) (south-east Asia, China, India)

Acute panic or anxiety reaction involving fear of genital retraction. In severe cases, men become convinced that the penis will suddenly withdraw into the abdomen; women sense that their breast, labia, or vulva will retract. Victims expect the consequences to be fatal. Studies cite factors such as illness, exposure to cold, or excess coitus as precursors, but interpersonal conflict and sociocultural demands reportedly exert greater influence on the condition. Onset is rapid, intense, and unexpected. Responses vary, but include grasping of the genitals by the victim or a family member, application of splints or devices to prevent retraction, herbal remedies, massage, or fellatio.

Suggested ICD-10 codes

F48.8 Other specified neurotic disorders
F45.34 Somatoform autonomic dysfunction of the genitourinary system
(may be used if autonomic anxiety symptoms are present)

Potentially related syndromes

dhat (India)
rabt (Egypt)

References

Adityanjee, Zain AM, Subramaniam M. Sporadic koro and marital dysharmony. *Psychopathology*, 1991, **24**(1): 49-52.

Bernstein RL, Gaw AC. Koro: proposed classification for DSM-IV. *American journal of psychiatry*, 1990, **147**(12): 1670-1674.

Nandi DN et al. Epidemic koro in West Bengal, India. *International journal of social psychiatry*, 1983, **29**: 265-268.

Simons RC, Hughes CC, eds. *The culture-bound syndromes*. Dordrecht, Reidel, 1985.

Turnier L, Chouinard G. Effet anti-koro d'un antidepresseur tricyclique. [The anti-koro effect of a tricyclic antidepressant.] *Canadian journal of psychiatry*, 1990, **35**: 331-333.

Latah (Indonesia; Malaysia)

Highly exaggerated responses to a fright or trauma, followed by involuntary echolalia, echopraxia, or trance-like states. Studies variously interpret cases as a neurophysiological response, a hyper-suggestible state, or a mechanism for expressing low self-image. On-lookers usually find such imitative episodes amusing, while victims feel humiliated.

Suggested ICD-10 codes

F48.8 Other specified neurotic disorders
F44.88 Other specified dissociative [conversion] disorders

Potentially related syndromes

amurakh (Siberia)
bah-tsi (Thailand)
imu (Ainu (indigenous people of Japan))
jumping frenchman (Canada)
Lapp panic (Lapps)
mali-mali (Philippines)

pibloktoq (Inuits living within the Arctic Circle)
susto (Mexico, Central and South America)
yaun (Myanmar (formerly Burma))

References

Jenner JA. Latah as coping: a case study offering a new paradox to solve the old one. *International journal of social psychiatry*, 1990, **36**(3): 194-199.

Jenner JA. A successfully treated Dutch case of latah. *Journal of nervous and mental disease*, 1991, **179**(10): 636-637.

Murphy HBM. Notes for a theory on latah. In: Lebra WP, ed. *Culture-bound syndromes, ethnopsychiatry, and alternate therapies*. Honolulu, University of Hawaii, 1976: 3-21.

Simons RC, Hughes CC, eds. *The culture-bound syndromes.* Dordrecht, Reidel, 1985: 41-113.

Nerfiza, nerves, nevra, nervios (Egypt; northern Europe; Greece; Mexico, Central and South America)

Common, often chronic, episodes of extreme sorrow or anxiety, inducing a complex of somatic complaints such as head and muscle pain, diminished reactivity, nausea, appetite loss, insomnia, fatigue, and agitation. The syndrome is more common in women than in men. Research links the condition to stress, anger, emotional distress, and low self-esteem. Cases are traditionally treated with herbal teas, "nerve pills", rest, isolation, and family support.

Suggested ICD-10 codes

F32.11 Moderate depressive episode with somatic syndrome
(this is the most likely code)
F48.0 Neurasthenia
F45.1 Undifferentiated somatoform disorder

Potentially related syndromes

anfechtung (Hutterites (a religious group))
brain fag (Nigeria)
colerina, pension, bilis (Mexico, Central and South America)
hsieh-ping (Taiwan (Province of China))
hwa-byung (Korean peninsula)
narahati-e a sab, maraz-e a sab (Islamic Republic of Iran)
qissaatuq (Inuits living within the Arctic Circle)

References

Historical and cross-cultural perspectives on nerves. *Social science and medicine*, 1988, **26**(12): 1197-1259.

Davis DL, Low SM, eds. *Gender, health and illness: the case of nerves*. New York, Hemisphere, 1989.

Good B, Good MJD, Moradi R. The interpretation of Iranian depressive illness and dysphoric affect. In: Kleinman A, Good B, eds. *Culture and depression.* Berkeley, University of California, 1985: 369-428.

Low SM. Culturally interpreted symptoms or culture-bound syndromes: a cross-cultural review of nerves. *Social science and medicine*, 1985, **21**(2): 187-196.

Pa-leng, frigophobia (Taiwan (Province of China); south-east Asia)

Anxiety state characterized by obsessive fear of cold and winds, believed to produce fatigue, impotence, or death. Victims compulsively dress in heavy or excessive clothing. Fears are reinforced by cultural views of the condition as a legitimate humoral disorder.

Suggested ICD-10 code

F40.2 Specific phobias

Potentially related syndromes

agua frio, aire frio, frio (Mexico, Central and South America)

References

Kiev A. *Transcultural psychiatry*. New York, Free Press, 1972.

Lin Keh-Ming, Kleinman A, Lin Tsung-Yi. Overview of mental disorders in Chinese cultures: review of epidemiological and clinical studies. In: Kleinman A, Lin Tsung-Yi, eds. *Normal and abnormal behaviour in Chinese culture*. Dordrecht, Reidel, 1981: 237-272.

Pibloktoq, Arctic hysteria (Inuits living within the Arctic Circle)

Prodromal fatigue, depression, or confusion, followed by a "seizure" of disruptive behaviour, including stripping or tearing off clothes, frenzied running, rolling in snow, glossolalia or echolalia, echopraxia, property destruction, and coprophagia. Most episodes last only minutes and are followed by loss of consciousness, amnesia, and complete remission. Injury is rare and, while some studies have related cause to hypocalcaemic tetany, most researchers link incidents to interpersonal anxieties and cultural stressors.

Suggested ICD-10 codes

F44.7 Mixed dissociative [conversion] disorders
F44.88 Other specified dissociative [conversion] disorders

Potentially related syndromes

amok (Indonesia; Malaysia)
banga, misala (Congo; Malawi (formerly Nyasaland)
ebenzi (southern Africa, among Shona and affiliated groups)
grisi siknis (Miskito (indigenous people of Honduras))
imu (Ainu)
latah (Indonesia; Malaysia)
mali-mali (Philippines)
nangiarpok, kayak angst, quajimaillituq (Inuits)
ufufuyane (southern Africa, especially among Bantu, Zulu, and affiliated groups)

References

Parker S. Eskimo psychopathology in the context of Eskimo personality and culture. *American anthropologist*, 1962, **64**: 76-96.

Simons RC, Hughes CC, eds. *The culture-bound syndromes*. Dordrecht, Reidel, 1985: 267-326.

Wallace A. Mental illness, biology and culture. In: Hsu FLK, ed. *Psychological anthropology*. Cambridge, MA, Schenkman, 1972: 363-402.

Susto, espanto (Mexico, Central and South America)

Highly diverse, chronic complaints attributed to "soul loss" induced by a severe, often supernatural, fright. In some cases, traumatic events are not personally experienced; individuals may be stricken when others (usually relatives) suffer a fright. Symptoms often include agitation, anorexia, insomnia, fever, diarrhoea, mental confusion and apathy, depression, and introversion. Studies variously attribute cases to hypoglycaemia, nonspecific organic disease, generalized anxiety, and stress resulting from social conflict and low self-esteem.

Suggested ICD-10 codes

F45.1 Undifferentiated somatoform disorder
F48.8 Other specified neurotic disorders

Potentially related syndromes

lanti (Philippines)
latah (Indonesia; Malaysia)
malgri (aborigines of Australia)
mogo laya (the island of New Guinea)
narahati (Islamic Republic of Iran)
saladera (regions around Amazon river)

References

Good B, Good MJD. Toward a meaning-centered analysis of popular illness categories: fright illness and heart distress in Iran. In: Marsella AJ, White GM, eds. *Cultural conceptions of mental health and therapy*. Dordrecht, Reidel, 1982: 150-158.

Houghton A, Boersma F. The grief-loss connection in susto. *Ethnology*, 1988, **27**: 145-154.

Lipp F. The study of disease in relation to culture - the susto complex among the Mixe of Oaxaca. *Dialectical anthropology*, 1989, **12**: 435-443.

Rubel AJ, O'Nell CW, Collado-Ardon R. *Susto, a folk illness*. Berkeley, University of California Press, 1984.

Simons RC, Hughes CC, eds. *The culture-bound syndromes*. Dordrecht, Reidel, 1985: 329-407.

Taijin kyofusho, shinkeishitsu, anthropophobia (Japan)

Anxiety or phobia more common among men and young adults. Cases are marked by a fear of social contact

(especially friends), extreme self-consciousness (concern about physical appearance, body odour, blushing), and a fear of contracting disease. Somatic symptoms include head, body, and stomach aches, fatigue, and insomnia. Victims, popularly regarded as highly intelligent and creative, may display perfectionist tendencies. Studies suggest cultural values encourage "over-socialization" of some children, producing feelings of inferiority and anxiety in social situations.

Suggested ICD-10 codes

F40.1 Social phobias
F40.8 Other phobic anxiety disorders
(may be used if there are many other fears)

Potentially related syndromes

anfechtung (Hutterites (a religious group))
itiju (Nigeria)

References

Lock M. *East Asian medicine in urban Japan*. Berkeley, University of California Press, 1980: 222-224.

Tanaka-Matsumi J. Taijin kyofusho. *Culture, medicine and psychiatry*, 1979, **3**: 231-245.

Prince R, Techeng-Laroche F. Culture bound syndromes and international classification of disease. *Culture, medicine and psychiatry*, 1987, **11**: 3-20.

Reynolds D. *Morita therapy*. Berkeley, University of California Press, 1976.

Ufufuyane, saka (southern Africa (among Bantu, Zulu, and affiliated groups; Kenya)

An anxiety state popularly attributed to magical potions administered by rejected lovers, or spirit possession. Features include shouting, sobbing, repeated neologisms, paralysis, convulsions, and a trance-like stupor or loss of consciousness. Most victims are young, unmarried women. Some experience nightmares with sexual themes or rare episodes of temporary blindness. Attacks, which can continue for days or weeks, may be provoked by the sight of men or foreigners.

Suggested ICD-10 codes

F44.3 Trance and possession disorders
F44.7 Mixed dissociative [conversion] disorders

Potentially related syndromes

aluro (Nigeria)
phii pob (Thailand)
zar (Egypt; Ethiopia; Sudan)

References

Harris G. Possession 'hysteria' in a Kenya tribe. *American anthropologist*, 1957, **59**: 1046-1066.

Loudon JB. Psychogenic disorder and social conflict among the Zulu. In: Opler MK, ed. *Culture and mental health*. New York, Macmillan, 1959: 351-369.

Uqamairineq (Inuits living within the Arctic Circle)

Sudden paralysis associated with borderline sleep states, accompanied by anxiety, agitation, or hallucinations. Prodromal indicators may include a detectable yet transient sound or smell. While the condition is usually chronic and can prompt panic, most attacks last only minutes and are followed by complete remission. Cases are fairly common, and traditionally alleged to result from soul loss, soul wandering, or spirit possession. Studies describe the experience as a dissociative hysterical reaction and possible variant of the narcolepsy-cataplexy syndrome.

Suggested ICD-10 codes

F44.88 Other specified dissociative [conversion] disorders
G47.4 Narcolepsy and cataplexy
Includes: sleep paralysis

Potentially related syndromes

aluro (Nigeria)
old hag (Newfoundland)
phii pob (Thailand)

References

Hufford D. *The terror that comes in the night*. Philadelphia, University of Pennsylvania, 1982.

Parker S. Eskimo psychopathology in the context of Eskimo personality and culture. *American anthropologist*, 1962, **64**: 76-96.

Simons RC, Hughes CC, eds. *The culture-bound syndromes*. Dordrecht, Reidel, 1985: 115-148.

Windigo (various spellings) (indigenous people of north-east America)

Rare, historic accounts of cannibalistic obsession. Traditionally, cases were ascribed to possession, with victims (usually male) turning into cannibal monsters. Symptoms included depression, homicidal or suicidal thoughts, and a delusional, compulsive wish to eat human flesh. Most victims were socially ostracized or put to death. Early research described episodes as hysterical psychosis, precipitated by chronic food shortages and cultural myths about starvation and windigo monsters. Some controversial new studies question the

syndrome's legitimacy, claiming cases were actually a product of hostile accusations invented to justify the victim's ostracism or execution.

Suggested ICD-10 code

The available information is too unreliable to suggest a likely code. If a code is needed, use:
F68.8 Other specified disorders of adult personality and behaviour

Potentially related syndromes

amok (Malaysia)
hsieh-ping (Taiwan (Province of China))
zar (Egypt; Ethiopia; Sudan)

References

Bishop C. Northern Algonkian cannibalism and windigo psychosis. In: Williams T, ed. *Psychological anthropology*, The Hague, Mouton, 1975: 237-248.

Hay T. The windigo psychosis. *American anthropologist*, 1971, **73**: 1-19.

Parker S. The wiitiko psychosis in the context of Ojibwa personality and culture. *American anthropologist*, 1960, **62**: 603-623.

Simons RC, Hughes CC, eds. *The culture-bound syndromes*. Dordrecht, Reidel, 1985: 409-465.

LIST OF INDIVIDUAL EXPERTS

The following list contains the names of experts who where involved in the drafting of this text or whose comments were very useful in refining the research criteria.

Dr G. Andrews, Darlinghurst, Australia
Dr J. Angst, Zürich, Switzerland
Dr T. Babor, Farmington, United States of America
Dr J. Bancroft, Edinburgh, United Kingdom
Dr F. Benson, Los Angeles, United States of America
Dr F. Bianco, Caracas, Venezuela
Dr J. Burke, Temple, United States of America
Dr D. Cantwell, Los Angeles, United States of America
Dr H. Christensen, Canberra, Australia
Dr A. Clare, London, United Kingdom
Dr J. E. Cooper, Nottingham, United Kingdom
Dr J. A. Corbett, London, United Kingdom
Dr W. Eicher, Mannheim, Germany
Dr W. Feuerlein, Munich, Germany
Dr R. Garcia, Santo Domingo, Dominican Republic
Dr M. G. Gelder, Oxford, United Kingdom
Dr R. Giel, Groningen, Netherlands
Dr J. Glatzel, Mainz, Germany
Dr D. Goldberg, Manchester, United Kingdom
Dr M. Gossop, London, United Kingdom
Dr P. Graham, London, United Kingdom
Dr J. Griffith Edwards, London, United Kingdom
Dr L. Gustafsen, Lund, Sweden
Dr S. Guze, St Louis, United States of America
Dr B. Hagberg, Gothenburg, Sweden
Dr J. Helzer, St Louis, United States of America
Dr A. S. Henderson, Canberra, Australia
Dr R. M. A. Hirschfeld, Galveston, United States of America
Dr P. Holzman, Cambridge, United States of America
Dr A. Janca, Geneva, Switzerland
Dr R. Jegede, Ibadan, Nigeria
Dr A. F. Jorm, Canberra, Australia
Dr E. G. Karam, Beirut, Lebanon
Dr R. E. Kendell, Edinburgh, United Kingdom
Dr A. Kleinman, Cambridge, United States of America
Dr G.-E. Kühne, Jena, Germany

Dr D. J. Kupfer, Pittsburgh, United States of America

Dr W. A. Lishman, London, United Kingdom

Dr Z. Lipowski, Toronto, Canada

Dr J. Lokar, Ljubljana, Slovenia

Dr U. Malt, Oslo, Norway

Dr M. Maj, Naples, Italy

Dr I. Marks, London, United Kingdom

Dr J. Mezzich, Pittsburgh, United States of America

Dr R. Misès, Paris, France

Dr R. A. Nadzharov, Moscow, Russia

Dr J. S. Neki, Dar es Salaam, Tanzania

Dr R. Onyango Sumba, Nairobi, Kenya

Dr J. Orley, Geneva, Switzerland

Dr E. S. Paykel, Cambridge, United Kingdom

Dr C. Perris, Umea, Sweden

Dr G. Russel, London, United Kingdom

Dr M. Rutter, London, United Kingdom

Dr B. I. Sacks, London, United Kingdom

Dr J. B. Saunders, Sydney, Australia

Dr C. Scharfetter, Zürich, Switzerland

Dr P. Sindelar, Geneva, Switzerland

Dr M. A. Schuckit, San Diego, United States of America

Dr Shen Yu-cun, Beijing, China

Dr M. Shepherd, London, United Kingdom

Dr A. B. Smulevitch, Moscow, Russia

Dr C. R. Soldatos, Athens, Greece

Dr R. Spitzer, New York, United States of America

Dr E. Strömgren, Aarhus, Denmark

Dr H. Strotzka, Vienna, Austria

Dr E. Taylor, London, United Kingdom

Dr M. Thorpy, Dunedin, New Zealand

Dr G. J. Tucker, Seattle, United States of America

Dr T. B. Üstün, Geneva, Switzerland

Dr J. K. Walsh, Rochester, United States of America

Lord J. N. Walton of Detchant, Oxford, United Kingdom

Dr D. J. West, Cambridge, United Kingdom

Dr J. Wing, London, United Kingdom

Dr L. Wing, London, United Kingdom

Dr Xu You-xin, Beijing, China

List of field trial coordinating centres, field trial centres reporting to them, and investigators

The names of the field trial coordinating centres are arranged in alphabetical order of their locations (Bangalore, Cairo, etc.).

The field trial centres reporting to a particular coordinating centre are arranged in alphabetical order of the country and then the city of their location.

The names of the directors of field trial centres are marked with an asterisk.

Field trial centres reporting to Bangalore, India

Coordinating centre

National Institute of Mental Health and Neurosciences, Bangalore

Dr ?. Chandrashekar

* Dr S. Channabasavanna

Dr S. Chatterti

Dr R. Raguram

Dr C. Shamascundar

Reporting centres

All-India Institute of Medical Sciences, New Delhi, India

Dr K. Chandirami

Dr S. Dube

Dr V. Kapur

Dr ?. Lal

Dr D. Mohan

* Dr S. Saxena

Burnpur Hospital, West Bengal, India

* Dr B. Sen

Christian Medical College, Vellore, India

* Dr J. John

Dr T.M. Kumar

King George's Medical College, Lucknow, India

* Dr A.K. Agarwal

Dr M. Katiyar

Dr S. Kumar

Dr P. Silhatey

Dr H. Singh

Dr J.K. Trivedi

RNT Medical College, Udaipur, India

* Dr L.N. Gupta

Dr D.M. Mathur

Field trial centres reporting to Cairo, Egypt

Coordinating centre

Institute of Psychiatry, Ain Shams University, Cairo

Dr S. Effat

Dr M.R. El Fiki

Dr M. Ghanem

Dr A.H. Khalil

Dr N. Mahawalli

* Dr A. Okasha

Dr M. Refaat

Dr A. Seif El Dawla

Dr A. Shohdi

Reporting centres

Bahrain

Psychiatric Hospital, Manama

* Dr M.K. Al Haddad

Dr C. Kamel

Dr M.A. Karim

Dr M. Kashaba

Dr A. Nabi

Dr O. Saleh

Dr A. Shooka

Egypt

East Town Hospital, Alexandria

Dr N. Fouda

Dr M Mickael

* Dr S. Nicolas

Maamoura Psychiatric Hospital, Alexandria

Dr E.K. Ahmed

* Dr K. El Fawal

Dr M.F. Wagdi

Lebanon

St George's Hospital, Beirut

* Dr E.G. Karam

Dr P.F. Yabroudi

Morocco

Centre Psychiatrique, Universitaire Ibn Roshd, Casablanca

Dr N. Kadri

* Dr D. Moussaoui

Dr M. Touhaii

Tunisia

Centre Hôpital-Universitaire, Monastir

Dr B. Hatem

* Dr T. Skihiri

United Arab Emirates

U.A.E. University, Al Ain

* Dr T.K. Daradhek

Dr A. Saad

Rashid Hospital, Dubai

Dr A.S. El Din

* Dr E.H. Ghoz

Field trial centres reporting to Lübeck, Germany

Coordinating centre

Klinik für Psychiatrie der Medizinischen Hochschule, Lübeck, Germany

Dr G. Arentewicz

Dr V. Arolt

Dr A. Beknisch

Dr H.-G. Brinkmann

* Dr H. Dilling

Dr M. Driessen

* Dr H.J. Freyberger

Dr U. John

Dr R.-D. Kanitz

Dr S. Kleinschmidt

Dr U. Krippendorf

Dr T. Lefèbre

Dr R. Michels

Dr T. Müller-Thomsen

Dr H. Neubauer

Dr S. Nowak

Dr U. Schüffelgen

Dr E. Schulte-Markwort

Dr A. Schürmann

Dr W. Seibert

Dr U. Siebel

Dr D. Steege

Dr C. Veltrup

Dr T. Wetterling

Reporting centres

Austria

Universitätsklinik für Neuropsychiatrie des Kindes- und Jugendalters, Vienna

* Dr F. Resch

Germany

Psychiatrische Klinik des Rheinisch-Westfälische technische Hochschule Aachen, Aachen

Dr H. Ebel

Dr S. Herpertz

Dr C. Menges

Dr A. Pirad

* Dr H. Sass

Dr H. Zimmer

Dr J. Zimmermann

Abteilung für Gerontopsychiatrie der Psychiatrischen Klinik und Poliklinik der Freien Universität, Berlin

* Dr H. Gutzmann

Dr H. Krüger

Psychiatrische Klinik und Poliklinik der Freien Universität Berlin, Berlin

Dr A. Aggias

Dr M. Bauer

Dr F. Bögner

Dr D. Bolk-Weischedel

Dr C. Brockhaus

Dr ?. Carstens

Dr T.R. Drochner

Dr J.S. Englert

Dr S. Englert

Dr ?. Frota

Dr W. Gaebel

Dr R. Gebhardt

Dr ?. Geiselmann

Dr ?. Gruneberg

Dr R. Hellweg

* Dr H. Helmchen

Dr ?. Hosten

Dr M. Lemke

Dr M. Linden

Dr ?. Loos

Dr A. Mackert

Dr C. Nehrig

Dr M. Otto

Dr A. Pietzcker

Dr J. Podschos

Dr U. Polzer

Dr F. Reischeis

Dr A. Rolfs

Dr T. Sander

Dr L. Schmidt

Dr B. Stotzek

Dr T. Steckler

Dr R.-D. Stieglitz

Dr M. Stöver

Dr G. Streb

Dr K. Thies

Dr M. Ufert

Dr T. Wernicke

Dr C. Wildgrube

Dr T. Wünscher

Klinik für Psychosomatik und Psychotherapie der Westfälischen Klinik für Psychiatrie in Dortmund, Dortmund

Dr H. Bast

Dr M. Becker

Dr P. Bösser

* Dr P. Janssen

Dr K. Martin

Dr H. Rath

Dr K. Rodewig

Dr W. Schneider

Dr M. Tetzlaff

Dr W. Wach

Allgemeine Psychiatrie der Landes- und Hochschulklinik, Essen

* Dr M. Gastpar

Dr C. Rösinger

Klinik für Psychotherapie und Psychosomatik der Rheinischen Landes- und Hochschulklinik, Essen

Dr G. Heuft

* Dr J. van Wyk

Abteilung für Kinder- und Jugendpsychiatrie am Zentrum Psychiatrie der Johann-Wolfgang-Goethe-Universität, Frankfurt-am-Main

Dr S. Denner

Dr E. Englert

Dr K. Koepsell

Dr B. Meyenburg

* Dr F. Poustka

Dr D. Rühl

Dr S. Schlüter-Müller

Dr K. Schmecl

Dr G. Schmötzer

Gelderlandklinik - Fachklinik für Psychotherapie und Psychosomatik, Geldern

* Dr R. Kriebel

Klinik für Psychosomatik und Psychotherapie der Justus-Liebig-Universität, Giessen

* Dr B. Brosig

Dr R. Woidera

Abteilung für Psychosomatik und Psychotherapie der Universität Göttingen, Göttingen

Dr C. Breuer

Dr A. Eckhof

Dr J. Konemann

Dr E. Leibing

* Dr U. Rüger

Dr H. Schauenburg

Dr G. Schlüssler

Dr M. Wächter

Dr A. Weddige-Diederichs

Psychiatrische Klinik der Universität Göttingen, Göttingen

Dr J. Grefe

* Dr E. Rüther

Dr A. Thiel

Abteilung für Psychosomatik der Medizinischen Hochschule Hannover, Hannover

Dr B. Albert

Dr U. Gast

Dr A. Kersting

Dr H.-W. Künsebeck

Dr W. Lempa

* Dr R. Liedtke

Dr I. Reimer

Dr G. Schmidt

Psychosomatische Klinik der Ruprechts-Universität, Heidelberg

* Dr G. Heuft

Dr A. Öri

Klinik für Psychiatrie und Neurologie "Hans Berger", Jena (in cooperation with the psychiatric department in Hildburghausen and Mühlhausen)

Dr ?. Aber

Dr ?. Auert

Dr ?. Barnstorf

Dr ?. Bauer

Dr ?. Bertram

Dr ?. Dietrich

Dr ?. Dörz

Dr ?. Fehlow

Dr ?. Fischer

Dr ?. Franke

Dr ?. Fritzsche

Dr ?. Fröhlich

Dr K. Häger

Dr ?. Heins

Dr ?. Hoffmann

Dr ?. Johns

Dr H. Kozian

Dr ?. Krause

Dr G.-E. Kühne

Dr ?. Lagmann

Dr ?. Langbein

Dr ?. Lemke

Dr ?. Lesser

Dr ?. Lobenstein

Dr ?. Misselwitz

Dr ?. Otto

Dr ?. Peter

Dr ?. Reitler

Dr ?. Roselt

Dr ?. Schmidt

Dr ?. Schuber

Dr ?. Schwertfeger

Dr ?. Seelisch

Dr ?. Siegel

Dr ?. Tawana

Dr ?. Tschiersch

Dr ?. Warnke

Dr ?. Wünscher

Klinik für Kinder und Jugendpsychiatrie der Medizinischen Universität, Lübeck

Dr H. Cyganek-Hartwig

Dr A. Harmani-Ochynski

Dr R. Hoppenkamps

* Dr U. Knölker

Dr M. Lücke

Dr M. Neuhauss

Dr ?. Radizi

Dr G. Roosen-Runge

Dr W. Ruhlender

Dr A. Schneider

Dr M. Schulte-Markwort

Dr E. Sochaczewsky

Dr T. Zenkl

Klinik für Psychosomatik der Medizinischen Universität Lübeck, Lübeck

Dr H. Federschmidt

Dr H. Feiereis

* Dr G. Jantschek

Dr I. Jantschek

Dr H.-G. Kollra

Dr K. Langner

Dr S. Marks-Mitusch

Dr B. Mensing

Dr M. Pollak

Dr B. Probst

Dr J. Redmann

Dr B. Scheferling

Dr R. Schichtling

Dr M. Sudeck

Dr I. Trotno

Dr J. von Wietersheim

Dr E. Wilke

Dr R. Zehendner

Klinik für Psychosomatische Medizin und Psychoanalyse am Zentralinstitut für Seelische Gesundheit, Mannheim

Dr M. Frans

Dr H. Käfer

Dr H.-D. Kortendieck

Dr A. Kriebel

Dr K. Lieberz

Dr M. Markstein

* Dr A. Muhs

* Dr H. Schepank **TWO DIRECTORS?**

Dr M. Schierer

Dr A. Schiller

Dr ?. Weber

Klinik für Kinder- and Jugendpsychiatrie der Universität Marburg, Marburg

* Dr B. Herpertz-Dahlmann

Dr K. Quaschner

Dr E. Schulz

Poliklinik der Max-Planck-Instituts für Psychiatrie, Munich

Dr J. Guldner

Dr F. Helgenberger

* Dr W. Mombour

Dr M. Oechsner

Dr T. Pätzold

Dr T. Schier

Dr F.-E. Seier

Dr H. Unland

Dr T. Wetter

Psychiatrisches Abteilung, Krankenhaus Haar, Haar bei München, Munich

* Dr M. Albus

Dr J. Baruth-Krischel

Dr E. Dietzfelbinger

Dr C. Hummel

Dr P. Lauer

Dr G. Scheibe

Dr E. Stiasny

Psychiatrische Klinik und Poliklinik der Ludwig-Maximilians-Universität, Munich

* Dr P. Hoff

Abteilung für Kinderneuropsychiatrie der Universitätsnervenklinik Rostock,

Rostock

*Dr H. Camman

Psychiatrische Klinik der Universität, Rostock

Dr B. Dreves

* Dr K. Ernst

Dr K. Friemert

Dr C. Lehmann

Dr R. Mau

Dr C. Rehn

Dr D. Roether

Dr D. Schläfke

Psychotherapeutische Klinik, Krankenhaus für Analytische Psychotherapie und Psychosomatik, Stuttgart

Dr K.-U. Adam

Dr J. Dittert

Dr W. Ehlers

Dr G. Eichner

Dr R. Hettinger

Dr I. Rothe-Kirchberger

Dr T. Seifert

* Dr G. Scmitt

Dr J.-M. Voigtländer

Klinik Berus - Zentrum für Psychosomatik und Verhaltensmedizin, Überherrn-Berus

Dr W. Bürger

Dr A. Dinger-Broda

Dr W. Engelhardt

Dr A. Herrmann

* Dr W. Köhl

Dr W. Miller

Dr P. Osterziel

Dr S. Rittmann

Dr J. Schwickerath

Dr J. Seifert-Haves

Dr T. Stau

Dr C. Thissen

Dr S. Tonscheidt

Dr R. Winter

Dr P. Zenner

Switzerland

Psychiatrische Klinik der Universität Basel, Basel

* Dr V. Dittmann

Poliklinik für Kinder und Jugendliche, Zurich

* Dr H.C. Steinhausen

Field trial centres reporting to Luxembourg

Coordinating centre

Service de Neuro-psychiatrie, Centre Hospitalier de Luxembourg, Luxembourg

Dr C. Ghaillet

* Dr C. Pull

Reporting centres

Belgium

Hôpital Erasme, Bruxelles

Dr P. Hubain

Dr I. Ramallo Pallast

* Dr L. Staner

France

Clinique Psychiatrique Jérome Bosch, Armentières

Dr V. Garcin

Dr C. Gignac

Dr M. Gomes

Dr A. Gurdal

Dr D. Ochin

Dr B. Parmentier

* Dr J.-L. Roelandt

Dr C. Vosgien

Centre Hopsitalier de Cayenne, Cayenne

* Dr E. Aronica

  Dr G. Simart

Centre Hospitalier Spécialisé Le Vinatier, Lyon

  Dr J.M. Guillaud-Bataille

* Dr J.L. Terra

Centre Hospitalier Spécialisé Le Vinatier, Lyon

  Dr T. Faivre

  Dr N. Georgieff

* Dr M. Marie-Cardine

  Dr G. Mecheri

Centre Hospitalier Spécialisé La Verrière, Le Mesnil-St-Denis

* Dr V. Kovess

Centre Hospitalier Specialisé de Colson, Fort-de-France, Martinique

  Dr A. Bottius

  Dr X. Bouveresse

  Dr P. Guillard

  Dr G. Gruel

* Dr G. Ursulet

Clinique de Psychiatrie, Nice

  Dr B. Bensmail

  Dr T. Braccini

* Dr G. Darcourt

Cliniques des maladies mentales, Paris

  Dr V. Gaillac

* Dr J.D. Guelfi

  Dr M.L. Seror

Hôpital Necker, Paris

  Dr X. Abillon

* Dr B. Granger

Hôpital Robert Debré, Paris

  Dr A.M. Badoual

  Dr M. Bouvard

* Dr M. Dugas
  Dr X. George
  Dr C. Gerard
  Dr M. Legendreux
  Dr M.F. Le Heuzey

Hôpital de la Salpêtrière, Paris
  Dr U. Barua
* Dr A. Lazartigues
  Dr H. Morales

Centre Hospitalier Spécialisé du Rouvray, Rouen
  Dr F. Besse
  Dr P. Brazo
* Dr S. Dollfus
  Dr P. Preterre

Hôpital de Bellevue, Saint-Etienne
  Dr C. Digonnet
  Dr D.G. Froissart
  Dr A. Guillot
  Dr F. Lang
  Dr F. Manipoud
  Dr M. Marcon
* Dr J. Pellet
  Dr M. Pichon
  Dr M.G. Pichon
  Dr C. Rascle
  Dr X. Tatu

Centre Médico-Psychologique, Saint Germain en Laye
  Dr U. Barua
* Dr A.-P. Van Amerongen
  Dr S. Virecoulon

Centre Hospitalier Universitaire, Strasbourg
  Dr S. Peretti
* Dr L. Singer
  Dr M.A. Zimmermann

Israel

Hôpital Psychiatrique Geha, Tel Aviv

Dr M. Danon

Dr M. Granek

Dr M. Radwan

* Dr S. Tyano

Switzerland

Clinique de Psychiatrie, Geneva

Dr E. Bishara

Dr P. Huguelet

* Dr I. Zabala

Clinique Psychiatrique, Lausanne

Dr D. Baettig

Dr J. Besson

Dr C. Bryois

* Dr F Ferrero

Dr C. Schnyder

Field trial centres reporting to Madrid, Spain

Coordinating centre

Clinica López-Ibor, Madrid

Dr M. Crespo

Dr F. Ferre

* Dr J.J. López-Ibor Jr

Dr L.I. Jordá

Dr J. Saíz Ruiz

Dr M. Vega

Reporting centres

Chile

Clínica Psiquiátrica Universitaria, Universidad de Chile, Santiago

Dr R. Chaparro

Dr B. Díaz Vargas

* Dr F. Lolas

Mrs A. Montenegro

Dr L. Risco

Dr C. Tchimino

Dr C. Téllez

Mrs E. Varela

Mr S. Véliz

Spain

Servicio di Psiquiatría, Hospital del Valle de Hebrón, Barcelona

Dr E. Miró

Dr L.A. Morales

Dr E. Rojo

Dr P. Salgado

Dr J.A. Sanz

Dr J. Serrallonga

* Dr J. Vallejo

Psychiatric Unit, Hospital de la Santa Creu y Sant Pau, Barcelona

* Dr J.C. Pérez de los Cobos

Dr C. Pinet

Dr M.L. Soto

Servicio de Psiquiatría, Ciudad Sanitaria La Paz, Madrid

Dr M.C. Bayón

Dr J. Bellot

Dr F. Cañas

Dr M.C. Culebro Fernández

Dr C. de Dios

Dr B. Franco

Dr R. García Pérez

Dr G. Gómez Mújica

Dr F.R. González-Nicolás

Dr M. Graell

Dr J.J. Martínez García

Dr F. Orengo

Dr B. Rodríguez Vega

* Dr J. Santo Domingo

Dr M.L. Soto

Servicio de Salud Mental, Comunidad de Madrid, Madrid

Dr A. Castaño Romero

* Dr V. Corces Pando

Dr C. González

Dr R. Gutierrez Labrador

Dr M.L. López Girones

Dr C. Polo Usaola

Dr A. Roig Moliner

Dr A. Tejeda Rivas

Dr B. Viar Lahera

Servico de Salud Mental, Principado de Asturias, Oviedo

* Dr V. Aparicio

Dr B. Cid

Dr G. García

Mrs S. García Tardón

Dr A. González

Dr F. González Aria

Dr S. Ocio Léon

Dr C. Pedrero

Dr E. Peñuela

Dr A. Rincón

Servicio de Psiquiatría, Universidad de Oviedo, Oviedo

* Dr J. Bobes García

Dr P. Gonzáles G. Portilla

Field trial centres reporting to Moscow, Russian Federation

Coordinating centre

Institute of Psychiatry, Academy of Medical Sciences, Moscow

Dr K. Kostyukova

* Dr S. Tzirkin

Dr O. Valova

Field trial centres reporting to Nagasaki, Japan

Coordinating centre

Nagasaki University, Nagasaki

Dr J. Kubota

* Dr Y. Nakane

Dr Y. Okazaki

Dr K. Takada

Reporting centres

Fukui Medical School, Fukui

Dr T. Hayashi

* Dr K. Isaki

Dr Y. Koshino

Dr S. Madokoro

Dr R. Matsubara

Dr K. Misaki

Dr I. Murata

Dr M. Oomori

Kyushu University, Fukuoka

Dr K. Hirata

* Dr H. Ninomiya

Dr T. Saito

Dr T. Tanaka

Fukushima Medical College, Fukushima

* Dr M. Kaneko
  Dr K. Takahagi

Hirosaki University, Hirosaki

* Dr Y. Fukushima
  Dr K. Hashimoto
  Dr S. Kaneko
  Dr K. Otani
  Dr F. Saito
  Dr H. Tasaki
  Dr H. Yabe
  Dr I. Yoshimura

Hiroshima University Hospital, Hiroshima

  Dr Y. Ishida
* Dr M. Osada

Teikyo University, Ichihara Hospital, Ichihara

  Dr M. Hasegawa
  Dr R. Hayashi
  Dr K. Hoshino
  Dr M. Ikeda
  Dr Y. Kim
  Ms M. Matsumori
  Dr T. Nemoto
* Dr T. Takahashi
  Dr T. Takeuchi

Kanazawa University Hospital, Kanazawa

  Dr H. Arai
  Dr T. Asano
  Dr T. Fukushima
  Dr H. Hasegawa
  Dr I. Jibiki
  Dr H. Kido
  Dr Y. Kiyota
  Dr K. Kosaka
  Dr Y. Koyama
  Dr T. Maeda
  Dr K. Miyazu

Dr K. Nakagawa

Dr H. Sakamoto

Dr T. Sumiyoshi

Dr K. Terai

Dr K. Urata

Dr K. Urasaki

Dr K. Ueno

* Dr N. Yamaguchi

Dr M. Yuasa

Tokyo Jikeikai University, Kashiwa Hospital, Kashiwa

Ms M. Kan

* Dr H. Kasahara

Dr S. Kishita

Dr H. Nishimura

Dr K. Nukariya

Dr M. Onda

Dr T. Shinozaki

University of Occupational and Environmental Health, Kitakyushu

Dr O. Ohmori

Dr T. Shiratsuchi

* Dr R. Yoshimura

Kurume University School of Medicine, Kurume

Dr Y. Ida

Dr T. Kotorii

Dr H. Mukasa

Dr J. Nakamura

* Dr Y. Nakazawa

Dr T. Sakamoto

Dr K. Takamuki

Dr S. Tsujimaru

Kyoto University, Kyoto

Dr S. Hamagaki

Dr Y. Inoue

Dr N. Marui

* Dr K. Nakayama

Dr A. Okae

Dr T. Yamashita

Miyazaki Medical College, Miyazaki

Dr O. Arakawa

Dr K. Hara

* Dr T. Ikeda

Kochi Medical School, Nangoku

Dr H. Hashizume

* Dr S. Inoue

Dr H. Sato

Hyogo College of Medicine, Nishinomiya

Dr K. Hori

Dr E. Hashiyama

Dr S. Hayashi

Dr S. Ikegami

Dr B. Iwamoto

Dr N. Kawasaki

Dr S. Komai

Dr H. Makihara

Dr M. Matsui

Dr K. Miki

Dr M. Miaymoto

* Dr K. Miyoshi

Dr Y. Morita

Dr Y. Nakai

Dr M. Sato

Dr Y. Shinoda

Dr S. Takauchi

Dr T. Takeda

Dr K. Tankiguchi

Dr S. Yamauchi

Dr A. Yoshikawa

Medical College of Oita, Oita

Dr J. Ando

* Dr I Fujii

Dr N. Hasama

Dr J. Ihara

Dr H. Naganuma

Dr T. Yanagisawa

Okayama University Medical School, Okayama

Dr K. Akiyama

* Dr Y. Fujiwara

University of the Ryukyus Hospital, Okinawa

Dr N. Kunimoto

Dr H. Nakamata

Dr H. Nakamoto

* Dr C. Ogura

Dr T. Uema

Dr K. Yamamoto

Shiga University of Medical Sciences, Ootsu

Ms R. Atsukawa

Dr K. Daimon

Dr K. Hanada

Mr H. Iida

Dr K. Ikemoto

Dr N. Kato

Dr T. Kato

Dr H. Kanai

Dr T. Noguchi

Dr K. Satoh

Dr T. Shioiri

Dr M. Shibasaki

Dr T. Someya

* Dr S. Takahashi

Kinki University, Osaka

* Dr M. Hanada

Dr T. Kusube

Dr A. Okada

Dr D. Takahashi

Dr H. Tazoe

Dr K. Yamaguchi

Dr T. Yokouchi

Osaka University Medical School, Osaka

Dr H. Sato

Dr A. Sekiyama

* Dr A. Yamamoto

Kitasato University, Sagamihara

Dr T. Arai

Dr J. Ishigooka

Dr T. Kasahara

Dr Y. Oguchi

* Dr Y. Ohtani

Hokkaido University, Sapporo

Dr K. Denda

Dr T. Kasahara

* Dr I. Yamashita

Keio University, Tokyo

* Dr M. Asai

Dr S. Kanba

Dr H. Kashima

Dr M. Mizuno

Dr A. Nishizono-Maher

Dr Y. Ono

Dr G. Yagi

Showa University, Tokyo

Dr F. Arakawa

Dr T. Hashimoto

Dr U. Inamoto

* Dr K. Kamijima

Dr M. Kawai

Dr N. Sakanishi

Dr I. Tadama

Tokyo Medical College Hospital, Tokyo

Dr S. Hikiba

Dr R. Ikeda

Dr M. Kato

Dr S. Koretsune

Dr T. Maruta

Dr S. Nagura

Dr N. Sakaue

* Dr M. Shimiz

Tokyo Medical and Dental University, Tokyo

Dr T. Kojima

Dr M. Matsuura

Dr Y. Okubo

* Dr M. Toru

Yamagata University Hospital, Yamagata

* Dr T. Nadaoka

Dr T. Tanaka

Field trial centres reporting to Oxford, England

Coordinating centre

Department of Psychiatry, Oxford University Hospital, Oxford

* Dr M. Gelder

Reporting centres

Czech Republic

Charles University, Hradec Kralove

* Dr M. Zaplatalek

Postgraduate Medical and Pharmaceutical Institute, Prague

Dr J. Beran

Dr K. Chromy

Dr K. Dusek

Dr D. Friedlova

Dr M. Hessler

Dr A. Janik

Dr N. Kubickova

Dr P. Pavlovsky

Dr P. Popov

* Dr P. Smolik

Prague Psychiatric Centre, Prague

Dr P. Baudis

Dr E. Bendova

Dr M. Benes

Dr I. Klar

* Dr D. Seifertova

England

Children's Hospital, Birmingham

* Dr R. Harrington

Dr P. Vostanis

Queen Elizabeth Psychiatric Hospital, Birmingham

Dr M. Baxter

Dr D. Clarke

* Dr J. Corbett

* Dr S. Cumella

Dr J. Langton

Dr V. Prasher

Dr A. Roy

Dr M. Roy

Dr K. Thinn

Ida Darwin Hospital, Cambridge

Dr S.J. Barnett

* Dr G. O'Brien

General Infirmary at Leeds, Leeds

* Dr I. Berg

Dr C. Lucas

Dr R. Sims

Dr A. Worrall

Department of Psychiatry, University of Leicester, Leicester

* Dr T.S. Brugha

Mossley Hill Hospital, Liverpool

Dr J. Copeland

Dr P. Saunders

* Dr K.C.M. Wilson

Guys Hospital, London

* Dr T. Craig
  Dr K. Sutherby

Institute of Psychiatry, London

* Dr A. Mann
  Dr M. Phelan
  Dr J. Rutherford

Maudsley Hospital, London

  Dr G.O. Donoghue
  Dr G.F.M. Russell
  Dr J. Rutherford
  Dr U. Schmidt
  Dr J. Tiller
* Dr J. Treasure

MRC Social and Community Psychiatric Unit, Institute of Psychiatry, University of London, London

* Dr P. Bebbington

St Bartholomew's Hospital, London

* Dr P.D. White

St Charles Hospital, London

  Dr P. Duke
  Ms F. Henderson
  Dr S. Merson
* Dr P. Tyrer

St Mary's Hospital, London

  Dr D. Baldwin
  Dr D. Montgomery
* Dr S.A. Montgomery

Worcester Royal Infirmary, Worcester

* Dr G. Milner
  Dr R. Sheen
  Dr J. Tarry
  Dr G. Wainscott

Ireland

St Loman's Hospital, Dublin

Dr B. Murphy

* Dr A. O'Grady Walsh

Dr D. Walsh

Turkey

Hacettepe University, Ankara

Dr M. Gürsoy

Dr A. Gögüs

Dr I. Kaplan

Dr R. Özbayrak

Dr G. Özgen

* Dr O.M. Öztürk

Dr M. Rezaki

Dr A. Sagduyu

Dr B. Ulug

Dr A. Ulusahin

Field trial centres reporting to Risskov, Denmark

Coordinating centre

Psychiatric University Hospital in Aarhus, Risskov

* Dr A. Bertelsen

Dr R. Licht

Dr S. Straarup

Reporting centres

Denmark

Psychiatric Hospital, Aarhus

* Dr N.C. Gulmann

Hvidovre Hospital, Copenhagen

* Dr M. Kastrup
  Dr K. Maarbjerg
  Dr E. Simonsen

Frederiksberg Hospital, Frederiksberg, Copenhagen

  Dr O. Jorgensen
* Dr J.K. Larsen
  Dr K. Olafsson
  Dr H. Raben
  Dr H.R. Vinding

Randers Centralsygehus, Randers

  Dr T. Mathiesen
* Dr J.A. Nielsen

Israel

"Talbieh" Mental Health Centre, Jerusalem

  Dr R. Aronzon
  Dr P. Brown
  Dr N. Cividali
  Dr R. Durst
  Dr M. Fliman
* Dr Y. Ginath
  Dr E. Perl
  Dr M. Ritsner
  Dr K.J. Rubin
  Dr H. Schonfeld
  Dr L. Zilberman

The Gehah Psychiatric Hospital, Petah-Tiqua, Tel-Aviv

  Dr Z. Marom
* Dr H. Munitz
  Dr G. Retzoni
  Dr J. Sever

Poland

Department of Psychiatry I, Institute of Psychiatry and Neurology, Sobieskiego, Warsaw
Dr A. Chojnowska
Dr I. Stanikowska
* Dr J. Wciórka

Department of Psychiatry IV, Institute of Psychiatry and Neurology, Brodno General Hospital, Warsaw
Dr A. Bialjszewski
Dr A. Piotrowski
Dr M. Zaluska

Romania

Psychiatric Department, Faculty of Medicine, University of Timisoara, Timisoara
Dr M. Dehelean
Dr P. Dehelean
Dr M. Ienciu
* Dr M. Lazarescu
Dr O. Nicoara
Dr F. Romosan

Field trial centres reporting to Rockville, MD, USA

Coordinating centre

Division of Clinical Research, National Institute of Mental Health, Rockville
* Dr G. Regier

Reporting centres

Canada

Alberta Hospital, Edmonton
Dr M. Cummins
* Dr P. Flor-Henry

Dr D. Spaner

Dr A. Van Zyl

London Psychiatric Hospital, London

Dr A. Hinsberger

Dr D. Mazmanian

* Dr E. Persad

Dr V. Sharma

University Hospital of Western Ontario, London

* Dr H. Merskey

Dr P. Monahar

Dr R. Manchanda

Douglas Hospital Research Center, Montreal

Dr S.K. Ahmed

* Dr H.E. Lehmann

Dr J. Martial

Dr A. Skorzewsky

Republic of Korea

Kyung-pook National University Hospital, Daegu

Dr Dong Ho Choo

Dr Hyun-Joon Kim

Dr Sang Un Park

* Dr Zuk Nae Lee

Maerinoll Hospital, Chung-gu, Pusan

* Dr Chong Kil Kim

Dr Chung-Ki Kim

Dr Young-Suk Park

ASAN Medical Center, Seoul

Dr Kim Chang Yoon

* Dr Lee Chul

Dr Park Jae Sun

Dr Park In Ho

Dr Han Oh-Su

Choong Anag University Hospital

Dr Lee Jae-Woo

* Dr Lee Kil Hong

Dr Lee Yong-Sik

Gyeongsang National University, Chinju-shi, Seoul

* Dr Kyu Hee Hahn

Dr Sung Il Woo

Hanlim University, Seoul

Dr Dong Hyun Ahn

* Dr Seok Cheol Ahn

Kangdong Sacred Heart Hospital, Chinju-shi, Seoul

Dr Byeong Kil Yeon

* Dr Jae Ho Suk

Dr Yu Moon Park

Kangnam St Mary's Hospital, Kangnam-gu, Seoul

Dr Bo Moon Choi

Dr Chul Lee

* Dr In Ho Paik

Dr Kyu Hwan Lee

Dr Young Lae Chae

Seoul Mental Hospital, Seoul

Dr Baek Ki-Cheong

* Dr Kwack Young Suok

Seoul National University Hospital, Seoul

* Dr Rhi Bou-Young

Dr Lee Chang-In

Dr Kim Do-Kwan

Dr Jeong Do-Un

Dr Woo Jong-Inn

Dr Kwon Jun-Soo

Dr Jo Maenj-Je

Dr Kim Moo-Jin

Dr Chang Soon-Kee

Dr Lee Taeck-Joong

Dr Tongwoo Suh

Dr Kim Yong-Sik

Seoul National University Hospital, Seoul

Dr Choi Jin Sook

* Dr Kang E.M. Hong

Dr Kim Haeng-Sook

Dr Park Jin-Seng

Dr Park Sung-Suk

Dr Soo-Churl Cho

Seoul Sangkye-dong University Hospital, Seoul

* Dr Lee Jeong-Ho

Dr Lee Ki-Cheol

Soonchunhyang University Hospital, Seoul

Dr Han Yong Jung

Dr Seung Hyun Kim

* Dr Sun Ho Han

Yonsei University, Seoul

* Dr Ho Young Lee

Dr Jun Ji Hong

Dr Kim Yong-Shin

Dr Lee B.Y.

Dr Lee H.S.

Dr Lee Jo-hun

Dr Man Hong Lee

Dr Sin Eui Jin

Dr Young Hoon Oh

United States of America

McLean Hospital, Belmont

* Dr S. Frazier

Dr K. Phillips

Dr J. Samson

Baylor College of Medicine, Houston

Dr H. Clay

Dr F. Dereboy

* Dr N. Gokcebay
  Dr M. Hirschkowitz
* Dr I. Karacan

Western Psychiatric Institute and Clinic, Pittsburgh
  Dr S. Blaha
  Dr J. Eichhorn
  Dr M. Landy
* Dr R. Pary
  Dr J.C. Rogers
  Dr J.E. Salta

Washington University School of Medicine, St Louis
  Dr T.S. Early
* Dr A Janca

Field trial centres reporting to Shanghai, China

Coordinating centre

Shanghai Mental Health Centre, Shanghai
  Dr Shi Shen-xun
  Dr Xia Mei-lan
* Dr Xu Tao-yuan
  Dr Zhang Yong-hua
  Dr Zhu Zi-qing

Reporting centres

Hunan Medical University, Changsha
  Dr Li Ling-jiang
* Dr Yang De-sen

West China Medical University, Chengdu
  Dr Guo Lan-ting
  Dr Li Tao
  Dr Lin Pei-yi

* Dr Liu Xie-he
  Dr Sun Xue-li
  Dr Yang Yan-chun
  Dr Ye Lu

Nanjing Institute of Child Mental Health, Nanjing
  Dr Luo Shuo-jun
* Dr Tao Guo-tai
  Dr Wang Ming-jie
  Dr Zhang Ju-feng

Field trial centres reporting to Wellington, New Zealand

Coordinating centre

Wellington Hospital, Wellington
  Dr J. Crawshaw
  Dr P.M. Ellis
* Dr G.W. Mellsop
  Dr N. Mendis
  Dr G. Purdie
  Dr C.S. Thomas

Reporting centre

University of Otago, Dunedin
  Dr N. Raja
* Dr G.S. Ungvari