of a preexisting physical condition, as in the acceptance of a penicillin injection despite a known previous history of an anaphylactic reaction; or any combination or variation of the above.

301.51 Chronic Factitious Disorder with Physical Symptoms

The essential feature is the individual's plausible presentation of factitious physical symptoms to such a degree that he or she is able to obtain and sustain multiple hospitalizations. The individual's entire life may consist of either trying to get admitted into or staying in hospitals. Common clinical pictures include severe right lower quadrant pain associated with nausea and vomiting, dizziness and blacking out, massive hemoptysis, generalized rash and abscesses, fevers of undetermined origin, bleeding secondary to ingestion of anticoagulants, and "lupuslike" syndromes. All organ systems are potential targets, and the symptoms presented are limited only by the individual's medical knowledge, sophistication, and imagination. This disorder has also been called Münchausen syndrome.

These individuals usually present their history with great dramatic flair, but are extremely vague and inconsistent when questioned in more detail. There may be uncontrollable pathological lying, in a manner intriguing to the listener, about any aspect of the individual's history or symptomatology (pseudologica fantastica). These individuals often have extensive knowledge of medical terminology and hospital routines. Once admitted to a hospital they can create havoc on the ward by demanding attention from hospital staff and by noncompliance with hospital routines and regulations. After an extensive work-up of their initial chief complaints proves negative, they will often complain of other physical problems and produce more factitious symptoms. Complaints of pain and requests for analgesics are very common. Individuals with this disorder often eagerly undergo multiple invasive procedures and operations. While in the hospital they usually have few visitors. When confronted with evidence of their factitious symptoms they either deny the allegations or rapidly discharge themselves against medical advice. They will frequently be admitted to another hospital the same day. Their courses of hospitalizations often take them to numerous cities, states, countries, and even different continents. Eventually a point is usually reached at which the individual is "caught" producing factitious symptomatology; he or she is recognized by someone from a previous admission or another hospital, or other hospitals are contacted and confirm multiple prior hospitalizations for factitious symptomatology.

Associated features. Substance abuse, particularly of analgesics and sedatives, often medically prescribed, may be present.

Age at onset and course. Onset is usually in early adult life, often with a hospitalization for true physical illness. Rapidly thereafter, a pattern of successive hospitalizations begins and becomes a lifelong pattern.

Impairment. This disorder is extremely incapacitating. The course of chronic hospitalizations is obviously incompatible with the individual's maintaining

steady employment, maintaining family ties, and forming lasting interpersonal relationships.

Complications. These individuals frequently acquire a "gridiron abdomen" from the multiple surgical procedures they have undergone. Multiple hospitalizations frequently lead to iatrogenically-induced physical illness, such as scar tissue formation from unnecessary surgery, abscesses from numerous injections, and adverse drug reactions. Occasionally they will spend time in jail because of vagrancy, or assault in mental hospitals because of transfers from general hospitals when the factitious nature of their symptoms is discovered.

Predisposing factors. These may include true physical disorder during childhood or adolescence leading to extensive medical treatment and hospitalization; a grudge against the medical profession, sometimes due to previous medical mismanagement; employment in the medical field as a nurse, technician, or other paraprofessional; underlying dependent, exploitative, or masochistic personality traits; an important relationship with a physician in the past, e.g., a family member who was a physician, or seduction by a physician during childhood or adolescence.

Prevalence. Some believe the disorder is common but rarely recognized. Others believe that it is rare and that the few individuals with the disorder are being overreported because they appear to different physicians at different hospitals, often using different names.

Sex ratio. The disorder is apparently more common in males.

Familial pattern. No information.

Differential diagnosis. The major diagnostic consideration is obviously **true physical disorder.** A high index of suspicion for Chronic Factitious Disorder with Physical Symptoms should be aroused if any combination of the following is noted: pseudologica fantastica, with emphasis on the dramatic presentation; disruptive behavior on the ward, including noncompliance with hospital rules and regulations and arguing excessively with the nurses and physicians; extensive knowledge of medical terminology and hospital routines; continued use of analgesics for "pain"; evidence of multiple surgical interventions, e.g., a "gridiron abdomen" or burr holes in the skull; extensive history of traveling; few, if any, visitors while hospitalized; and a fluctuating clinical course with the rapid production of "complications" or new "pathology" once the initial work-up proves to be negative.

In **Somatoform Disorders** there are also physical complaints not due to true physical disorder. However, the symptom production is not under voluntary control, and admissions to hospitals are rarely as common as in Chronic Factitious Disorder with Physical Symptoms.

Individuals with **Malingering** may seek hospitalization by producing symptoms in attempts to obtain compensation, evade the police, or simply "get a

bed for the night." However, the goal is usually apparent, and they can "stop" the symptom when it is no longer useful to them.

Antisocial Personality Disorder is often incorrectly diagnosed on the basis of the pseudologica fantastica, the lack of close relations with others, and the occasionally associated drug and criminal histories. Antisocial Personality Disorder differs from this disorder by its earlier onset and its rare association with chronic hospitalization as a way of life.

Schizophrenia is often incorrectly diagnosed because of the bizarre life-style. However, the characteristic psychotic symptoms of Schizophrenia are not present.

Diagnostic criteria for Chronic Factitious Disorder with Physical Symptoms

A. Plausible presentation of physical symptoms that are apparently under the individual's voluntary control to such a degree that there are multiple hospitalizations.

B. The individual's goal is apparently to assume the "patient" role and is not otherwise understandable in light of the individual's environmental circumstances (as is the case in Malingering).

300.19 Atypical Factitious Disorder with Physical Symptoms

This is a residual category for Factitious Disorders with Physical Symptoms that do not fulfill the criteria for Chronic Factitious Disorder with Physical Symptoms.

Usually individuals with Atypical Factitious Disorder with Physical Symptoms do not require hospitalization. Examples include dermatitis artifacta (induced by excoriation or chemicals) and voluntary dislocation of the shoulder.

Disorders of Impulse Control Not Elsewhere Classified

This is a residual diagnostic class for disorders of impulse control that are not classified in other categories, e.g., as a Substance Use Disorder or Paraphilia.

The essential features of disorders of impulse control are:

1. Failure to resist an impulse, drive, or temptation to perform some act that is harmful to the individual or others. There may or may not be conscious resistance to the impulse. The act may or may not be premeditated or planned.

2. An increasing sense of tension before committing the act.

3. An experience of either pleasure, gratification, or release at the time of committing the act. The act is ego-syntonic in that it is consonant with the immediate conscious wish of the individual. Immediately following the act there may or may not be genuine regret, self-reproach, or guilt.

This class contains five specific categories: Pathological Gambling, Kleptomania, Pyromania, Intermittent Explosive Disorder, and Isolated Explosive Disorder. Finally, there is a residual category, Atypical Impulse Control Disorder.

312.31 Pathological Gambling

The essential features are a chronic and progressive failure to resist impulses to gamble and gambling behavior that compromises, disrupts, or damages personal, family, or vocational pursuits. The gambling preoccupation, urge, and activity increase during periods of stress. Problems that arise as a result of the gambling lead to an intensification of the gambling behavior. Characteristic problems include loss of work due to absences in order to gamble, defaulting on debts and other financial responsibilities, disrupted family relationships, borrowing money from illegal sources, forgery, fraud, embezzlement, and income tax evasion.

Commonly these individuals have the attitude that money causes and is also the solution to all their problems. As the gambling increases, the individual is usually forced to lie in order to obtain money and to continue gambling, but hides the extent of the gambling. There is no serious attempt to budget or save money. When borrowing resources are strained, antisocial behavior in order to obtain money for more gambling is likely. Any criminal behavior—e.g., forgery, embezzlement, or fraud—is typically nonviolent. There is a conscious intent to return or repay the money.

Associated features. These individuals most often are overconfident, somewhat abrasive, very energetic, and "big spenders"; but there are times when they show obvious signs of personal stress, anxiety, and depression.

Age at onset and course. The disorder usually begins in adolescence and waxes and wanes, tending to be chronic.

Impairment. The disorder is extremely incapacitating and results in failure to maintain financial solvency or provide basic support for oneself or one's family. The individual may become alienated from family and acquaintances and may lose what he or she has accomplished or attained in life.

Complications. Suicide attempts, association with fringe and illegal groups, and arrest for nonviolent crimes that may lead to imprisonment are among the possible complications.

Predisposing factors. These may include: loss of parent by death, separation, divorce, or desertion before the child is 15 years of age; inappropriate parental discipline (absence, inconsistency, or harshness); exposure to gambling activities as an adolescent; a high family value on material and financial symbols; and lack of family emphasis on saving, planning, and budgeting.

Prevalence. No information.

Sex ratio. The disorder is apparently more common among males than females.

Familial pattern. Pathological Gambling and Alcoholism are more common in the fathers of males and in the mothers of females with the disorder than in the general population.

Differential diagnosis. In **social gambling,** gambling with friends is engaged in mainly on special occasions and with predetermined acceptable losses.

During a **manic or hypomanic episode** loss of judgment and excessive gambling may follow the onset of the mood disturbance. When manic-like mood changes occur in Pathological Gambling they typically follow winning.

Problems with gambling are often associated with **Antisocial Personality Disorder** and in Pathological Gambling antisocial behavior is frequent. However, in Pathological Gambling any antisocial behavior that occurs is out of desperation to obtain money to gamble when money is no longer available and legal resources have been exhausted. Criminal behavior is rare when the individual has money. Also, unlike the individual with Antisocial Personality Disorder, the individual with Pathological Gambling usually has a good work history until it is disrupted because of the gambling.

Diagnostic criteria for Pathological Gambling

A. The individual is chronically and progressively unable to resist impulses to gamble.

B. Gambling compromises, disrupts, or damages family, personal, and vocational pursuits, as indicated by at least three of the following:

(1) arrest for forgery, fraud, embezzlement, or income tax evasion due to attempts to obtain money for gambling
(2) default on debts or other financial responsibilities
(3) disrupted family or spouse relationship due to gambling
(4) borrowing of money from illegal sources (loan sharks)
(5) inability to account for loss of money or to produce evidence of winning money, if this is claimed
(6) loss of work due to absenteeism in order to pursue gambling activity
(7) necessity for another person to provide money to relieve a desperate financial situation

C. The gambling is not due to Antisocial Personality Disorder.

312.32 Kleptomania

The essential feature is a recurrent failure to resist impulses to steal objects that are not for immediate use or their monetary value: the objects taken are either given away, returned surreptitiously, or kept and hidden. Almost invariably the individual has enough money to pay for the stolen objects. The individual experiences an increasing sense of tension before committing the act and intense gratification while committing it. Although the theft does not occur when immediate arrest is probable (e.g., in full view of a policeman), it is not preplanned, and the chances of apprehension are not fully taken into account. The stealing is done without long-term planning and without assistance from, or collaboration with, others.

The diagnosis is not made if the stealing is due to Conduct Disorder or Antisocial Personality Disorder.

Associated features. The individual often displays signs of depression, anxiety, and guilt over the possibility or actuality of being apprehended and the resultant loss of status in society. Often, but not invariably, there are signs of personality disturbance.

Age at onset and course. The age at onset may be as early as childhood. The condition waxes and wanes and tends to be chronic; how often it "burns itself out" is unknown.

Impairment and complications. Impairment is usually due to the legal consequences of being apprehended, the major complication of the disorder.

Predisposing factors, prevalence, and familial pattern. No information.

Sex ratio. Although the majority of individuals apprehended for shop-

lifting are female, only a very small proportion of these individuals have Kleptomania. No data are available on the true sex ratio for the disorder.

Differential diagnosis. In **ordinary stealing** there is no evidence of a failure to resist the impulse; the act is usually planned, and the objects are stolen for their immediate use or monetary gain.

In **Malingering,** there may be an attempt to simulate the disorder in order to avoid criminal prosecution for common thievery. In **Conduct Disorder, Antisocial Personality Disorder,** and **manic episodes** stealing may occur; however, in such cases the act is obviously due to the more pervasive disorder.

In **Schizophrenia** stealing may be in response to delusions or hallucinations. In **Organic Mental Disorders** it may occur because of a failure to appreciate the consequences of the act, or because of failure to remember to pay for the object that has been taken.

Diagnostic criteria for Kleptomania

A. Recurrent failure to resist impulses to steal objects that are not for immediate use or their monetary value.

B. Increasing sense of tension before committing the act.

C. An experience of either pleasure or release at the time of committing the theft.

D. Stealing is done without long-term planning and assistance from, or collaboration with, others.

E. Not due to Conduct Disorder or Antisocial Personality Disorder.

312.33 Pyromania

The essential features are recurrent failure to resist impulses to set fires and intense fascination with setting fires and seeing them burn. Before setting the fire, the individual experiences a buildup of tension; and once the fire is underway, he or she experiences intense pleasure or release. Although the fire-setting results from a failure to resist an impulse, there may be considerable advance preparation for starting the fire, and the individual may leave obvious clues.

The diagnosis is not made when fire-setting is due to Conduct Disorder, Antisocial Personality Disorder, Schizophrenia, or an Organic Mental Disorder.

Individuals with the disorder are often recognized as regular "watchers" at fires in their neighborhoods, frequently set off false alarms, and show interest in fire-fighting paraphernalia. They may be indifferent to the consequences of the fire for life or property, or they may get satisfaction from the resulting destruction.

Associated features. Alcohol Intoxication, Psychosexual Dysfunctions, lower than average IQ, chronic personal frustrations, and resentment of authority

figures are among the associated features. Cases have been described in which the individual was sexually aroused by fires.

Age at onset. Onset is usually in childhood. When it is in adolescence or adulthood, the fire-setting tends to be more deliberately destructive.

Course. No information.

Impairment and complications. Impairment is usually due to the legal consequences of being apprehended, the major complication of the disorder.

Sex ratio. The disorder is diagnosed far more commonly in males than in females.

Predisposing factors, prevalence, and familial pattern. No information.

Differential diagnosis. Young children's experimentation and fascination with matches, lighters, and fire may be a part of their normal investigation of their environment.

In **Conduct Disorder, Antisocial Personality Disorder,** and the **incendiary acts of sabotage** carried out by political extremists or by "paid torches," fire-setting occurs as a deliberate act rather than as a failure to resist an impulse. In **Schizophrenia,** fire-setting may be in response to delusions or hallucinations. In **Organic Mental Disorders,** fire-setting may occur because of failure to appreciate the consequences of the act.

Diagnostic criteria for Pyromania

A. Recurrent failure to resist impulses to set fires.

B. Increasing sense of tension before setting the fire.

C. An experience of either intense pleasure, gratification, or release at the time of committing the act.

D. Lack of motivation, such as monetary gain or sociopolitical ideology, for setting fires.

E. Not due to an Organic Mental Disorder, Schizophrenia, Antisocial Personality Disorder, or Conduct Disorder.

312.34 Intermittent Explosive Disorder

The essential features are several discrete episodes of loss of control of aggressive impulses that result in serious assault or destruction of property. For example, with no or little provocation the individual may suddenly start to hit strangers and throw furniture. The degree of aggressivity expressed during an

episode is grossly out of proportion to any precipitating psychosocial stressor. The individual may describe the episodes as "spells" or "attacks." The symptoms appear within minutes or hours and, regardless of duration, remit almost as quickly. Genuine regret or self-reproach at the consequences of the action and the inability to control the aggressive impulse may follow each episode. There are no signs of generalized impulsivity or aggressiveness between the episodes.

The diagnosis is not made if the loss of control is due to Schizophrenia, Antisocial Personality Disorder, or Conduct Disorder. Mild forms of this disorder have, in the past, been called Explosive Personality.

Prodromal affective or autonomic symptoms may signal an impending episode. During the episode there may be subtle changes in sensorium; and following the episode there may be partial or spotty amnesia. The behavior is usually a surprise to those in the individual's milieu, and even the afflicted individual is often startled by his or her own behavior, sometimes describing the events as resulting from a compelling force beyond his or her control, even though he or she is willing to accept responsibility for his or her actions.

Associated features. It is not clear to what extent other associated psychopathology is usually present between episodes.

Often individuals claim hypersensitivity to sensory input such as loud noises, rhythmic auditory or visual stimuli, and bright lights. Other features suggesting an organic disturbance may be present, such as nonspecific EEG abnormalities or minor neurological signs and symptoms thought to reflect subcortical or limbic system dysfunction. Epilepsy is rarely present, but is nevertheless more common than in individuals without the disorder. Medical history often reveals hyperactive motor behavior and proneness to accident.

Age at onset. The disorder may begin at any stage of life, but more commonly begins in the second or third decade.

Course. No information.

Impairment. Normal social relations may be impaired because of social ostracism that results from the unpredictable aggressive behavior.

Complications. Incarceration or chronic hospitalization may result.

Predisposing factors. Any toxic agent, such as alcohol, that may lower the threshold for violent outbursts, and conditions conducive to brain dysfunction, such as perinatal trauma, infantile seizures, head trauma, and encephalitis may predispose to this disorder.

Prevalence. The disorder is apparently very rare.

Sex ratio. The disorder is apparently more common in males than in females. The males are likely to be seen in a correctional institution and the females, in a mental health facility.

Familial pattern. The disorder is apparently more common in family members than in the general population.

Differential diagnosis. An **underlying physical disorder,** such as a brain tumor or epilepsy, may in rare cases cause this syndrome. In such instances the diagnosis Intermittent Explosive Disorder should be recorded on Axis I, and the physical disorder, on Axis III.

In **Antisocial Personality Disorder,** outbursts of aggressiveness are common, but aggressiveness and impulsivity are also present between the outbursts. In **Dissociative Disorder** any loss of control that occurs invariably follows a major stressful event, whereas in this disorder there is usually only a minor or no precipitating event. In any case, if the disturbance meets the criteria for Intermittent Explosive Disorder, this precludes a diagnosis of a Dissociative Disorder.

In **Paranoid Disorder** or **Schizophrenia, Catatonic Type,** there may be outbursts of violent behavior in response to delusions or hallucinations.

Diagnostic criteria for Intermittent Explosive Disorder

A. Several discrete episodes of loss of control of aggressive impulses resulting in serious assault or destruction of property.

B. Behavior that is grossly out of proportion to any precipitating psychosocial stressor.

C. Absence of signs of generalized impulsivity or aggressiveness between episodes.

D. Not due to Schizophrenia, Antisocial Personality Disorder, or Conduct Disorder.

312.35 Isolated Explosive Disorder

The essential feature is a single, discrete episode of failure to resist an impulse that led to a single, violent, externally directed act, which had a catastrophic impact on others and for which the available information does not justify the diagnosis of Schizophrenia, Antisocial Personality Disorder, or Conduct Disorder. An example would be an individual who for no apparent reason suddenly began shooting at total strangers in a fit of rage and then shot himself. In the past this disorder was referred to as "catathymic crisis."

In some cases additional information indicates an underlying psychosis, such as Schizophrenia, Paranoid Type, which would then preempt this diagnosis. As with Intermittent Explosive Disorder, this category is defined behaviorally. In those rare instances in which an underlying organic etiology is revealed, such as a brain tumor, this would be an additional diagnosis, coded on Axis III.

Other features of this disorder are similar to those of Intermittent Explosive Disorder.

Diagnostic criteria for Isolated Explosive Disorder

A. A single, discrete episode in which failure to resist an impulse led to a single, violent, externally directed act that had a catastrophic impact on others.

B. The degree of aggressivity expressed during the episode was grossly out of proportion to any precipitating psychosocial stressor.

C. Before the episode there were no signs of generalized impulsivity or aggressiveness.

D. Not due to Schizophrenia, Antisocial Personality Disorder, or Conduct Disorder.

312.39 Atypical Impulse Control Disorder

This category is for Disorders of Impulse Control that cannot be classified elsewhere.

Adjustment Disorder

The essential feature is a maladaptive reaction to an identifiable psychosocial stressor, that occurs within three months after the onset of the stressor. The maladaptive nature of the reaction is indicated by either impairment in social or occupational functioning or symptoms that are in excess of a normal and expected reaction to the stressor. The disturbance is not merely one instance of a pattern of overreaction to a stressor or an exacerbation of one of the mental disorders previously described. It is assumed that the disturbance will eventually remit after the stressor ceases or, if the stressor persists, when a new level of adaptation is achieved. This category should not be used if the disturbance meets the criteria for a specific disorder, such as an Anxiety or Affective Disorder.

The stressors may be single, such as divorce, or multiple, such as marked business difficulties and marital problems. They may be recurrent, as with seasonal business crises, or continuous, as with chronic illness or residence in a deteriorating neighborhood. They can occur in a family setting, e.g., in discordant intrafamilial relationships. They may affect only the individual, e.g., the psychological reaction to a physical illness, or they may affect a group or community, e.g., a natural disaster, or persecution based on racial, social, religious, or other group affiliation. Some stressors are associated with specific developmental stages, such as going to school, leaving the parental home, getting married, becoming a parent, failing to attain occupational goals, and retirement.

The severity of the stressor and the specific stressor may be noted on Axis IV (p. 26). The severity of a specific stressor is affected by its duration, timing, and context in a person's life. For example, the stress of losing a parent is different for a child and an adult.

The severity of the reaction is not completely predictable from the severity of the stressor. Individuals who are particularly vulnerable may have a more severe form of the disorder following only a mild or moderate stressor, whereas others may have only a mild form of the disorder in response to a marked and continuing stressor.

Types. The manifestations of the disorder are varied. Each specific type represents a predominant clinical picture (p. 301), many of which are partial syndromes of specific disorders. For example, Adjustment Disorder with Depressed Mood is manifested by an incomplete depressive syndrome in response to a psychosocial stressor.

Age at onset. Adjustment Disorder may begin at any age.

Course. By definition the disturbance begins within three months of the

onset of the stressor. If the stressor is a discrete event, such as being fired from a job, the onset of the disturbance is usually within a few days, and the duration is relatively brief—no more than a few months. If the stressor continues, as with a chronic physical illness, the duration may be much longer until a new level of adaptation is achieved.

Predisposing factors. A preexisting Personality Disorder or Organic Mental Disorder may increase an individual's vulnerability to stress and predispose to the development of Adjustment Disorder.

Prevalence. The disorder is apparently common.

Sex ratio and familial pattern. No information.

Differential diagnosis. In **Conditions Not Attributable to a Mental Disorder** (V codes), such as Other Interpersonal Problem or Phase of Life Problem or Other Life Circumstance Problem, there is neither impairment in social or occupational functioning nor symptoms that are in excess of a normal and expectable reaction to the stressor. No absolute guidelines are available to aid in this fundamental distinction, so clinical judgment will often be required.

Personality Disorders are often repeatedly exacerbated by stress, in which case the additional diagnosis of Adjustment Disorder is not made. However, if new features are seen in response to a stressor—such as depressed mood in an individual with Paranoid Personality Disorder who has never been bothered by depression—then the additional diagnosis of Adjustment Disorder may be appropriate.

In **Psychological Factors Affecting Physical Condition** the individual may be reacting to a psychosocial stressor, but the predominant symptomatology is a physical condition or disorder.

Diagnostic criteria for Adjustment Disorder

A. A maladaptive reaction to an identifiable psychosocial stressor, that occurs within three months of the onset of the stressor.

B. The maladaptive nature of the reaction is indicated by either of the following:

(1) impairment in social or occupational functioning
(2) symptoms that are in excess of a normal and expectable reaction to the stressor

C. The disturbance is not merely one instance of a pattern of overreaction to stress or an exacerbation of one of the mental disorders previously described.

D. It is assumed that the disturbance will eventually remit after the stressor ceases or, if the stressor persists, when a new level of adaptation is achieved.

E. The disturbance does not meet the criteria for any of the specific disorders listed previously or for Uncomplicated Bereavement.

TYPES OF ADJUSTMENT DISORDER. Code predominant symptoms.

309.00 Adjustment Disorder with Depressed Mood
This category should be used when the predominant manifestation involves such symptoms as depressed mood, tearfulness, and hopelessness. The major differential is with Major Depression and Uncomplicated Bereavement.

309.24 Adjustment Disorder with Anxious Mood
This category should be used when the predominant manifestation involves such symptoms as nervousness, worry, and jitteriness. The major differential is with Anxiety Disorders.

309.28 Adjustment Disorder with Mixed Emotional Features
This category should be used when the predominant manifestation involves various combinations of depression and anxiety or other emotions. The major differential is with Depressive and Anxiety Disorders. An example would be an adolescent, after moving away from home and parental supervision, who reacts with ambivalence, depression, anger, and signs of increased dependency.

309.30 Adjustment Disorder with Disturbance of Conduct
This category should be used when the predominant manifestation involves conduct in which there is violation of the rights of others or of major age-appropriate societal norms and rules. Examples: truancy, vandalism, reckless driving, fighting, defaulting on legal responsibilities. The major differential is with Conduct Disorder and Antisocial Personality Disorder.

309.40 Adjustment Disorder with Mixed Disturbance of Emotions and Conduct
This category should be used when the predominant manifestation involves both emotional features (e.g., depression, anxiety) and a disturbance of conduct (see above).

309.23 Adjustment Disorder with Work (or Academic) Inhibition
This category should be used when the predominant manifestation is an inhibition in work or academic functioning occurring in an individual whose previous work or academic performance has been adequate. Frequently there are also varying mixtures of anxiety and depression. Examples include inability to study and to write papers or reports. The major differential is with Depressive Disorders and Anxiety Disorders.

309.83 Adjustment Disorder with Withdrawal
This category should be used when the predominant manifestation involves social withdrawal without significant depressed or anxious mood. The major differential is with Depressive Disorders.

309.90 Adjustment Disorder with Atypical Features
This category should be used when the predominant manifestation involves symptoms that cannot be coded in any of the specific categories.

Psychological Factors Affecting Physical Condition

316.00 Psychological Factors Affecting Physical Condition

This category enables a clinician to note that psychological factors contribute to the initiation or exacerbation of a physical condition. The physical condition will usually be a physical disorder, but in some instances may be only a single symptom, such as vomiting. The physical condition should be recorded on Axis III.

This manual accepts the tradition of referring to certain factors as "psychological," although it is by no means easy to define what this phrase means. A limited but useful definition in this context is the meaning ascribed to environmental stimuli by the individual. Common examples of such stimuli are the sights and sounds arising in interpersonal transactions, such as arguments, and information that a loved one has died. The individual may not be aware of the meaning that he or she has given to such environmental stimuli or of the relationship between these stimuli and the initiation or exacerbation of the physical condition.

The judgment that psychological factors are affecting the physical condition requires evidence of a temporal relationship between the environmental stimuli and the meaning ascribed to them and the initiation or exacerbation of the physical condition. Obviously, this judgment is more certain when there are repeated instances of a temporal relationship.

This category can be used for any physical condition to which psychological factors are judged to be contributory. It can be used to describe disorders that in the past have been referred to as either "psychosomatic" or "psychophysiological."

Common examples of physical conditions for which this category may be appropriate include, but are not limited to: obesity, tension headache, migraine headache, angina pectoris, painful menstruation, sacroiliac pain, neurodermatitis, acne, rheumatoid arthritis, asthma, tachycardia, arrhythmia, gastric ulcer, duodenal ulcer, cardiospasm, pylorospasm, nausea and vomiting, regional enteritis, ulcerative colitis, and frequency of micturition.

This category should not be used for Conversion Disorders, which are regarded as disturbances in which the specific pathophysiological process involved in the disorder is not demonstrable by existing standard laboratory procedures and which are conceptualized with psychological constructs only.

Diagnostic criteria for Psychological Factors Affecting Physical Condition

A. Psychologically meaningful environmental stimuli are temporally

related to the initiation or exacerbation of a physical condition (recorded on Axis III).

B. The physical condition has either demonstrable organic pathology (e.g., rheumatoid arthritis) or a known pathophysiological process (e.g., migraine headache, vomiting).

C. The condition is not due to a Somatoform Disorder.

Personality Disorders

(NOTE: These are coded on Axis II.)

Personality *traits* are enduring patterns of perceiving, relating to, and thinking about the environment and oneself, and are exhibited in a wide range of important social and personal contexts. It is only when *personality traits* are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress that they constitute *Personality Disorders*. The manifestations of Personality Disorders are generally recognizable by adolescence or earlier and continue throughout most of adult life, though they often become less obvious in middle or old age.

Many of the features characteristic of the various Personality Disorders, such as Dependent, Paranoid, Schizotypal, or Borderline Personality Disorder, may be seen during an episode of another mental disorder, such as Major Depression. The diagnosis of a Personality Disorder should be made only when the characteristic features are typical of the individual's long-term functioning and are not limited to discrete episodes of illness.

DIAGNOSIS OF PERSONALITY DISORDERS IN CHILDREN AND ADOLESCENTS

Certain Personality Disorders have a relationship to corresponding diagnostic categories in the section Disorders Usually First Evident in Infancy, Childhood, or Adolescence. The corresponding disorders are as follows:

Disorders of Childhood or Adolescence	Personality Disorders
Schizoid Disorder of Childhood or Adolescence	Schizoid Personality Disorder
Avoidant Disorder of Childhood or Adolescence	Avoidant Personality Disorder
Conduct Disorder	Antisocial Personality Disorder
Oppositional Disorder	Passive-Aggressive Personality Disorder
Identity Disorder	Borderline Personality Disorder

If the features of Schizoid or Avoidant Disorder of Childhood or Adolescence continue into adult life, i.e., after age 18, the diagnosis should be changed to the corresponding Personality Disorder. Some children or adolescents with Conduct Disorder, particularly the Undersocialized Aggressive type, may meet the criteria for Antisocial Personality Disorder in adulthood, in which case the diagnosis should be changed. Similarly, some children with Oppositional Dis-

order as adults may have a disorder meeting the criteria for Passive-Aggressive Personality Disorder, and some cases of Identity Disorder may later meet the criteria for Borderline Personality Disorder.

The other Personality Disorder categories may be applied to children or adolescents in those unusual instances in which the particular maladaptive personality traits appear to be stable. When this is done, there is obviously less certainty that the Personality Disorder will persist unchanged over time.

Associated features. Frequently the individual with a Personality Disorder is dissatisfied with the impact his or her behavior is having on others or with his or her inability to function effectively. This may be the case even when the traits that lead to these difficulties are ego-syntonic, that is, are not regarded by the individual as undesirable. In other cases, the traits may be ego-dystonic, but the individual may be unable to modify them despite great effort.

Disturbances of mood, frequently involving depression or anxiety, are common, and may even be the individual's chief complaint.

Age at onset and course. As noted above, Personality Disorders by definition begin in childhood or adolescence and are characteristic of most of adult life.

Impairment. Marked impairment in social and occupational functioning may exist. When occupational functioning is impaired, the impairment is usually sustained, but may be episodic and take the form of recurrent periods of work inhibition (e.g., "writer's block"). With the exception of Antisocial, Schizotypal, and Borderline Personality Disorders, individuals with Personality Disorders rarely require hospitalization unless there is a superimposed disorder, such as a Substance Use Disorder or Major Depression.

PERSONALITY DISORDERS AND PSYCHOTIC DISORDERS

When an individual with a psychotic disorder coded on Axis I, for example, Schizophrenia or Paranoia, has had a preexisting Personality Disorder, the Personality Disorder should also be recorded on Axis II, followed by "Premorbid" in parentheses. For example:

Axis I: 295.32 Schizophrenia, Paranoid, Chronic

Axis II: 301.20 Schizoid Personality Disorder (Premorbid)

SPECIFIC PERSONALITY DISORDERS

Traditionally, in diagnosing Personality Disorders the clinician has been directed to find a single, specific Personality Disorder that adequately describes the individual's disturbed personality functioning. Frequently this can be done only with difficulty, since many individuals exhibit features that are not limited to a single Personality Disorder. In this manual diagnoses of more than one Personality Disorder should be made if the individual meets the criteria for more than one.

The Personality Disorders have been grouped into three clusters. The first cluster includes Paranoid, Schizoid, and Schizotypal Personality Disorders. Individuals with these disorders often appear "odd" or eccentric. The second cluster includes Histrionic, Narcissistic, Antisocial, and Borderline Personality Disorders. Individuals with these disorders often appear dramatic, emotional, or erratic. The third cluster includes Avoidant, Dependent, Compulsive, and Passive-Aggressive Personality Disorders. Individuals with these disorders often appear anxious or fearful. Finally, there is a residual category, Atypical, Mixed, or Other Personality Disorder, that can be used for other specific Personality Disorders or for conditions that do not qualify as any of the specific Personality Disorders described in this manual.

There is great variability in the detail with which the various Personality Disorders are described and the specificity of the diagnostic criteria. Disorders studied more extensively and rigorously than others, such as Antisocial Personality Disorder, are described in greater detail.

301.00 Paranoid Personality Disorder

The essential feature is a Personality Disorder (p. 305) in which there is a pervasive and unwarranted suspiciousness and mistrust of people, hypersensitivity, and restricted affectivity not due to another mental disorder, such as Schizophrenia, or a Paranoid Disorder.

An attitude of suspicion is not only justified but is adaptive in many difficult life situations. A person without signs of mental disorder is willing in such a situation to abandon suspicions when presented with convincing contradictory evidence, but one with Paranoid Personality Disorder ignores such evidence, and may even become suspicious of someone who challenges his or her suspicious ideas. Individuals with this disorder are typically hypervigilant and take precautions against any perceived threat. They tend to avoid blame even when it is warranted. They are often viewed by others as guarded, secretive, devious, and scheming. They may question the loyalty of others, always expecting trickery. For this reason, there may be pathological jealousy.

When individuals with this disorder find themselves in a new situation, they intensely and narrowly search for confirmation of their expectations, with no appreciation of the total context. Their final conclusion is usually precisely what they expected in the first place. They are concerned with hidden motives and special meanings. Often, transient ideas of reference occur, e.g., that others are taking special notice of them, or saying vulgar things about them.

Individuals with this disorder are usually argumentative and exaggerate difficulties by "making mountains out of molehills." They often find it difficult to relax, usually appear tense, and show a tendency to counterattack when they perceive any threat. Though they are critical of others, and often litigious, they have great difficulty accepting criticism themselves.

These individuals' affectivity is restricted, and they may appear "cold" to others. They have no true sense of humor and are usually serious. They may pride themselves on always being objective, rational, and unemotional. They usually lack passive, soft, sentimental, and tender feelings.

Associated features. Individuals with this disorder are occasionally seen by others as keen observers who are energetic, ambitious, and capable; but more often they are viewed as hostile, stubborn, and defensive. They tend to be rigid and unwilling to compromise. They often generate uneasiness and fear in others. Often there is an inordinate fear of losing independence or the power to shape events in accordance with their own wishes.

They usually avoid intimacy except with those in whom they have absolute trust. They show an excessive need to be self-sufficient, to the point of egocentricity and exaggerated self-importance. They avoid participation in group activities unless they are in a dominant position.

They are often interested in mechanical devices, electronics, and automation. They are keenly aware of power and rank and of who is superior or inferior, and are often envious and jealous of those in positions of power. They disdain people seen as weak, soft, sickly, or defective. They are generally uninterested in art or aesthetics.

During periods of extreme stress, transient psychotic symptoms may occur, but of insufficient severity or duration to warrant an additional diagnosis.

Impairment. Because individuals with this disorder usually realize that it is prudent to keep their unusual ideas to themselves, impairment is generally minimal. However, occupational difficulties are common, especially in relating to authority figures or co-workers. In more severe cases, all relationships are grossly impaired.

Complications. The relationship of this disorder to the Paranoid Disorders (p. 196) and Schizophrenia, Paranoid Type (p. 188), is unclear. However, certain of the essential features of Paranoid Personality Disorder, such as suspiciousness and hypersensitivity, may predispose to the development of these other disorders.

Predisposing factors. No information.

Prevalence. This disorder rarely comes to clinical attention, since such persons rarely seek help for their personality problems or require hospitalization. Owing to a tendency of some of them to be moralistic, grandiose, and extrapunitive, it seems likely that individuals with this disorder are overrepresented among leaders of mystical or esoteric religions and of pseudoscientific and quasi-political groups.

Sex ratio. This disorder is more commonly diagnosed in men.

Familial pattern. No information.

Differential diagnosis. In **Paranoid Disorders** and **Schizophrenia, Paranoid Type**, there are persistent psychotic symptoms, such as delusions and hallucinations, that are never part of Paranoid Personality Disorder. However, these disorders may be superimposed on Paranoid Personality Disorder. **Antisocial Personality Disorder** shares several features with Paranoid Personality Disorder,

e.g., difficulty in forming and sustaining close relationships, and poor occupational performance; but except when the two disorders coexist, a lifelong history of antisocial behavior is not present in Paranoid Personality Disorder.

Diagnostic criteria for Paranoid Personality Disorder

The following are characteristic of the individual's current and long-term functioning, are not limited to episodes of illness, and cause either significant impairment in social or occupational functioning or subjective distress.

A. Pervasive, unwarranted suspiciousness and mistrust of people as indicated by at least three of the following:

(1) expectation of trickery or harm
(2) hypervigilance, manifested by continual scanning of the environment for signs of threat, or taking unneeded precautions
(3) guardedness or secretiveness
(4) avoidance of accepting blame when warranted
(5) questioning the loyalty of others
(6) intense, narrowly focused searching for confirmation of bias, with loss of appreciation of total context
(7) overconcern with hidden motives and special meanings
(8) pathological jealousy

B. Hypersensitivity as indicated by at least two of the following:

(1) tendency to be easily slighted and quick to take offense
(2) exaggeration of difficulties, e.g., "making mountains out of molehills"
(3) readiness to counterattack when any threat is perceived
(4) inability to relax

C. Restricted affectivity as indicated by at least two of the following:

(1) appearance of being "cold" and unemotional
(2) pride taken in always being objective, rational, and unemotional
(3) lack of a true sense of humor
(4) absence of passive, soft, tender, and sentimental feelings

D. Not due to another mental disorder such as Schizophrenia or a Paranoid Disorder.

Schizoid Personality Disorder

Schizotypal Personality Disorder

Schizoid and Schizotypal Personality Disorders are new diagnostic categories.

In the past, the term Schizoid was applied to individuals with defects in the capacity to form social relationships. In addition, the term was applied to individuals with various eccentricities of communication or behavior. Because recent evidence suggests a possible relationship between the latter group of individuals and a family history of chronic Schizophrenia, they are diagnosed in this manual separately as having Schizotypal Personality Disorder (see p. 312). The term Schizotypal is given to this category because, in addition, the features of this disorder are frequently present in individuals with Schizophrenia, Residual Type.

Some cases previously diagnosed as Borderline, Latent, or Simple Schizophrenia are likely to be classified in this manual as Schizotypal Personality Disorder.

Individuals with defects in the capacity to form social relationships but without eccentricities of communication or behavior are diagnosed here as having Schizoid Personality Disorder, even though the term is more inclusive in other classifications and suggests a relationship to Schizophrenia.

301.20 Schizoid Personality Disorder

The essential feature is a Personality Disorder (p. 305) in which there is a defect in the capacity to form social relationships, evidenced by the absence of warm, tender feelings for others and indifference to praise, criticism, and the feelings of others. The diagnosis is not made if eccentricities of speech, behavior, or thought characteristic of Schizotypal Personality Disorder are present or if the disturbance is due to a psychotic disorder such as Schizophrenia.

Individuals with this disorder show little or no desire for social involvement, usually prefer to be "loners," and have few, if any, close friends. They appear reserved, withdrawn, and seclusive and usually pursue solitary interests or hobbies. Individuals with this disorder are usually humorless or dull and without affect in situations in which an emotional response would be appropriate. They usually appear "cold" and aloof.

Associated features. Individuals with this disorder are often unable to express aggressiveness or hostility. They may seem vague about their goals, indecisive in their actions, self-absorbed, absentminded, and detached from their environment ("not with it" or "in a fog"). Excessive daydreaming is often present.

Because of a lack of social skills, males with this disorder are usually incapable of dating and rarely marry. Females may passively accept courtship and marry.

Impairment. Social relations are, by definition, severely restricted. Occupational functioning may be impaired, particularly if interpersonal involvement is required. On the other hand, individuals with this disorder may, in some instances, be capable of high occupational achievement in situations requiring work performance under conditions of social isolation.

Complications. Some believe that Schizophrenia may develop as a complication of this disorder, although others believe that in such cases, the Schizoid

Personality Disorder merely represented the prodromal phase of the Schizophrenia.

Predisposing factors. Schizoid Disorder of Childhood or Adolescence predisposes to the development of Schizoid Personality Disorder.

Prevalence. Although the prevalence is unknown, a significant proportion of individuals working in jobs that involve little or no contact with others, or living in skid-row sections of cities may have this disorder.

Sex ratio and familial pattern. No information.

Differential diagnosis. In **Schizotypal Personality Disorder** there are eccentricities of communication or behavior, and these preclude a diagnosis of Schizoid Personality Disorder.

In **Avoidant Personality Disorder,** social isolation is due to hypersensitivity to rejection, but a desire to enter social relationships is present if there are strong guarantees of uncritical acceptance. In contrast, individuals with Schizoid Personality Disorder have no desire for social relations.

In **Schizoid Disorder of Childhood or Adolescence** there is a similar clinical picture and this diagnosis preempts the diagnosis of Schizoid Personality Disorder if the individual is under 18.

Diagnostic criteria for Schizoid Personality Disorder

The following are characteristic of the individual's current and long-term functioning, are not limited to episodes of illness, and cause either significant impairment in social or occupational functioning or subjective distress.

A. Emotional coldness and aloofness, and absence of warm, tender feelings for others.

B. Indifference to praise or criticism or to the feelings of others.

C. Close friendships with no more than one or two persons, including family members.

D. No eccentricities of speech, behavior, or thought characteristic of Schizotypal Personality Disorder.

E. Not due to a psychotic disorder such as Schizophrenia or Paranoid Disorder.

F. If under 18, does not meet the criteria for Schizoid Disorder of Childhood or Adolescence.

301.22 Schizotypal Personality Disorder

The essential feature is a Personality Disorder (p. 305) in which there are various oddities of thought, perception, speech, and behavior that are not severe enough to meet the criteria for Schizophrenia. No single feature is invariably present. The disturbance in the content of thought may include magical thinking (or in children, bizarre fantasies or preoccupations), ideas of reference, or paranoid ideation. Perceptual disturbances may include recurrent illusions, depersonalization, or derealization (not associated with panic attacks). Often, speech shows marked peculiarities: concepts may be expressed unclearly or oddly or words used deviantly, but never to the point of loosening of associations or incoherence. Frequently, but not invariably, the behavioral manifestations include social isolation and constricted or inappropriate affect that interferes with rapport in face-to-face interaction.

Associated features. Varying admixtures of anxiety, depression, and other dysphoric moods are common. Features of Borderline Personality Disorder (p. 321) are often present, and in some cases both diagnoses may be warranted. During periods of extreme stress transient psychotic symptoms may be present. Because of peculiarities in thinking, individuals with Schizotypal Personality Disorder are prone to eccentric convictions, such as bigotry and fringe religious beliefs.

Impairment. Usually some interference with social or occupational functioning occurs.

Complications. Psychotic disorders such as Brief Reactive Psychosis may occur.

Prevalance and sex ratio. No information.

Familial pattern. There is some evidence that chronic Schizophrenia is more common among family members of individuals with Schizotypal Personality Disorder than among the general population.

Differential diagnosis. In **Schizophrenia, Residual Type**, there is a history of an active phase of Schizophrenia with psychotic symptoms. When psychotic symptoms occur in Schizotypal Personality Disorder, they are transient and not as severe. In **Schizoid Personality Disorder** and **Avoidant Personality Disorder**, there are no oddities of behavior, thinking, perception, and speech as are present in Schizotypal Personality Disorder. Frequently, individuals with **Borderline Personality Disorder** also meet the criteria for Schizotypal Personality Disorder; in such instances, both diagnoses should be recorded. In **Depersonalization Disorder**, oddities of thought, speech, and behavior are not present, although in rare cases both disorders may coexist.

Diagnostic criteria for Schizotypal Personality Disorder

The following are characteristic of the individual's current and long-term

functioning, are not limited to episodes of illness, and cause either significant impairment in social or occupational functioning or subjective distress.

A. At least four of the following:

(1) magical thinking, e.g., superstitiousness, clairvoyance, telepathy, "6th sense," "others can feel my feelings" (in children and adolescents, bizarre fantasies or preoccupations)
(2) ideas of reference
(3) social isolation, e.g., no close friends or confidants, social contacts limited to essential everyday tasks
(4) recurrent illusions, sensing the presence of a force or person not actually present (e.g., "I felt as if my dead mother were in the room with me"), depersonalization, or derealization not associated with panic attacks
(5) odd speech (without loosening of associations or incoherence), e.g., speech that is digressive, vague, overelaborate, circumstantial, metaphorical
(6) inadequate rapport in face-to-face interaction due to constricted or inappropriate affect, e.g., aloof, cold
(7) suspiciousness or paranoid ideation
(8) undue social anxiety or hypersensitivity to real or imagined criticism

B. Does not meet the criteria for Schizophrenia.

301.50 Histrionic Personality Disorder

The essential feature is a Personality Disorder (p. 305) in which there are overly dramatic, reactive, and intensely expressed behavior and characteristic disturbances in interpersonal relationships.

Individuals with this disorder are lively and dramatic and are always drawing attention to themselves. They are prone to exaggeration and often act out a role, such as the "victim" or the "princess," without being aware of it.

Behavior is overly reactive and intensely expressed. Minor stimuli give rise to emotional excitability, such as irrational, angry outbursts or tantrums. Individuals with this disorder crave novelty, stimulation, and excitement and quickly become bored with normal routines.

Interpersonal relationships show characteristic disturbances. Initially, people with this disorder are frequently perceived as shallow and lacking genuineness, though superficially charming and appealing. They are often quick to form friendships; but once a relationship is established they can become demanding, egocentric, and inconsiderate; manipulative suicidal threats, gestures, or attempts may be made; there may be a constant demand for reassurance because of feelings of helplessness and dependency. In some cases both patterns are

present in the same relationship. These people's actions are frequently inconsistent, and may be misinterpreted by others.

Such individuals are typically attractive and seductive. They attempt to control the opposite sex or enter into a dependent relationship. Flights into romantic fantasy are common; in both sexes overt behavior often is a caricature of femininity. The actual quality of their sexual relationships is variable. Some individuals are promiscuous; others, naïve and sexually unresponsive; but still others have apparently normal sexual adjustment.

In other classifications this category is termed Hysterical Personality.

Associated features. Individuals with this disorder often experience periods of intense dissatisfaction and a variety of dysphoric moods, usually related to obvious changes in external circumstances, such as a breakup with a lover. They may make suicidal gestures or attempts.

Usually these individuals show little interest in intellectual achievement and careful, analytic thinking, though they are often creative and imaginative.

Individuals with this disorder tend to be impressionable and easily influenced by others or by fads. They are apt to be overly trusting of others, suggestible, and show an initially positive response to any strong authority figure who they think can provide a magical solution for their problems. Though they adopt convictions strongly and readily, their judgment is not firmly rooted, and they often play hunches.

Frequent complaints of poor health, such as weakness or headaches, or subjective feelings of depersonalization may be present. During periods of extreme stress, there may be transient psychotic symptoms of insufficient severity or duration to warrant an additional diagnosis.

When the disorder is present in men, it is sometimes associated with a homosexual arousal pattern.

Impairment. Interpersonal relations are usually stormy and ungratifying. In extreme cases there is gross inability to function.

Complications. A common complication is Substance Use Disorder, particularly in women. Additional complications include Major Depression, Dysthymic Disorder, Brief Reactive Psychosis, Conversion Disorder, and Somatization Disorder.

Predisposing factors. No information.

Prevalence and sex ratio. The disorder is apparently common, and diagnosed far more frequently in females than in males.

Familial pattern. The disorder is apparently more common among family members than in the general population.

Differential diagnosis. In **Somatization Disorder** complaints of physical illness dominate the clinical picture, although histrionic features are common. In many cases Somatization Disorder and Histrionic Personality Disorder coexist.

Borderline Personality Disorder is also often present; in such cases both diagnoses should be made.

Diagostic criteria for Histrionic Personality Disorder
The following are characteristic of the individual's current and long-term functioning, are not limited to episodes of illness, and cause either significant impairment in social or occupational functioning or subjective distress.

A. Behavior that is overly dramatic, reactive, and intensely expressed, as indicated by at least three of the following:

(1) self-dramatization, e.g., exaggerated expression of emotions
(2) incessant drawing of attention to oneself
(3) craving for activity and excitement
(4) overreaction to minor events
(5) irrational, angry outbursts or tantrums

B. Characteristic disturbances in interpersonal relationships as indicated by at least two of the following:

(1) perceived by others as shallow and lacking genuineness, even if superficially warm and charming
(2) egocentric, self-indulgent, and inconsiderate of others
(3) vain and demanding
(4) dependent, helpless, constantly seeking reassurance
(5) prone to manipulative suicidal threats, gestures, or attempts

301.81 Narcissistic Personality Disorder
The essential feature is a Personality Disorder (p. 305) in which there are a grandiose sense of self-importance or uniqueness; preoccupation with fantasies of unlimited success; exhibitionistic need for constant attention and admiration; characteristic responses to threats to self-esteem; and characteristic disturbances in interpersonal relationships, such as feelings of entitlement, interpersonal exploitativeness, relationships that alternate between the extremes of overidealization and devaluation, and lack of empathy.

The exaggerated sense of self-importance may be manifested as extreme self-centeredness and self-absorption. Abilities and achievements tend to be unrealistically overestimated. Frequently the sense of self-importance alternates with feelings of special unworthiness. For example, a student who ordinarily expects an A and receives an A minus may at that moment express the view that he or she, more than any other student, is revealed to all as a failure.

Fantasies involving unrealistic goals may involve achieving unlimited ability, power, wealth, brilliance, beauty, or ideal love. Although these fantasies

frequently substitute for realistic activity, when these goals are actually pursued, it is often with a "driven," pleasureless quality, and an ambition that cannot be satisfied.

Individuals with this disorder are constantly seeking admiration and attention, and are more concerned with appearances than with substance. For example, there might be more concern about being seen with the "right" people than having close friends.

Self-esteem is often fragile; the individual may be preoccupied with how well he or she is doing and how well he or she is regarded by others. In response to criticism, defeat, or disappointment, there is either a cool indifference or marked feelings of rage, inferiority, shame, humiliation, or emptiness.

Interpersonal relationships are invariably disturbed. A lack of empathy (inability to recognize and experience how others feel) is common. For example, annoyance and surprise may be expressed when a friend who is seriously ill has to cancel a date.

Entitlement, the expectation of special favors without assuming reciprocal responsibilities, is usually present. For example, surprise and anger are felt because others will not do what is wanted; more is expected from people than is reasonable.

Interpersonal exploitativeness, in which others are taken advantage of in order to indulge one's own desires or for self-aggrandizement, is common; and the personal integrity and rights of others are disregarded. For example, a writer might plagiarize the ideas of someone befriended for that purpose.

Relations with others lack sustained, positive regard. Close relationships tend to alternate between idealization and devaluation ("splitting"). For example, a man repeatedly becomes involved with women whom he alternately adores and despises.

Associated features. Frequently, many of the features of Histrionic, Borderline, and Antisocial Personality Disorders are present; in some cases more than one diagnosis may be warranted.

During periods of severe stress transient psychotic symptoms of insufficient severity or duration to warrant an additional diagnosis are sometimes seen.

Depressed mood is extremely common. Frequently there is painful self-consciousness, preoccupation with grooming and remaining youthful, and chronic, intense envy of others. Preoccupation with aches and pains and other physical symptoms may also be present. Personal deficits, defeats, or irresponsible behavior may be justified by rationalization, prevarication, or outright lying. Feelings may be faked in order to impress others.

Impairment. By definition, some impairment in interpersonal relations always exists. Occupational functioning may be unimpaired, or may be interfered with by depressed mood, interpersonal difficulties, or the pursuit of unrealistic goals.

Complications. Dysthymic Disorder, Major Depression and psychotic disorders such as Brief Reactive Psychosis are possible complications.

Prevalence. This disorder appears to be more common recently than in the past, although this may only be due to greater professional interest in the category.

Predisposing factors, sex ratio, and familial pattern. No information.

Differential diagnosis. Borderline and **Histrionic Personality Disorders** are often also present; in such instances, multiple diagnoses should be given.

Diagnostic criteria for Narcissistic Personality Disorder

The following are characteristic of the individual's current and long-term functioning, are not limited to episodes of illness, and cause either significant impairment in social or occupational functioning or subjective distress:

A. Grandiose sense of self-importance or uniqueness, e.g., exaggeration of achievements and talents, focus on the special nature of one's problems.

B. Preoccupation with fantasies of unlimited success, power, brilliance, beauty, or ideal love.

C. Exhibitionism: the person requires constant attention and admiration.

D. Cool indifference or marked feelings of rage, inferiority, shame, humiliation, or emptiness in response to criticism, indifference of others, or defeat.

E. At least two of the following characteristic of disturbances in interpersonal relationships:

(1) entitlement: expectation of special favors without assuming reciprocal responsibilities, e.g., surprise and anger that people will not do what is wanted
(2) interpersonal exploitativeness: taking advantage of others to indulge own desires or for self-aggrandizement; disregard for the personal integrity and rights of others
(3) relationships that characteristically alternate between the extremes of overidealization and devaluation
(4) lack of empathy: inability to recognize how others feel, e.g., unable to appreciate the distress of someone who is seriously ill.

301.70 Antisocial Personality Disorder

The essential feature is a Personality Disorder (p. 305) in which there are a history of continuous and chronic antisocial behavior in which the rights of

others are violated, persistence into adult life of a pattern of antisocial behavior that began before the age of 15, and failure to sustain good job performance over a period of several years (although this may not be evident in individuals who are self-employed or who have not been in a position to demonstrate this feature, e.g., students or housewives). The antisocial behavior is not due to either severe Mental Retardation, Schizophrenia, or manic episodes.

Lying, stealing, fighting, truancy, and resisting authority are typical early childhood signs. In adolescence, unusually early or aggressive sexual behavior, excessive drinking, and use of illicit drugs are frequent. In adulthood, these kinds of behavior continue, with the addition of inability to sustain consistent work performance or to function as a responsible parent and failure to accept social norms with respect to lawful behavior. After age 30 the more flagrant aspects may diminish, particularly sexual promiscuity, fighting, criminality, and vagrancy.

Associated features. Despite the stereotype of a normal mental status in this disorder, frequently there are signs of personal distress, including complaints of tension, inability to tolerate boredom, depression, and the conviction (often correct) that others are hostile toward them. The interpersonal difficulties and dysphoria tend to persist into late adult life even when the more flagrant antisocial behavior has diminished. Almost invariably there is markedly impaired capacity to sustain lasting, close, warm, and responsible relationships with family, friends, or sexual partners.

Impairment. The disorder is often extremely incapacitating, resulting in failure to become an independent, self-supporting adult and in many years of institutionalization, more commonly penal than medical. It is possible, however, for individuals who have some of the features of the disorder to achieve political and economic success; but these people virtually never present the full picture of the disorder, lacking in particular the early onset in childhood that usually interferes with educational achievement and prohibits most public careers.

Complications. Illiteracy and Substance Use Disorders are frequent complications.

Predisposing factors. Predisposing factors are Attention Deficit Disorder and Conduct Disorder during prepuberty. The absence of parental discipline apparently increases the likelihood that Conduct Disorder will develop into Antisocial Personality Disorder. Other predisposing factors include extreme poverty, removal from the home, and growing up without parental figures of both sexes.

Age at onset. By definition the disorder begins before the age of 15. Females' first symptoms usually begin in puberty, whereas males' are usually obvious in early childhood.

Sex ratio. The disorder is much more common in males than in females.

Prevalence. Estimates of the prevalence of Antisocial Personality Disorder for American men are about 3%, and for American women, less than 1%. The disorder is more common in lower-class populations, partly because it is associated with impaired earning capacity and partly because fathers of those with the disorder frequently have the disorder themselves, and consequently their children often grow up in impoverished homes.

Familial pattern. Antisocial Personality Disorder is particularly common in the fathers of both males and females with the disorder. Studies attempting to separate genetic from environmental influences within the family suggest that both are important, since there seems to be inheritance from biological fathers separated from their offspring early in life and a social influence from adoptive fathers. Because of a tendency toward assortative mating, the children of women with Antisocial Personality Disorder who have the disorder themselves are likely to have both a mother and a father with the disorder.

Differential diagnosis. Conduct Disorder consists of the typical childhood signs of Antisocial Personality Disorder. Since such behavior may terminate spontaneously or evolve into other disorders such as Schizophrenia, a diagnosis of Antisocial Personality Disorder should not be made in children; it is reserved for adults (18 or over), who have had time to show the full longitudinal pattern.

Adult Antisocial Behavior, in the category Conditions Not Attributable to a Mental Disorder, should be considered when criminal or other aggressive or antisocial behavior occurs in individuals who do not meet the full criteria for Antisocial Personality Disorder and whose antisocial behavior cannot be attributed to any other mental disorder.

When **Substance Abuse** and antisocial behavior begin in childhood and continue into adult life, both Substance Use Disorder and Antisocial Personality Disorder should be diagnosed if the criteria for each disorder are met, regardless of the extent to which some of the antisocial behavior may be a consequence of the Substance Use Disorder, e.g., illegal selling of drugs, or the assaultive behavior associated with Alcohol Intoxication. When antisocial behavior in an adult is associated with a Substance Use Disorder, the diagnosis of Antisocial Personality Disorder is not made unless the childhood signs of Antisocial Personality Disorder were also present and continued without a remission of five years or more between age 15 and adult life.

Severe Mental Retardation and **Schizophrenia** preempt the diagnosis of Antisocial Personality Disorder, because at the present time there is no way to determine when antisocial behavior that occurs in an individual with severe Mental Retardation or Schizophrenia is due to these more severe disorders or to Antisocial Personality Disorder.

Manic episodes may be associated with antisocial behavior. The differential diagnosis is easily made by noting the absence of severe behavior problems in childhood and the sudden change in adult behavior.

Diagnostic criteria for Antisocial Personality Disorder

A. Current age at least 18.

B. Onset before age 15 as indicated by a history of three or more of the following before that age:

(1) truancy (positive if it amounted to at least five days per year for at least two years, not including the last year of school)

(2) expulsion or suspension from school for misbehavior

(3) delinquency (arrested or referred to juvenile court because of behavior)

(4) running away from home overnight at least twice while living in parental or parental surrogate home

(5) persistent lying

(6) repeated sexual intercourse in a casual relationship

(7) repeated drunkenness or substance abuse

(8) thefts

(9) vandalism

(10) school grades markedly below expectations in relation to estimated or known IQ (may have resulted in repeating a year)

(11) chronic violations of rules at home and/or at school (other than truancy)

(12) initiation of fights

C. At least four of the following manifestations of the disorder since age 18:

(1) inability to sustain consistent work behavior, as indicated by any of the following: (a) too frequent job changes (e.g., three or more jobs in five years not accounted for by nature of job or economic or seasonal fluctuation), (*b*) significant unemployment (e.g., six months or more in five years when expected to work), (c) serious absenteeism from work (e.g., average three days or more of lateness or absence per month, (*d*) walking off several jobs without other jobs in sight (Note: similar behavior in an academic setting during the last few years of school may substitute for this criterion in individuals who by reason of their age or circumstances have not had an opportunity to demonstrate occupational adjustment)

(2) lack of ability to function as a responsible parent as evidenced by one or more of the following: (a) child's malnutrition, (*b*) child's illness resulting from lack of minimal hygiene standards, (c) failure to obtain medical care for a seriously ill child, (*d*) child's dependence on neighbors or nonresident relatives for food or shelter, (e) failure to arrange for a caretaker for a child under six when parent

is away from home, (*f*) repeated squandering, on personal items, of money required for household necessities
(3) failure to accept social norms with respect to lawful behavior, as indicated by any of the following: repeated thefts, illegal occupation (pimping, prostitution, fencing, selling drugs), multiple arrests, a felony conviction
(4) inability to maintain enduring attachment to a sexual partner as indicated by two or more divorces and/or separations (whether legally married or not), desertion of spouse, promiscuity (ten or more sexual partners within one year)
(5) irritability and aggressiveness as indicated by repeated physical fights or assault (not required by one's job or to defend someone or oneself), including spouse or child beating
(6) failure to honor financial obligations, as indicated by repeated defaulting on debts, failure to provide child support, failure to support other dependents on a regular basis
(7) failure to plan ahead, or impulsivity, as indicated by traveling from place to place without a prearranged job or clear goal for the period of travel or clear idea about when the travel would terminate, or lack of a fixed address for a month or more
(8) disregard for the truth as indicated by repeated lying, use of aliases, "conning" others for personal profit
(9) recklessness, as indicated by driving while intoxicated or recurrent speeding

D. A pattern of continuous antisocial behavior in which the rights of others are violated, with no intervening period of at least five years without antisocial behavior between age 15 and the present time (except when the individual was bedridden or confined in a hospital or penal institution).

E. Antisocial behavior is not due to either Severe Mental Retardation, Schizophrenia or manic episodes.

301.83 Borderline Personality Disorder

The essential feature is a Personality Disorder (p. 305) in which there is instability in a variety of areas, including interpersonal behavior, mood, and self-image. No single feature is invariably present. Interpersonal relations are often intense and unstable, with marked shifts of attitude over time. Frequently there is impulsive and unpredictable behavior that is potentially physically self-damaging. Mood is often unstable, with marked shifts from a normal mood to a dysphoric mood or with inappropriate, intense anger or lack of control of anger. A profound identity disturbance may be manifested by uncertainty about several issues relating to identity, such as self-image, gender identity, or long-term goals or values. There may be problems tolerating being alone, and chronic feelings of emptiness or boredom.

Some conceptualize this condition as a level of personality organization rather than as a specific Personality Disorder. As noted below, Borderline Personality Disorder is frequently associated with other Personality Disorders.

Associated features. Frequently this disorder is accompanied by many features of other Personality Disorders such as Schizotypal, Histrionic, Narcissistic, and Antisocial Personality Disorders. In many cases more than one diagnosis is warranted. Quite often social contrariness and a generally pessimistic outlook are seen. Alternation between dependency and self-assertion is common. During periods of extreme stress transient psychotic symptoms of insufficient severity or duration to warrant an additional diagnosis may occur.

Impairment. Often there is considerable interference with social or occupational functioning.

Complications. Dysthymic Disorder and Major Depression as well as psychotic disorders such as Brief Reactive Psychosis may be complications.

Sex ratio. The disorder is more commonly diagnosed in women.

Prevalence. Borderline Personality Disorder is apparently common.

Predisposing factors and familial pattern. No information.

Differential diagnosis. In **Identity Disorder** there is a similar clinical picture and this diagnosis preempts the diagnosis of Borderline Personality Disorder if the individual is under 18. In **Cyclothymic Disorder** there is also affective instability, but in Borderline Personality Disorder there are no hypomanic periods. However, in some cases, both disorders may coexist.

Diagnostic criteria for Borderline Personality Disorder

The following are characteristic of the individual's current and long-term functioning, are not limited to episodes of illness, and cause either significant impairment in social or occupational functioning or subjective distress.

A. At least five of the following are required:

(1) impulsivity or unpredictability in at least two areas that are potentially self-damaging, e.g., spending, sex, gambling, substance use, shoplifting, overeating, physically self-damaging acts

(2) a pattern of unstable and intense interpersonal relationships, e.g., marked shifts of attitude, idealization, devaluation, manipulation (consistently using others for one's own ends)

(3) inappropriate, intense anger or lack of control of anger, e.g., frequent displays of temper, constant anger

(4) identity disturbance manifested by uncertainty about several issues relating to identity, such as self-image, gender identity, long-term goals or career choice, friendship patterns, values, and loyalties, e.g., "Who am I?", "I feel like I am my sister when I am good"
(5) affective instability: marked shifts from normal mood to depression, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days, with a return to normal mood
(6) intolerance of being alone, e.g., frantic efforts to avoid being alone, depressed when alone
(7) physically self-damaging acts, e.g., suicidal gestures, self-mutilation, recurrent accidents or physical fights
(8) chronic feelings of emptiness or boredom

B. If under 18, does not meet the criteria for Identity Disorder.

301.82 Avoidant Personality Disorder

The essential feature is a Personality Disorder (p. 305) in which there are hypersensitivity to potential rejection, humiliation, or shame; an unwillingness to enter into relationships unless given unusually strong guarantees of uncritical acceptance; social withdrawal in spite of a desire for affection and acceptance; and low self-esteem.

Individuals with this disorder are exquisitely sensitive to rejection, humiliation, or shame. Most people are somewhat concerned about how others assess them, but these individuals are devastated by the slightest hint of disapproval. Consequently, they withdraw from opportunities for developing close relationships because of a fearful expectation of being belittled or humiliated. They may have one or two close friends, but these relationships are contingent on unconditional approval.

Unlike individuals with Schizoid Personality Disorder, who are socially isolated but have no desire for social relations, those with Avoidant Personality Disorder yearn for affection and acceptance. They are distressed by their lack of ability to relate comfortably to others and suffer from low self-esteem.

Associated features. Depression, anxiety, and anger at oneself for failing to develop social relations are commonly present.

Impairment. Social relations are, by definition, severely restricted. Occupational functioning may be impaired, particularly if interpersonal involvement is required.

Complications. Social Phobia may be a complication of this disorder.

Predisposing factors. Avoidant Disorder of Childhood or Adolescence predisposes to the development of this disorder.

Prevalence. Avoidant Personality Disorder is apparently common.

Familial pattern. No information.

Differential diagnosis. In **Schizoid Personality Disorder** there is also social isolation, but without a desire for social involvement and with an indifference to criticism.

In **Social Phobias** humiliation is a concern, but a specific situation, such as public speaking, is avoided rather than personal relationships. However, as noted in Complications, these disorders may coexist.

In **Avoidant Disorder of Childhood or Adolescence** there is a similar clinical picture and this diagnosis preempts the diagnosis of Avoidant Personality Disorder if the individual is under 18.

Diagnostic criteria for Avoidant Personality Disorder

The following are characteristic of the individual's current and long-term functioning, are not limited to episodes of illness, and cause either significant impairment in social or occupational functioning or subjective distress.

A. Hypersensitivity to rejection, e.g., apprehensively alert to signs of social derogation, interprets innocuous events as ridicule.

B. Unwillingness to enter into relationships unless given unusually strong guarantees of uncritical acceptance.

C. Social withdrawal, e.g., distances self from close personal attachments, engages in peripheral social and vocational roles.

D. Desire for affection and acceptance.

E. Low self-esteem, e.g., devalues self-achievements and is overly dismayed by personal shortcomings.

F. If under 18, does not meet the criteria for Avoidant Disorder of Childhood or Adolescence.

301.60 Dependent Personality Disorder

The essential feature is a Personality Disorder (p. 305) in which the individual passively allows others to assume responsibility for major areas of his or her life because of a lack of self-confidence and an inability to function independently; the individual subordinates his or her own needs to those of others on whom he or she is dependent in order to avoid any possibility of having to be self-reliant.

Such individuals leave major decisions to others. For example, an adult with this disorder will typically assume a passive role and allow his or her spouse to decide where they should live, what kind of job he or she should have, and with

which neighbors they should be friendly. A child or adolescent with this disorder may allow his or her parents to decide what he or she should wear, with whom to associate, and how to spend free time.

Generally individuals with this disorder are unwilling to make demands on the people they depend on for fear of jeopardizing the relationships and being forced to rely on themselves. For example, a wife with this disorder may tolerate a physically abusive husband for fear that he will leave her.

Individuals with this disorder invariably lack self-confidence. They tend to belittle their abilities and assets. For example, an individual with this disorder may constantly refer to himself or herself as "stupid."

Associated features. Frequently another Personality Disorder is present, such as Histrionic, Schizotypal, Narcissistic, or Avoidant Personality Disorder. Anxiety and depression are common. Unless the individual has managed to secure a permanent relationship that satisfies his or her dependency needs, there is invariably preoccupation with the possibility of being abandoned.

The individual often experiences intense discomfort when alone for more than brief periods of time.

Impairment. Occupational functioning may be impaired if the nature of the job requires independence. Social relations tend to be limited to those with the few individuals on whom one is dependent.

Complications. Dysthymic Disorder and Major Depression are common complications.

Predisposing factors. Chronic physical illness may predispose to the development of this disorder in children and adolescents. Some believe that Separation Anxiety Disorder and Avoidant Disorder of Childhood or Adolescence predispose to the development of Dependent Personality Disorder.

Prevalence and sex ratio. The disorder is apparently common, and is diagnosed more frequently in women.

Familial pattern. No information.

Differential diagnosis. In **Agoraphobia**, dependent behavior is common, but the individual is more likely to *actively* insist that others assume responsibility, whereas in Dependent Personality Disorder, the individual *passively* maintains a dependent relationship.

Diagnostic criteria for Dependent Personality Disorder

The following are characteristic of the individual's current and long-term functioning, are not limited to episodes of illness, and cause either significant impairment in social or occupational functioning or subjective distress.

A. Passively allows others to assume responsibility for major areas of life because of inability to function independently (e.g., lets spouse decide what kind of job he or she should have).

B. Subordinates own needs to those of persons on whom he or she depends in order to avoid any possibility of having to rely on self, e.g., tolerates abusive spouse.

C. Lacks self-confidence, e.g., sees self as helpless, stupid.

301.40 Compulsive Personality Disorder

The essential feature is a Personality Disorder (p. 305) in which there generally are restricted ability to express warm and tender emotions; perfectionism that interferes with the ability to grasp "the big picture"; insistence that others submit to his or her way of doing things; excessive devotion to work and productivity to the exclusion of pleasure; and indecisiveness.

Individuals with this disorder are stingy with their emotions and material possessions. For example, they rarely give compliments or gifts. Everyday relationships have a conventional, formal, and serious quality. Others often perceive these individuals as stilted and "stiff."

Preoccupation with rules, efficiency, trivial details, procedures, or form interferes with the ability to take a broad view of things. For example, such an individual, having misplaced a list of things to be done, will spend an inordinate amount of time looking for the list rather than spend a few moments to recreate the list from memory and proceed with accomplishing the activities. Time is poorly allocated, the most important tasks being left to the last moment. Although efficiency and perfection are idealized, they are rarely attained.

Individuals with this disorder are always mindful of their relative status in dominance-submission relationships. Although they resist the authority of others, they stubbornly insist that people conform to their way of doing things. They are unaware of the feelings of resentment or hurt that this behavior evokes in others. For example, a husband may insist that his wife complete errands for him regardless of her plans.

Work and productivity are prized to the exclusion of pleasure and the value of interpersonal relationships. When pleasure is considered, it is something to be planned and worked for. However, the individual usually keeps postponing the pleasurable activity, such as a vacation, so that it may never occur.

Decision-making is avoided, postponed, or protracted, perhaps because of an inordinate fear of making a mistake. For example, assignments cannot be completed on time because the individual is ruminating about priorities.

Associated features. Individuals with this disorder may complain of difficulty expressing tender feelings. Considerable distress is often associated with their indecisiveness and general ineffectiveness. Their speech may be circumstantial. Depressed mood is common. Individuals with this disorder tend to be

excessively conscientious, moralistic, scrupulous, and judgmental of self and others. (For example, a man believed it was "sinful" for his neighbor to leave his child's bicycle in the rain.) When they are unable to control others, a situation, or their environment, they often ruminate about the situation and become angry, although the anger is usually not expressed directly. (For example, a man may be angry when service in a restaurant is poor, but instead of complaining to the management, ruminates about how much he will leave as a tip.) Frequently there is extreme sensitivity to social criticism, especially if it comes from someone with considerable status or authority.

Impairment. This disorder frequently is quite incapacitating, particularly in its effect on occupational functioning.

Complications. Obsessive Compulsive Disorder, Hypochondriasis, Major Depression, and Dysthymic Disorder may be complications. Many of the features of Compulsive Personality Disorder are apparently present in individuals who develop myocardial infarction.

Predisposing factors. No information.

Prevalence and sex ratio. The disorder is apparently common and is more frequently diagnosed in men.

Familial pattern. The disorder is apparently more common among family members than in the general population.

Differential diagnosis. In **Obsessive Compulsive Disorder** there are, by definition, true obsessions and compulsions, which are not present in Compulsive Personality Disorder. However, if the criteria for both disorders are met, both diagnoses should be recorded.

Diagnostic criteria for Compulsive Personality Disorder

At least four of the following are characteristic of the individual's current and long-term functioning, are not limited to episodes of illness, and cause either significant impairment in social or occupational functioning or subjective distress.

(1) restricted ability to express warm and tender emotions, e.g., the individual is unduly conventional, serious and formal, and stingy

(2) perfectionism that interferes with the ability to grasp "the big picture," e.g., preoccupation with trivial details, rules, order, organization, schedules, and lists

(3) insistence that others submit to his or her way of doing things, and lack of awareness of the feelings elicited by this behavior, e.g., a husband stubbornly insists his wife complete errands for him regardless of her plans

(4) excessive devotion to work and productivity to the exclusion of pleasure and the value of interpersonal relationships

(5) indecisiveness: decision-making is either avoided, postponed, or protracted, perhaps because of an inordinate fear of making a mistake, e.g., the individual cannot get assignments done on time because of ruminating about priorities

301.84 Passive-Aggressive Personality Disorder

The essential feature is a Personality Disorder (p. 305) in which there is resistance to demands for adequate performance in both occupational and social functioning; the resistance is expressed indirectly rather than directly. The consequence is pervasive and persistent social or occupational ineffectiveness, even when more self-assertive and effective behavior is possible. The name of this disorder is based on the assumption that such individuals are passively expressing covert aggression.

Individuals with this disorder habitually resent and oppose demands to increase or maintain a given level of functioning. This occurs most clearly in work situations, but is also evident in social functioning. The resistance is expressed indirectly, through such maneuvers as procrastination, dawdling, stubbornness, intentional inefficiency, and "forgetfulness." For example, when an executive gives a subordinate some material to review for a meeting the next morning, rather than complain that he or she has no time to do the work, the subordinate may misplace or misfile the material and thus attain his or her goal by passively resisting the demand on him or her. Similarly, when an individual always comes late to appointments, promises to help make arrangements for particular events but never does, and keeps "forgetting" to bring important documents to club meetings, he or she is passively resisting demands made on him or her by others.

The individual is ineffective both socially and occupationally because of the passive-resistant behavior. For example, job promotions are not offered because of the individual's intentional inefficiency. A housewife with the disorder fails to do the laundry or to stock the kitchen with food because of procrastination and dawdling.

For the diagnosis to be made, it is essential that this pattern of behavior occur in a variety of contexts in which more adaptive functioning is clearly possible.

Associated features. Often individuals with this disorder are dependent and lack self-confidence. Typically, they are pessimistic about the future but have no realization that their behavior is responsible for their difficulties. Although the individual may experience conscious resentment against authority figures, he or she never connects his or her passive-resistant behavior with this resentment.

Impairment. By definition, some impairment in social and occupational functioning is always present.

Complications. Frequent complications include Major Depression, Dysthymic Disorder, and Alcohol Abuse or Dependence.

Predisposing factors. Oppositional Disorder in childhood or adolescence apparently predisposes to the development of this disorder.

Prevalence, sex ratio, and familial pattern. No information.

Differential diagnosis. In **Oppositional Disorder** there may be a similar clinical picture and this diagnosis preempts the diagnosis of Passive-Aggressive Personality Disorder if the individual is under 18.

Passive-aggressive maneuvers that are used in certain situations in which assertive behavior is discouraged or actually punished and that are not part of a pervasive pattern of personality functioning do not warrant this diagnosis.

Diagnostic criteria for Passive-Aggressive Personality Disorder

The following are characteristic of the individual's current and long-term functioning, and are not limited to episodes of illness.

A. Resistance to demands for adequate performance in both occupational and social functioning.

B. Resistance expressed indirectly through at least two of the following:

(1) procrastination
(2) dawdling
(3) stubbornness
(4) intentional inefficiency
(5) "forgetfulness"

C. As a consequence of A and B, pervasive and long-standing social and occupational ineffectiveness (including in roles of housewife or student), e.g., intentional inefficiency that has prevented job promotion.

D. Persistence of the behavior pattern even under circumstances in which more self-assertive and effective behavior is possible.

E. Does not meet the criteria for any other Personality Disorder, and if under age 18, does not meet the criteria for Oppositional Disorder.

301.89 Atypical, Mixed, or Other Personality Disorder

If an individual qualifies for any of the specific Personality Disorders, that category should be noted even if some features from other categories are present. For example, an individual who fits the description of Compulsive Personality Disorder should be given that diagnosis even if some mild dependent or paranoid features are present.

When an individual qualifies for two or more Personality Disorders, multiple diagnoses should be made.

Atypical Personality Disorder should be used when the clinician judges that a Personality Disorder is present but there is insufficient information to make a more specific designation.

Mixed Personality Disorder should be used when the individual has a Personality Disorder that involves features from several of the specific Personality Disorders, but does not meet the criteria for any one Personality Disorder.

Other Personality Disorder should be used when the clinician judges that a specific Personality Disorder not included in this classification is appropriate, such as Masochistic, Impulsive, or Immature Personality Disorder. In such instances the clinician should record the specific Other Personality Disorder, using the 301.89 code.

V Codes For Conditions Not Attributable To a Mental Disorder That Are A Focus of Attention Or Treatment

The ICD-9-CM includes V Codes for a "Supplementary Classification of Factors Influencing Health Status and Contact with Health Services." A brief list of V Codes adapted from ICD-9-CM is provided here for conditions that are a focus of attention or treatment but are not attributable to any of the mental disorders noted previously. In some instances one of these conditions will be noted because, after a thorough evaluation, no mental disorder is found. In other instances the scope of the diagnostic evaluation has not been adequate to determine the presence or absence of a mental disorder but there is a need to note the reason for contact with the mental health care system. (With further information, the presence of a mental disorder may become apparent.) Finally, an individual may have a mental disorder, but the focus of attention or treatment is on a condition that is not due to the mental disorder. For example, an individual with Bipolar Disorder may have marital problems that are not directly related to manifestations of the Affective Disorder but are the principal focus of treatment.

V65.20 Malingering

The essential feature is the voluntary production and presentation of false or grossly exaggerated physical or psychological symptoms. The symptoms are produced in pursuit of a goal that is obviously recognizable with an understanding of the individual's circumstances rather than of his or her individual psychology. Examples of such obviously understandable goals include: to avoid military conscription or duty, to avoid work, to obtain financial compensation, to evade criminal prosecution, or to obtain drugs.

Under some circumstances Malingering may represent adaptive behavior, for example, feigning illness while a captive of the enemy during wartime.

A high index of suspicion of Malingering should be aroused if any combination of the following is noted:

(1) medicolegal context of presentation, e.g., the person's being referred by his attorney to the physician for examination;
(2) marked discrepancy between the person's claimed distress or disability and the objective findings;
(3) lack of cooperation with the diagnostic evaluation and prescribed treatment regimen;
(4) the presence of Antisocial Personality Disorder.

The differentiation of Malingering from Factitious Disorder depends on the clinician's judgment as to whether the symptom production is in pursuit of a goal that is obviously recognizable and understandable in the circumstances. Individuals with Factitious Disorders have goals that are not recognizable in

light of their specific circumstances but are understandable only in light of their psychology as determined by careful examination. Evidence of an intrapsychic need to maintain the sick role suggests Factitious Disorder. Thus, the diagnosis of Factitious Disorder excludes the diagnosis of the act of Malingering.

Malingering is differentiated from Conversion and the other Somatoform Disorders by the voluntary production of symptoms and by the obvious, recognizable goal. The malingering individual is much less likely to present his or her symptoms in the context of emotional conflict, and the symptoms presented are less likely to be "symbolic" of an underlying emotional conflict. Symptom relief in Malingering is not often obtained by suggestion, hypnosis, or intravenous barbiturates, as it frequently is in Conversion Disorder.

V62.89 Borderline Intellectual Functioning

This category can be used when a focus of attention or treatment is associated with Borderline Intellectual Functioning, i.e., an IQ in the 71-84 range. The differential diagnosis between Borderline Intellectual Functioning and Mental Retardation (an IQ of 70 or below) is especially difficult and important when certain mental disorders coexist. For example, when the diagnosis is of Schizophrenic Disorder, Undifferentiated or Residual Type, and impairment in adaptive functioning is prominent, the existence of Borderline Intellectual Functioning is easily overlooked, and hence the level and quality of potential adaptive functioning may be incorrectly assessed.

V71.01 Adult Antisocial Behavior

This category can be used when a focus of attention or treatment is adult antisocial behavior that is apparently not due to a mental disorder, such as a Conduct Disorder, Antisocial Personality Disorder, or a Disorder of Impulse Control. Examples include the behavior of some professional thieves, racketeers, or dealers in illegal substances.

V71.02 Childhood or Adolescent Antisocial Behavior

Same as above. Examples include isolated antisocial acts of children or adolescents (not a pattern of antisocial behavior).

V62.30 Academic Problem

This category can be used when a focus of attention or treatment is an academic problem that is apparently not due to a mental disorder. An example is a pattern of failing grades or of significant underachievement in an individual with adequate intellectual capacity, in the absence of a Specific Developmental Disorder or any other mental disorder to account for the problem.

V62.20 Occupational Problem

This category can be used when a focus of attention or treatment is an occupational problem that is apparently not due to a mental disorder. Examples include job dissatisfaction and uncertainty about career choices.

V62.82 Uncomplicated Bereavement

This category can be used when a focus of attention or treatment is a normal reaction to the death of a loved one (bereavement).

A full depressive syndrome frequently is a normal reaction to such a loss, with feelings of depression and such associated symptoms as poor appetite, weight loss, and insomnia. However, morbid preoccupation with worthlessness, prolonged and marked functional impairment, and marked psychomotor retardation are uncommon and suggest that the bereavement is complicated by the development of a Major Depression.

In Uncomplicated Bereavement, guilt, if present, is chiefly about things done or not done at the time of the death by the survivor; thoughts of death are usually limited to the individual's thinking that he or she would be better off dead or that he or she should have died with the person who died. The individual with Uncomplicated Bereavement generally regards the feeling of depressed mood as "normal," although he or she may seek professional help for relief of such associated symptoms as insomnia and anorexia.

The reaction to the loss may not be immediate, but rarely occurs after the first two or three months. The duration of "normal" bereavement varies considerably among different subcultural groups.

V15.81 Noncompliance with Medical Treatment

This category can be used when a focus of attention or treatment is noncompliance with medical treatment that is apparently not due to a mental disorder. Examples include failure to follow a prescribed diet because of religious beliefs or to take required medication because of a considered decision that the treatment is worse than the illness. The major differential is with Personality Disorders with prominent paranoid, passive-aggressive, or masochistic features.

V62.89 Phase of Life Problem or Other Life Circumstance Problem

This category can be used when a focus of attention or treatment is a problem associated with a particular developmental phase or some other life circumstance that is apparently not due to a mental disorder. Examples include problems associated with going to school, separating from parental control, starting a new career, marriage, divorce, and retirement.

V61.10 Marital Problem

This category can be used when a focus of attention or treatment is a marital problem that is apparently not due to a mental disorder. An example is marital conflict related to estrangement or divorce.

V61.20 Parent-Child Problem

This category can be used when a focus of attention or treatment is a parent-child problem that is apparently not due to a mental disorder of the individual (parent or child) who is being evaluated. An example is child abuse not attributable to a mental disorder of the parent.

V61.80 Other Specified Family Circumstances

This category can be used when a focus of attention or treatment is a family

circumstance that is apparently not due to a mental disorder and is not a Parent-Child or a Marital Problem. Examples are interpersonal difficulties with an aged in-law, or sibling rivalry.

V62.81 Other Interpersonal Problem

This category can be used when a focus of attention or treatment is an interpersonal problem (other than marital or parent-child) that is apparently not due to a mental disorder of the individual who is being evaluated. Examples are difficulties with co-workers, or with romantic partners.

Additional Codes*

300.90 Unspecified Mental Disorder (nonpsychotic)
This is a residual category to be used when enough information is available to rule out a psychotic disorder, but further specification is not possible. In some cases, with more information, the diagnosis can be changed to a specific disorder.

V71.09 No Diagnosis or Condition on Axis I
This category should be used to indicate that following an examination, no Axis I diagnosis or condition (including the V code categories) is present. There may or may not be an Axis II diagnosis.

799.90 Diagnosis or Condition Deferred on Axis I
This category should be used to indicate that there is insufficient information to make any diagnostic judgment about an Axis I diagnosis or condition.

V71.09 No Diagnosis on Axis II
This category should be used to indicate that, following an examination, no Axis II diagnosis (i.e., no Personality Disorder or Specific Developmental Disorder) is present. There may or may not be an Axis I diagnosis or condition.

799.90 Diagnosis Deferred on Axis II
This category should be used to indicate that there is insufficient information to make any diagnostic judgment about an Axis II diagnosis.

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* Although the terms distinguish between Axis I and Axis II, in order to maintain compatibility with ICD-9-CM, these Axis I and Axis II codes are the same.

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Appendix A

Decision Trees For Differential Diagnosis

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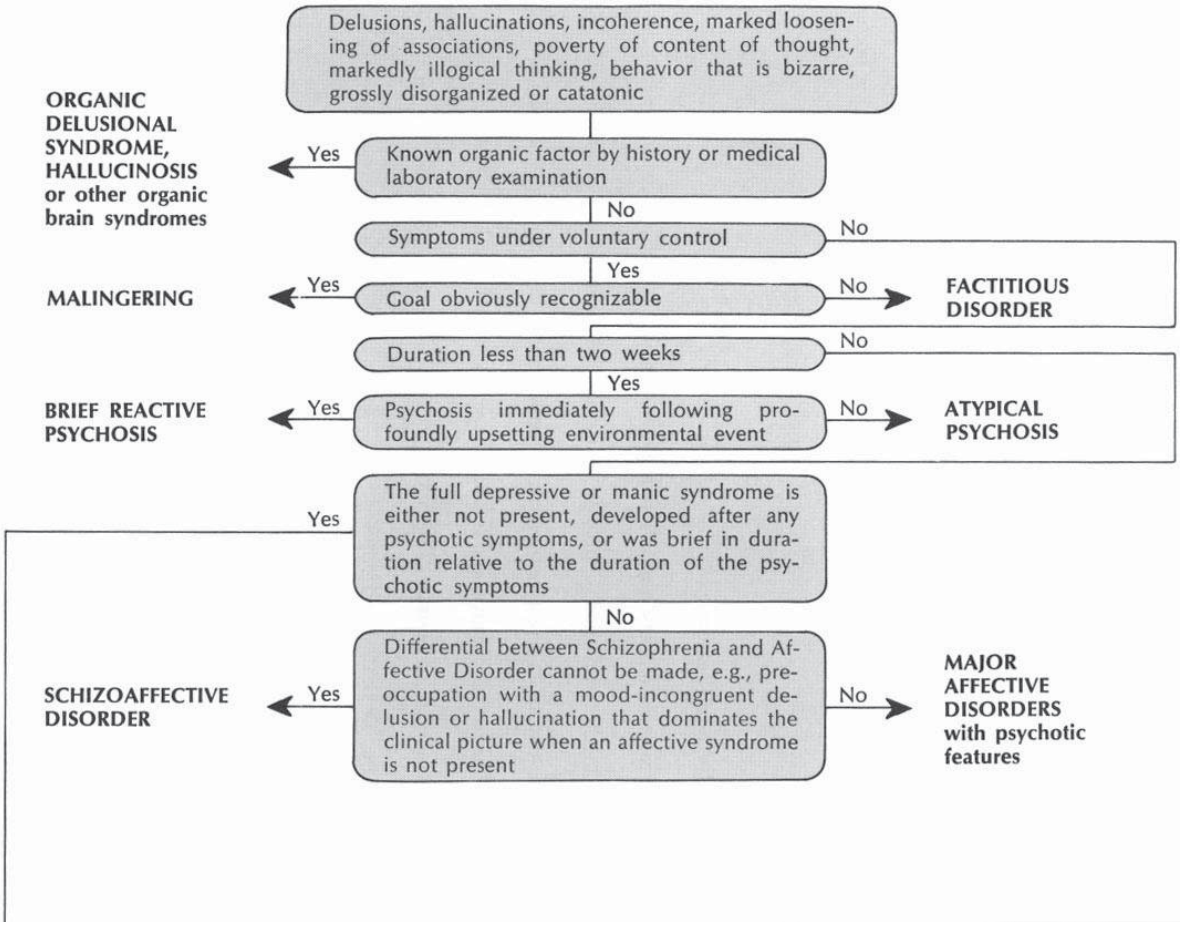
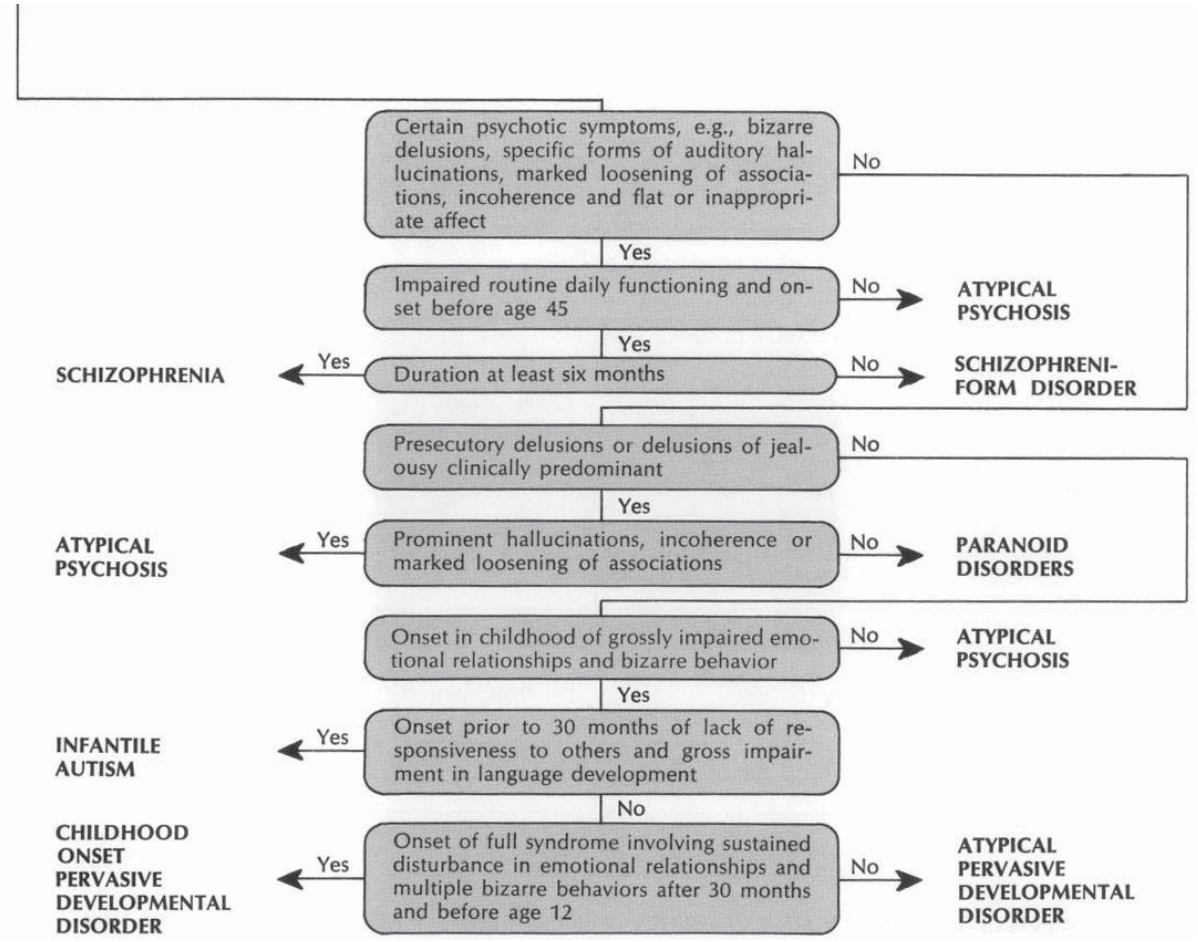
Appendix A:
Decision Trees For Differential Diagnosis*

The purpose of these decision trees is to aid the clinician in understanding the organization and hierarchical structure of the classification. Each decision tree starts with a set of clinical features. When one of these features is a prominent part of the presenting clinical picture, the clinician can follow the series of questions to rule in or out various diagnostic categories. The questions are only approximations of the actual diagnostic criteria. The decision trees are not meant to replace the specific diagnostic criteria.

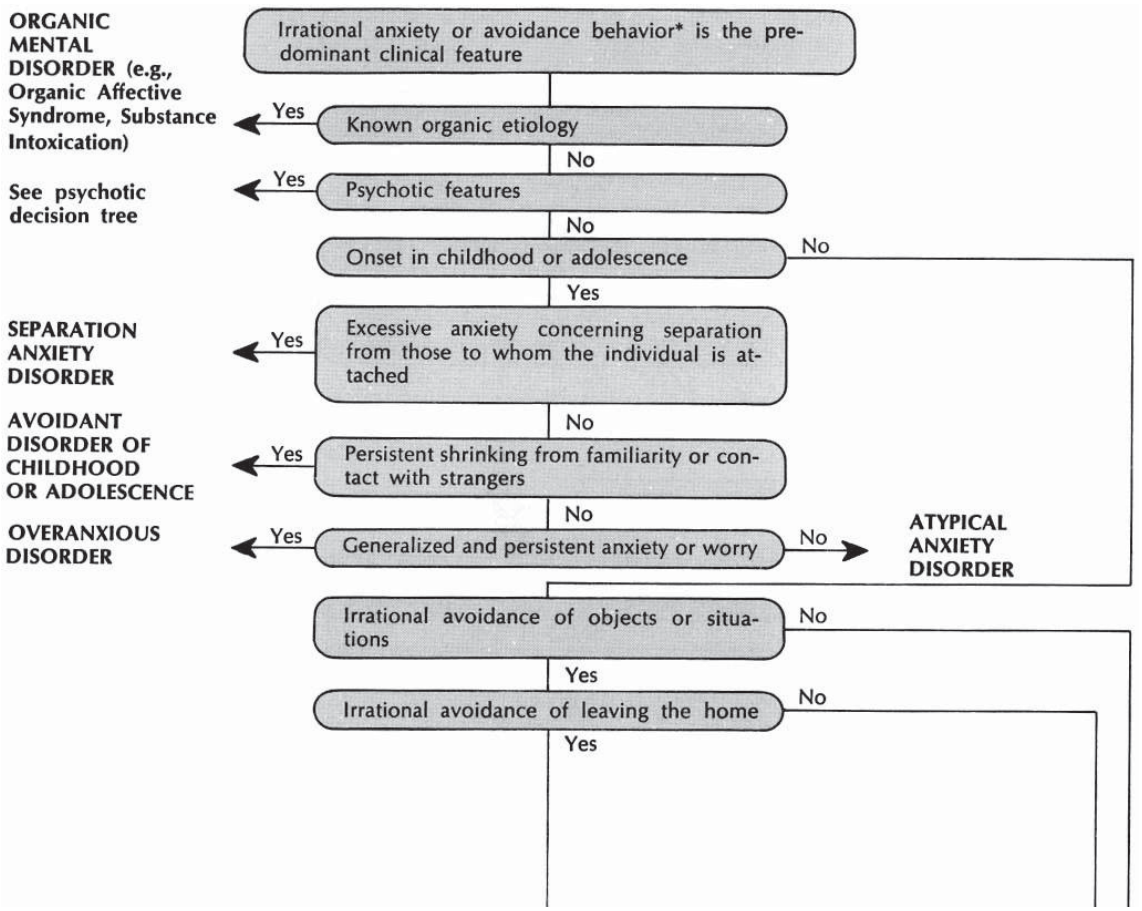
* Prepared by Robert L. Spitzer, M.D. and Janet B.W. Williams, M.S.W.

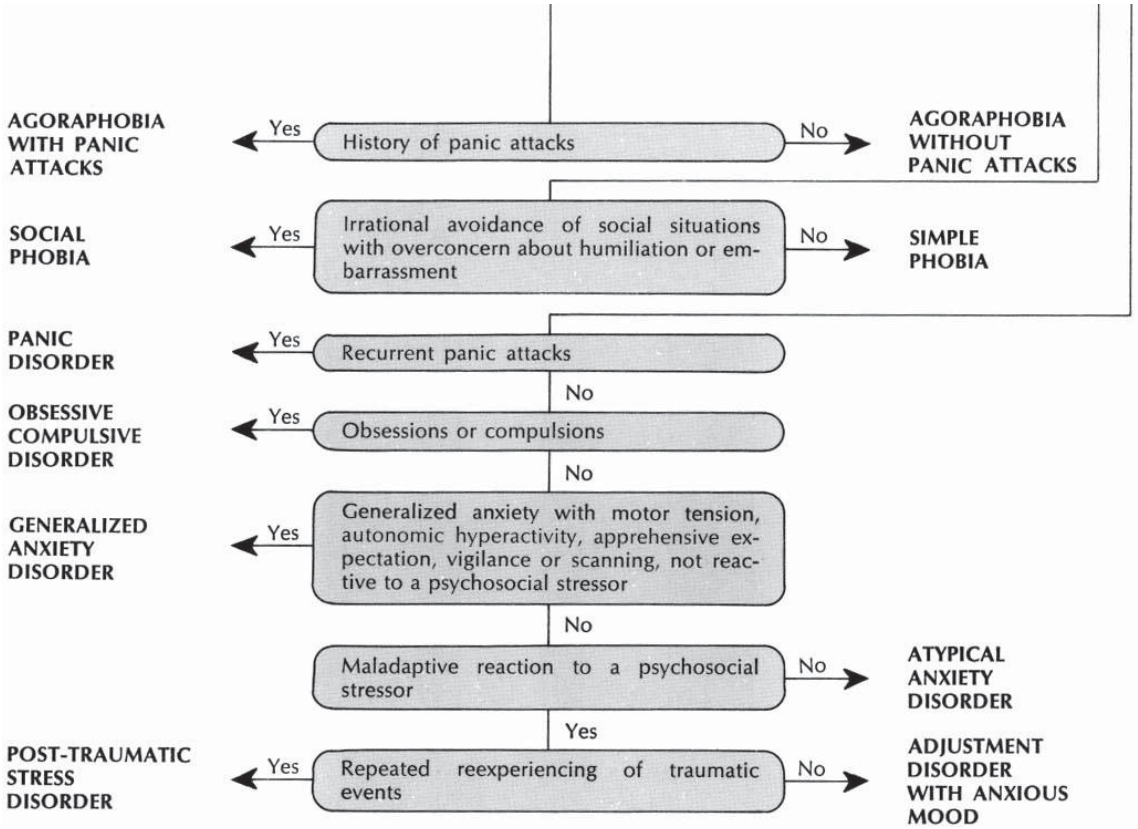
DIFFERENTIAL DIAGNOSIS OF PSYCHOTIC FEATURES




Certain psychotic symptoms, e.g., bizarre delusions, specific forms of auditory hallucinations, marked loosening of associations, incoherence and flat or inappropriate affect
No
Yes
Impaired routine daily functioning and onset before age 45
No
ATYPICAL PSYCHOSIS
Yes
Yes
SCHIZOPHRENIA
Duration at least six months
No
SCHIZOPHRENIFORM DISORDER
Presecutory delusions or delusions of jealousy clinically predominant
No
Yes
ATYPICAL PSYCHOSIS
Yes
Prominent hallucinations, incoherence or marked loosening of associations
No
PARANOID DISORDERS
Onset in childhood of grossly impaired emotional relationships and bizarre behavior
No
ATYPICAL PSYCHOSIS
Yes
INFANTILE AUTISM
Yes
Onset prior to 30 months of lack of responsiveness to others and gross impairment in language development
No
CHILDHOOD ONSET PERVASIVE DEVELOPMENTAL DISORDER
Yes
Onset of full syndrome involving sustained disturbance in emotional relationships and multiple bizarre behaviors after 30 months and before age 12
No
ATYPICAL PERVASIVE DEVELOPMENTAL DISORDER

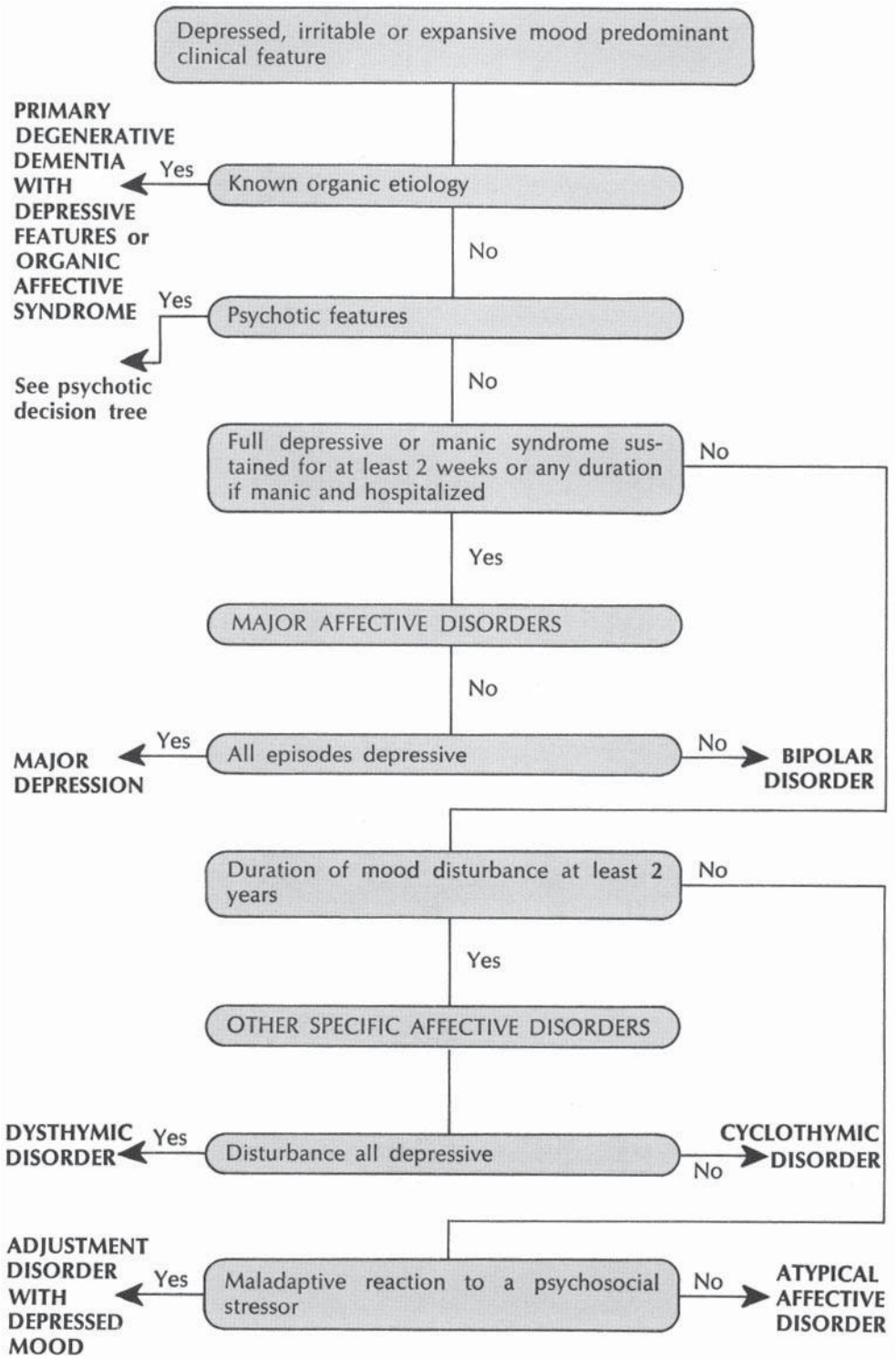
DIFFERENTIAL DIAGNOSIS OF IRRATIONAL ANXIETY AND AVOIDANCE BEHAVIOR



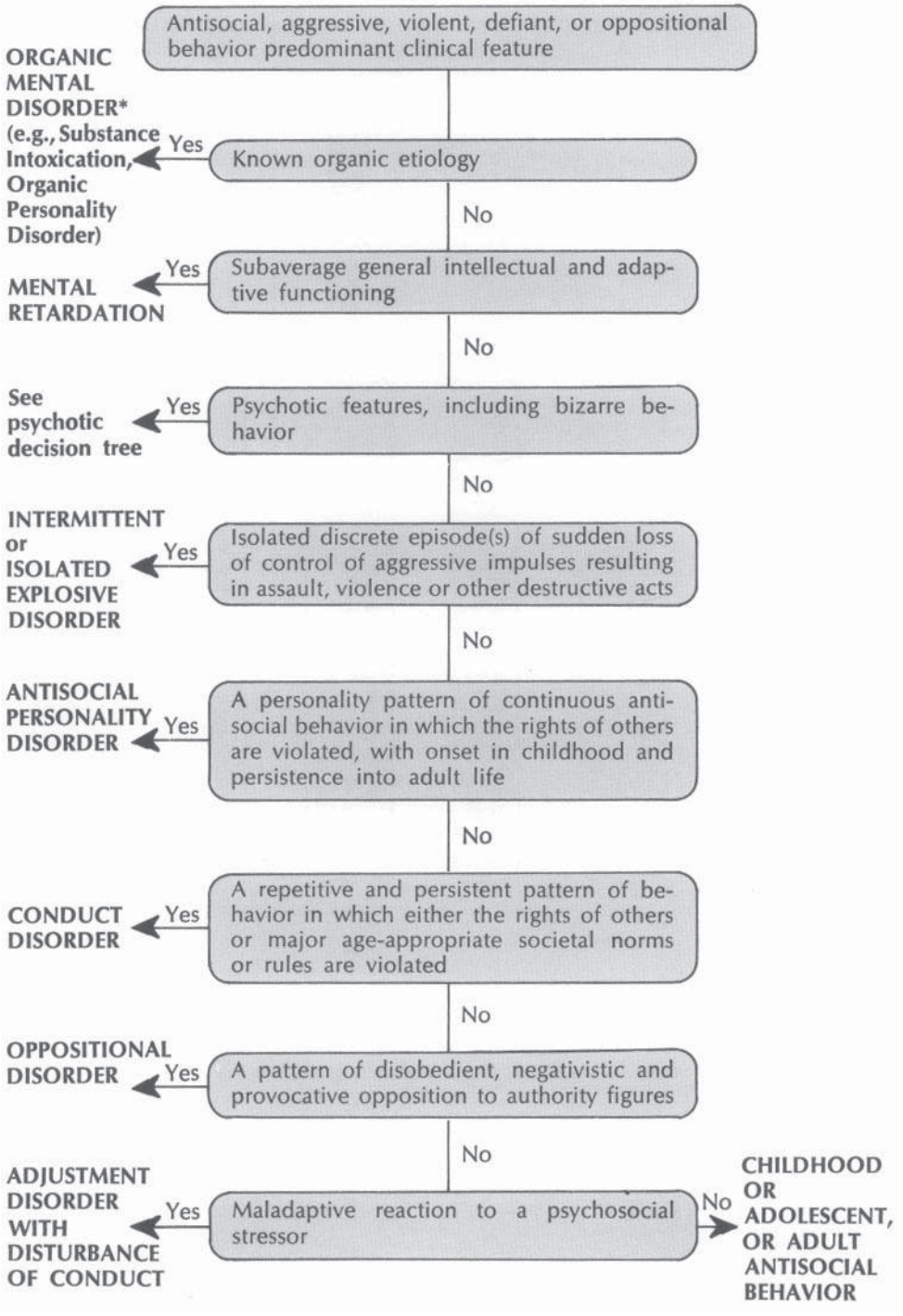


* Also consider Personality Disorders (Axis II), such as Avoidant, Borderline, Compulsive, and Schizotypal Personality Disorders.

DIFFERENTIAL DIAGNOSIS OF MOOD DISTURBANCE

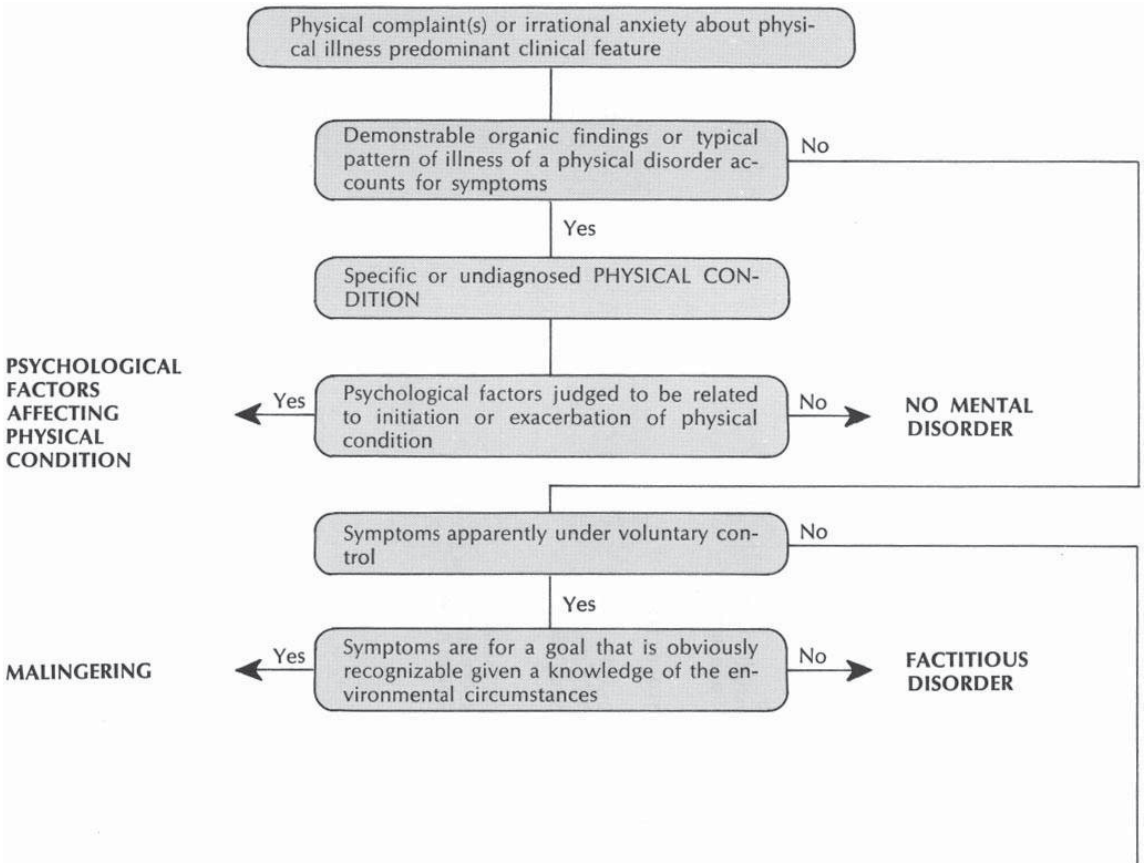


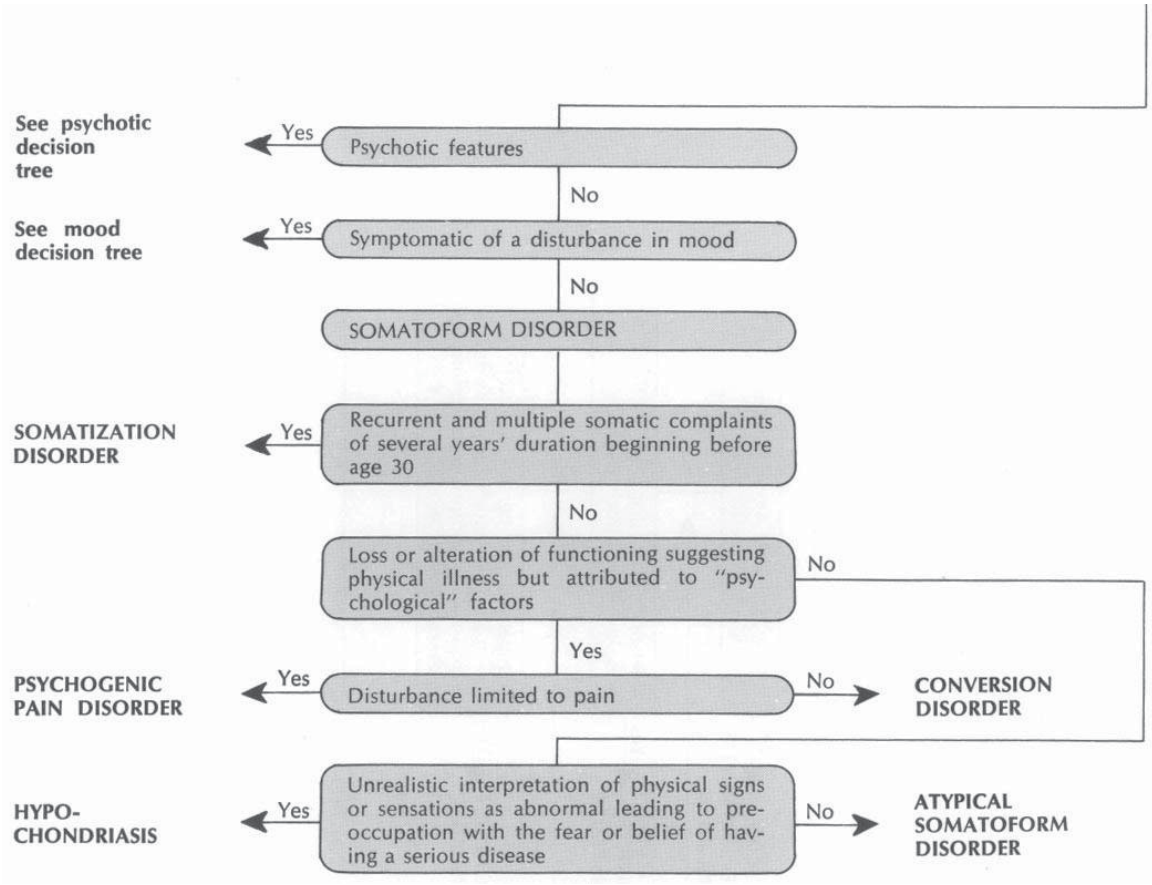
DIFFERENTIAL DIAGNOSIS OF ANTISOCIAL, AGGRESSIVE, DEFIANT, OR OPPOSITIONAL BEHAVIOR



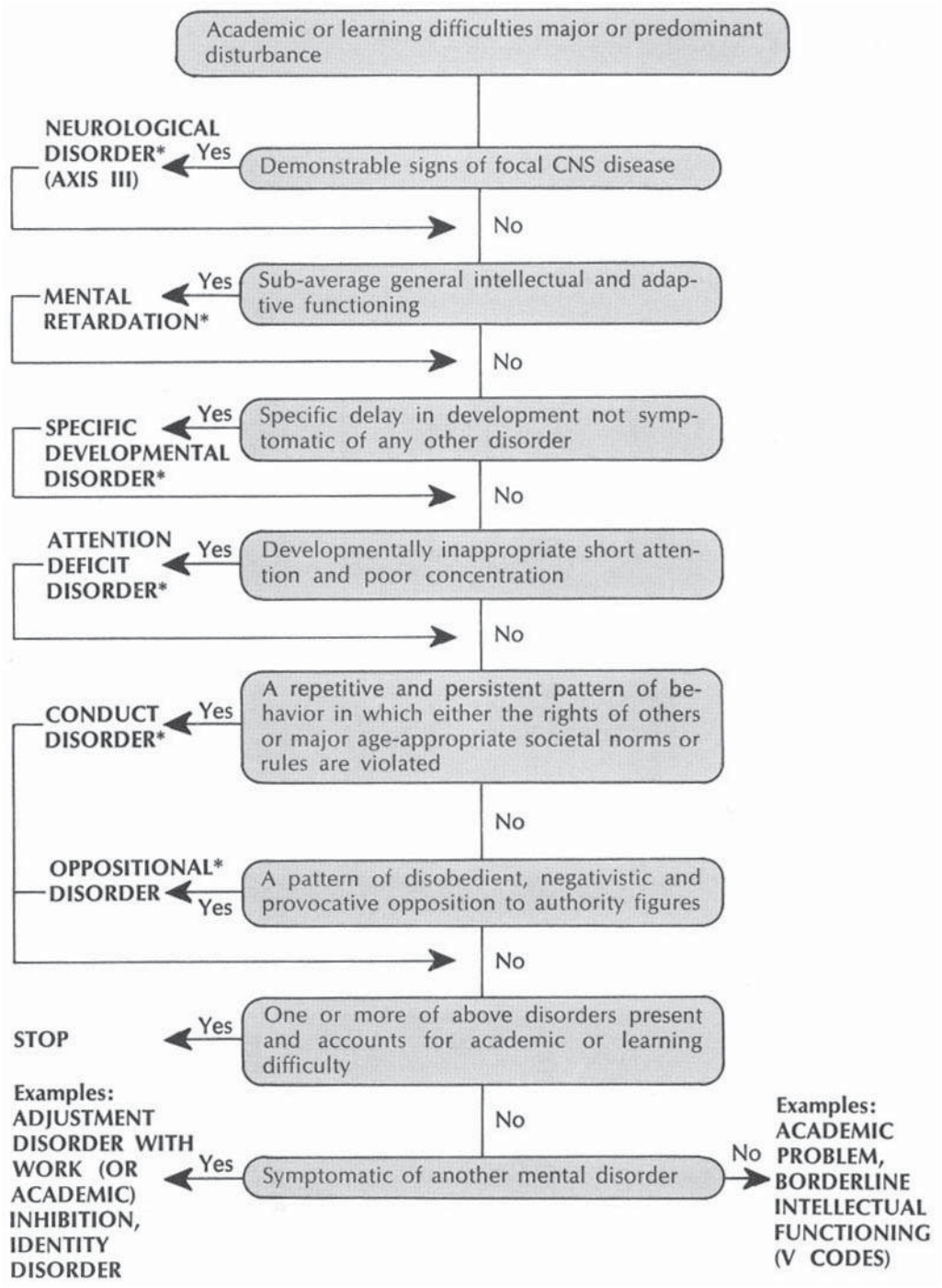
* Also consider Intermittent Explosive Disorder which can be diagnosed when symptomatic of an Organic Mental Disorder.

DIFFERENTIAL DIAGNOSIS OF PHYSICAL COMPLAINTS AND IRRATIONAL ANXIETY ABOUT PHYSICAL ILLNESS



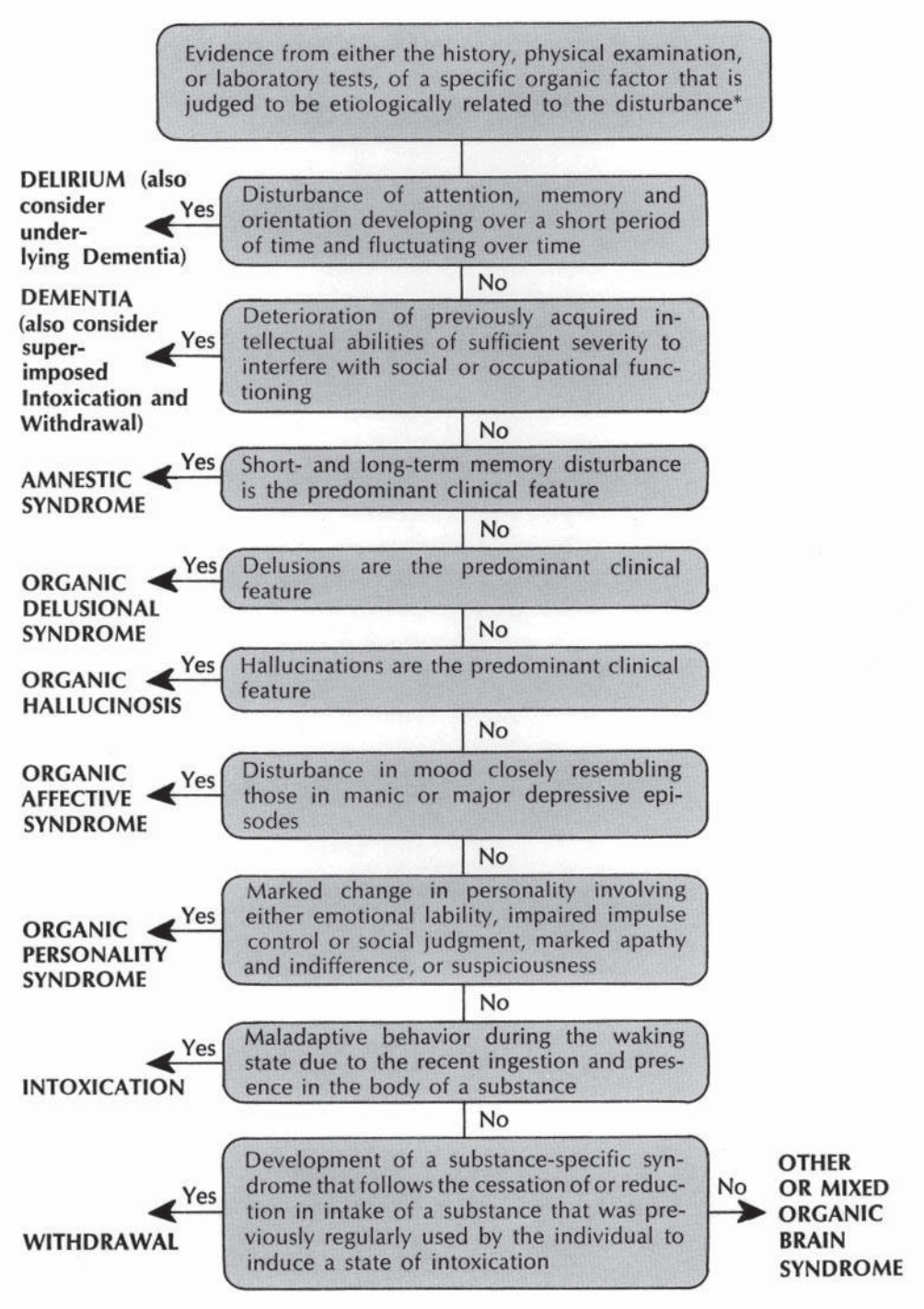

See psychotic decision tree
Yes
Psychotic features
No
See mood decision tree
Yes
Symptomatic of a disturbance in mood
No
SOMATOFORM DISORDER
SOMATIZATION DISORDER
Yes
Recurrent and multiple somatic complaints of several years' duration beginning before age 30
No
Loss or alteration of functioning suggesting physical illness but attributed to "psychological" factors
No
Yes
PSYCHOGENIC PAIN DISORDER
Yes
Disturbance limited to pain
No
CONVERSION DISORDER
HYPOCHONDRIASIS
Yes
Unrealistic interpretation of physical signs or sensations as abnormal leading to preoccupation with the fear or belief of having a serious disease
No
ATYPICAL SOMATOFORM DISORDER

DIFFERENTIAL DIAGNOSIS OF ACADEMIC OR LEARNING DIFFICULTIES



* The arrows returning to the trunk of the tree indicate the possibility of multiple diagnoses.

DIFFERENTIAL DIAGNOSIS OF ORGANIC BRAIN SYNDROMES



* In the absence of such evidence, an organic factor can be presumed if conditions outside of the Organic Mental Disorders category have been reasonably excluded and if the disturbance meets the symptomatic criteria for Dementia.

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Appendix B

Glossary of Technical Terms

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Appendix B:
Glossary of Technical Terms

DSM-III, by and large, includes only those technical terms that are essential for differential diagnosis; thus, many important terms relevant to psychopathology are omitted. This glossary of technical terms is limited to those that are used in either the descriptions and definitions or the diagnostic criteria of DSM-III and that are associated with a number of mental disorders. For example, bulimia is not in this glossary because it is rarely encountered except among Eating Disorders, and the reader wishing to learn about this symptom should refer to the text on those disorders. On the other hand, such symptoms as delusions, phobias, obsessions, and depersonalization are included because they all occur in a number of mental disorders.

Many of the entries list the disorders in which the symptom most frequently occurs; it should be understood, however, that the symptom may also be present in other disorders.

AFFECT. An immediately expressed and observed emotion. A feeling state becomes an affect when it is observable, for example, as overall demeanor or tone and modulation of voice. Affect is to be distinguished from mood, which refers to a pervasive and sustained emotion. Affect is to mood as weather is to climate. Common examples of affect are euphoria, anger, and sadness.

A range of affect may be described as *broad* (normal), *restricted* (constricted), *blunted*, or *flat*. What is considered the normal range of the expression of affect varies considerably, both within and among different cultures. The normal expression of affect involves variability in facial expression, pitch of voice, and the use of hand and body movements. Restricted affect is characterized by a clear reduction in the expressive range and intensity of affects. Blunted affect is marked by a severe reduction in the intensity of affective expression. In flat affect there is a lack of signs of affective expression; the voice may be monotonous and the face, immobile.

Affect is *inappropriate* when it is clearly discordant with the content of the person's speech or ideation. Example: A patient smiled and laughed while discussing demons who were persecuting him. An affect should not be termed inappropriate, however, when it is inappropriate merely to the situation, such as laughing when told that a relative has died; in such instances it would be more apt to refer to inappropriate behavior.

Affect is *labile* when it is characterized by repeated, rapid, and abrupt shifts. Examples: An elderly man is tearful one moment and combative the next; a young woman is observed by her friends to be friendly, gregarious, and happy one moment and angry and abusive the next, without readily apparent reason.

AGITATION. See psychomotor agitation.

ANXIETY. Apprehension, tension, or uneasiness that stems from the anticipation of danger, which may be internal or external. Some definitions of anxiety distinguish it from fear by limiting it to the anticipation of danger, the source of which is largely unknown, whereas fear is the response to a consciously recognized and usually external threat or danger. The manifestations of anxiety and fear are the same and include motor tension, autonomic hyperactivity, apprehensive expectation, and vigilance and scanning.

Anxiety may be focused on an object, situation, or activity which is avoided (phobia), or may be unfocused (free-floating anxiety). It may be experienced in discrete periods of sudden onset and be accompanied by physical symptoms (panic attacks). When anxiety is focused on physical signs or symptoms and causes preoccupation with the fear or belief of having a disease, it is termed hypochondriasis.

ATTENTION. The ability to focus in a sustained manner on one task or activity. A disturbance in attention may be manifested by difficulty in finishing tasks that have been started, easy distractibility, and/or difficulty in concentrating on work.

BLOCKING. Interruption of a train of speech before a thought or idea has been completed. After a period of silence, which may last from a few seconds to minutes, the person indicates that he or she cannot recall what he or she has been saying or meant to say. Blocking should be judged to be present only if the person spontaneously describes losing his or her thought or if upon questioning by the interviewer, the person gives that as the reason for pausing.

CATATONIC BEHAVIOR. Marked motor anomalies, generally limited to disturbances in the context of a diagnosis of a non-organic psychotic disorder.

Catatonic excitement. Excited motor activity, apparently purposeless and not influenced by external stimuli.

Catatonic negativism. An apparently motiveless resistance to all instructions or attempts to be moved. When passive, the person may resist any effort to be moved; when active, he or she may do the opposite of what is asked—for example, firmly clench jaws when asked to open mouth.

Catatonic rigidity. Maintenance of a rigid posture against all efforts to be moved.

Catatonic posturing. Voluntary assumption of an inappropriate or bizarre posture, usually held for a long period of time. Example: A patient may stand with arms outstretched as if he were Jesus on the cross.

Catatonic stupor. Marked decrease in reactivity to environment and

reduction in spontaneous movements and activity, sometimes to the point of appearing to be unaware of one's surroundings.

Catatonic waxy flexibility. The person's limbs can be "molded" into any position, which is then maintained. When the limb is being moved, it feels to the examiner as if it were made of pliable wax.

CIRCUMSTANTIALITY. A term used to describe speech that is indirect and delayed in reaching the point because of unnecessary, tedious details, and parenthetic remarks. Circumstantial replies or statements may be prolonged for many minutes if the speaker is not interrupted and urged to get to the point. Interviewers often respond to circumstantiality by interrupting the speaker in order to complete the process of history taking within an allotted time. This may make it difficult to distinguish loosening of associations from circumstantiality. In the former there is a lack of connection between clauses, but in the latter the clauses always retain a meaningful connection. In loosening of associations the original point is lost, whereas in circumstantiality the speaker is always aware of the original point, goal, or topic.

Circumstantiality is common in Compulsive Personality Disorder and in many people without mental disorder.

CLANGING. Speech in which sounds, rather than meaningful, conceptual relationships govern word choice; it may include rhyming and punning. The term is usually applied only when it is a manifestation of a pathological condition; thus, it would not be used to describe the rhyming word play of children. Example: "I'm not trying to make noise. I'm trying to make sense. If you can make sense out of nonsense, well, have fun. I'm trying to make sense out of sense. I'm not making sense (cents) anymore. I have to make dollars."

Clanging is observed most commonly in Schizophrenia and manic episodes.

COMPULSION. Repetitive and seemingly purposeful behavior that is performed according to certain rules or in a stereotyped fashion. The behavior is not an end in itself, but is designed to produce or prevent some future state of affairs; the activity, however, either is not connected in a realistic way with the state of affairs it is designed to produce or prevent, or it may be clearly excessive. The act is performed with a sense of subjective compulsion coupled with a desire to resist it (at least initially); performing the particular act is not pleasurable, although it may afford some relief of tension. Example: An individual feels compelled to wash his or her hands, every time he or she shakes hands because of a fear of contamination that he or she recognizes as excessive.

Compulsions are characteristic of Obsessive Compulsive Disorder and may also be seen in Schizophrenia.

CONFABULATION. Fabrication of facts or events in response to questions about situations or events that are not recalled because of memory impairment. It differs from lying in that the individual is not consciously attempting to deceive.

Confabulation is common in Organic Amnestic Syndrome.

CONVERSION SYMPTOM. A loss or alteration of physical functioning that suggests a physical disorder but that is actually a direct expression of a psychological conflict or need. The disturbance is not under voluntary control, and is not explained by any physical disorder (this possibility having been excluded by appropriate investigation).

Conversion symptoms are observed in Conversion Disorder, and may occur in Schizophrenia.

DELUSION. A false personal belief based on incorrect inference about external reality and firmly sustained in spite of what almost everyone else believes and in spite of what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture (i.e., it is not an article of religious faith).

When a false belief involves an extreme value judgment, it is regarded as a delusion only when the judgment is so extreme as to defy credibility. Example: If someone claims he or she is terrible and has disappointed his or her family, this is generally not regarded as a delusion even if an objective assessment of the situation would lead observers to think otherwise; but if someone claims he or she is the worst sinner in the world, this would generally be considered a delusional conviction. Similarly, a person judged by most people to be moderately underweight who asserted he or she was fat would not be regarded as delusional; but one with Anorexia Nervosa who at the point of extreme emaciation insisted he or she was fat could rightly be considered delusional.

A delusion should be distinguished from a hallucination, which is a false sensory perception (although a hallucination may give rise to the delusion that the perception is true). A delusion is also to be distinguished from an overvalued idea, in which an unreasonable belief or idea is not as firmly held as is the case with a delusion.

Delusions are subdivided according to their content. Some of the more common types are listed below.

Delusion of being controlled. A delusion in which feelings, impulses, thoughts, or actions are experienced as being not one's own, as being imposed by some external force. This does not include the mere conviction that one is acting as an agent of God, has had a curse placed on him or her, is the victim of fate, or is not sufficiently assertive. The symptom should be judged present only when the subject experiences his or her will, thoughts, or feelings as operating under some external force. Examples: A man claimed that his words were not his own, but those of his father; a student believed that his actions were under the control of a yogi; a housewife believed that sexual feelings were being put into her body from without.

Delusion, bizarre. A false belief whose content is patently absurd and has no possible basis in fact. Example: A man believed that when his adenoids had been removed in childhood, a box had been inserted into his

head, and that wires had been placed in his head so that the voice he heard was that of the governor.

Delusion, grandiose. A delusion whose content involves an exaggerated sense of one's importance, power, knowledge, or identity. It may have a religious, somatic, or other theme.

Delusional jealousy. The delusion that one's sexual partner is unfaithful.

Delusion, mood-congruent. See mood-congruent psychotic features.

Delusion, mood-incongruent. See mood-incongruent psychotic features.

Delusion, nihilistic. A delusion involving the theme of non-existence of the self or part of the self, others, or the world. Examples: "The world is finished"; "I no longer have a brain"; "There is no need to eat, because I have no insides." A somatic delusion may also be a nihilistic delusion if the emphasis is on nonexistence of the body or a part of the body.

Delusion, persecutory. A delusion in which the central theme is that a person or group is being attacked, harassed, cheated, persecuted, or conspired against. Usually the subject or someone or some group or institution close to him or her is singled out as the object of the persecution.

It is recommended that the term "paranoid delusion" not be used, because its meanings are multiple, confusing, and contradictory. It has often been employed to refer to both persecutory and grandiose delusions because of their presence in the paranoid subtype of Schizophrenia.

Delusion of poverty. A delusion that the person is, or will be, bereft of all, or virtually all, material possessions.

Delusion of reference. A delusion whose theme is that events, objects, or other people in the person's immediate environment have a particular and unusual significance, usually of a negative or pejorative nature. This differs from an idea of reference, in which the false belief is not as firmly held as in a delusion. If the delusion of reference involves a persecutory theme, then a delusion of persecution is present as well. Examples: A woman was convinced that programs on the radio were directed especially to her; when recipes were broadcast, it was to tell her to prepare wholesome food for her child and stop feeding her candy; when dance music was broadcast, it was to tell her to stop what she was doing and start dancing, and perhaps even to resume ballet lessons. A patient notes that the room number of his therapist's office is the same as the number of the hospital room in which his father died and feels that this means there is a plot to kill him.

Delusion, somatic. A delusion whose main content pertains to the functioning of one's body. Examples: One's brain is rotting; one is pregnant despite being postmenopausal.

Extreme value judgments about the body may, under certain circumstances, also be considered somatic delusions. Example: A person insists that his nose is grossly misshaped despite lack of confirmation of this by observers.

Hypochondriacal delusions are also somatic delusions when they involve specific changes in the functioning or structure of the body rather than merely an insistent belief that one has a disease.

Delusions, systematized. A single delusion with multiple elaborations or a group of delusions that are all related by the individual to a single event or theme. Example: A man who failed his bar examination developed the delusion that this occurred because of a conspiracy involving the university and the bar association. He then attributed all other difficulties in his social and occupational life to this continuing conspiracy.

DEPERSONALIZATION. An alteration in the perception or experience of the self so that the feeling of one's own reality is temporarily lost. This is manifested in a sense of self-estrangement or unreality, which may include the feeling that one's extremities have changed in size, or a sense of seeming to perceive oneself from a distance (usually from above).

Depersonalization is seen in Depersonalization Disorder, and may also occur in Schizotypal Personality Disorder, and Schizophrenia. It also occurs in the absence of any mental disorder in the presence of overwhelming anxiety, stress or fatigue.

DIAGNOSIS. In general usage, and in DSM-III, this term refers to the process of identifying specific mental or physical disorders. Some, however, use the term more broadly to refer to a comprehensive evaluation that is not limited to the identification of specific disorders. Thus in the limited sense of the term, only Axes I, II and III are diagnostic, whereas in the broader sense, Axes IV and V and other aspects of assessment can also be considered diagnostic.

DISORIENTATION. Confusion about the date or time of day, where one is (place), or who one is (identity).

Disorientation is characteristic of some Organic Mental Disorders, such as Delirium and Dementia.

DISTRACTIBILITY. Attention drawn too frequently to unimportant or irrelevant external stimuli. Example: While being interviewed, a subject's attention is repeatedly drawn to noise from an adjoining office, a book that is on a shelf, or the interviewer's school ring.

ECHOLALIA. Repetition (echoing) of the words or phrases of others. Typical

echolalia tends to be repetitive and persistent. The echo is often uttered with a mocking, mumbling, or staccato intonation. Echolalia should not be confused with habitual repetition of questions, apparently to clarify the question and formulate its answer, as when a patient is asked, "When did you come to the hospital?" and replies, "Come to the hospital? Yesterday."

Example: An interviewer says to a subject, "I'd like to talk with you for a few minutes"; and the subject responds, in a mumbling tone, "Talk with you for a few minutes. Talk with you for a few minutes."

Echolalia is observed in some Pervasive Developmental Disorders, Organic Mental Disorders, and in Schizophrenia.

EGO-DYSTONIC. A symptom or personality trait that is recognized by the individual as unacceptable and undesirable and is experienced as alien. Examples: obsessions and compulsions; a homosexual arousal pattern that is unacceptable to the individual would be ego-dystonic, whereas, if the individual were not distressed by the pattern and experienced it as acceptable, it would be ego-syntonic.

FLIGHT OF IDEAS. A nearly continuous flow of accelerated speech with abrupt changes from topic to topic, usually based on understandable associations, distracting stimuli, or plays on words. When severe, the speech may be disorganized and incoherent.

Flight of ideas is most frequently seen in manic episodes, but may also be observed in some cases of Organic Mental Disorders, Schizophrenia, other psychotic disorders, and, occasionally, acute reactions to stress.

FORMAL THOUGHT DISORDER. A disturbance in the form of thought as distinguished from the content of thought. The boundaries of the concept are not clear and there is no consensus as to which disturbances in speech or thought are included in the concept. For this reason, "formal thought disorder" is not used as a specific descriptive term in DSM-III. See loosening of associations, incoherence, poverty of content of speech, neologisms, perseveration, blocking, echolalia, clanging.

GRANDIOSITY. An inflated appraisal of one's worth, power, knowledge, importance, or identity. When extreme, grandiosity may be of delusional proportions. Example: A professor who frequently puts his students to sleep with his boring lectures is convinced that he is one of the more dynamic and exciting teachers at the university.

HALLUCINATION. A sensory perception without external stimulation of the relevant sensory organ. A hallucination has the immediate sense of reality of a true perception, although in some instances the source of the hallucination may be perceived as within the body (e.g., an auditory hallucination may be experienced as coming from within the head rather than through the ears). (Some investigators limit the concept of true hallucinations to sensations whose source

is perceived as being external to the body, but the clinical significance of this distinction has yet to be demonstrated, so it is not made in this manual.)

There may or may not be a delusional interpretation of the hallucinatory experience. For example, one person with auditory hallucinations may recognize that he or she is having a false sensory experience whereas another may be convinced that the source of the sensory experience has an independent physical reality. Strictly speaking, hallucinations indicate a psychotic disturbance only when they are associated with gross impairment in reality testing (see psychotic). The term hallucination, by itself, is not ordinarily applied to the false perceptions that occur during dreaming, while falling asleep (hypnagogic), or when awakening (hypnopompic). Hallucinations occurring in the course of an intensely shared religious experience generally have no pathological significance.

Hallucinations should be distinguished from illusions, in which an external stimulus is misperceived or misinterpreted, and from normal thought processes that are exceptionally vivid. Transient hallucinatory experiences are common in individuals without mental disorder.

Hallucination, auditory. A hallucination of sound, most commonly of voices, but sometimes of clicks, rushing noises, music, etc.

Hallucination, gustatory. A hallucination of taste, unpleasant tastes being the most common.

Hallucination, mood-congruent. See mood-congruent psychotic features.

Hallucination, mood-incongruent. See mood-incongruent psychotic features.

Hallucination, olfactory. A hallucination involving smell. Example: A woman complained of a persistent smell of dead bodies. Some individuals are convinced they have a body odor they themselves cannot smell; this symptom is a delusion, not an olfactory hallucination.

Hallucination, somatic. A hallucination involving the perception of a physical experience localized within the body. Example: A feeling of electricity running through one's body.

Somatic hallucinations are to be distinguished from unexplained physical sensations; a somatic hallucination can be identified with certainty only when a delusional interpretation of a physical illness is present. A somatic hallucination is to be distinguished also from hypochondriacal preoccupation with, or exaggeration of, normal physical sensations and from a tactile hallucination, in which the sensation is usually related to the skin.

Hallucination, tactile. A hallucination involving the sense of touch, often of something on or under the skin. Almost invariably the symptom is associated with a delusional interpretation of the sensation. Examples:

A man said he could feel the Devil putting pins into his flesh; another claimed he could feel himself being penetrated anally; still another complained of experiencing pains, which he attributed to the Devil, throughout his body, although there was no evidence of any physical illness.

A particular tactile hallucination is *formication*, which is the sensation of something creeping or crawling on or under the skin. Often there is a delusional interpretation of the sensation, as when it is attributed to insects or worms. Formication is seen in Alcohol Withdrawal Delirium and the withdrawal phase of Cocaine Intoxication.

Tactile hallucinations of pain are to be distinguished from Psychogenic Pain Disorder, in which there is no delusional interpretation.

Hallucination, visual. A hallucination involving sight, which may consist of formed images, such as of people, or of unformed images, such as flashes of light. Visual hallucinations should be distinguished from illusions, which are misperceptions of real external stimuli.

HYPOCHONDRIASIS. Unrealistic interpretation of physical signs or sensations as abnormal, leading to preoccupation with the fear or belief of having a disease.

IDEA OF REFERENCE. An idea, held less firmly than a delusion, that events, objects, or other people in the person's immediate environment have a particular and unusual meaning specifically for him or her. See also delusion of reference.

IDENTITY. The sense of self, providing a unity of personality over time. Prominent disturbances in identity or the sense of self are seen in Schizophrenia, Borderline Personality Disorder, and Identity Disorder.

ILLOGICAL THINKING. Thinking that contains clear internal contradictions or in which conclusions are reached that are clearly erroneous, given the initial premises. It may be seen in individuals without mental disorder, particularly in situations in which they are distracted or fatigued. Illogical thinking has psychopathological significance only when it is marked, as in the examples noted below, and when it is not due to cultural or religious values or to intellectual deficit. Markedly illogical thinking may lead to, or result from, a delusional belief or may be observed in the absence of a delusion.

Examples: A patient explained that she gave her family IBM cards, which she punched, in an effort to improve communication with them. Another patient stated: "Parents are the people that raise you. Parents can be anything—material, vegetable, or mineral—that has taught you something. A person can look at a rock and learn something from it, so a rock is a parent." In response to the question "Why did you go to Kingston?" a patient replied, "Because I believe in the King James Bible and my name is James. I went to Kingston to see the Queen."

ILLUSION. A misperception of a real external stimulus. Examples: The rustling of leaves is heard as the sound of voices; a man claims that when he looks in a mirror, he sees his face distorted and misshapen. See also hallucination.

INCOHERENCE. Speech that, for the most part, is not understandable, owing to any of the following: a lack of logical or meaningful connection between words, phrases, or sentences; excessive use of incomplete sentences; excessive irrelevancies or abrupt changes in subject matter; idiosyncratic word usage; distorted grammar. Mildly ungrammatical constructions or idiomatic usages characteristic of particular regional or ethnic backgrounds, lack of education, or low intelligence should not be considered incoherence; and the term is generally not applied when there is evidence that the disturbance in speech is due to an aphasia.

Example: Interviewer: "Why do you think people believe in God?" Subject: "Um, because making a do in life. Isn't none of that stuff about evolution guiding isn't true anymore now. It all happened a long time ago. It happened in eons and eons and stuff they wouldn't believe in Him. The time that Jesus Christ people believe in their thing people believed in, Jehovah God that they didn't believe in Jesus Christ that much."

Incoherence may be seen in some Organic Mental Disorders, Schizophrenia, and other psychotic disorders.

INSOMNIA. Difficulty falling or staying asleep. Initial insomnia is difficulty in falling asleep. Middle insomnia involves an awakening, followed by difficulty returning to sleep, but eventually doing so. Terminal insomnia is awakening at least two hours before one's usual waking time and being unable to return to sleep.

LOOSENING OF ASSOCIATIONS. Thinking characterized by speech in which ideas shift from one subject to another that is completely unrelated or only obliquely related without the speaker's showing any awareness that the topics are unconnected. Statements that lack a meaningful relationship may be juxtaposed, or the individual may shift idiosyncratically from one frame of reference to another: When loosening of associations is severe, speech may be incoherent. The term is generally not applied when abrupt shifts in topics are associated with a nearly continuous flow of accelerated speech (as in flight of ideas).

Example: Interviewer: "What did you think of the whole Watergate affair?" Subject: "You know I didn't tune in on that, I felt so bad about it. I said, Boy, I'm not going to know what's going on in this. But it seemed to get so murky, and everybody's reports were so negative. Huh, I thought, I don't want any part of this, and I don't care who was in on it, and all I could figure out was Artie had something to do with it. Artie was trying to flush the bathroom toilet of the White House or something. She was trying to do something fairly simple. The tour guests stuck or something. She got blamed because the water overflowed, went down in the basement, down, to the kitchen. They had a, they were going to have to repaint and restore the White House room, the enormous living room. And then it was at this reunion they were having. And it's just such a mess and I just thought, well, I'm just going to pretend like I don't even know what's going on. So I came downstairs and 'cause I pretended like I didn't know what was going on, I slipped on the floor of the

kitchen, cracking my toe, when I was teaching some kids how to do some double dives."

Loosening of associations may be seen in Schizophrenia, manic episodes, and other psychotic disorders.

MAGICAL THINKING. The individual believes that his or her thoughts, words, or actions might, or will in some manner cause or prevent a specific outcome in some way that defies the normal laws of cause and effect. Example: A man believed that if he said a specific prayer three times each night, his mother's death might be prevented indefinitely; a mother believed that if she had an angry thought her child would become ill.

Magical thinking may be part of ideas of reference or may reach delusional proportions when the individual maintains a firm conviction about the belief despite evidence to the contrary.

Magical thinking is seen in children, in people in primitive cultures, and in Schizotypal Personality Disorder, Schizophrenia, and Obsessive Compulsive Disorder.

MENTAL DISORDER. In DSM-III, a mental disorder is conceptualized as a clinically significant behavioral or psychologic syndrome or pattern that occurs in an individual and that typically is associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability). In addition, there is an inference that there is a behavioral, psychologic, or biologic dysfunction, and that the disturbance is not only in the relationship between the individual and society. When the disturbance is limited to a conflict between an individual and society, this may represent social deviance, which may or may not be commendable, but is not by itself a mental disorder.

MOOD. A pervasive and sustained emotion that in the extreme, markedly colors the person's perception of the world. Mood is to affect as climate is to weather. Common examples of mood include depression, elation, anger, and anxiety.

Mood, dysphoric. An unpleasant mood, such as depression, anxiety, or irritability.

Mood, elevated. A mood that is more cheerful than normal; it does not necessarily imply pathology.

Mood, euphoric. An exaggerated feeling of well-being. As a technical term, euphoria implies a pathological mood. Whereas the individual with a normally elevated mood may describe himself or herself as being in "good spirits," "very happy," or "cheerful," the euphoric person is likely to exclaim that he or she is "on top of the world," "up in the clouds," or to say, "I feel ecstatic," "I'm flying," or "I am high."

Mood, euthymic. Mood in the "normal" range, which implies the absence of depressed or elevated mood.

Mood, expansive. Lack of restraint in expressing one's feelings, frequently with an overvaluation of one's significance or importance. There may also be elevated or euphoric mood.

Mood, irritable. Internalized feeling of tension associated with being easily annoyed and provoked to anger.

MOOD-CONGRUENT PSYCHOTIC FEATURES. Delusions or hallucinations whose content is entirely consistent with either a depressed or a manic mood. If the mood is depressed, the content of the delusions or hallucinations would involve themes of either personal inadequacy, guilt, disease, death, nihilism, or deserved punishment. If the mood is manic, the content of the delusions or hallucinations would involve themes of inflated worth, power, knowledge, or identity, or special relationship to a deity or a famous person.

MOOD-INCONGRUENT PSYCHOTIC FEATURES. Delusions or hallucinations whose content is not consistent with either a depressed or a manic mood. In the case of depression, a delusion or hallucination whose content does not involve themes of either personal inadequacy, guilt, disease, death, nihilism, or deserved punishment. In the case of mania, a delusion or hallucination whose content does not involve themes of either inflated worth, power, knowledge, or identity or special relationship with a deity or a famous person. Examples of such symptoms are persecutory delusions, thought insertion, thought broadcasting, and delusions of being controlled, whose content has no apparent relationship to any of the themes noted above. (Note: The catatonic symptoms of stupor, mutism, negativism, and posturing in manic episodes are also considered mood-incongruent psychotic features.)

NEOLOGISMS. New words invented by the subject, distortions of words, or standard words to which the subject has given new, highly idiosyncratic meaning. The judgment that neologisms are present should be made cautiously, taking into account the subject's educational and cultural background. Examples: "I was accused of midigation" (meaning the subject was accused of breaking the law). "They had an insinuating machine next door" (person explaining how her neighbors were bothering her).

Neologisms may be observed in Schizophrenia and other psychotic disorders.

NEUROTIC DISORDER. A mental disorder in which the predominant disturbance is a symptom or group of symptoms that is distressing to the individual and is recognized by him or her as unacceptable and alien (ego-dystonic); reality testing is grossly intact. Behavior does not actively violate gross social norms (though it may be quite disabling). The disturbance is relatively enduring or recurrent without treatment, and is not limited to a transitory reaction to stressors. There is no demonstrable organic etiology or factor.

NEUROTIC PROCESS. A specific etiological process involving the following

sequence: (1) unconscious conflicts between opposing desires or between desires and prohibitions, which cause (2) unconscious perception of anticipated danger or dysphoria, which leads to (3) use of defense mechanisms that result in (4) either symptoms, personality disturbance, or both.

OBSESSIONS. Recurrent, persistent ideas, thoughts, images, or impulses that are ego-dystonic, that is, they are not experienced as voluntarily produced, but rather as ideas that invade consciousness.

Obsessions are characteristic of Obsessive Compulsive Disorder and may also be seen in Schizophrenia.

ORIENTATION. Awareness of where one is in relation to time, place, and person.

OVERVALUED IDEA. An unreasonable and sustained belief or idea that is maintained with less than delusional intensity. It differs from an obsessional thought in that the person holding the overvalued idea does not recognize its absurdity and thus does not struggle against it. As with a delusion, the idea or belief is not one that is ordinarily accepted by other members of the person's culture or subculture.

Example: A patient with a long-standing hand-washing compulsion thought there might be danger in shaking hands with people, because they might have recently been inoculated against smallpox and be infectious. Although she acknowledged that the danger might not be real, she could not accept reassurances that there was medically no danger.

PANIC ATTACKS. Discrete periods of sudden onset of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom. During the attacks there are such symptoms as dyspnea, palpitations, chest pain or discomfort, choking or smothering sensations, and fear of going crazy or losing control.

Panic attacks are characteristic of Panic Disorder, but may also occur in Somatization Disorder, Major Depression and Schizophrenia.

PARANOID IDEATION. Ideation, of less than delusional proportions, involving suspiciousness or the belief that one is being harassed, persecuted, or unfairly treated. In some instances the term is used when the clinician is unsure of whether the disturbances are actually delusional. Ideas of reference often involve paranoid ideation.

PERSEVERATION. Persistent repetition of words, ideas, or subjects so that, once an individual begins speaking about a particular subject or uses a particular word, it continually recurs. Perseveration differs from the repetitive use of "stock words" or interjections such as "you know" or "like."

Examples: "I think I'll put on my hat, my hat, my hat, my hat." Interviewer: "Tell me what you are like, what kind of person you are." Subject:

"I'm from Marshalltown, Iowa. That's 60 miles northwest, northeast of Des Moines, Iowa. And I'm married at the present time. I'm 36 years old. My wife is 35. She lives in Garwin, Iowa. That's 15 miles southeast of Marshalltown, Iowa. I'm getting a divorce at the present time. And I am at present in a mental institution in Iowa City, Iowa, which is 100 miles southeast of Marshalltown, Iowa."

Perseveration is most commonly seen in Organic Mental Disorders, Schizophrenia, and other psychotic disorders.

PERSONALITY. Deeply ingrained patterns of behavior, which include the way one relates to, perceives, and thinks about the environment and oneself. Personality *traits* are prominent aspects of personality, and do not imply pathology. Personality *disorder* implies inflexible and maladaptive patterns of sufficient severity to cause either significant impairment in adaptive functioning or subjective distress.

PHOBIA. A persistent, irrational fear of a specific object, activity, or situation that results in a compelling desire to avoid the dreaded object, activity, or situation (the phobic stimulus). More commonly, the individual does actually avoid the feared situation or object, though he or she recognizes that the fear is unreasonable and unwarranted by the actual dangerousness of the object, activity, or situation. Some individuals with a phobia claim that their avoidance is rational because they anticipate overwhelming anxiety or some other strong emotion that is out of their control; they do not claim, however, that their anxiety is rationally justified.

POVERTY OF CONTENT OF SPEECH. Speech that is adequate in amount but conveys little information because of vagueness, empty repetitions, or use of stereotyped or obscure phrases. The interviewer may observe that the individual has spoken at some length but has not given adequate information to answer a question. Alternatively, the individual may provide enough information to answer the question, but require many words to do so, so that his or her lengthy reply can be summarized in a sentence or two. The term poverty of content of speech is generally not used when the speech is, for the most part, not understandable (incoherence).

Example: Interviewer: "OK. Why is it, do you think, that people believe in God?" Patient: "Well, first of all because, He is the person that, is their personal savior. He walks with me and talks with me. And uh, the understanding that I have, a lot of peoples, they don't really know their own personal self. Because they ain't, they all, just don't know their own personal self. They don't, know that He uh, seemed like to me, a lot of em don't understand that He walks and talks with them. And uh, show 'em their way to go. I understand also that, every man and every lady, is just not pointed in the same direction. Some are pointed different. They go in their different ways. The way that Jesus Christ wanted 'em to go. Myself, I am pointed in the ways of uh, knowing right from wrong, and doing it. I can't do any more, or not less, than that."

POVERTY OF SPEECH. Restriction in the amount of speech, so that spontaneous speech and replies to questions are brief and unelaborated. When the condition is marked, replies may be monosyllabic, and some questions may be unanswered.

Poverty of speech occurs frequently in Schizophrenia, major depressive episodes, and Organic Mental Disorders, such as Dementia.

PRESSURE OF SPEECH. Speech that is increased in amount, accelerated, and difficult or impossible to interrupt. Usually it is also loud and emphatic. Frequently, the individual talks without any social stimulation and may continue to talk even though no one is listening.

Pressure of speech is most often seen in manic episodes, but may also occur in some cases of Organic Mental Disorders, Major Depression with psychomotor agitation, Schizophrenia, other psychotic disorders, and, occasionally, acute reactions to stress.

PRODROMAL. Early signs or symptoms of a disorder.

PSEUDODEMENTIA. Clinical features resembling a Dementia that are not due to organic brain dysfunction or disease. Pseudodementia may occur in a major depressive episode or may be seen in Factitious Disorder with Psychological Symptoms.

PSYCHOMOTOR AGITATION. Excessive motor activity associated with a feeling of inner tension; the activity is usually nonproductive and repetitious. When the agitation is severe, it may be accompanied by shouting or loud complaining. The term should be used in a technical sense to refer only to states of tension or restlessness that are accompanied by observable excessive motor activity. Examples: Inability to sit still, pacing, wringing of hands, pulling at clothes.

PSYCHOMOTOR RETARDATION. Visible generalized slowing down of physical reactions, movements, and speech.

PSYCHOTIC. A term indicating gross impairment in reality testing. It may be used to describe the behavior of an individual at a given time, or a mental disorder in which at some time during its course all individuals with the disorder have grossly impaired reality testing. When there is gross impairment in reality testing, the individual incorrectly evaluates the accuracy of his or her perceptions and thoughts and makes incorrect inferences about external reality, even in the face of contrary evidence. The term psychotic does not apply to minor distortions of reality that involve matters of relative judgment. For example, a depressed person who underestimated his achievements would not be described as psychotic, whereas one who believed he had caused a natural catastrophe would be so described.

Direct evidence of psychotic behavior is the presence of either delusions or hallucinations without insight into their pathological nature. The term psychotic is sometimes appropriate when an individual's behavior is so grossly disorga-

nized that a reasonable inference can be made that reality testing is disturbed. Examples include markedly incoherent speech without apparent awareness by the person that the speech is not understandable, and the agitated, inattentive, and disoriented behavior seen in Alcohol Withdrawal Delirium.

In DSM-II the term psychotic was applied to individuals whose "mental functioning [was] sufficiently impaired to interfere grossly with their capacity to meet the ordinary demands of life," whether or not there was impaired reality testing. This definition of psychotic did not conform to common usage, which generally limited use of the term to impairment in reality testing, as does the DSM-III definition. As a result, the value of the term for communication was diminished, since it was then unclear whether or not an individual described as being psychotic had gross impairment in reality testing. It should also be noted that an individual with a nonpsychotic mental disorder may exhibit psychotic behavior, though rarely. For example, an individual with Obsessive Compulsive Disorder may at times come to believe in the reality of the danger of being contaminated by shaking hands with strangers.

In DSM-III the psychotic disorders include Pervasive Developmental Disorders, Schizophrenic and Paranoid Disorders, Psychotic Disorders Not Elsewhere Classified, some Organic Mental Disorders, and some Affective Disorders.

RESIDUAL. The phase of an illness that occurs after remission of the florid symptoms or the full syndrome. Examples: The residual states of Infantile Autism, Attention Deficit Disorder, and Schizophrenia.

SIGN. An objective manifestation of a pathological condition. Signs are observed by the examiner rather than reported by the individual.

SYMPTOM. A manifestation of a pathological condition. Although in some uses of the term it is limited to subjective complaints, in common use "symptom" includes objective signs of pathological conditions as well.

SYNDROME. A grouping of symptoms that occur together and that constitute a recognizable condition. The term "syndrome" is less specific than "disorder" or "disease." The term "disease" generally implies a specific etiology or pathophysiological process. In DSM-III most of the disorders are, in fact, syndromes.

Appendix C

Annotated Comparative Listing of DSM-II and DSM-III*

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Appendix C:
Annotated Comparative Listing of DSM-II and DSM-III*

This section lists all of the specific categories included in the previous manual (DSM-II) and the specific DSM-III categories that are equivalent to or subsumed by them. Because of the greater precision with which the DSM-III categories are described and because the diagnostic concepts have often been modified, the degree of equivalence varies. (For example, in DSM-III the category of Schizophrenia is more restrictive than the DSM-II category.) Whenever a category in one manual corresponds to several categories in the other, the latter categories are enclosed by one brace. In some instances, several categories from one manual are equivalent to several categories from the other manual. In such cases, a double brace is used.

This text should not be used as a conversion between DSM-II and ICD-9-CM. In a number of instances, the conceptual reclassification of disorders is unique to DSM-III and does not conform to the classification of these disorders in ICD-9-CM. When these departures occur, the DSM-III titles have been asterisked.

When a DSM-II category is listed without a corresponding DSM-III category, it indicates that the DSM-II category was not included in DSM-III. Likewise, when a DSM-III category is listed with no corresponding DSM-II category, it indicates that the DSM-III diagnostic concept was not included in DSM-II.

Included in the table are comments that attempt to explain the reasons for major changes in the DSM-II classification, terminology, or definitions of the categories. References are cited when the reason for a change is based on evidence cited in the literature or when the article referred to provides a fuller discussion of the rationale for the change.

The DSM-II classification follows, in order to assist the reader in locating specific categories, since the diagnostic categories are listed in the order in which they appear in DSM-II.

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* Prepared by Robert L. Spitzer, M.D., Steven E. Hyler, M.D., and Janet B.W. Williams, M.S.W.

DSM-II	DSM-III
I Mental Retardation	**Mental Retardation**

Since the large majority of persons with borderline intellectual functioning (IQ=71-84) do not have significant impairment in adaptive behavior, this range of intellectual functioning is no longer included within Mental Retardation (1). DSM-III includes Borderline Intellectual Functioning as a V code for Conditions Not Attributable to a Mental

DSM-II		DSM-III	
Disorder because of the frequent need to attend to this condition when planning treatment (2).			
310.x	**Borderline mental retardation**	**V62.89**	**Borderline intellectual functioning (included as a Condition not attributable to a mental disorder)**
311.x	**Mild mental retardation**	**317.00**	**Mild mental retardation**
312.x	**Moderate mental retardation**	**318.00**	**Moderate mental retardation**
313.x	**Severe mental retardation**	**318.10**	**Severe mental retardation**
314.x	**Profound mental retardation**	**318.20**	**Profound mental retardation**
315.x	**Unspecified mental retardation**	**319.00**	**Unspecified mental retardation**

In DSM-II the fourth digit was used to note associated physical conditions. In DSM-III, the multiaxial system permits a more specific designation of associated physical conditions, noted on Axis III.

II	Organic Brain Syndromes	Organic Mental Disorders

The introduction to the Organic Brain Syndromes section of DSM-II implied the concept of a *single* organic brain syndrome with a limited number of manifestations. They were divided into the Psychoses and the Non-psychotic Organic Brain Syndromes. Because psychosis was defined in terms of "severity of functional impairment" and the "capacity to meet the ordinary demands of life," the psychotic-nonpsychotic distinction was difficult to make. Within the psychotic Organic Brain Syndromes, DSM-II retained the DSM-I distinction of acute vs. chronic brain syndrome. This distinction was based on the potential reversibility of the syndrome and not on course of the illness, as the terms "acute" and "chronic" are ordinarily used. This approach had many limitations; for example, it discouraged recognition of the possible reversibility of seemingly "chronic" brain syndromes, such as "reversible dementia" (3, 4, 5).

The DSM-III approach recognizes nine different organic brain syndromes: intoxication, withdrawal, delirium, dementia, amnestic syndrome, delusional syndrome, hallucinosis, affective syndrome, and personality syndrome. When the etiological factor is either associated with aging or is substance-induced, the etiological factor together with the specific organic brain syndrome constitutes the DSM-III Organic Mental Disorder. When there is some other etiology (e.g., pneumonia) or the etiology or pathophysiological process is unknown, the organic brain syndrome from Section 2 of the Organic Mental Disorders section of DSM-III is noted on Axis I and the specific physical disorder, if known, is noted on Axis III.

In DSM-II the category of "Drug Intoxication (other than alcohol)" did not allow for identifying the class of drug, or the more specific brain syndrome.

The DSM-II categories that have equivalent specific DSM-III categories are presented below.

The large number of specific DSM-III Organic Mental Disorders that have no direct DSM-II equivalents are not listed in this table.

290	**Senile and presenile dementia**	**290.xx**	**Dementias arising in the senium and presenium**
290.0	**Senile dementia**	**290.xx**	**Primary degenerative dementia, senile onset**
290.1	**Presenile dementia**	**290.1x**	**Primary degenerative dementia, presenile onset**

Fourth and fifth digits in DSM-III are used to code complications of delirium, delusional features or depressive features.

DSM-II		DSM-III	
291	**Alcoholic psychosis**		
291.0	**Delirium tremens**	**291.00**	**Alcohol withdrawal delirium**
291.1	**Korsakov's psychosis, alcoholic**	**291.10**	**Alcohol amnestic disorder**
291.2	**Other alcoholic hallucinosis**	**291.30**	**Alcohol hallucinosis**
291.3	**Alcohol paranoid state**	**303.9x**	**Alcohol Dependence* and a Paranoid Disorder***

Because there is no compelling evidence that a paranoid state due to chronic alcohol use is a distinct entity, DSM-III does not include a category for alcohol paranoid state.

291.4	**Acute alcohol intoxication**	**303.00**	**Alcohol intoxication***
291.5	**Alcoholic deterioration**	**291.2x**	**Dementia associated with alcoholism**

There is no compelling evidence that alcohol itself is the causative factor in Dementia in individuals with chronic Alcohol Dependence. For this reason, the ICD-9 term "Alcohol Dementia" is avoided since it implies that alcohol is known to be the causative factor (6).

291.6	**Pathological intoxication**	**291.40**	**Alcohol idiosyncratic intoxication**

The DSM-III term is more precise than the DSM-II term.

293.0	**Psychosis with cerebral arteriosclerosis**	**290.4x**	**Multi-infarct dementia**

There is evidence that the dementia is related to the presence of multiple infarcts rather than the degree of cerebral arteriosclerosis (7, 8).

294.4	**Psychosis with childbirth**	**298.90**	**Atypical psychosis***

As with DSM-II, the DSM-III category is to be used only when no other psychotic disorder can be diagnosed. There is no compelling evidence that post-partum psychosis is a distinct entity.

II B. Non-psychotic Organic Brain Syndromes

309.13	**Non-psychotic organic brain syndrome with alcohol (simple drunkenness)**	**303.00**	**Alcohol intoxication***
309.30	**Non-psychotic organic brain syndrome with circulatory disturbance**	**290.4x**	**Multi-infarct dementia***
309.60	**Non-psychotic organic brain syndrome with senile or presenile brain disease**	**290.xx**	**Primary degenerative dementia, senile onset**
		290.1x	**Primary degenerative dementia, presenile onset**

III B. Psychoses Not Attributed to Physical Conditions Listed Previously

DSM-III does not use "psychotic" as a fundamental basis for classifying the non-organic mental disorders in order to avoid classifying the Major Affective Disorders as psychotic, since such disorders usually do not have psychotic features.

Schizophrenia ..... **Schizophrenic Disorders**

The DSM-III concept is more restrictive in order to identify a group that is more homogeneous in regard to differential response to somatic therapy, presence of a familial pattern, a tendency toward onset in early adult life, recurrence, and severe functional impairment (9, 10).

DSM-II	DSM-III

In DSM-II, two of the subtypes were defined by course, and the remaining subtypes were defined only by symptomatology. In DSM-III, the fourth digit is used to characterize symptomatology of the current episode, and the fifth digit is used to code the course of the illness as subchronic, chronic, subchronic with acute exacerbation, chronic with acute exacerbation, or in remission.

295.0 Schizophrenia, simple type ..... **301.22 Schizotypal personality disorder***

The DSM-III concept of Schizophrenia requires the presence of psychotic features at some time during the illness. Furthermore, the validity of the category of Simple Schizophrenia has been questioned (11, 12). The closest approximation is Schizotypal Personality Disorder.

295.1 Schizophrenia, hebephrenic type .... **295.1x Schizophrenia, disorganized type**

The term "hebephrenic" in this country has included only cases with regressive and silly behavior whereas the more common meaning has emphasized the disorganized aspect of the behavior (13).

295.2 Schizophrenia, catatonic type
295.23 Schizophrenia, catatonic type, excited
295.24 Schizophrenia, catatonic type, withdrawn
.... **295.2x Schizophrenia, catatonic type**
296.4x Bipolar disorder, manic*

Because of changes in the concepts of Schizophrenia and Affective Disorders, some cases of the DSM-II category of catatonic type will be diagnosed as having an Affective Disorder in DSM-III (14).

295.3 Schizophrenia, paranoid type ..... **295.3x Schizophrenia, paranoid type**

295.4 Acute schizophrenic episode .....
295.40 Schizophreniform disorder
298.80 Brief reactive psychosis*
295.70 Schizoaffective disorder*

The DSM-III category of Schizophrenia requires a duration of six months (including prodromal and residual phases), as this criterion defines a group that is more homogeneous with regard to familial pattern and course (15, 16, 17).

295.5 Schizophrenia, latent type .....
301.22 Schizotypal personality disorder
301.83 Borderline personality disorder

The criteria for Schizotypal Personality Disorder were developed to identify a group of individuals clinically diagnosed as having Borderline Schizophrenia, a term included with the DSM-II category (18). However, this category is not included with the DSM-III category of Schizophrenia, since the category requires psychotic features at some time during the illness. Some individuals diagnosed as having Schizophrenia, Latent Type, in DSM-II may meet the criteria for Borderline Personality Disorder in DSM-III, instead of, or in addition to, Schizotypal Personality Disorder (18).

295.6 Schizophrenia, residual type
295.7 Schizophrenia, schizo-affective type
295.73 Schizophrenia, schizo-affective type, excited
295.74 Schizophrenia, schizo-affective type, depressed

295.6x Schizophrenia, residual type
296.x4 Major affective disorder (depressed or manic) with psychotic features*
296.40 Schizophreniform disorder
298.80 Brief reactive psychosis*
295.xx Schizophrenia with superimposed Atypical affective disorder*
295.70 Schizoaffective disorder

DSM-II **DSM-III**

DSM-III acknowledges that certain bizarre psychotic symptoms are not incompatible with otherwise fully validated Affective Disorder (19). The other DSM-III categories are included here because of the heterogeneous nature of individuals previously classified as having Schizo-affective Schizophrenia (20, 21). In DSM-III Schizoaffective Disorder is a residual category, not included in Schizophrenia, and is to be used when there is uncertainty about the differential diagnosis between an Affective Disorder and either Schizophrenia, Schizophreniform Disorder, or Paranoid Disorder.

295.8 Schizophrenia, childhood type ..... **299.0x Infantile autism**
299.9x Childhood onset pervasive developmental disorder

When children or adolescents have an illness that meets the criteria for Schizophrenia in DSM-III that diagnosis is given. There is evidence that the syndrome of Infantile Autism has little relationship to the psychotic disorders of adult life, particularly adult onset Schizophrenia (22). The relationship between the DSM-III category of Childhood Onset Pervasive Developmental Disorder and the psychotic disorders of adult life is unclear (23, 24, 25). The criteria for this disorder describe children who have been described by some clinicians as Childhood Schizophrenia, Childhood Psychosis, Atypical Children, and Symbiotic Psychosis. It is likely that some children with this disorder will indeed develop Schizophrenia as adults. However, there is currently no way of predicting which children will develop Schizophrenia as adults.

295.9 Schizophrenia, chronic undifferentiated type ..... **295.9x Schizophrenia, undifferentiated type**

Major Affective Disorders ..... **Major Affective Disorders**

In DSM-II Major Affective Disorders were included within the Non-organic Psychoses, and Affective Disorders that seemed to be "related directly to a precipitating life experience" were excluded. In contrast, the DSM-III category of Affective Disorders groups all the Affective Disorders together, regardless of the presence or absence of psychotic features or association with precipitating life experiences.

The DSM-III classification recognizes the heterogeneous nature of a major depressive episode (26) and uses the term melancholia to designate the subtype that tends to be more severe, associated with a constellation of characteristic symptoms, and is apparently particularly responsive to somatic therapy (27).

296.0 Involutional melancholia ..... **296.23 Major depression, single episode with melancholia or 296.24 with psychotic features**

There is no compelling evidence that depression occurring in the involutional period is distinct from depression occurring at other stages of life (28).

296.1 Manic-depressive illness, manic type **296.4x Bipolar disorder, manic***

Since virtually all individuals with manic episodes eventually develop depressive episodes, most investigators now conceptualize manic episodes as being subsumed under Bipolar Disorder (29). Therefore, in DSM-III, the diagnosis of Bipolar Disorder is made when there is a manic episode, whether or not there has been a depressive episode.

296.2 Manic-depressive illness, depressed type ..... **Major depression**
296.2x single episode
296.3x recurrent

DSM-II		DSM-III	
296.3	**Manic-depressive illness, circular type**	**Bipolar disorder**	
296.33	**manic**	**296.4x**	**manic**
296.34	**depressed**	**296.5x**	**depressed**
		296.6x	**mixed**

The DSM-II classification implied the unity of manic-depressive illness. DSM-III accepts the evidence pointing to the importance of the distinction between unipolar and bipolar forms of Affective Disorder (30, 31).

Paranoid States	**Paranoid Disorders**
297.0 Paranoia	**297.10 Paranoia**
297.1 Involutional paranoid state	**297.10 Paranoia***
	297.90 Atypical paranoid disorder*

There is no compelling evidence that a Paranoid Disorder occurring in the involutional period is distinct from Paranoid Disorders occurring in other periods of life (32).

297.30 Shared paranoid disorder

This category is the traditional category of Folie à deux. The justification for its inclusion in DSM-III, despite its rarity, rests on the distinct clinical picture and the treatment implications (33, 34).

298.30 Acute paranoid disorder

This category permits the identification of the most common form of Paranoid Disorder which is of acute onset and of brief duration (32).

298.0 Psychotic depressive reaction	**296.24 Major depression, single episode, with psychotic features,* with coding of severity of psychosocial stressor on Axis IV**

There is no compelling evidence that once a Major Depression has developed, its course and response to treatment are affected by whether or not its onset was associated with a stressor.

IV Neuroses

In DSM-II disorders in which the "chief characteristic" was anxiety, whether "felt and expressed directly" or "controlled unconsciously and automatically by conversion, displacement and various other psychological mechanisms" were grouped together as Neuroses. In contrast, in DSM-III the disorders in which anxiety is experienced directly are grouped together in the class of Anxiety Disorders. The other DSM-II neuroses are distributed among other classes, each defined by shared symptoms or other descriptive characteristics. So that one can identify the categories that in DSM-II were grouped together in the class of Neuroses, the DSM-II terms are included separately in parentheses after the corresponding DSM-III categories. (See DSM-III classification.)

300.0 Anxiety neurosis	**300.01 Panic disorder**
	300.02 Generalized anxiety disorder

There is compelling evidence that Panic Disorder, as a distinct entity, has differential treatment response as compared with other disorders in which anxiety is prominent (35, 36).

DSM-II **DSM-III**

300.13 Hysterical neurosis

In DSM-III, the concept and the term "hysteria" have been avoided. Instead, the multiple meanings of the term have been included within new categories, such as Somatoform Disorders and Dissociative Disorders (37).

300.1 Hysterical neurosis, conversion type — **300.11 Conversion disorder**; **307.80 Psychogenic pain disorder***

This latter DSM-III category permits the identification of individuals whose predominant complaint is pain, apparently of psychogenic origin (38).

300.14 Hysterical neurosis, dissociative type — **300.12 Psychogenic amnesia**; **300.13 Psychogenic fugue**; **300.14 Multiple personality**; **307.46 Sleepwalking disorder* (in the childhood section)**

In DSM-III, the four disorders included in the DSM-II description are defined as separate disorders because of differing clinical pictures, predisposing factors, and course (39, 40). The first three disorders are included within the Dissociative Disorders. Sleepwalking Disorder is listed in the section Disorders Usually First Evident in Infancy, Childhood or Adolescence and is defined as a disturbance of a particular stage of sleep (41, 42).

Phobic disorders

300.2 Phobic neurosis — **300.21 Agoraphobia with panic attacks**; **300.22 Agoraphobia without panic attacks**; **300.23 Social phobia**; **300.29 Simple phobia**; **309.21 Separation anxiety disorder* (in the childhood section)**

DSM-III subdivides phobias into separate categories because of differing clinical pictures, ages at onset, and differential treatment responses (43). Even though Separation Anxiety Disorder is a form of Phobia, because it characteristically begins in infancy or childhood, and rarely persists into adulthood, it is classified in the section "Disorders Usually First Evident in Infancy, Childhood or Adolescence" (44, 45).

300.3 Obsessive compulsive neurosis — **300.30 Obsessive compulsive disorder**

300.4 Depressive neurosis — **Major depression**; **296.22 single episode, without melancholia**; **296.32 recurrent, without melancholia**; **300.40 Dysthymic disorder**; **309.00 Adjustment disorder with depressed mood**

The DSM-II category was defined merely as "an excessive reaction of depression due to an internal conflict or to an identifiable event . . ." For this reason, it was applied to a heterogeneous group of conditions (46). The three major conditions to which it was applied have each been defined descriptively without reference to etiology. When an "identifiable event" is judged to have contributed to the development of the illness, this factor can be noted on Axis IV.

300.5 Neurasthenic neurosis

This DSM-II category was rarely used.

DSM-II	DSM-III
300.6 Depersonalization neurosis	**300.60 Depersonalization disorder**

The DSM-III category is included within the class of Dissociative Disorders, even though this is controversial, because the feeling of one's own reality, a component of identity, is lost (47).

300.7 Hypochondriacal neurosis	**300.70 Hypochondriasis**

Hypochondriasis is included within the class of Somatoform Disorders because of the presentation of symptoms suggestive of physical disorder.

300.81 Somatization disorder

This disorder has been described in the literature as either "Hysteria" or "Briquet's Syndrome" and validity data have been gathered in a series of studies (48).

Post-traumatic stress disorder

308.30 acute
309.81 chronic or delayed

This DSM-III category used to be referred to as Traumatic Neurosis (49). Its subdivision into acute and chronic forms is justified by longitudinal studies showing differential outcomes for the two forms (50, 51, 52).

V Personality Disorders	**Personality Disorders**

Personality Disorders in DSM-III are coded on Axis II in order to insure that they are not overlooked when attention is directed to the usually more florid Axis I disorder.

DSM-III recognizes the distinction between personality traits and personality disorders. For this reason, the term "disorder" appears in the diagnostic term. Although prominent personality traits may be noted on Axis II, they are not given code numbers since they do not represent mental disorders.

301.0 Paranoid personality	**301.00 Paranoid personality disorder**
301.1 Cyclothymic personality	**301.13 Cyclothymic disorder**

Cyclothymic disorder is included in DSM-III within the Affective Disorders rather than the Personality Disorders, because of evidence that it is related to Bipolar Disorder (53).

301.2 Schizoid personality	**301.22 Schizotypal personality disorder** **301.20 Schizoid personality disorder** **301.82 Avoidant personality disorder***

The DSM-II category included "shyness, over-sensitivity, seclusiveness, avoidance of close or competitive relationships, and often eccentricity." In DSM-III Schizotypal Personality Disorder describes individuals with the eccentric features referred to in the DSM-II description.

The criteria for Schizotypal Personality Disorder were developed to identify individuals who had been described as having Borderline Schizophrenia (18). There is evidence that Chronic Schizophrenia is more common among family members of individuals who were described as having Borderline Schizophrenia than in the general population (54). The distinction between the DSM-III categories of Schizoid and Avoidant Personality Disorders is based on whether or not there is a defect in the motivation and capacity for emotional involvement (55). It is expected that this descriptive distinction will have therapeutic and prognostic implications.

DSM-II **DSM-III**

301.3 Explosive personality ..... **312.34 Intermittent explosive disorder***

Because the explosive behavior is, by definition, in contrast to the individual's usual behavior, the disorder in DSM-III is not classified among the personality disorders.

301.4 Obsessive compulsive personality .... **301.40 Compulsive personality disorder**

The DSM-III label omits the term "obsessive" in order to avoid confusion with Obsessive Compulsive Disorder.

301.5 Hysterical personality ..... **301.50 Histrionic personality disorder**

The term "hysterical" has many irrelevant historical connotations and suggests a relationship to conversion symptoms (56, 57). The essential feature of this disorder, as described in both DSM-II and DSM-III, is the histrionic pattern of behavior.

301.6 Asthenic personality

This DSM-II category was rarely used.

301.7 Antisocial personality ..... **301.70 Antisocial personality disorder**

The DSM-III description and criteria are based on longitudinal studies of children whose antisocial behavior persisted into adult life (58).

301.81 Passive-aggressive personality ..... **301.84 Passive-aggressive personality disorder**

301.82 Inadequate personality

This DSM-II category was defined primarily in terms of functional impairment, rather than a distinctive behavior pattern.

301.81 Narcissistic personality disorder

In recent years considerable attention has been given to narcissistic disturbances in personality in the psychoanalytic literature (59, 60).

301.83 Borderline personality disorder

This category identifies a constellation of relatively enduring personality features of instability and vulnerability believed to have important treatment and outcome implications (61). The criteria for this category are supported by the results of a factor analytic study of symptom data of patients clinically designated as having a borderline condition and are consistent with the literature describing borderline conditions (18). Some of these individuals were diagnosed as having Schizophrenia, latent type, in DSM-II.

301.60 Dependent personality disorder

This category is roughly equivalent to the DSM-I category of Passive aggressive personality, dependent type.

Sexual Deviations ..... **Paraphilias**

The term "paraphilias" is preferable to "sexual deviations" in that it correctly emphasizes that the deviation (para) is in that to which the individual is attracted (philia).

DSM-II	DSM-III
302.0 Homosexuality (replaced in 1973 with Sexual orientation disturbance)	**302.00 Ego-dystonic homosexuality (included in Other Psychosexual Disorders)**

Whether or not homosexuality per se should be classified as a mental disorder has been the focus of considerable controversy (62). In December 1973, the Board of Trustees of the American Psychiatric Association voted to eliminate homosexuality per se as a mental disorder and to substitute a new category, Sexual Orientation Disturbance, reserved for those homosexuals who are "disturbed by, in conflict with, or wish to change their sexual orientation." This change appeared in the seventh and subsequent printings of DSM-II.

The removal of homosexuality per se from DSM-II was supported by the following rationale: The crucial issue in determining whether or not homosexuality per se should be regarded as a mental disorder is not the etiology of the condition, but its consequences and the definition of mental disorder (63). A significant proportion of homosexuals are apparently satisfied with their sexual orientation, show no significant signs of manifest psychopathology (unless homosexuality, by itself, is considered psychopathology), and are able to function socially and occupationally with no impairment (64, 65, 66, 67). If one uses the criteria of *distress* or *disability*, homosexuality per se is not a mental disorder. If one uses the criterion of *inherent disadvantage*, it is not at all clear that homosexuality is a disadvantage in all cultures or subcultures (68, 69).

In DSM-III, the category of Ego-dystonic Homosexuality is a modification of the DSM-II category of Sexual Orientation Disturbance. The change in terminology was made to make it clear that the category is limited to individuals with a homosexual arousal pattern. Changes in the definition of the category emphasize the impairment in heterosexual functioning. Ego-dystonic Homosexuality is not included as a Paraphilia in DSM-III, in contrast to the inclusion of both Homosexuality and Sexual Orientation Disturbance in DSM-II as Sexual Deviations, because in DSM-III the Paraphilias are limited to conditions that are associated with (1) preference for the use of a nonhuman object for sexual arousal, (2) repetitive sexual activity with humans involving real or simulated suffering or humiliation, or (3) repetitive sexual activity with nonconsenting or inappropriate partners. In contrast, the DSM-II category of Sexual Deviations also included those "Individuals whose sexual interests are directed primarily toward objects other than people of the opposite sex."

302.1	**Fetishism**	**302.81**	**Fetishism**
302.2	**Pedophilia**	**302.20**	**Pedophilia**
302.3	**Transvestism**	**302.30**	**Transvestism**
302.4	**Exhibitionism**	**302.40**	**Exhibitionism**
302.5	**Voyeurism**	**302.82**	**Voyeurism**
302.6	**Sadism**	**302.84**	**Sexual sadism**
302.7	**Masochism**	**302.83**	**Sexual masochism**

The DSM-III terms for the last two categories above avoid any confusion with nonsexual meanings of these terms.

302.10 Zoophilia (70)

Gender Identity Disorders

302.5x Transsexualism (71, 72)
302.60 Gender identity disorder of childhood (73)

DSM-II	DSM-III
	Psychosexual Dysfunctions
	302.71 Inhibited sexual desire
	302.72 Inhibited sexual excitement
	302.73 Inhibited female orgasm
	302.74 Inhibited male orgasm
	302.75 Premature ejaculation
	302.76 Functional dyspareunia
	306.51 Functional vaginismus

DSM-II listed, as examples of Psychophysiologic Genito-urinary Disorder, both Dyspareunia and Impotence, whose DSM-III equivalents are Functional Dyspareunia and Inhibited Sexual Excitement (in a male). The justification for including the other specific Psychosexual Dysfunctions rests on their clinical importance and differential treatments (74, 75).

Alcoholism	**Alcohol Abuse and Dependence (included within Substance Use Disorders)**

In DSM-III, the equivalent categories are included within the Substance Use Disorders to emphasize the fact that the effects of the maladaptive use of alcohol are similar to the effects of the maladaptive use of other substances of potential abuse and dependence.

303.0	**Episodic excessive drinking**	**305.02**	**Alcohol abuse, episodic***
303.1	**Habitual excessive drinking**	**305.01**	**Alcohol abuse, continuous***
303.2	**Alcohol addiction**	**303.9x**	**Alcohol dependence**

In DSM-III, for each Substance Use Disorder, the course of the illness may be noted in the fifth digit as continuous, episodic, or in remission.

Drug Dependence	**Substance Use Disorders**

The DSM-II Drug Dependence category included what in DSM-III is referred to as Substance Abuse and Substance Dependence. In DSM-II, the term "dependence" included both psychological dependence and physiological dependence. In DSM-III, dependence is used only in the physiological sense and requires evidence of either tolerance or withdrawal. The DSM-II Drug Dependence category specifically excluded alcohol (coded separately) and tobacco, whereas these substances are both included within the DSM-III Substance Use Disorders.

304.0	**Drug dependence, opium, opium alkaloids and their derivatives**	**305.5x**	**Opioid abuse**
304.1	**Drug dependence, synthetic analgesics with morphine-like effects**	**304.0x**	**Opioid dependence**
304.2	**Drug dependence, barbiturates**	**305.4x**	**Barbiturate or similarly acting sedative or hypnotic abuse**
304.3	**Drug dependence, other hypnotics and sedatives or "tranquilizers"**	**304.1x**	**Barbiturate or similarly acting sedative or hypnotic dependence**
304.4	**Drug dependence, cocaine**	**305.6x**	**Cocaine abuse**
304.5	**Drug dependence, Cannabis sativa (hashish, marihuana)**	**305.2x**	**Cannabis abuse**
		304.3x	**Cannabis dependence**

The existence and significance of tolerance or withdrawal with regular heavy use of cannabis (Cannabis Dependence) is controversial (76, 77).

DSM-II	DSM-III
304.6 Drug dependence, other psychostimulants (amphetamines, etc.)	**305.7x Amphetamine or similarly acting sympathomimetic abuse** **304.4x Amphetamine or similarly acting sympathomimetic dependence**
304.7 Drug dependence, hallucinogens	**305.3x Hallucinogen abuse**

No withdrawal syndrome from hallucinogens has ever been described.

305.9x Phencyclidine (PCP) or similarly acting arylcyclohexylamine abuse

This relatively new substance of abuse is distinguished from hallucinogens, despite some similarities in their effects (78).

305.1x Tobacco dependence

The justification for the inclusion of Tobacco Dependence in DSM-III (as it is in the Ninth Revision of the International Classification of Diseases) rests on the serious medical complications of long-term use (79, 80, 81). It could be argued that the absence of both an intoxication state and the kinds of social complications associated with other substances of dependence speak for classifying Tobacco Dependence as a physical disorder, not a mental disorder. However, the behavioral manifestations of the dependence (inability to control use) and the withdrawal syndrome are by no means inconsequential. Furthermore, by tradition, substance dependence is classified as a mental disorder.

304.7x Dependence on combination of opioid and other non-alcoholic substance

304.8x Dependence on combination of substances, excluding opioids and alcohol

These two categories are necessary to indicate poly-substance use when it is not possible to identify all the specific substances involved.

VI Psychophysiologic Disorders ..... **316.00 Psychological Factors Affecting Physical Condition***

The DSM-II approach to the classification of so-called "psychophysiologic" or "psychosomatic disorders" had several practical and theoretical shortcomings. The categories of psychophysiologic disorders were rarely used. The choice between a psychophysiological diagnosis and an "organic" diagnosis tended to be made idiosyncratically. The DSM-II approach did not encourage collaboration between psychiatrists and other medical specialists. The theoretical basis for the category perpetuated a simplistic, unicausational concept about disease etiology. The DSM-III approach attempts to overcome these shortcomings by the use of the multiaxial system. When the clinician judges that a psychological factor is associated with either the initiation or exacerbation of a physical condition or disorder, the category of Psychological Factors Affecting Physical Condition is noted on Axis I. The physical condition or disorder is noted on Axis III. The limitations of the DSM-II approach and the potential advantages of this approach are discussed more fully elsewhere (82, 83).

VII Special Symptoms

This section of DSM-II was intended for "discrete, specific symptoms" as distinguished

DSM-II **DSM-III**

from mental disorders. The names of the symptoms were listed with no descriptions. In DSM-III most of these "symptoms" are included as mental disorders because of their syndromal nature (e.g., Anorexia Nervosa), or because they represent a distinct clinical pattern (e.g., Functional Enuresis).

306.0 Speech disturbance ..... **307.00 Stuttering**

The only speech disturbance included in DSM-III is Stuttering. Other speech disturbances are unlikely to come to the attention of a mental health professional.

Specific Developmental Disorders

306.1 Specific learning disturbance .....
- **315.00 Developmental reading disorder**
- **315.10 Developmental arithmetic disorder**
- **315.31 Developmental language disorder**
- **315.39 Developmental articulation disorder**
- **315.50 Mixed specific developmental disorder**

The DSM-III term, Specific Developmental Disorders, indicates that these disorders are characterized by specific delays in development. Because of differential treatment implications they are divided according to the predominant area of functioning that is impaired (84, 85, 86, 87, 88). They are coded on Axis II in order to insure that they are considered when the individual has a more florid Axis I disorder.

Stereotyped movement disorders

306.2 Tic .....
- **307.21 Transient tic disorder**
- **307.22 Chronic motor tic disorder**
- **307.23 Tourette's disorder**

The three major forms of Tic Disorders are described separately because of differing clinical pictures, courses, and treatment implications (89).

306.4 Disorders of sleep .....
- **307.46* Sleepwalking disorder**
- **307.46* Sleep terror disorder**

Of the many disorders of sleep, DSM-III includes only these two because of their marked behavioral manifestations, because of the frequency with which they come to the attention of a mental health professional, and because, by tradition, they are thought of as mental disorders (41, 90, 91). (A new classification of Sleep and Arousal Disorders appears in Appendix E.)

Eating disorders

306.5 Feeding disturbance .....
- **307.10 Anorexia nervosa**
- **307.51 Bulimia**
- **307.52 Pica**
- **307.53 Rumination disorder of infancy**

The Eating Disorders are described separately because of differing clinical pictures, courses, and treatment implications (92).

306.6 Enuresis ..... **307.60 Functional enuresis**
306.7 Encopresis ..... **307.70 Functional encopresis**

The DSM-III terms emphasize the exclusion of known physical etiology.

* Not an error. The same code is used to maintain compatibility with ICD-9-CM.

DSM-II **DSM-III**

306.80 Cephalalgia

It is not clear what was included within this DSM-II category.

VIII Transient Situational Disturbances . . . . Adjustment Disorder

The DSM-II category was "reserved for more or less transient disorders of any severity (including those of psychotic proportions) that occur in individuals without any apparent underlying mental disorders . . ."

The DSM-III category of Adjustment Disorder excludes reactions of psychotic proportion since they are adequately classified elsewhere. Adjustment Disorder can be given as an additional diagnosis to an individual with an underlying disorder, e.g., a Personality Disorder, since there is evidence that individuals with Personality Disorders are particularly vulnerable to stress (93).

The DSM-II classification of Transient Situational Disturbances by developmental stage, infancy to late life, offered no information about the manifestations of the disturbance that would be of importance in planning treatment. For this reason, in DSM-III Adjustment Disorder is subtyped by predominant symptomatology.

307.0 Adjustment reaction of infancy
307.1 Adjustment reaction of childhood
307.2 Adjustment reaction of adolescence
307.3 Adjustment reaction of adult life
307.4 Adjustment reaction of late life

309.00 with depressed mood
309.24 with anxious mood
309.28 with mixed emotional features
309.30 with disturbance of conduct
309.40 with mixed disturbance of emotions and conduct
309.23 with work (or academic) inhibition
309.83 with withdrawal

IX Behavior Disorders of Childhood and Adolescence — **Disorders Usually First Evident in Infancy, Childhood, or Adolescence**

The DSM-II category was limited to a small number of categories appropriate only for children or adolescents. They were conceptualized as midway between Transient Situational Disturbances, on one hand, and Psychoses, Neuroses and Personality Disorders, on the other hand, in terms of stability and resistance to treatment. In contrast, the DSM-III section includes a large number of diagnoses of varying degrees of severity and stability. Furthermore, when appropriate, some of the diagnoses may be given to adults.

308.0 Hyperkinetic reaction of childhood (or adolescence) . . . . . 314.01 Attention deficit disorder, with hyperactivity

The DSM-III term is used to reflect the observation that attentional dfficulties are prominent and virtually always present in hyperkinetic children. Alternative terms for this disorder, such as Minimal Brain Dysfunction, are based on unproven assumptions (94, 95).

308.1 Withdrawing reaction of childhood (or adolescence) . . . . .

313.21 Avoidant disorder of childhood or adolescence
313.22 Schizoid disorder of childhood or adolescence

DSM-II	DSM-III

The distinction between Avoidant and Schizoid Disorders of Childhood or Adolescence is based on whether or not there is a defect in the motivation and capacity for emotional involvement. It is expected that this descriptive distinction will have therapeutic and prognostic implications.

308.2 Overanxious reaction of childhood (or adolescence)	**313.00 Overanxious disorder**
308.3 Runaway reaction of childhood (or adolescence)	**312.10 Conduct disorder, undersocialized, nonaggressive**
308.4 Unsocialized aggressive reaction of childhood (or adolescence)	**312.00 Conduct disorder, undersocialized, aggressive**
308.5 Group delinquent reaction of childhood (or adolescence)	**312.23 Conduct disorder, socialized, aggressive** **312.21 Conduct disorder, socialized, nonaggressive**

In DSM-III the category of Conduct Disorder includes cases in which there is a repetitive and persistent pattern of aggressive or non-aggressive conduct in which either the rights of others or major age-appropriate societal norms or rules are violated. The subdivision of Conduct Disorder is controversial. There is evidence that the frequency and the variety of childhood antisocial behaviors are predictive of adult antisocial behavior (96, 97, 98). At the same time, there is evidence that the presence or the absence of adequate social attachments (socialization) in children with antisocial behavior has prognostic significance (99, 100). The DSM-III approach divides Conduct Disorder into four subtypes. The justification for the aggressive-nonaggressive distinction rests on an obvious difference in clinical picture, with management considerations. The socialized-undersocialized dichotomy is likely to have treatment implications, even if the prognostic implications are still unclear.

314.00 Attention deficit disorder, without hyperactivity

It is clinically recognized that some children with attentional difficulties have never had concomitant hyperactivity (101).

314.80 Attention deficit disorder, residual type

There is evidence that some individuals who, as children, had Attention Deficit Disorder with Hyperactivity, in adolescence or adulthood no longer have hyperactivity, although they continue to have attentional difficulties (102, 103).

313.89 Reactive attachment disorder of infancy

This category has been described in the literature under a variety of names, including "failure to thrive without organic basis" (104, 105).

313.23 Elective mutism

This is a well-recognized syndrome (106, 107).

313.81 Oppositional disorder

This category was included as a Personality Disorder in a classification of disorders in childhood proposed by the Group for the Advancement of Psychiatry (108). It is

DSM-II **DSM-III**

included in DSM-III in modified form and is to be distinguished from Passive-Aggressive Personality Disorder and from Conduct Disorder, Socialized, Nonaggressive.

313.82 Identity disorder

There is a large literature on identity problems in adolescence (109, 110). This category is to be distinguished from the DSM-III category of Borderline Personality Disorder.

Disorders with no corresponding DSM-II categories

Factitious Disorders

300.16 Factitious disorder with psychological symptoms

301.51 Chronic factitious disorder with physical symptoms (Munchausen syndrome)

The prototype of Factitious Disorders, Munchausen Syndrome, has been recognized in the literature (111, 112), as have other factitious illnesses with physical symptoms, such as Factitious Dermatitis (113). Despite the rarity of these disorders, it seems useful to distinguish them as a class of disorders (37).

Disorders of Impulse Control Not Elsewhere Classified

312.31 Pathological gambling
312.32 Kleptomania
312.33 Pyromania
312.35 Isolated explosive disorder

These disorders have been recognized in the literature as having distinct clinical pictures with differing treatment implications and with obvious relevance to forensic issues (114, 115, 116, 117, 118). In DSM-III, this class also includes Intermittent Explosive Disorder, which is roughly equivalent to the DSM-II category of Explosive Personality Disorder, as noted above.

X Conditions Without Manifest Psychiatric Disorder and Non-Specific Conditions

316 Social Maladjustments Without Manifest Psychiatric Disorder ..... **V Codes for Conditions Not Attributable to a Mental Disorder That Are a Focus of Attention or Treatment**

The DSM-II category was limited to "individuals who are psychiatrically normal but who nevertheless have severe enough problems to warrant examination by a psychiatrist." No definition of normality was provided. As the DSM-III name implies, these categories may be given to an individual who has a mental disorder, as long as the condition itself is not attributable to a mental disorder.

316.0	**Marital maladjustment**	**V61.10**	**Marital problem**
316.1	**Social maladjustment**	**V62.89**	**Phase of life problem or other life circumstance problem***
316.2	**Occupational maladjustment**	**V62.20**	**Occupational problem**
316.3	**Dyssocial behavior**	**V71.01**	**Adult antisocial behavior**
		V71.02	**Childhood or adolescent antisocial behavior**
		V65.20	**Malingering**

Malingering (119) has been included because of its obvious relevance to forensic psychiatry.

DSM-II	DSM-III	
	V62.30	Academic problem
	V62.82	Uncomplicated bereavement
	V15.81	Noncompliance with medical treatment
	V61.20	Parent-child problem
	V61.80	Other specified family circumstance
	V62.81	Other interpersonal problem

It seems useful to be able to distinguish these problems from mental disorders. The study of bereavement has made it possible to distinguish it from Major Depression (120, 121).

317 Non-specific conditions	300.90	Unspecified mental disorder (non-psychotic)
	298.90	Atypical psychosis
318 No mental disorder	V71.09	No diagnosis or condition on Axis I
	V71.09	No diagnosis on Axis II
319 Diagnosis deferred	799.90	Diagnosis or condition deferred on Axis I
	799.90	Diagnosis deferred on Axis II

REFERENCES

1. Gross HJ: Manual on Terminology and Classification in Mental Retardation. Baltimore, Garamond/Pridemark Press, 1977, p. 19
2. Gift TE, Strauss JS, Ritzler BA: Failure to detect low IQ in psychiatric assessment. Am J Psychiatry 135:345-349, 1978
3. Lipowski ZJ: Organic brain syndromes: a reformulation. Comprehensive Psychiatry 19:309-322, 1978
4. Seltzer B, Sherwin I: "Organic Brain Syndromes": An empirical study and critical review. Am J Psychiatry 135:13-21, 1978
5. Wells CE: Chronic brain diseases: an overview. Am J Psychiatry 135:1-21, 1978
6. Goodwin DW, Hill SY: Chronic effects of alcohol and other psychoactive drugs on intellect, learning and memory, in Alcohol, Drugs and Brain Damage. Edited by Rankin, JG. Toronto, Addiction Research Foundation, 1975, pp 55-71
7. Fisher CM: Dementia and cerebral vascular disease, in Cerebral Vascular Diseases: Sixth Conference. Edited by Toole JF, Siekert RG, Whisnant JP. New York, Grune & Stratton, 1969, pp 232-236
8. Hachinski VC, Lassen NA, Marshall J: Multi-infarct dementia: a cause of mental deterioration in the elderly. Lancet 2:207-210, 1974
9. Spitzer RL, Andreasen N, Endicott J: Schizophrenia and other psychotic disorders in DSM-III. Schizophrenia Bull 4:489-509, 1978
10. Kendell RE, Brockington IF, Leff JP: Prognostic implications of six alternative definitions of schizophrenia. Arch Gen Psychiatry 36:25-34, 1979
11. Munoz RA, Kulak G, Marten S, et al: Simple and hebephrenic schizophrenia: a follow-up study in Life History Research, in Psychopathology, Volume II. Edited by Roff M, Robins L, Pollack M. Minneapolis, University of Minnesota Press, 1972, pp 228-235
12. Stone AA, Hopkins R, Mahnke MW, et al: Simple schizophrenia: syndrome or shibboleth. Am J Psychiatry 125:61-68, 1968
13. Tsuang M, Winokur G: Criteria for subtyping schizophrenia: clinical differentiation of hebephrenic and paranoid schizophrenia. Arch Gen Psychiatry 31:43-47, 1974
14. Abrams R, Taylor MA: Catatonia: prediction of response to somatic treatments. Am J Psychiatry 134:78-80, 1977
15. Astrup C, Noreik K: Functional Psychoses: Diagnostic and Prognostic Models. Springfield, Ill, Charles C Thomas, 1966
16. Sartorius N, Jablensky A, Shapiro R: Cross cultural differences in the short term prognosis of schizophrenic psychoses. Schizophrenia Bull 4:102-113, 1978
17. Tsuang MT, Dempsey GM, Rauscher F: A study of "atypical schizophrenia". Arch Gen Psychiatry 33:1157-1160, 1976
18. Spitzer RL, Endicott J, Gibbon M: Crossing the border into borderline personality and borderline schizophrenia: the development of criteria. Arch Gen Psychiatry 36:17-24, 1979
19. Pope HG Jr, Lipinski J: Diagnosis in schizophrenia and manic-depressive illness: a reassessment of the specificity of "schizophrenic" symptoms in the light of current research. Arch Gen Psychiatry 35:811-828, 1978
20. Procci WR: Schizo-affective psychosis: fact or fiction?: A survey of the literature. Arch Gen Psychiatry 33:1167-1178, 1976
21. Brockington IF, Leff JP: Schizo-affective psychosis: definitions and incidence. Psychological Med 9:91-99, 1979
22. Rutter M, Schopler E: Autism: A Reappraisal of Concepts and Treatments. New York, Plenum Press, 1978
23. Rutter M: The development of infantile autism. Psychological Med 4:147-163, 1974

REFERENCES

24. Kolvin I, et al: Studies in the childhood psychoses, I-VI. Br J Psychiatry 118: 381-419, 1971
25. Brown J: Follow up of children with atypical development (infantile psychosis). Am J Orthopsychiatry 33:855-861, 1963
26. Nelson JC, Charney DS: Primary affective disorder criteria and the endogenous-reactive distinction. Arch Gen Psychiatry (in press)
27. Bielski RJ, Friedel RO: Prediction of tricyclic antidepressant response: a critical review. Arch Gen Psychiatry 33: 1479-1489, 1976
28. Weissman M: The myth of involutional melancholia. JAMA 242:742-744, 1979
29. Nurnberger J, Roose S, Dunner D, et al: Unipolar mania: a distinct clinical entity? Am J Psychiatry (in press)
30. Winokur G, Clayton P, Reich T: Manic Depressive Illness. St. Louis, CV Mosby Co, 1969
31. Perris C: A study of bipolar (manic depressive) and unipolar recurrent depressive psychosis. Acta Psychiatrica Scand 42 (Suppl):9-188, 1966
32. Retterstol N: Paranoid and Paranoiac Psychosis. Springfield, Ill, Charles C Thomas, 1966
33. Gralnick A: Folie à deux, the psychoses of association: a review of 103 cases and the entire English literature with case presentations, Parts I and II. Psychiatr Q 16:230-263, 491-520, 1942
34. McNeil JN, Verwoerdt A, Peak D: Folie à deux in the aged: review and case report of role reversal. J Am Geriatric Soc 20:316-323, 1972
35. Klein DF, Zitrin CM, Woerner MG: Antidepressants, anxiety, panic and phobia, in Psychopharmacology: A Generation of Progress. Edited by Lipton MA, DiMascio A, Killam KF. New York, Raven Press, 1978, pp 1401-1410
36. Zitrin CM, Klein DF, Woerner MG: Behavior therapy, supportive psychotherapy, imipramine and phobias. Arch Gen Psychiatry 35:307-316, 1978
37. Hyler SE, Spitzer RL: Hysteria split asunder. Am J Psychiatry 135:1500-1504, 1978
38. Sternbach RA: Pain: A Psychophysiological Analysis. New York, Academic Press, 1968
39. Nemiah J: Hysterical neurosis, dissociative type, in Comprehensive Textbook of Psychiatry, 2nd ed, vol I. Edited by Freedman A, Kaplan H, Sadock B. Baltimore, Williams & Wilkins, 1975, pp 1220-1231
40. Ludwig AM, Brandsma JM, Wilbur CB: The objective study of multiple personality. Arch Gen Psychiatry 26:298-310, 1972
41. Jacobson A, Kales JD, Kales A: Clinical and electrophysiological correlates of sleep disorders in children, in Sleep, Physiology and Pathology. Edited by Kales A. Philadelphia, JB Lippincott Co 1969, Chapter 8, pp 109-118
42. Jacobson A, Kales A, Lehmann, et al: Somnambulism: all-night electro encephalographic studies. Science 148: 975-977, 1965
43. Marks I: Fears and Phobias. New York, Academic Press, 1969, p 109
44. Bowlby J: Separation anxiety: a critical review of the literature. J Child Psychology and Psychiatry 1:251-259, 1960
45. Gittelman-Klein R, Klein DF: School phobia: diagnostic considerations in the light of imipramine effects. J Nerv Ment Dis 156:199-215, 1973
46. Klerman GL, Endicott J, Spitzer RL, et al: Neurotic depression: a systematic analysis of multiple criteria and multiple meanings. Am J Psychiatry 136:57-61, 1979
47. Lehmann LS: Depersonalization. Am J Psychiatry 131:1221-1224, 1974
48. Guze S: The validity and significance of the clinical diagnosis of hysteria (Briquet's syndrome). Am J Psychiatry 132: 138-141, 1975
49. Keiser L: The Traumatic Neurosis. Philadelphia, JB Lippincott Co, 1968
50. Kamman GR: Traumatic neurosis, compensation neurosis, or attitudinal pathosis. Arch Neurology and Psychiatry, 65:593-603, 1951
51. Adler A: Neuropsychiatric complications in victims of Boston's Cocoanut

REFERENCES

Grove Disaster. JAMA 123:1098-1101, 1943

52. Adler A: Mental symptoms following head injury: a statistical analysis of 200 cases. Arch Neurology and Psychiatry, 53:34-43, 1945
53. Akiskal HS, Djenderedjian AH, Rosenthal RH, et al: Cyclothymic disorder: validating criteria for inclusion in the bipolar affective group. Am J Psychiatry 134:1227-1233, 1977
54. Rosenthal D, Kety SS: The transmission of schizophrenia. London, Pergamon Press Ltd, 1968
55. Millon T: Modern Psychopathology. Philadelphia, WB Saunders, 1969, pp 223-240
56. Chodoff P, Lyons H: Hysteria, the hysterical personality and "hysterical conversion". Am J Psychiatry 114:734-740, 1958
57. Chodoff P: The diagnosis of hysteria: an overview. Am J Psychiatry 131:1073-1078, 1974
58. Robins L: Deviant children grown up. Huntington, New York, Robert E Kreiger, 1974
59. Kohut H: Analysis of the Self: A Systematic Approach to the Psychoanalytic Treatment of Narcissistic Personality Disorders. New York, International Universities Press, 1971
60. Kernberg O: Borderline Conditions and Pathological Narcissism. New York, J Aronson, 1975
61. Gunderson JG, Singer MT: Defining borderline patients: an overview. Am J Psychiatry 132:1-10, 1975
62. Stoller RJ, Marmor J, Bieber I, et al: A symposium: should homosexuality be in the APA nomenclature? Am J Psychiatry 130:1207-1216, 1973
63. Spitzer RL, Endicott J: Medical and mental disorder: proposed definition and criteria, in Critical Issues in Psychiatric Diagnosis. Edited by Spitzer RL, Klein DF. New York, Raven Press, 1978, pp 15-39
64. Bell AP, Weinberg MS: Homosexualities: A Study of Diversity Among Men and Women. New York, Simon & Schuster, 1978
65. Hooker E: The adjustment of the male overt homosexual, in The Problem of Homosexuality in Modern Society. Edited by Ruitenbeek HM. New York, Dutton, 1963, pp 141-161
66. Siegelman M: Adjustment of homosexual and heterosexual women. Br J Psychiatry 120:477-481, 1972
67. Siegelman M: Adjustment of male homosexuals and heterosexuals. Archives Sexual Behavior, 2:9-25, 1972
68. Ford CS, Beach FA: Patterns of Sexual Behavior. New York, Harper & Row, 1970
69. Davenport W: Sexual patterns and their regulation in a society of the Southwest Pacific, in Sex and Behavior. Edited by Beach FA. New York, John Wiley & Sons, 1965, pp 164-207
70. Shenken LI: Some clinical and psychopathological aspects of bestiality. J Nerv Ment Dis 139:137-142, 1964
71. Benjamin H: The Transsexual Phenomenon. New York, Julian Press Inc, 1966
72. Green R, Money J: Transsexualism and Sex Reassignment. Baltimore, The Johns Hopkins Press, 1969
73. Green R: Sexual Identity Conflict in Children and Adults. New York, Penguin, 1975
74. Masters WH, Johnson VE: Human Sexual Inadequacy. Boston, Little, Brown, 1970
75. Kaplan HS: The New Sex Therapy: Active Treatment of Sexual Dysfunction. New York, Brunner/Mazel, 1974
76. Jones RT, Benowitz N, Bachman J: Clinical studies of cannabis tolerance and dependence. Ann NY Acad Sci V 282:221-239, 1976
77. Petersen RC: Marihuana Research Findings: 1976. NIDA Research Monograph 14. Rockville, Md, US Department of Health, Education, and Welfare, July 1977
78. Petersen RC, Stillman RC: Phencyclidine (PCP) Abuse: An Appraisal. National Institute on Drug Abuse Research Monograph 21. Rockville, Md, US Department of Health, Education, and Welfare, August 1978
79. Report on Smoking and Health. Rockville, Md, US Department of Health, Education, and Welfare, Office of the Surgeon General, 1979

REFERENCES

80. Jaffe JH, Jarvik ME: Tobacco use and tobacco use disorder, in Psychopharmacology, A Generation of Progress. Edited by Lipton MA, DiMascio A, Killam KF. New York, Raven Press, 1978, pp 1665-1676

81. Larson PS, Silvetle H: Tobacco: Experimental and Clinical Studies. Baltimore, Williams & Wilkins Co, 1975

82. Looney JG, Lipp MR, Spitzer RL: A new method of classification for psychophysiologic disorders. Am J Psychiatry 135:304-308, 1978

83. Latimer P: Psychophysiologic disorders: a critical appraisal of concept and theory illustrated with reference to the irritable bowel syndrome (IBS). Psychological Med 9:71-80, 1979

84. Baker L, Cantwell DP: Developmental language disorder, in Comprehensive Textbook of Psychiatry, 3rd ed. Edited by Kaplan H, Freedman A, Sadock B. Baltimore, Williams & Wilkins Co, 1980

85. Baker L, Cantwell DP: Developmental articulation disorder, in Comprehensive Textbook of Psychiatry, 3rd ed. Edited by Kaplan H, Freedman A, Sadock B. Baltimore, Williams & Wilkins Co, 1980

86. Baker L, Cantwell DP: Specific arithmetic disorders, in Comprehensive Textbook of Psychiatry, 3rd ed. Edited by Kaplan H, Freedman A, Sadock B. Baltimore, Williams & Wilkins Co, 1980

87. Rutter M, Yule W: The concept of specific reading retardation. J Child Psychol & Psychiatry 16:181-197, 1975

88. Rutter M, Yule W: Specific Reading Retardation, in The First Review of Special Education. Edited by Mann L, Sabatino D, USA, Buttonwood Farms, 1973

89. Shapiro AK, Shapiro ES, Bruun KD, et al: Gilles de la Tourette Syndrome. New York, Raven Press, 1978

90. Fisher C, Kahn E, Edwards A, et al: A psychophysiological study of nightmares and night terrors, III: mental content and recall of stage 4 night terrors. J Nerv Ment Dis 158:174-188, 1974

91. Fisher C, Kahn E, Edwards E, et al: A psychophysiological study of nightmares and night terrors I. Physiological aspects of stage 4 night terrors. J Nerv Ment Dis 157:75-98, 1973

92. Halmi KA: Anorexia nervosa and eating disorders in Comprehensive Textbook of Psychiatry, 3rd ed. Edited by Kaplan H, Freedman A, Sadock B. Baltimore, Williams & Wilkins Co, 1980

93. Looney JG, Gunderson EKE: Transient situational disturbances: course and outcome. Am J Psychiatry 135:660-663, 1978

94. Cantwell D: The Hyperactive Child: Diagnosis and Management and Current Research. New York, Halstead Press, 1975

95. Cantwell D: Scientific myth of minimal brain damage. Frontiers of Psychiatry, June 1:5-6, 1975

96. Robins L: Sturdy childhood predictors of adult outcomes: replications from longitudinal studies, Psychological Med 8:611-622, 1978

97. Kirkegaard-Sorensen L and Mednick SA: A prospective study of predictors of criminality: 4. school behavior, in Mednick S and Christiansen KO, Biosocial Bases of Criminal Behavior, Halsted Press, New York, 1977, pp 255-266

98. Cloninger CR, Christiansen KO, Reich T, Gottesman II: Implications of sex differences in the prevalence of antisocial personality, alcoholism, and criminality for familial transmission, Arch Gen Psychiatry 35:941-951, 1978

99. Jenkins RL: Behavior Disorders of Childhood and Adolescence. Springfield, Ill, Charles C Thomas, 1973

100. Lewis H: Deprived Children. New York, Oxford University Press, 1954, pp 63-69

101. Wender P: Minimal Brain Dysfunction in Children. New York, John Wiley & Sons, 1971

REFERENCES

102. Weiss G, Minde K, Werry JS, et al: Studies on the hyperactive child, VIII, five year follow-up. Arch Gen Psychiatry 24:409-414, 1971

103. Wood DR, Reimherr FW, Wender PH, et al: Diagnosis and treatment of minimal brain dysfunction in adults. Arch Gen Psychiatry 33:1453-1460, 1976

104. Fischoff J: Failure to thrive, in Handbook of Child Psychiatry. Edited by Noshpitz J. New York, Basic Books (in press)

105. Lozoff B, et al: The mother-newborn relationship: limits of adaptability. J Pediat 91:1-12, 1977

106. Elson A, Pearson C, Jones CD, et al: Follow-up study of childhood elective mutism. Arch Gen Psychiatry 13:182-187, 1965

107. Browne E, Wilson V, Layborne PC: Diagnosis and treatment of elective mutism in children. J Am Acad Child Psychiatry 2:605-617, 1963

108. Group for the Advancement of Psychiatry: (Report #62) Psychopathological Disorders in Childhood. Theoretical Considerations and a Proposed Classification. Formulated by the Committee on Child Psychiatry. New York, GAP, 1966

109. Erikson E: Identity: Youth and Crisis. New York, WW Norton, 1968

110. Lichtenstein H: The Dilemma of Human Identity. New York, J. Aronson, 1977

111. Asher R: The Münchausen syndrome. Lancet 1:339-341, 1951

112. Sussman N, Hyler S: Factitious disorders, in Comprehensive Textbook of Psychiatry, 3rd ed. Edited by Kaplan H, Freedman A, Sadock B. Baltimore, Williams & Wilkins Co, 1980

113. Kingsley HJ: Peculiarities in dermatology: a case of dermatitis artefacta. Central African J Med 13:264, 1967

114. Lesieur HR: The compulsive gambler's spiral of options and involvement. Psychiatry 42:79-87, 1979

115. Bolen DW, Boyd WH: Gambling and the gambler. Arch Gen Psychiatry 18: 617-630, 1968

116. Wihels F: Kleptomania and other psychopathic crimes. J Criminal Psychopath 4:205-216, 1942

117. Lewis NDC, Yarnell H: Pathological firesetting. Monograph No. 82. New York, Nervous and Mental Diseases, 1951

118. Bach-y-Rita G, Lion JR, Climent CE, et al: Episodic dyscontrol, a study of 130 violent patients. Am J Psychiatry 127:1473-1478, 1971

119. Weiss JMA, David D: Malingering and associated syndromes, in American Handbook of Psychiatry, 2nd ed, vol 3. Edited by Arieti S, Caplan G. New York, Basic Books, 1974, pp 270-287

120. Clayton PJ, Halikas JA, Maurice WL: The bereavement of the widowed. Dis Nerv Syst 32: 597-604, 1971

121. Clayton PJ, Herjanic M, Murphy GE, et al: Mourning and depression: their similarities and differences. Can Psychiatr Assoc J 19:309-312, 1974

DSM-II DIAGNOSES and CODES

MENTAL RETARDATION
310. Borderline
311. Mild
312. Moderate
313. Severe
314. Profound
315. Unspecified

With each: Following or associated with
.00 Infection or intoxication
.10 Trauma or physical agent
.20 Disorders of metabolism, growth or nutrition
.30 Gross brain disease (postnatal)
.40 Unknown prenatal influence
.50 Chromosomal abnormality
.60 Prematurity
.70 Major psychiatric disorder
.80 Psycho-social (environmental) deprivation
.90 Other condition

ORGANIC BRAIN SYNDROMES (OBS)
A PSYCHOSES
Senile and pre-senile dementia
290.00 Senile dementia
290.10 Pre-senile dementia

Alcoholic psychosis
291.00 Delirium tremens
291.10 Korsakov's psychosis
291.20 Other alcoholic hallucinosis
291.30 Alcohol paranoid state
291.40 Acute alcohol intoxication
291.50 Alcoholic deterioration
291.60 Pathological intoxication
291.90 Other alcoholic psychosis

Psychosis associated with intracranial infection
292.00 General paralysis
292.10 Syphilis of central nervous system
292.20 Epidemic encephalitis
292.30 Other and unspecified encephalitis
292.90 Other intracranial infection

Psychosis associated with other cerebral condition
293.00 Cerebral arteriosclerosis
293.10 Other cerebrovascular disturbance
293.20 Epilepsy
293.30 Intracranial neoplasm
293.40 Degenerative disease of the CNS
293.50 Brain trauma
293.90 Other cerebral condition

Psychosis associated with other physical condition
294.00 Endocrine disorder
294.10 Metabolic or nutritional disorder
294.20 Systemic infection
294.30 Drug or poison intoxication (other than alcohol)
294.40 Childbirth
294.80 Other and unspecified physical condition

B NON-PSYCHOTIC OBS
309.00 Intracranial infection
309.13 Alcohol (simple drunkenness)
309.14 Other drug, poison, or systemic intoxication
309.20 Brain trauma
309.30 Circulatory disturbance
309.40 Epilepsy
309.50 Disturbance of metabolism, growth or nutrition
309.60 Senile or pre-senile brain disease
309.70 Intracranial neoplasm
309.80 Degenerative disease of the CNS
309.90 Other physical condition

PSYCHOSES NOT ATTRIBUTED TO PHYSICAL CONDITIONS LISTED PREVIOUSLY
Schizophrenia
295.00 Simple
295.10 Hebephrenic
295.20 Catatonic
295.23 Catatonic type, excited
295.24 Catatonic type, withdrawn
295.30 Paranoid
295.40 Acute schizophrenic episode
295.50 Latent
295.60 Residual
295.70 Schizo-affective
295.73 Schizo-affective, excited
295.74 Schizo-affective, depressed
295.80 Childhood
295.90 Chronic undifferentiated
295.99 Other schizophrenic

Major affective disorders
296.00 Involutional melancholia
296.10 Manic-depressive illness, manic
296.20 Manic-depressive illness, depressed
296.30 Manic-depressive illness, circular
296.33 Manic-depressive, circular, manic
296.34 Manic-depressive, circular, depressed
296.80 Other major affective disorder

Paranoid states
297.00 Paranoia
297.10 Involutional paranoid state
297.90 Other paranoid state

Other psychoses
298.00 Psychotic depressive reaction

NEUROSES
300.00 Anxiety
300.10 Hysterical
300.13 Hysterical, conversion type
300.14 Hysterical, dissociative type
300.20 Phobic
300.30 Obsessive compulsive
300.40 Depressive
300.50 Neurasthenic
300.60 Depersonalization
300.70 Hypochondriacal
300.80 Other neurosis

PERSONALITY DISORDERS AND CERTAIN OTHER NON-PSYCHOTIC MENTAL DISORDERS

Personality disorders
301.00 Paranoid
301.10 Cyclothymic
301.20 Schizoid
301.30 Explosive
301.40 Obsessive compulsive
301.50 Hysterical
301.60 Asthenic
301.70 Antisocial
301.81 Passive-aggressive
301.82 Inadequate
301.89 Other specified types

Sexual deviation
302.00 Homosexuality
302.10 Fetishism
302.20 Pedophilia
302.30 Transvestism
302.40 Exhibitionism
302.50 Voyeurism
302.60 Sadism
302.70 Masochism
302.80 Other sexual deviation

Alcoholism
303.00 Episodic excessive drinking
303.10 Habitual excessive drinking
303.20 Alcohol addiction
303.90 Other alcoholism

Drug dependence
304.00 Opium, opium alkaloids and their derivatives
304.10 Synthetic analgesics with morphine-like effects
304.20 Barbiturates
304.30 Other hypnotics and sedatives or "tranquilizers"
304.40 Cocaine
304.50 Cannabis sativa (hashish, marihuana)
304.60 Other psycho-stimulants
304.70 Hallucinogens
304.80 Other drug dependence

PSYCHOPHYSIOLOGIC DISORDERS
305.00 Skin
305.10 Musculoskeletal
305.20 Respiratory
305.30 Cardiovascular
305.40 Hemic and lymphatic
305.50 Gastro-intestinal
305.60 Genito-urinary
305.70 Endocrine
305.80 Organ of special sense
305.90 Other type

SPECIAL SYMPTOMS
306.00 Speech disturbance
306.10 Specific learning disturbance
306.20 Tic
306.30 Other psychomotor disorder
306.40 Disorders of sleep
306.50 Feeding disturbance
306.60 Enuresis
306.70 Encopresis
306.80 Cephalalgia
306.90 Other special symptom

TRANSIENT SITUATIONAL DISTURBANCES

307.00 Adjustment reaction of infancy
307.10 Adjustment reaction of childhood
307.20 Adjustment reaction of adolescence
307.30 Adjustment reaction of adult life
307.40 Adjustment reaction of late life

BEHAVIOR DISORDERS OF CHILDHOOD AND ADOLESCENCE

308.00 Hyperkinetic reaction
308.10 Withdrawing reaction
308.20 Overanxious reaction
308.30 Runaway reaction
308.40 Unsocialized aggressive reaction
308.50 Group delinquent reaction
308.90 Other reaction

CONDITIONS WITHOUT MANIFEST PSYCHIATRIC DISORDER AND NON-SPECIFIC CONDITIONS

Social maladjustment without manifest psychiatric disorder

316.00 Marital maladjustment
316.10 Social maladjustment
316.20 Occupational maladjustment
316.30 Dyssocial behavior
316.90 Other social maladjustment

Non-specific conditions

317.00 Non-specific conditions

No mental disorder

318.00 No mental disorder

NON-DIAGNOSTIC TERMS FOR ADMINISTRATIVE USE

319.00 Diagnosis deferred
319.10 Boarder
319.20 Experiment only
319.90 Other

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Appendix D

Historical Review, and Mental Disorders Sections of ICD-9 and ICD-9-CM

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Appendix D:

Historical Review, and Mental Disorders Sections of ICD-9 and ICD-9-CM

HISTORICAL REVIEW*

This historical review covers the activities of the World Health Organization (WHO) in developing the classification of mental disorders (Section V) of the Ninth Revision of the International Classification of Diseases (ICD-9), and some of the major changes from ICD-8. In addition, the clinical modification of ICD-9 (ICD-9-CM) that was introduced in the United States, and the relationship between it and the DSM-III classification are discussed.

Purposes and Uses of the ICD

The ICD is a statistical classification not only of mental disorders but of diseases and other morbid conditions; complications of pregnancy, childbirth, and the puerperium; congenital abnormalities; causes of perinatal morbidity and mortality; accidents, poisonings, and violence; and symptoms, signs, and ill-defined conditions. Its principal use is in the classification of morbidity and mortality information for statistical purposes, as the unabridged title of the classification makes quite clear: *The International Statistical Classification of Diseases, Injuries, and Causes of Death.*

The ICD has also been adapted for use as a nomenclature of diseases for indexing medical records. The basic purpose of such indexing is to facilitate retrieval of medical records for a variety of purposes (for example, studies of management of patients with specific conditions; follow-up studies of patients with specific diseases who have undergone various operative and therapeutic procedures). Its limitations for these purposes led to the development of the ICD-9-CM in the United States—a subject to be discussed below.

It is essential to keep in mind that the ICD is a statistical classification of diseases, not a nomenclature of diseases. The distinction between these two is important. A nomenclature of diseases is a list or catalogue of approved terms for describing and recording clinical and pathological observations. To serve its full function it must be sufficiently extensive so that any pathological condition can be accurately recorded. As medical science advances, a nomenclature must expand to include the new terms necessary to record new observations. In contrast, a statistical classification indicates the relationship between diagnostic

* Prepared by Morton Kramer, Sc.D.

categories and must be confined to a limited number of categories that encompass the entire range of diseases and morbid conditions.

Organizational Arrangement of ICD-9

The ICD is organized into 17 major sections, each of which is devoted to a specific set of conditions (Table 1). Each of these major sections is subdivided into a defined set of categories, each identified by three digits ranging from 001 to 999. To provide greater detail, each such category is further divided into additional subcategories by a fourth digit (.0 to .9). Table 1 shows the number of three-digit categories allotted to each major section. Only 30 are allotted to mental disorders, so that all mental disorders must be classified within these 30 categories and their fourth-digit subdivisions.

The structure of the classification is such that the axes of classification are not consistent within each of the 17 major sections. In some of these categories (e.g., diseases of the respiratory system) the primary axis is topographical; less frequently it is etiological (e.g., infectious diseases) or situational (e.g., complications of pregnancy). In other sections, still other primary axes are used, reflecting the fact that the ICD provides a pragmatic classification that can be used for a variety of purposes.

There are also two supplementary chapters: one for classification of external causes of injury and poisoning (the E codes), and the other for classification of factors influencing health status and contact with health services (the V codes). Both of these classifications contain items of relevance to agencies and facilities that provide mental health services.

Revisions of the ICD

The ICD is revised regularly, at approximately ten-year intervals. This pattern was initiated with the First Revision Conference of the International List of Causes of Death, held in Paris in 1900. The original classification, as indicated by its title, was used solely for coding causes of death, and did not provide a separate section for the mental disorders until the Fifth Revision of that List (1938). In that Revision, mental disorders were assigned only a single three-digit rubric with four subcategories within the section on Diseases of the Nervous System and Sense Organs: (*a*) mental deficiency; (*b*) schizophrenia; (*c*) manic depressive psychosis; and (*d*) all other mental disorders. The Conference for the Sixth Revision (1948) expanded the classification for use not only for causes of death but also for causes of morbidity. ICD-6 contained the first separate section on mental disorders (Section V). No major revisions were made in that section in ICD-7 (1955).

The international community of psychiatrists expressed considerable dissatisfaction with the classification of mental disorders in ICD-6 and ICD-7; consequently, it was not widely used (Stengel, 1959). As the importance of mental disorders as an international public health problem became more widely

Table 1

Distribution of the 3-Digit Categories of the ICD-9 by the Number of Digits Allocated to Each Category

	Major 3-digit categories	Digits allocated to category	Number of 3-digit categories
I	Infectious and Parasitic Diseases	001-139	139
II	Neoplasms	140-239	100
III	Endocrine, Nutritional, and Metabolic Disorders	240-279	40
IV	Diseases of Blood and Blood-forming Organs	280-289	10
V	Mental Disorders	290-319	30
VI	Diseases of the Nervous System and Sense Organs	320-389	70
VII	Diseases of the Circulatory System	390-459	70
VIII	Diseases of the Respiratory System	460-519	60
IX	Diseases of the Digestive System	520-579	60
X	Diseases of the Genito-urinary System	580-629	50
XI	Complications of Pregnancy, Childbirth, and Puerperium	630-679	50
XII	Diseases of the Skin and Subcutaneous Tissue	680-709	30
XIII	Diseases of the Musculoskeletal System and Connective Tissue	710-739	30
XIV	Congenital Abnormalities	740-759	20
XV	Certain Conditions Originating in the Prenatal Period	760-779	20
XVI	Symptoms, Signs, and Ill-defined Conditions	780-799	20
XVII	Injury and Poisoning	800-999	200
		TOTAL	999

recognized, the need for an internationally acceptable classification of mental disorders became increasingly urgent. Accordingly, the World Health Organization developed an active program for revising the content and form of that classification to reflect new knowledge of the differential characteristics of specific mental disorders and their diagnosis and treatment to meet the increasing needs of health and social agencies, research workers, and users of health statistics for more detailed statistical and epidemiological data on mental disorders. The mental disorders chapter of ICD-8, adopted in 1965, reflected these changes (WHO, 1969).

To achieve more uniform usage of the terms in the mental disorders classification of ICD-8, WHO convened a working group of experts from dif-

ferent countries for the purpose of preparing a *Glossary of Mental Disorders and Guide to Their Classification* for use in conjunction with ICD-8 (WHO, 1974). The main aim of this glossary was:

> to ensure as far as possible that those who apply it will arrive at a uniform use of the principal diagnostic terms current in psychiatry. In addition to helping to minimize the discrepancies among the diagnostic concepts used by psychiatrists in different countries for the statistical reporting of mental illness, use of the Glossary in publications dealing with either clinical work or research will also assist psychiatrists from different countries and schools of thought in understanding each other's work and concepts.

The Ninth Revision of ICD

To develop revision proposals for ICD-9, WHO initiated an intensive program to obtain information on problems encountered by psychiatrists in different countries in the use of the mental disorders section of ICD-8 and to formulate recommendations for their solutions (Shepherd, et al, 1968). This program resulted in the classification of mental disorders that appears in ICD-9, adopted by the World Health Assembly in 1975 (WHO, 1977).

As stated by WHO (1978):

> Changes and new categories in the International Classification of Diseases (ICD-9) have been introduced only for sound reasons and after much consideration. As far as possible, the changes in Chapter V (ICD-9) have been based upon evidence that the new codes function better than the old ones. Some of this evidence, and a large proportion of other changes based upon discussion and consideration of different viewpoints, emanated from the World Health Organization's program on the standardization of psychiatric diagnosis, classification and statistics. A central feature of this program was a series of eight international seminars held annually between 1965 and 1972, each of which focused upon a recognized problem area in psychiatric diagnosis. Psychiatrists from more than 40 countries participated, and the documents and proposals that were used to produce the recommendations for ICD-9 in the eighth and final seminar were seen and commented upon by many more.

The first seven of the seminars focused on the classification of major groups of psychiatric disorders, and the last seminar on program review.

Dr. Jack Ewalt, past President of the American Psychiatric Association, and Dr. Henry Brill, former Chairman of the APA Task Force on Nomenclature and Statistics, played active roles in these seminars and in the development of the final classification of mental disorders of ICD-9. Other members of the Association who participated in and made important contributions to the recommendations developed in several of the seminars included: Dr. Leon Eisenberg (disorders of childhood) and Drs. George Tarjan, Julius Richmond, and J. Wortis (mental retardation) (WHO, 1970, 1971, 1972, 1973).

Place	Year	Subject
London	1965	Functional psychoses, with emphasis on schizophrenia
Oslo	1966	Borderline psychosis, reactive psychosis
Paris	1967	Psychiatric disorders of childhood
Moscow	1968	Mental disorders of old age
Washington, DC	1969	Mental retardation
Basle	1970	Neurotic and psychosomatic disorders
Tokyo	1971	Personality disorders and drug addiction
Geneva	1972	Summary, conclusions, recommendations, and proposals for further research

WHO Glossary of Mental Disorders

A major innovation of the mental disorders section of ICD-9 is the incorporation of a glossary as an integral part of that section. It is the only section of ICD-9 that contains such a glossary. The reason for this, as stated by WHO, is as follows (WHO, 1977a):

> This section of the Classification differs from the others in that it includes a glossary, prepared after consultation with experts from many different countries, defining the contents of the rubrics. This difference is considered to be justified because of the special problems posed for psychiatrists by the relative lack of independent laboratory information upon which to base their diagnoses. The diagnosis of many of the most important mental disorders still relies largely upon descriptions of abnormal experience and behaviour, and without some guidance in the form of a glossary that can serve as a common frame of reference, psychiatric communications easily became unsatisfactory at both clinical and statistical levels.
>
> Many well-known terms have different meanings in current use, and it is important for the user to use the glossary descriptions and not merely the category titles when searching for the best fit for the condition he is trying to code. This is particularly important if a separate national glossary also exists.

Differences between the Mental Disorders Sections of ICD-8 and ICD-9

Table 2 provides a comparison of the three-digit categories of mental disorders in ICD-8 and ICD-9.

Table 2
Comparison of ICD-8 and ICD-9 3-Digit Categories of Mental Disorders

ICD-8	ICD-9
PSYCHOSES (290-299)	ORGANIC PSYCHOTIC CONDITIONS (290-294)
290 Senile and presenile dementia	290 Senile and presenile organic psychotic conditions
291 Alcoholic psychosis	291 Alcoholic psychoses
292 Psychosis associated with intracranial infection	292 Drug psychoses
293 Psychosis associated with other cerebral condition	293 Transient organic psychotic conditions
294 Psychosis associated with other physical condition	294 Other organic psychotic conditions (chronic)
295 Schizophrenia	OTHER PSYCHOSES (295-299)
296 Affective psychoses	295 Schizophrenic psychoses
297 Paranoid states	296 Affective psychoses
298 Other psychoses	297 Paranoid states
299 Unspecified psychosis	298 Other nonorganic psychoses
	*299 Psychoses with origin specific to childhood
NEUROSES, PERSONALITY DISORDERS AND OTHER NONPSYCHOTIC MENTAL DISORDERS (300-309)	NEUROTIC DISORDERS, PERSONALITY DISORDERS AND OTHER NONPSYCHOTIC MENTAL DISORDERS (300-316)
300 Neuroses	300 Neurotic disorders
301 Personality disorders	301 Personality disorders
302 Sexual deviations	302 Sexual deviations and disorders
303 Alcoholism	303 Alcohol dependence syndrome
304 Drug dependence	304 Drug dependence
305 Physical disorders of presumably psychogenic origin	*305 Nondependent abuse of drugs
306 Special symptoms not elsewhere classified	306 Physiological malfunction arising from mental factors
307 Transient situational disturbances	307 Special symptoms or syndromes not elsewhere classified
308 Behavior disorders of childhood	*308 Acute reaction to stress
309 Mental disorders not specified as psychotic associated with physical conditions	*309 Adjustment reaction
	310 Specific nonpsychotic mental disorders following organic brain damage
	*311 Depressive disorder, not elsewhere classified
	*312 Disturbance of conduct not elsewhere classified
	*313 Disturbance of emotions specific to childhood and adolescence
MENTAL RETARDATION (310-315)	*314 Hyperkinetic syndrome of childhood
310 Borderline mental retardation	*315 Specific delays in development
311 Mild mental retardation	*316 Psychic factors associated with diseases classified elsewhere
312 Moderate mental retardation	MENTAL RETARDATION (317-319)
313 Severe mental retardation	317 Mild mental retardation
314 Profound mental retardation	318 Other specified mental retardation
315 Unspecified mental retardation	319 Unspecified mental retardation

Adapted from: World Health Organization (1978) **Mental Disorders: Glossary and Guide to Their Classification in Accordance with the Ninth Revision of the International Classification of Diseases,** Geneva, WHO, 1978.

* New categories in ICD-9 that were not in ICD-8

The classification of the following disorders was thoroughly recast in ICD-9:

Disorder	ICD-9 Codes
Affective psychoses	296
Organic mental disorders	290, 293, 294
Acute reaction to stress	308
Adjustment reaction	309
Specific nonpsychotic mental disorder following organic brain damage	310
Disturbance of conduct, not elsewhere classified	312
Disturbance of emotions specific to childhood and adolescence	313
Hyperkinetic syndrome of childhood	314
Specific delays in development	315
Alcohol disorders	291, 303, 305
Drug disorders	292, 304, 305

Several new three-digit categories were also added:

299 Psychoses with origin specific to childhood
305 Nondependent abuse of drugs
308 Acute reaction to stress
309 Adjustment reaction
311 Depressive disorder, not elsewhere classified
312 Disturbance of conduct, not elsewhere classified
313 Disturbance of emotions specific to childhood and adolescence
314 Hyperkinetic syndrome of childhood
315 Specific delays in development
316 Psychic factors associated with diseases classified elsewhere

Elimination of Combination Categories from ICD-9

ICD-9 also differs from ICD-8 in that it does not include so-called "combination categories," for coding combined mental and physical disorders such as organic mental disorders and mental retardation. To illustrate, in certain instances an ICD-8 category designated a mental disorder associated with a specific physical condition (e.g., psychosis with cerebral arteriosclerosis); in other instances, the category consisted of a specified mental condition and a general class of associated physical disorders (e.g., moderate mental retardation following infections and intoxications). "Combination categories" such as these have been eliminated from ICD-9 and replaced by categories that require coding on two independent axes. Thus, a psychotic condition arising from a physical disorder would be classified by using two code numbers: one for the mental disorder, and one for the underlying physical disorder. The following are categories in which multiple coding is necessary:

Disorder	ICD-9 Codes
Senile and presenile organic psychotic conditions	290
Transient organic psychotic conditions	293
Other organic psychotic conditions (chronic)	294
Specific nonpsychotic mental disorder following organic brain damage	310
Physiological malfunction arising from mental factors	306
Psychic factors associated with diseases classified elsewhere	316
Mental retardation	317 — 319

The use of the second code will require the clinician to familiarize himself or herself with all of the sections of the ICD and its alphabetical index (WHO, 1977a,b). This index assists in locating the code number for the associated condition.

Multiaxial Classification

The concept of a multiaxial classification system for mental disorders was first proposed at the WHO seminar on the mental disorders of childhood, in Paris in 1967 (Rutter et al., 1969). The condition of the child was to be recorded on three axes: clinical syndrome, intellectual level, and etiologic factors. Two years later, during the seminar in Washington on the problems of classification of mental retardation, another axis was suggested for coding associated social and cultural factors (Tarjan et al., 1972).

WHO has initiated a number of international studies to obtain empirical data about the usefulness of the multiaxial classification. In one of these, carried out in the United Kingdom and involving a large number of child psychiatrists, a series of patients were assessed using both the triaxial approach and the ICD. Case histories were also used to assess the agreement between psychiatrists using these two classificatory systems. The results of this study clearly demonstrated that a multiaxial classification system can be used, and that it provides more and better data about the patients seen and assessed (Rutter et al., 1975). This study has now been expanded, and psychiatrists from several European countries are participating. Similar studies are about to begin in other countries. Some of these are concerned with the classification of disorders in old age, and others with the classification of mental disorders in criminals.

Other Details of ICD-9

The interested reader will find more details on the development of the ICD-9 Classification of Mental Disorders and its content in *Mental Disorders: Glossary and Guide to Their Classification in accordance with the Ninth Revision of the ICD* (WHO, 1978), and a review of other highlights in a paper by Kramer et al. (1979).

International Classification of Diseases, Clinical Modification (ICD-9-CM)

As stated earlier, the ICD is primarily a classification of diseases for use in coding morbidity and mortality data for statistical purposes, and it has been adapted for use in clinical situations for the indexing of hospital records by disease and procedure (H-ICD-A). However, in the United States, clinicians and others responsible for the care of patients found they needed a classification with more specificity than that provided by ICD-9. Accordingly, the National Center for Health Statistics convened during 1977 a steering committee to advise the Council on Clinical Classifications on how to modify ICD-9 to satisfy this need. This Council was sponsored by the following organizations: American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, American Psychiatric Association, and Commission on Professional and Hospital Activities. The task forces on classification of these organizations provided clinical guidance and technical input to the development of ICD-9-CM, the *Clinical Modification of the World Health Organization's International Classification of Diseases, 9th Revision*. As stated in the introduction to ICD-9-CM (1978):

> The term 'clinical' is used to emphasize the modification's intent: to serve as a useful tool in the area of classification of morbidity data for indexing of medical records, medical care review, and ambulatory and other medical care programs, as well as for basic health statistics. To describe the clinical picture of the patient, the codes must be more precise than those needed only for statistical groupings and trends analysis.

ICD-9-CM is compatible with its parent system, ICD-9, thus meeting the need for comparability of morbidity and mortality statistics at the international level. This was accomplished by: (*a*) keeping the contents and the sequence of the three-digit rubrics of ICD-9 unchanged; (*b*) not adding new three-digit rubrics to the main body of the classification; (*c*) adding a fifth digit to the existing ICD-9 rubrics; and (*d*) creating a few four-digit codes in existing three-digit rubrics only when the necessary detail could not be accommodated by the use of a fifth-digit subclassification.

As of the time when WHO had essentially completed its work on ICD-9, the American Psychiatric Association's Task Force on Nomenclature and Statistics was still in the midst of preparing the third edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-III). As a result, it was not possible to have revised diagnostic terms submitted in time for inclusion in ICD-9. However, the Chair of this APA Task Force was invited by the Council on Clinical Classifications to submit for inclusion in ICD-9-CM, those DSM-III terms not included in ICD-9. After ICD-9-CM went into effect on 1 January 1979, further changes were made in the still evolving DSM-III classification. All of the terms in the final DSM-III classification are either included in the ICD-9-CM volume itself or published as addenda to the ICD-9-CM in issues of

Medical Record News as recommended terms or inclusion terms (acceptable as alternative terms).*

The classification of affective psychoses in ICD-9-CM (code 296) departs considerably from that in ICD-9. It is important for the users of this category to be aware of the fact that, in some instances, the same four-digit code numbers refer to different conditions in ICD-9 and ICD-9-CM. For example, the code 296.2 in ICD-9 is "Manic depressive psychoses, circular type but currently manic," whereas in ICD-9-CM, the same code is used for "Major Depressive Disorder, Single Episode."

It should also be noted that following the practice of ICD-9, "combination codes" are not included in ICD-9-CM. Therefore, it is important for clinicians and others using ICD-9-CM to become acquainted with codes for other diseases and other conditions that are to be entered on Axis III of the DSM-III classification (for Physical Disorders and Conditions).

Summary

The International Classification of Diseases (ICD) is an essential tool for the collection and dissemination of comparable mortality and morbidity data throughout the world. Mental disorders have been assigned an increasingly prominent place in the ICD; and the proposals for their classification in the 9th Revision, which became effective as of 1 January 1979, have been formulated on the basis of an extensive WHO program involving a series of seminars and consultations with leading mental health experts in many countries.

An accompanying glossary and guide to the classification rubrics for the mental disorders were developed for the first time in connection with the 8th Revision. A major innovation in the 9th Revision is the incorporation of the glossary within the text of the section on mental disorders.

The new elements in the ICD-9 section on mental disorders include thoroughly recast rubrics for several categories, including affective disorders and psychiatric conditions specific to childhood. The "combination categories" for coding associations between mental and physical disorders are eliminated and replaced by categories requiring independent coding.

The next revision of the ICD will have to take into account a variety of needs that have emerged since the publication of ICD-9. These include: multiaxial classification methods, classification of disabilities, adaptation of the ICD for use in primary health care, and standardization of medical nomenclature on multilingual bases.

A major development in the United States was the preparation of the ICD-9-CM (Clinical Modification) to provide the additional specificity required by clinicians, research workers, epidemiologists, program planners, medical record librarians, and administrators of inpatient, outpatient, and community programs.

The experiences derived from the use of ICD-9, ICD-9-CM, and DSM-III in the United States will be invaluable for those who will participate in the development of ICD-10.

* Mr. Robert Seeman, Chief Nosologist, Council on Clinical Classifications, provided invaluable consultation that helped achieve compatibility between the DSM-III and ICD-9-CM classifications.

REFERENCES*

World Health Organization: Manual of the International List of Causes of Death, 5th revision, and Manual of Joint Causes of Death, 4th ed. Geneva, WHO, 1939

World Health Organization: Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death, 6th revision, Vol 1. Geneva, WHO, 1948

World Health Organization: Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death, 7th revision, Vol 1. Geneva, WHO, 1955

Stengel, E: Classification of mental disorders. Bull World Health Organization 21:601-603, 1960

World Health Organization: Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death, 8th revision, Vol 1. Geneva, WHO, 1969

World Health Organization: Glossary of Mental Disorders and Guide to Their Classification for Use in Conjunction with the International Classification of Diseases, 8th revision. Geneva, WHO, 1974

Shepherd M, et al: An experimental approach to psychiatric diagnosis: an international study. Acta Psychiat Scand, 44:Suppl 201, 1968

World Health Organization: Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death, 9th revision, Vol 1. Geneva, WHO, 1977

World Health Organization: Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death, 9th revision, Vol 2, (Alphabetical Index). Geneva, WHO, 1977

World Health Organization: Fourth Seminar on Standardization of Psychiatric Diagnosis, Classification, and Statistics. Geneva, WHO, 1970

World Health Organization: Report of the Sixth Seminar of Standardization of Psychiatric Diagnosis, Classification, and Statistics. Geneva, WHO, 1971

World Health Organization: Fifth WHO seminar on the standardization of psychiatric diagnosis, classification and statistics. Am J Psychiatry 128(May Suppl):3-14, 1972

World Health Organization: Report of the eighth seminar on the standardization of psychiatric diagnosis, classification, and statistics. Geneva, WHO, 1973

World Health Organization: Mental Disorders: Glossary and Guide to Their Classification in Accordance with the Ninth Revision of the International Classification of Diseases. Geneva, WHO, 1978

Rutter M, et al: A tri-axial classification of mental disorder in childhood. J Child Psychol & Psychiatry 10:41-61, 1969

Tarjan G, Eisenberg L: Some thoughts on the classification of mental retardation in the United States of America. Am J Psychiatry 128(May suppl):14-18, 1972

Rutter M, et al: A Multi-axial Classification of Child Psychiatric Disorders: An Evaluation of a Proposal. Geneva, World Health Organization, 1975

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

Commission on Professional and Hospital Activities: The International Classification of Diseases, 9th Revision, Clinical Modification. Ann Arbor, Mich., Commission on Professional and Hospital Activities, 1978

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 2nd ed. Washington, D.C., APA, 1968

* A list of published material and reports is available from the World Health Organization upon request.

OFFPRINT OF MENTAL DISORDERS CHAPTER OF ICD-9

From **Mental Disorders: Glossary and Guide to Their Classification in Accordance with the Ninth Revision of the International Classification of Diseases,** World Health Organization, Geneva, 1978

This section of the Classification differs from the others in that it includes a glossary, prepared after consultation with experts from many different countries, defining the content of the rubrics. This difference is considered to be justified because of the special problems posed for psychiatrists by the relative lack of independent laboratory information upon which to base their diagnoses. The diagnosis of many of the most important mental disorders still relies largely upon descriptions of abnormal experience and behaviour, and without some guidance in the form of a glossary that can serve as a common frame of reference, psychiatric communications easily become unsatisfactory at both clinical and statistical levels.

Many well-known terms have different meanings in current use, and it is important for the user to use the glossary descriptions and not merely the category titles when searching for the best fit for the condition he is trying to code. This is particularly important if a separate national glossary also exists.

The instructions "Use additional code to identify . . ." are important because of the nature of many psychiatric conditions in which two or more codes are necessary to describe the condition and the associated or causal factors. It should be used whenever possible.

In cases where no other information is available except that a mental disorder is present, the code V40.9 (unspecified mental or behavioural problems) can be used.

Psychoses (290-299)

Mental disorders in which impairment of mental function has developed to a degree that interferes grossly with insight, ability to meet some ordinary demands of life or to maintain adequate contact with reality. It is not an exact or well defined term. Mental retardation is excluded.

Organic psychotic conditions (290-294)

Syndromes in which there is impairment of orientation, memory, comprehension, calculation, learning capacity and judgement. These are the essential features but there may also be shallowness or lability of affect, or a more persistent disturbance of mood, lowering of ethical standards and exaggeration or emergence of personality traits, and diminished capacity for independent decision.

Psychoses of the types classifiable to 295-298 and without the above features are excluded even though they may be associated with organic conditions.

The term *'dementia'* in this glossary includes organic psychoses as just specified, of a chronic or progressive nature, which if untreated are usually irreversible and terminal.

The term *'delirium'* in this glossary includes organic psychoses with a short course in which the above features are overshadowed by clouded consciousness, confusion, disorientation, delusions, illusions and often vivid hallucinations.

Includes: psychotic organic brain syndrome

Excludes: nonpsychotic syndromes of organic aetiology (see 310.–)
psychoses classifiable to 295-298 and without the above features but associated with physical disease, injury or condition affecting the brain [e.g., following childbirth]; code to 295-298 and use additional code to identify the associated physical condition

290 Senile and presenile organic psychotic conditions

Excludes: psychoses classifiable to 295-298.8 occurring in the senium without dementia or delirium (295-298)
transient organic psychotic conditions (293.–)
dementia not classified as senile, presenile, or arteriosclerotic (294.1)

290.0 *Senile dementia, simple type*

Dementia occurring usually after the age of 65 in which any cerebral pathology other than that of senile atrophic change can be reasonably excluded.

Excludes: mild memory disturbances, not amounting to dementia, associated with senile brain disease (310.1)
senile dementia:
depressed or paranoid type (290.2)
with confusion and/or delirium (290.3)

290.1 *Presenile dementia*

Dementia occurring usually before the age of 65 in patients with the relatively rare forms of diffuse or lobar cerebral atrophy. Use additional code to identify the associated neurological condition.

Brain syndrome with presenile brain disease
Circumscribed atrophy of the brain
Dementia in:
Alzheimer's disease
Pick's disease of the brain

Excludes: arteriosclerotic dementia (290.4)
dementia associated with other cerebral conditions (294.1)

290.2 *Senile dementia, depressed or paranoid type*

A type of senile dementia characterized by development in advanced old age, progressive in nature, in which a variety of delusions and hallucinations of a persecutory, depressive and somatic content are also present. Disturbance of the sleep/waking cycle and preoccupation with dead people are often particularly prominent.

Senile psychosis NOS

Excludes: senile dementia:
with confusion and/or delirium (290.3)
NOS (290.0)

290.3 *Senile dementia with acute confusional state*

Senile dementia with a superimposed reversible episode of acute confusional state

Excludes: senile:
dementia NOS (290.0)
psychosis NOS (290.2)

290.4 *Arteriosclerotic dementia*

Dementia attributable, because of physical signs [on examination of the central nervous system] to degenerative arterial disease of the brain. Symptoms suggesting a focal lesion in the brain are common. There may be a fluctuating or patchy intellectual defect with insight, and an intermittent course is common. Clinical differentiation from senile or presenile dementia, which may coexist with it, may be very difficult or impossible. Use additional code to identify cerebral atherosclerosis (437.0).

Excludes: suspected cases with no clear evidence of arteriosclerosis (290.9)

290.8 *Other*

290.9 *Unspecified*

291 Alcoholic psychoses

Organic psychotic states due mainly to excessive consumption of alcohol; defects of nutrition are thought to play an important role. In some of these states, withdrawal of alcohol can be of aetiological significance.

Excludes: alcoholism without psychosis (303)

291.0 *Delirium tremens*

Acute or subacute organic psychotic states in alcoholics, characterized by clouded consciousness, disorientation, fear, illusions, delusions, hallucinations of any kind, notably visual and tactile, and restlessness, tremor and sometimes fever.

Alcoholic delirium

291.1 *Korsakov's psychosis, alcoholic*

A syndrome of prominent and lasting reduction of memory span, including striking loss of recent memory, disordered time appreciation and confabulation, occurring in alcoholics as the sequel to an acute alcoholic psychosis [especially delirium tremens] or, more rarely, in the course of chronic alcoholism. It is usually accompanied by peripheral neuritis and may be associated with Wernicke's encephalopathy.

Alcoholic polyneuritic psychosis

Excludes: Korsakov's psychosis:
NOS (294.0)
nonalcoholic (294.0)

291.2 *Other alcoholic dementia*

Nonhallucinatory dementias occurring in association with alcoholism but not characterized by the features of either delirium tremens or Korsakov's psychosis.

Alcoholic dementia NOS
Chronic alcoholic brain syndrome

291.3 *Other alcoholic hallucinosis*

A psychosis usually of less than six months' duration, with slight or no clouding of consciousness and much anxious restlessness in which auditory hallucinations, mostly of voices uttering insults and threats, predominate.

Excludes: schizophrenia (295.–) and paranoid states (297.–) taking the form of chronic hallucinosis with clear consciousness in an alcoholic

291.4 *Pathological drunkenness*

Acute psychotic episodes induced by relatively small amounts of alcohol. These are regarded as individual idiosyncratic reactions to alcohol, not due to excessive consumption and without conspicuous neurological signs of intoxication.

Excludes: simple drunkenness (305.0)

291.5 *Alcoholic jealousy*

Chronic paranoid psychosis characterized by delusional jealously and associated with alcoholism.

Alcoholic paranoia

Excludes: nonalcoholic paranoid states (297.–)
schizophrenia, paranoid type (295.3)

291.8 *Other*

Alcoholic withdrawal syndrome

Excludes: delirium tremens (291.0)

291.9 *Unspecified*

Alcoholic:
  mania NOS
  psychosis NOS
Alcoholism (chronic) with psychosis

292 Drug psychoses

Syndromes that do not fit the descriptions given in 295-298 (nonorganic psychoses) and which are due to consumption of drugs [notably amphetamines, barbiturates and the opiate and LSD groups] and solvents. Some of the syndromes in this group are not as severe as most conditions labelled "psychotic" but they are included here for practical reasons. Use additional E Code to identify the drug and also code drug dependence (304.—) if present.

292.0 *Drug withdrawal syndrome*

States associated with drug withdrawal ranging from severe, as specified for alcohol under 291.0 (delirium tremens) to less severe characterized by one or more symptoms such as convulsions, tremor, anxiety, restlessness, gastrointestinal and muscular complaints, and mild disorientation and memory disturbance.

292.1 *Paranoid and/or hallucinatory states induced by drugs*

States of more than a few days but not usually of more than a few months duration, associated with large or prolonged intake of drugs, notably of the amphetamine and LSD groups. Auditory hallucinations usually predominate, and there may be anxiety and restlessness.

Excludes: the described conditions with confusion or delirium (293.–)
states following LSD or other hallucinogens, lasting only a few days or less ["bad trips"] (305.3)

292.2 *Pathological drug intoxication*

Individual idiosyncratic reactions to comparatively small quantities of a drug, which take the form of acute, brief psychotic states of any type.

Excludes: physiological side-effects of drugs [e.g., dystonias]
expected brief psychotic reactions to hallucinogens ["bad trips"] (305.3)

292.8 *Other*

292.9 *Unspecified*

293 Transient organic psychotic conditions

States characterized by clouded consciousness, confusion, disorientation, illusions and often vivid hallucinations. They are usually due to some intra- or extracerebral toxic, infectious, metabolic or other systemic disturbance and are generally reversible. Depressive and paranoid symptoms may also be present but are not the main feature. Use additional code to identify the associated physical or neurological condition.

Excludes: confusional state or delirium superimposed on senile dementia (290.3)
dementia due to:
alcohol (291.–)
arteriosclerosis (290.4)
senility (290.0)

293.0 *Acute confusional state*

Short-lived states, lasting hours or days, of the above type.

Acute:
delirium
infective psychosis
organic reaction
post-traumatic organic psychosis

Acute:
psycho-organic syndrome
psychosis associated with endocrine, metabolic or cerebrovascular disorder

Epileptic:
confusional state
twilight state

293.1 *Subacute confusional state*

States of the above type in which the symptoms, usually less florid, last for several weeks or longer, during which they may show marked fluctuations in intensity.

Subacute:
- delirium
- infective psychosis
- organic reaction
- post-traumatic organic psychosis

Subacute:
- psycho-organic syndrome
- psychosis associated with endocrine or metabolic disorder

293.8 *Other*

293.9 *Unspecified*

294 Other organic psychotic conditions (chronic)

294.0 *Korsakov's psychosis or syndrome (nonalcoholic)*

Syndromes as described under 291.1 but not due to alcohol.

294.1 *Dementia in conditions classified elsewhere*

Dementia not classifiable as senile, presenile or arteriosclerotic (290.–) but associated with other underlying conditions.

Dementia in:
- cerebral lipidoses
- epilepsy
- general paralysis of the insane
- hepatolenticular degeneration
- Huntington's chorea
- multiple sclerosis
- polyarteritis nodosa

Use additional code to identify the underlying physical condition

294.8 *Other*

States that fulfill the criteria of an organic psychosis but do not take the form of a confusional state (293.–), a nonalcoholic Korsakov's psychosis (294.0) or a dementia (294.1).

Mixed paranoid and affective organic psychotic states

Epileptic psychosis NOS (code also 345.–)

Excludes: mild memory disturbances, not amounting to dementia (310.1)

294.9 *Unspecified*

OTHER PSYCHOSES (295-299)

295 Schizophrenic psychoses

A group of psychoses in which there is a fundamental disturbance of personality, a characteristic distortion of thinking, often a sense of being controlled by alien forces, delusions which may be bizarre, disturbed perception, abnormal affect out of keeping with the real

situation, and autism. Nevertheless, clear consciousness and intellectual capacity are usually maintained. The disturbance of personality involves its most basic functions which give the normal person his feeling of individuality, uniqueness and self-direction. The most intimate thoughts, feelings and acts are often felt to be known to or shared by others and explanatory delusions may develop, to the effect that natural or supernatural forces are at work to influence the schizophrenic person's thoughts and actions in ways that are often bizarre. He may see himself as the pivot of all that happens. Hallucinations, especially of hearing, are common and may comment on the patient or address him. Perception is frequently disturbed in other ways; there may be perplexity, irrelevant features may become all-important and, accompanied by passivity feelings, may lead the patient to believe that everyday objects and situations possess a special, usually sinister, meaning intended for him. In the characteristic schizophrenic disturbance of thinking, peripheral and irrelevant features of a total concept, which are inhibited in normal directed mental activity, are brought to the forefront and utilized in place of the elements relevant and appropriate to the situation. Thus thinking becomes vague, elliptical and obscure, and its expression in speech sometimes incomprehensible. Breaks and interpolations in the flow of consecutive thought are frequent, and the patient may be convinced that his thoughts are being withdrawn by some outside agency. Mood may be shallow, capricious or incongruous. Ambivalence and disturbance of volition may appear as inertia, negativism or stupor. Catatonia may be present. The diagnosis "schizophrenia" should not be made unless there is, or has been evident during the same illness, characteristic disturbance of thought, perception, mood, conduct, or personality—preferably in at least two of these areas. The diagnosis should not be restricted to conditions running a protracted, deteriorating, or chronic course. In addition to making the diagnosis on the criteria just given, effort should be made to specify one of the following subdivisions of schizophrenia, according to the predominant symptoms.

Includes: schizophrenia of the types described in 295.0-295.9 occurring in children

Excludes: childhood type schizophrenia (299.9)
infantile autism (299.0)

295.0 *Simple type*

A psychosis in which there is insidious development of oddities of conduct, inability to meet the demands of society, and decline in total performance. Delusions and hallucinations are not in evidence and the condition is less obviously psychotic than are the hebephrenic, catatonic and paranoid types of schizophrenia. With increasing social impoverishment vagrancy may ensue and the patient becomes self-absorbed, idle and aimless. Because the schizophrenic symptoms are not clear-cut, diagnosis of this form should be made sparingly, if at all.

Schizophrenia simplex

Excludes: latent schizophrenia (295.5)

295.1 *Hebephrenic type*

A form of schizophrenia in which affective changes are prominent, delusions and hallucinations fleeting and fragmentary, behaviour irresponsible and unpredictable and mannerisms common. The mood is shallow and inappropriate, accompanied by giggling or self-satisfied, self-absorbed smiling, or by a lofty manner, grimaces, mannerisms, pranks, hypochondriacal complaints and reiterated phrases. Thought is disorganized. There is a tendency to remain solitary, and behaviour seems empty of purpose and feeling. This form of schizophrenia usually starts between the ages of 15 and 25 years.

Hebephrenia

295.2 *Catatonic type*

Includes as an essential feature prominent psychomotor disturbances often alternating between extremes such as hyperkinesis and stupor, or automatic obedience and negativism. Constrained attitudes may be maintained for long periods: if the patient's limbs are put in some unnatural position they may be held there for some time after the external force has been removed. Severe excitement may be a striking feature of the condition. Depressive or hypomanic concomitants may be present.

Catatonic:	Schizophrenic:
agitation	catalepsy
excitation	catatonia
stupor	flexibilitas cerea

295.3 *Paranoid type*

The form of schizophrenia in which relatively stable delusions, which may be accompanied by hallucinations, dominate the clinical picture. The delusions are frequently of persecution but may take other forms [for example of jealousy, exalted birth, Messianic mission, or bodily change]. Hallucinations and erratic behaviour may occur; in some cases conduct is seriously disturbed from the outset, thought disorder may be gross, and affective flattening with fragmentary delusions and hallucinations may develop.

Paraphrenic schizophrenia

Excludes: paraphrenia, involutional paranoid state (297.2)
paranoia (297.1)

295.4 *Acute schizophrenic episode*

Schizophrenic disorders, other than those listed above, in which there is a dream-like state with slight clouding of consciousness and perplexity. External things, people and events may become charged with personal significance for the patient. There may be ideas of reference and emotional turmoil. In many such cases remission occurs within a few weeks or months, even without treatment.

Oneirophrenia	Schizophreniform:
	attack
	psychosis, confusional type

Excludes: acute forms of schizophrenia of:
catatonic type (295.2)
hebephrenic type (295.1)
paranoid type (295.3)
simple type (295.0)

295.5 *Latent schizophrenia*

It has not been possible to produce a generally acceptable description for this condition. It is not recommended for general use, but a description is provided for those who believe it to be useful: a condition of eccentric or inconsequent behaviour and anomalies of affect which give the impression of schizophrenia though no definite and characteristic schizophrenic anomalies, present or past, have been manifest.

The inclusion terms indicate that this is the best place to classify some other poorly defined varieties of schizophrenia.

Latent schizophrenic reaction
Schizophrenia:
  borderline
  prepsychotic
  prodromal
Schizophrenia:
  pseudoneurotic
  pseudopsychopathic

Excludes: schizoid personality (301.2)

295.6 *Residual schizophrenia*

A chronic form of schizophrenia in which the symptoms that persist from the acute phase have mostly lost their sharpness. Emotional response is blunted and thought disorder, even when gross, does not prevent the accomplishment of routine work.

Chronic undifferentiated schizophrenia
Restzustand (schizophrenic)
Schizophrenic residual state

295.7 *Schizoaffective type*

A psychosis in which pronounced manic or depressive features are intermingled with schizophrenic features and which tends towards remission without permanent defect, but which is prone to recur. The diagnosis should be made only when both the affective and schizophrenic symptoms are pronounced.

Cyclic schizophrenia
Mixed schizophrenic and affective psychosis
Schizoaffective psychosis
Schizophreniform psychosis, affective type

295.8 *Other*

Schizophrenia of specified type not classifiable under 295.0–295.7.

Acute (undifferentiated) schizophrenia
Atypical schizophrenia
Coenesthopathic schizophrenia

Excludes: infantile autism (299.0)

295.9 *Unspecified*

To be used only as a last resort.

Schizophrenia NOS
Schizophrenic reaction NOS
Schizophreniform psychosis NOS

296 Affective psychoses

Mental disorders, usually recurrent, in which there is a severe disturbance of mood [mostly compounded of depression and anxiety but also manifested as elation and excitement] which is accompanied by one or more of the following: delusions, perplexity, disturbed attitude to

self, disorder of perception and behaviour; these are all in keeping with the patient's prevailing mood [as are hallucinations when they occur]. There is a strong tendency to suicide. For practical reasons, mild disorders of mood may also be included here if the symptoms match closely the descriptions given; this applies particularly to mild hypomania.

Excludes: reactive depressive psychosis (298.0)
reactive excitation (298.1)
neurotic depression (300.4)

296.0 *Manic-depressive psychosis, manic type*

Mental disorders characterized by states of elation or excitement out of keeping with the patient's circumstances and varying from enhanced liveliness [hypomania] to violent, almost uncontrollable excitement. Aggression and anger, flight of ideas, distractibility, impaired judgement, and grandiose ideas are common.

Hypomania NOS
Hypomanic psychosis
Mania (monopolar) NOS
Manic disorder
Manic psychosis
Manic-depressive psychosis or reaction:
hypomanic
manic

Excludes: circular type if there was a previous attack of depression (296.2)

296.1 *Manic-depressive psychosis, depressed type*

An affective psychosis in which there is a widespread depressed mood of gloom and wretchedness with some degree of anxiety. There is often reduced activity but there may be restlessness and agitation. There is a marked tendency to recurrence; in a few cases this may be at regular intervals.

Depressive psychosis
Endogenous depression
Involutional melancholia
Manic-depressive reaction, depressed
Monopolar depression
Psychotic depression

Excludes: circular type if previous attack was of manic type (296.3)
depression NOS (311)

296.2 *Manic-depressive psychosis, circular type but currently manic*

An affective psychosis which has appeared in both the depressive and the manic form, either alternating or separated by an interval of normality, but in which the manic form is currently present. [The manic phase is far less frequent than the depressive].

Bipolar disorder, now manic

Excludes: brief compensatory or rebound mood swings (296.8)

296.3 *Manic-depressive psychosis, circular type but currently depressed*

Circular type (see 296.2) in which the depressive form is currently present.

Bipolar disorder, now depressed

Excludes: brief compensatory or rebound mood swings (296.8)

296.4 *Manic-depressive psychosis, circular type, mixed*

An affective psychosis in which both manic and depressive symptoms are present at the same time.

296.5 *Manic-depressive psychosis, circular type, current condition not specified*

Circular type (see 296.2) in which the current condition is not specified as either manic or depressive.

296.6 *Manic-depressive psychosis, other and unspecified*

Use this code for cases where no other information is available, except the unspecified term, manic-depressive psychosis, or for syndromes corresponding to the descriptions of depressed (296.1) or manic (296.0) types but which for other reasons cannot be classified under 296.0-296.5.

Manic-depressive psychosis:
NOS
mixed type

Manic-depressive:
reaction NOS
syndrome NOS

296.8 *Other*

Excludes: psychogenic affective psychoses (298.–)

296.9 *Unspecified*

Affective psychosis NOS
Melancholia NOS

297 Paranoid states

Excludes: acute paranoid reaction (298.3)
alcoholic jealousy (291.5)
paranoid schizophrenia (295.3)

297.0 *Paranoid state, simple*

A psychosis, acute or chronic, not classifiable as schizophrenia or affective psychosis, in which delusions, especially of being influenced, persecuted or treated in some special way, are the main symptoms. The delusions are of a fairly fixed, elaborate and systematized kind.

297.1 *Paranoia*

A rare chronic psychosis in which logically constructed systematized delusions have developed gradually without concomitant hallucinations or the schizophrenic type of disordered thinking. The delusions are mostly of grandeur [the paranoiac prophet or inventor], persecution or somatic abnormality.

Excludes: paranoid personality disorder (301.0)

297.2 *Paraphrenia*

Paranoid psychosis in which there are conspicuous hallucinations, often in several modalities. Affective symptoms and disordered thinking, if present, do not dominate the clinical picture and the personality is well preserved.

Involutional paranoid state
Late paraphrenia

297.3 *Induced psychosis*

Mainly delusional psychosis, usually chronic and often without florid features, which appears to have developed as a result of a close, if not dependent, relationship with another person who already has an established similar psychosis. The delusions are at least partly shared. The rare cases in which several persons are affected should also be included here.

Folie à deux Induced paranoid disorder

297.8 *Other*

Paranoid states which, though in many ways akin to schizophrenic or affective states, cannot readily be classified under any of the preceding rubrics, nor under 298.4.

Paranoia querulans Sensitiver Beziehungswahn

Excludes: senile paranoid state (297.2)

297.9 *Unspecified*

Paranoid:
psychosis NOS
reaction NOS
state NOS

298 Other nonorganic psychoses

Categories 298.0-298.8 should be restricted to the small group of psychotic conditions that are largely or entirely attributable to a recent life experience. They should not be used for the wider range of psychoses in which environmental factors play some [but not the *major*] part in aetiology.

298.0 *Depressive type*

A depressive psychosis which can be similar in its symptoms to manic-depressive psychosis, depressed type (296.1) but is apparently provoked by saddening stress such as a bereavement, or a severe disappointment or frustration. There may be less diurnal variation of symptoms than in 296.1, and the delusions are more often understandable in the context of the life experiences. There is usually a serious disturbance of behaviour, e.g., major suicidal attempt.

Reactive depressive psychosis
Psychogenic depressive psychosis

Excludes: manic-depressive psychosis, depressed type (296.1)
neurotic depression (300.4)

298.1 *Excitative type*

An affective psychosis similar in its symptoms to manic-depressive psychosis, manic type, but apparently provoked by emotional stress.

Excludes: manic-depressive psychosis, manic type (296.0)

298.2 *Reactive confusion*

Mental disorders with clouded consciousness, disorientation [though less marked than in organic confusion] and diminished accessibility often accompanied by excessive activity and apparently provoked by emotional stress.

Psychogenic confusion
Psychogenic twilight state

Excludes: acute confusional state (293.0)

298.3 *Acute paranoid reaction*

Paranoid states apparently provoked by some emotional stress. The stress is often misconstrued as an attack or threat. Such states are particularly prone to occur in prisoners or as acute reactions to a strange and threatening environment, e.g., in immigrants.

Bouffée délirante

Excludes: paranoid states (297.-)

298.4 *Psychogenic paranoid psychosis*

Psychogenic or reactive paranoid psychosis of any type which is more protracted than the acute reactions covered in 298.3. Where there is a diagnosis of psychogenic paranoid psychosis which does not specify "acute" this coding should be made.

Protracted reactive paranoid psychosis

298.8 *Other and unspecified reactive psychosis*

Hysterical psychosis
Psychogenic psychosis NOS
Psychogenic stupor

298.9 *Unspecified psychosis*

To be used only as a last resort, when no other term can be used.

Psychosis NOS

299 Psychoses with origin specific to childhood

This category should be used only for psychoses which always begin before puberty. Adult-type psychoses such as schizophrenia or manic-depressive psychoses when occurring in childhood should be coded elsewhere under the appropriate heading—i.e., 295 and 296 for the examples given.

299.0 *Infantile autism*

A syndrome present from birth or beginning almost invariably in the first 30 months. Responses to auditory and sometimes to visual stimuli are abnormal and there are usually severe problems in the understanding of spoken language. Speech is delayed and, if it develops, is characterized by echolalia, the reversal of pronouns, immature grammatical structure and inability to use abstract terms. There is generally an impairment in the social

use of both verbal and gestural language. Problems in social relationships are most severe before the age of five years and include an impairment in the development of eye-to-eye gaze, social attachments, and cooperative play. Ritualistic behaviour is usual and may include abnormal routines, resistance to change, attachment to odd objects and stereotyped patterns of play. The capacity for abstract or symbolic thought and for imaginative play is diminished. Intelligence ranges from severely subnormal to normal or above. Performance is usually better on tasks involving rote memory or visuospatial skills than on those requiring symbolic or linguistic skills.

Childhood autism Kanner's syndrome
Infantile psychosis

Excludes: disintegrative psychosis (299.1)
Heller's syndrome (299.1)
schizophrenic syndrome of childhood (299.9)

299.1 *Disintegrative psychosis*

A disorder in which normal or near-normal development for the first few years is followed by a loss of social skills and of speech, together with a severe disorder of emotions, behaviour and relationships. Usually this loss of speech and of social competence takes place over a period of a few months and is accompanied by the emergence of overactivity and of stereotypies. In most cases there is intellectual impairment, but this is not a necessary part of the disorder. The condition may follow overt brain disease—such as measles encephalitis—but it may also occur in the absence of any known organic brain disease or damage. Use additional code to identify any associated neurological disorder.

Heller's syndrome

Excludes: infantile autism (299.0)
schizophrenic syndrome of childhood (299.9)

299.8 *Other*

A variety of atypical psychoses which may show some, but not all, of the features of infantile autism. Symptoms may include stereotyped repetitive movements, hyperkinesis, self-injury, retarded speech development, echolalia and impaired social relationships. Such disorders may occur in children of any level of intelligence but are particularly common in those with mental retardation.

Atypical childhood psychosis

Excludes: simple stereotypies without psychotic disturbance (307.3)

299.9 *Unspecified*

Child psychosis NOS
Schizophrenia, childhood type NOS
Schizophrenic syndrome of childhood NOS

Excludes: schizophrenia of adult type occurring in childhood (295.0-295.8)

NEUROTIC DISORDERS, PERSONALITY DISORDERS AND OTHER NONPSYCHOTIC MENTAL DISORDERS (300-316)

300 Neurotic disorders

The distinction between neurosis and psychosis is difficult and remains subject to debate. However, it has been retained in view of its wide use.

Neurotic disorders are mental disorders without any demonstrable organic basis in which the patient may have considerable insight and has unimpaired reality testing, in that he usually does not confuse his morbid subjective experiences and fantasies with external reality. Behaviour may be greatly affected although usually remaining within socially acceptable limits, but personality is not disorganized. The principal manifestations include excessive anxiety, hysterical symptoms, phobias, obsessional and compulsive symptoms, and depression.

300.0 *Anxiety states*

Various combinations of physical and mental manifestations of anxiety, not attributable to real danger and occurring either in attacks or as a persisting state. The anxiety is usually diffuse and may extend to panic. Other neurotic features such as obsessional or hysterical symptoms may be present but do not dominate the clinical picture.

Anxiety:	Panic:
neurosis	attack
reaction	disorder
state (neurotic)	state

Excludes: neurasthenia (300.5)
psychophysiological disorders (306.-)

300.1 *Hysteria*

Mental disorders in which motives, of which the patient seems unaware, produce either a restriction of the field of consciousness or disturbances of motor or sensory function which may seem to have psychological advantage or symbolic value. It may be characterized by conversion phenomena or dissociative phenomena. In the conversion form the chief or only symptoms consist of psychogenic disturbance of function in some part of the body, e.g., paralysis, tremor, blindness, deafness, seizures. In the dissociative variety, the most prominent feature is a narrowing of the field of consciousness which seems to serve an unconscious purpose and is commonly accompanied or followed by a selective amnesia. There may be dramatic but essentially superficial changes of personality sometimes taking the form of a fugue [wandering state]. Behaviour may mimic psychosis or, rather, the patient's idea of psychosis.

Astasia-abasia, hysterical	Dissociative reaction or state
Compensation neurosis	Ganser's syndrome, hysterical
Conversion hysteria	Hysteria NOS
Conversion reaction	Multiple personality

Excludes: adjustment reaction (309.-)
anorexia nervosa (307.1)
gross stress reaction (308.-)
hysterical personality (301.5)
psychophysiological disorders (306.-)

300.2 *Phobic state*

Neurotic states with abnormally intense dread of certain objects or specific situations which would not normally have that effect. If the anxiety tends to spread from a specified situation or object to a wider range of circumstances, it becomes akin to or identical with anxiety state, and should be classified as such (300.0).

Agoraphobia
Animal phobias
Anxiety-hysteria
Claustrophobia
Phobia NOS

Excludes: anxiety state (300.0)
obsessional phobias (300.3)

300.3 *Obsessive-compulsive disorders*

States in which the outstanding symptom is a feeling of subjective compulsion—which must be resisted—to carry out some action, to dwell on an idea, to recall an experience, or to ruminate on an abstract topic. Unwanted thoughts which intrude, the insistency of words or ideas, ruminations or trains of thought are perceived by the patient to be inappropriate or nonsensical. The obsessional urge or idea is recognized as alien to the personality but as coming from within the self. Obsessional actions may be quasi-ritual performances designed to relieve anxiety e.g., washing the hands to cope with contamination. Attempts to dispel the unwelcome thoughts or urges may lead to a severe struggle, with intense anxiety.

Anankastic neurosis
Compulsive neurosis

Excludes: obsessive-compulsive symptoms occurring in:
endogenous depression (296.1)
schizophrenia (295.-)
organic states, e.g., encephalitis

300.4 *Neurotic depression*

A neurotic disorder characterized by disproportionate depression which has usually recognizably ensued on a distressing experience: it does not include among its features delusions or hallucinations, and there is often preoccupation with the psychic trauma which preceded the illness, e.g., loss of a cherished person or possession. Anxiety is also frequently present and mixed states of anxiety and depression should be included here. The distinction between depressive neurosis and psychosis should be made not only upon the degree of depression but also on the presence or absence of other neurotic and psychotic characteristics and upon the degree of disturbance of the patient's behaviour.

Anxiety depression
Depressive reaction
Neurotic depressive state
Reactive depression

Excludes: adjustment reaction with depressive symptoms (309.0)
depression NOS (311)
manic-depressive psychosis, depressed type (296.1)
reactive depressive psychosis (298.0)

300.5 *Neurasthenia*

A neurotic disorder characterized by fatigue, irritability, headache, depression, insomnia, difficulty in concentration, and lack of capacity for enjoyment [anhedonia]. It may follow

or accompany an infection or exhaustion, or arise from continued emotional stress. If neurasthenia is associated with a physical disorder, the latter should also be coded.

Nervous debility

Excludes: anxiety state (300.0)
neurotic depression (300.4)
psychophysiological disorders (306.-)
specific nonpsychotic mental disorders following organic brain damage (310.-)

300.6 *Depersonalization syndrome*

A neurotic disorder with an unpleasant state of disturbed perception in which external objects or parts of one's own body are experienced as changed in their quality, unreal, remote or automatized. The patient is aware of the subjective nature of the change he experiences. Depersonalization may occur as a feature of several mental disorders including depression, obsessional neurosis, anxiety and schizophrenia; in that case the condition should not be classified here but in the corresponding major category.

Derealization (neurotic)

300.7 *Hypochondriasis*

A neurotic disorder in which the conspicuous features are excessive concern with one's health in general or the integrity and functioning of some part of one's body, or, less frequently, one's mind. It is usually associated with anxiety and depression. It may occur as a feature of severe mental disorder and in that case should not be classified here but in the corresponding major category.

Excludes: hysteria (300.1)
manic-depressive psychosis, depressed type (296.1)
neurasthenia (300.5)
obsessional disorder (300.3)
schizophrenia (295.-)

300.8 *Other neurotic disorders*

Neurotic disorders not classified elsewhere, e.g., occupational neurosis. Patients with mixed neuroses should not be classified in this category but according to the most prominent symptoms they display.

Briquet's disorder
Occupational neurosis, including writer's cramp
Psychasthenia
Psychasthenic neurosis

300.9 *Unspecified*

To be used only as a last resort.

Neurosis NOS
Psychoneurosis NOS

301 Personality disorders

Deeply ingrained maladaptive patterns of behaviour generally recognizable by the time of adolescence or earlier and continuing throughout most of adult life, although often

becoming less obvious in middle or old age. The personality is abnormal either in the balance of its components, their quality and expression or in its total aspect. Because of this deviation or psychopathy the patient suffers or others have to suffer and there is an adverse effect upon the individual or on society. It includes what is sometimes called psychopathic personality, but if this is determined primarily by malfunctioning of the brain, it should not be classified here but as one of the nonpsychotic organic brain syndromes (310). When the patient exhibits an anomaly of personality directly related to his neurosis or psychosis, e.g., schizoid personality and schizophrenia or anankastic personality and obsessive compulsive neurosis, the relevant neurosis or psychosis which is in evidence should be diagnosed in addition.

Character neurosis

301.0 *Paranoid personality disorder*

Personality disorder in which there is excessive sensitiveness to setbacks or to what are taken to be humiliations and rebuffs, a tendency to distort experience by misconstruing the neutral or friendly actions of others as hostile or contemptuous, and a combative and tenacious sense of personal rights. There may be a proneness to jealousy or excessive self-importance. Such persons may feel helplessly humiliated and put upon; others, likewise excessively sensitive, are aggressive and insistent. In all cases there is excessive self-reference.

Fanatic personality
Paranoid personality (disorder)
Paranoid traits

Excludes: acute paranoid reaction (298.3)
alcoholic paranoia (291.5)
paranoid schizophrenia (295.3)
paranoid states (297.-)

301.1 *Affective personality disorder*

Personality disorder characterized by lifelong predominance of a pronounced mood which may be persistently depressive, persistently elated, or alternately one then the other. During periods of elation there is unshakeable optimism and an enhanced zest for life and activity, whereas periods of depression are marked by worry, pessimism, low output of energy and a sense of futility.

Cycloid personality
Depressive personality
Cyclothymic personality

Excludes: affective psychoses (296.-)
cyclothymia (296.2-296.5)
neurasthenia (300.5)
neurotic depression (300.4)

301.2 *Schizoid personality disorder*

Personality disorder in which there is withdrawal from affectional, social and other contacts with autistic preference for fantasy and introspective reserve. Behaviour may be slightly eccentric or indicate avoidance of competitive situations. Apparent coolness and detachment may mask an incapacity to express feeling.

Excludes: schizophrenia (295.-)

301.3 *Explosive personality disorder*

Personality disorder characterized by instability of mood with liability to intemperate outbursts of anger, hate, violence or affection. Aggression may be expressed in words or in physical violence. The outbursts cannot readily be controlled by the affected persons, who are not otherwise prone to antisocial behaviour.

Aggressive:
  personality
  reaction
Aggressiveness
Emotional instability (excessive)
Pathological emotionality
Quarrelsomeness

Excludes: dyssocial personality (301.7)
hysterical neurosis (300.1)

301.4 *Anankastic personality disorder*

Personality disorder characterized by feelings of personal insecurity, doubt and incompleteness leading to excessive conscientiousness, checking, stubbornness and caution. There may be insistent and unwelcome thoughts or impulses which do not attain the severity of an obsessional neurosis. There is perfectionism and meticulous accuracy and a need to check repeatedly in an attempt to ensure this. Rigidity and excessive doubt may be conspicuous.

Compulsive personality
Obsessional personality

Excludes: obsessive-compulsive disorder (300.3)
phobic state (300.2)

301.5 *Hysterical personality disorder*

Personality disorder characterized by shallow, labile affectivity, dependence on others, craving for appreciation and attention, suggestibility and theatricality. There is often sexual immaturity, e.g., frigidity and over-responsiveness to stimuli. Under stress hysterical symptoms [neurosis] may develop.

Histrionic personality
Psychoinfantile personality

Excludes: hysterical neurosis (300.1)

301.6 *Asthenic personality disorder*

Personality disorder characterized by passive compliance with the wishes of elders and others and a weak inadequate response to the demands of daily life. Lack of vigour may show itself in the intellectual or emotional spheres; there is little capacity for enjoyment.

Dependent personality
Inadequate personality
Passive personality

Excludes: neurasthenia (300.5)

301.7 *Personality disorder with predominantly sociopathic or asocial manifestation*

Personality disorder characterized by disregard for social obligations, lack of feeling for others, and impetuous violence or callous unconcern. There is a gross disparity between behaviour and the prevailing social norms. Behaviour is not readily modifiable by experi-

ence, including punishment. People with this personality are often affectively cold and may be abnormally aggressive or irresponsible. Their tolerance to frustration is low; they blame others or offer plausible rationalizations for the behaviour which brings them into conflict with society.

Amoral personality
Antisocial personality
Asocial personality

Excludes: disturbance of conduct without specifiable personality disorder (312.-)
explosive personality (301.3)

301.8 *Other personality disorders*

Personality:
eccentric
"haltlose" type
Personality:
immature
passive-aggressive
psychoneurotic

Excludes: psychoinfantile personality (301.5)

301.9 *Unspecified*

Pathological personality NOS
Personality disorder NOS
Psychopathic:
constitutional state
personality (disorder)

302 Sexual deviations and disorders

Abnormal sexual inclinations or behaviour which are part of a referral problem. The limits and features of normal sexual inclination and behaviour have not been stated absolutely in different societies and cultures but are broadly such as serve approved social and biological purposes. The sexual activity of affected persons is directed primarily either towards people not of the opposite sex, or towards sexual acts not associated with coitus normally or towards coitus performed under abnormal circumstances. If the anomalous behaviour becomes manifest only during psychosis or other mental illness the condition should be classified under the major illness. It is common for more than one anomaly to occur together in the same individual; in the case the predominant deviation is classified. It is preferable not to include in this category individuals who perform deviant sexual acts when normal sexual outlets are not available to them.

302.0 *Homosexuality*

Exclusive or predominant sexual attraction for persons of the same sex with or without physical relationship. Code homosexuality here whether or not it is considered as a mental disorder.

Lesbianism

Excludes: homosexual paedophilia (302.2)

302.1 *Bestiality*

Sexual or anal intercourse with animals.

302.2 *Paedophilia*

Sexual deviations in which an adult engages in sexual activity with a child of the same or opposite sex.

302.3 *Transvestism*

Sexual deviation in which sexual pleasure is derived from dressing in clothes of the opposite sex. There is no consistent attempt to take on the identity or behaviour of the opposite sex.

Excludes: trans-sexualism (302.5)

302.4 *Exhibitionism*

Sexual deviation in which the main sexual pleasure and gratification is derived from exposure of the genitals to a person of the opposite sex.

302.5 *Trans-sexualism*

Sexual deviation centered around fixed beliefs that the overt bodily sex is wrong. The resulting behaviour is directed towards either changing the sexual organs by operation, or completely concealing the bodily sex by adopting both the dress and behaviour of the opposite sex.

Excludes: transvestism (302.3)

302.6 *Disorders of psychosexual identity*

Behaviour occurring in preadolescents of immature psychosexuality which is similar to that shown in the sexual deviations described under transvestism (302.3) and trans-sexualism (302.5). Cross-dressing is intermittent, although it may be frequent, and identification with the behaviour and appearance of the opposite sex is not yet fixed. The commonest form is feminism in boys.

Gender-role disorder

Excludes: homosexuality (302.0)
trans-sexualism (302.5)
transvestism (302.3)

302.7 *Frigidity and impotence*

Frigidity—dislike of or aversion to sexual intercourse, of psychological origin, of sufficient intensity to lead, if not to active avoidance, to marked anxiety, discomfort or pain when normal sexual intercourse takes place. Less severe degrees of this disorder that also give rise to consultation should also be coded here.

Impotence—sustained inability, due to psychological causes, to maintain an erection which will allow normal heterosexual penetration and ejaculation to take place.

Dyspareunia, psychogenic

Excludes: impotence of organic origin
normal transient symptoms from ruptured hymen
transient or occasional failures of erection due to fatigue, anxiety, alcohol or drugs

302.8 *Other*

Fetishism
Masochism
Sadism

302.9 *Unspecified*

303 Alcohol dependence syndrome

A state, psychic and usually also physical, resulting from taking alcohol, characterized by behavioural and other responses that always include a compulsion to take alcohol on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence; tolerance may or may not be present. A person may be dependent on alcohol and other drugs; if so also make the appropriate 304 coding. If dependence is associated with alcoholic psychosis or with physical complications, *both* should be coded.

Acute drunkenness in alcoholism
Chronic alcoholism
Dipsomania

Excludes: alcoholic psychoses (291.-)
drunkenness NOS (305.0)
physical complications of alcohol, such as:
cirrhosis of liver (571.2)
epilepsy (345.-)
gastritis (535.3)

304 Drug dependence

A state, psychic and sometimes also physical, resulting from taking a drug, characterized by behavioural and other responses that always include a compulsion to take a drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. A person may be dependent on more than one drug.

Excludes: nondependent abuse of drugs (305.-)

304.0 *Morphine type*

Heroin
Methadone
Opium
Opium alkaloids and their derivatives
Synthetics with morphine-like effects

304.1 *Barbiturate type*

Barbiturates
Nonbarbiturate sedatives and tranquillizers with a similar effect:
chlordiazepoxide
diazepam
glutethimide
meprobamate

304.2 *Cocaine*

Coca leaves and derivatives

304.3 *Cannabis*

Hemp
Hashish
Marijuana

304.4 *Amphetamine type and other psychostimulants*

Phenmetrazine
Methylphenidate

304.5 *Hallucinogens*

LSD and derivatives
Mescaline
Psilocybin

304.6 *Other*

Absinthe addiction
Glue sniffing

Excludes: tobacco dependence (305.1)

304.7 *Combinations of morphine type drug with any other*

304.8 *Combinations excluding morphine type drug*

304.9 *Unspecified*

Drug addiction NOS
Drug dependence NOS

305 Nondependent abuse of drugs

Includes cases where a person, for whom no other diagnosis is possible, has come under medical care because of the maladaptive effect of a drug on which he is not dependent (as defined in 304.–) and that he has taken on his own initiative to the detriment of his health or social functioning. When drug abuse is secondary to a psychiatric disorder, code the disorder.

Excludes: alcohol dependence syndrome (303)
drug dependence (304.-)
drug withdrawal syndrome (292.0)
poisoning by drugs or medicaments (960-979)

305.0 *Alcohol*

Cases of acute intoxication or "hangover" effects.

Drunkenness NOS
"Hangover" (alcohol)
Excessive drinking of alcohol NOS
Inebriety NOS

Excludes: alcoholic psychoses (291.-)
physical complications of alcohol, such as:
cirrhosis of liver (571.2)
epilepsy (345.-)
gastritis (535.3)

305.1 *Tobacco*

Cases in which tobacco is used to the detriment of a person's health or social functioning or in which there is tobacco dependence. Dependence is included here rather than under 304.– because tobacco differs from other drugs of dependence in its psychotoxic effects.

Tobacco dependence

305.2 *Cannabis*

305.3 *Hallucinogens*

Cases of acute intoxication or "bad trips".

LSD reaction

305.4 *Barbiturates and tranquillizers*

Cases where a person has taken the drug to the detriment of his health or social functioning, in doses above or for periods beyond those normally regarded as therapeutic.

305.5 *Morphine type*

305.6 *Cocaine type*

305.7 *Amphetamine type*

305.8 *Antidepressants*

305.9 *Other, mixed or unspecified*

"Laxative habit"
Misuse of drugs NOS
Nonprescribed use of drugs or patent medicinals

306 Physiological malfunction arising from mental factors

A variety of physical symptoms or types of physiological malfunction of mental origin, not involving tissue damage and usually mediated through the autonomic nervous system. The disorders are grouped according to body system. Codes 306.0-306.9 should not be used if the physical symptom is secondary to a psychiatric disorder classifiable elsewhere. If tissue damage is involved, code under 316.

Excludes: hysteria (300.1)
psychic factors associated with physical conditions involving tissue damage classified elsewhere (316)
specific nonpsychotic mental disorders following organic brain damage (310.-)

306.0 *Musculoskeletal*

Psychogenic torticollis

Excludes: Gilles de la Tourette's syndrome (307.2)
tics (307.2)

306.1 *Respiratory*

Air hunger
Hiccough (psychogenic)
Hyperventilation
Psychogenic cough
Yawning

Excludes: psychogenic asthma (316 and 493.9)

306.2 *Cardiovascular*

Cardiac neurosis
Cardiovascular neurosis
Neurocirculatory asthenia
Psychogenic cardiovascular disorder

Excludes: psychogenic paroxysmal tachycardia (316 and 427.9)

306.3 *Skin*

Psychogenic pruritus

Excludes: psychogenic:
alopecia (316 and 704.0)
dermatitis (316 and 692.-)
eczema (316 and 691.9 or 692.-)
urticaria (316 and 708.-)

306.4 *Gastrointestinal*

Aerophagy
Cyclical vomiting, psychogenic

Excludes: cyclical vomiting NOS (536.2)
mucous colitis (316 and 564.1)
psychogenic:
cardiospasm (316 and 530.0)
duodenal ulcer (316 and 532.-)
gastric ulcer (316 and 531.-)
peptic ulcer (316 and 533.-)

306.5 *Genitourinary*

Psychogenic dysmenorrhoea

Excludes: dyspareunia (302.7)
enuresis (307.6)
frigidity (302.7)
impotence (302.7)

306.6 *Endocrine*

306.7 *Organs of special sense*

Excludes: hysterical blindness or deafness (300.1)

306.8 *Other*

Teeth-grinding

306.9 *Unspecified*

Psychophysiologic disorder NOS
Psychosomatic disorder NOS

307 Special symptoms or syndromes not elsewhere classified

Conditions in which an outstanding symptom or group of symptoms is not manifestly part of a more fundamental classifiable condition.

Excludes: when due to mental disorders classified elsewhere
when of organic origin

307.0 *Stammering and stuttering*

Disorders in the rhythm of speech, in which the individual knows precisely what he wishes to say, but at the time is unable to say it because of an involuntary, repetitive prolongation or cessation of a sound.

Excludes: dysphasia (784.5)
lisping or lalling (307.9)
retarded development of speech (315.3)

307.1 *Anorexia nervosa*

A disorder in which the main features are persistent active refusal to eat and marked loss of weight. The level of activity and alertness is characteristically high in relation to the degree of emaciation. Typically the disorder begins in teenage girls but it may sometimes begin before puberty and rarely it occurs in males. Amenorrhoea is usual and there may be a variety of other physiological changes including slow pulse and respiration, low body temperature and dependent oedema. Unusual eating habits and attitudes toward food are typical and sometimes starvation follows or alternates with periods of overeating. The accompanying psychiatric symptoms are diverse.

Excludes: eating disturbance NOS (307.5)
loss of appetite (783.0)
of nonorganic origin (307.5)

307.2 *Tics*

Disorders of no known organic origin in which the outstanding feature consists of quick, involuntary, apparently purposeless, and frequently repeated movements which are not due to any neurological condition. Any part of the body may be involved but the face is most frequently affected. Only one form of tic may be present, or there may be a combination of tics which are carried out simultaneously, alternatively or consecutively. Gilles de la Tourette's syndrome refers to a rare disorder occurring in individuals of any level of intelligence in which facial tics and tic-like throat noises become more marked and more generalized and in which later, whole words or short sentences [often with an obscene content] are ejaculated spasmodically and involuntarily. There is some overlap with other varieties of tic.

Excludes: nail-biting or thumb-sucking (307.9)
stereotypies occurring in isolation (307.3)
tics of organic origin (333.3)

307.3 *Stereotyped repetitive movements*

Disorders in which voluntary repetitive stereotyped movements, which are not due to any psychiatric or neurological condition, constitute the main feature. Includes headbanging, spasmus nutans, rocking, twirling, finger-flicking mannerisms and eye poking. Such move-

ments are particularly common in cases of mental retardation with sensory impairment or with environmental monotony.

Stereotypies NOS

Excludes: tics:
NOS (307.2)
of organic origin (333.3)

307.4 *Specific disorders of sleep*

This category should only be used when a more precise medical or psychiatric diagnosis cannot be made.

Hypersomnia
Insomnia
Inversion of sleep rhythm
Nightmares
Night terrors
Sleepwalking
} of nonorganic origin

Excludes: narcolepsy (347.0)
when of unspecified cause (780.5)

307.5 *Other and unspecified disorders of eating*

This category should only be used when a more precise medical or psychiatric diagnosis cannot be made.

Infantile feeding disturbances
Loss of appetite
Overeating
Pica
} of nonorganic origin
Psychogenic vomiting

Excludes: anorexia:
nervosa (307.1)
of unspecified cause (783.0)
overeating of unspecified cause (783.6)
vomiting:
NOS (787.0)
cyclical (536.2)
psychogenic (306.4)

307.6 *Enuresis*

A disorder in which the main manifestation is a persistent involuntary voiding of urine by day or night which is considered abnormal for the age of the individual. Sometimes the child will have failed to gain bladder control and in other cases he will have gained control and then lost it. Episodic or fluctuating enuresis should be included. The disorder would not usually be diagnosed under the age of four years.

Enuresis (primary) (secondary) of nonorganic origin

Excludes: enuresis of unspecified cause (788.3)

307.7 *Encopresis*

A disorder in which the main manifestation is the persistent voluntary or involuntary passage of formed motions of normal or near-normal consistency into places not intended for that purpose in the individual's own sociocultural setting. Sometimes the child has failed to gain bowel control, and sometimes he has gained control but then later again became encopretic. There may be a variety of associated psychiatric symptoms and there may be smearing of faeces. The condition would not usually be diagnosed under the age of four years.

Encopresis (continuous) (discontinuous) of nonorganic origin

Excludes: encopresis of unspecified cause (787.6)

307.8 *Psychalgia*

Cases in which there are pains of mental origin, e.g., headache or backache, when a more precise medical or psychiatric diagnosis cannot be made.

Tension headache
Psychogenic backache

Excludes: migraine (346.-)
pains not specifically attributable to a psychological cause (in):
back (784.5)
headache (784.0)
joint (719.4)
limb (729.5)
lumbago (724.2)
rheumatic (729.0)

307.9 *Other and unspecified*

The use of this category should be discouraged. Most of the items listed in the inclusion terms are not indicative of psychiatric disorder and are included only because such terms may sometimes still appear as diagnoses.

Hair plucking
Lalling
Lisping
Masturbation
Nail-biting
Thumb-sucking

308 Acute reaction to stress

Very transient disorders of any severity and nature which occur in individuals without any apparent mental disorder in response to exceptional physical or mental stress, such as natural catastrophe or battle, and which usually subside within hours or days.

Catastrophic stress
Combat fatigue
Exhaustion delirium

Excludes: adjustment reaction (309.-)

308.0 *Predominant disturbance of emotions*

Panic states, excitability, fear, depressions and anxiety fulfilling the above criteria.

308.1 *Predominant disturbance of consciousness*

Fugues fulfilling the above criteria.

308.2 *Predominant psychomotor disturbance*

Agitation states, stupor fulfilling the above criteria.

308.3 *Other*

Acute situational disturbance

308.4 *Mixed*

Many gross stress reactions include several elements but whenever possible a specific coding under .0, .1, .2 or .3 should be made according to the *preponderant* type of disturbance. The category of mixed disorders should only be used when there is such an admixture that this cannot be done.

308.9 *Unspecified*

309 Adjustment reaction

Mild or transient disorders lasting longer than acute stress reactions (308.–) which occur in individuals of any age without any apparent pre-existing mental disorder. Such disorders are often relatively circumscribed or situation-specific, are generally reversible, and usually last only a few months. They are usually closely related in time and content to stresses such as bereavement, migration or separation experiences. Reactions to major stress that last longer than a few days are also included here. In children such disorders are associated with no significant distortion of development.

Excludes: acute reaction to major stress (308.-)
neurotic disorders (300.-)

309.0 *Brief depressive reaction*

States of depression, not specifiable as manic-depressive, psychotic or neurotic, generally transient, in which the depressive symptoms are usually closely related in time and content to some stressful event.

Grief reaction

Excludes: affective psychoses (296.-)
neurotic depression (300.4)
prolonged depressive reaction (309.1)
psychogenic depressive psychosis (298.0)

309.1 *Prolonged depressive reaction*

States of depression, not specifiable as manic-depressive, psychotic or neurotic, generally long-lasting; usually developing in association with prolonged exposure to a stressful situation.

Excludes: affective psychoses (296.-)
brief depressive reaction (309.0)
neurotic depression (300.4)
psychogenic depressive psychosis (298.0)

309.2 *With predominant disturbance of other emotions*

States, fulfilling the general criteria for adjustment reaction, in which the main symptoms are emotional in type [anxiety, fear, worry, etc.] but not specifically depressive.

Abnormal separation anxiety Culture shock

309.3 *With predominant disturbance of conduct*

Mild or transient disorders, fulfilling the general criteria for adjustment reaction, in which the main disturbance predominantly involves a disturbance of conduct. For example, an adolescent grief reaction resulting in aggressive or antisocial disorder would be included here.

Excludes: disturbance of conduct NOS (312.-)
dyssocial behaviour without manifest psychiatric disorder (V71.0)
personality disorder with predominantly sociopathic or asocial manifestations (301.7)

309.4 *With mixed disturbance of emotions and conduct*

Disorders fulfilling the general definition in which both emotional disturbance and disturbance of conduct are prominent features.

309.8 *Other*

Adjustment reaction with elective mutism
Hospitalism in children NOS

309.9 *Unspecified*

Adjustment reaction NOS Adaptation reaction NOS

310 Specific nonpsychotic mental disorders following organic brain damage

Note: This category should be used only for conditions where the *form* of the disorder is determined by the brain pathology.

Excludes: neuroses, personality disorders or other nonpsychotic conditions occurring in a form similar to that seen with functional disorders but in association with a physical condition; code to 300.-, 301.-, etc., and use additional code to identify the physical condition

310.0 *Frontal lobe syndrome*

Changes in behaviour following damage to the frontal areas of the brain or following interference with the connections of those areas. There is a general diminution of self-control, foresight, creativity and spontaneity, which may be manifest as increased irritability, selfishness, restlessness and lack of concern for others. Conscientiousness and powers of concentration are often diminished, but measurable deterioration of intellect or memory is not necessarily present. The overall picture is often one of emotional dullness, lack of drive and slowness; but, particularly in persons previously with energetic, restless or aggressive characteristics, there may be a change towards impulsiveness, boastfulness, temper

outbursts, silly fatuous humour, and the development of unrealistic ambitions; the direction of change usually depends upon the previous personality. A considerable degree of recovery is possible and may continue over the course of several years.

Lobotomy syndrome
Postleucotomy syndrome (state)

Excludes: postcontusional syndrome (310.2)

310.1 *Cognitive or personality change of other type*

Chronic, mild states of memory disturbance and intellectual deterioration, often accompanied by increased irritability, querulousness, lassitude and complaints of physical weakness. These states are often associated with old age, and may precede more severe states due to brain damage classifiable under dementia of any type (290.–, and 294.–) or any condition in 293.– (Transient organic psychotic conditions).

Mild memory disturbance
Organic psychosyndrome of nonpsychotic severity

310.2 *Postconcussional syndrome*

States occurring after generalized contusion of the brain, in which the symptom picture may resemble that of the frontal lobe syndrome (310.0) or that of any of the neurotic disorders (300.0-300.9), but in which in addition, headache, giddiness, fatigue, insomnia and a subjective feeling of impaired intellectual ability are usually prominent. Mood may fluctuate, and quite ordinary stress may produce exaggerated fear and apprehension. There may be marked intolerance of mental and physical exertion, undue sensitivity to noise, and hypochondriacal preoccupation. The symptoms are more common in persons who have previously suffered from neurotic or personality disorders, or when there is a possiblity of compensation. This syndrome is particularly associated with the closed type of head injury when signs of localized brain damage are slight or absent, but it may also occur in other conditions.

Postcontusional syndrome (encephalopathy)
Status post commotio cerebri
Post-traumatic brain syndrome, nonpsychotic

Excludes: frontal lobe syndrome (310.0)
postencephalitic syndrome (310.8)
any organic psychotic conditions following head injury (290.- to 294.0)

310.8 *Other*

Include here disorders resembling the postcontusional syndrome (310.2), associated with infective or other diseases of the brain or surrounding tissues.

Other focal (partial) organic psychosyndromes

310.9 *Unspecified*

311 Depressive disorders, not elsewhere classified

States of depression, usually of moderate but occasionally of marked intensity, which have no specifically manic-depressive or other psychotic depressive features and which do not

appear to be associated with stressful events or other features specified under neurotic depression.

Depressive disorder NOS Depression NOS
Depressive state NOS

Excludes: acute reaction to major stress with depressive symptoms (308.0)
affective personality disorder (301.1)
affective psychoses (296.-)
brief depressive reaction (309.0)
disturbance of emotions specific to childhood and adolescence, with misery and unhappiness (313.1)
mixed adjustment reaction with depressive symptoms (309.4)
neurotic depression (300.4)
prolonged depressive adjustment reaction (309.1)
psychogenic depressive psychosis (298.0)

312 Disturbance of conduct not elsewhere classified

Disorders mainly involving aggressive and destructive behaviour and disorders involving delinquency. It should be used for abnormal behaviour, in individuals of any age, which gives rise to social disapproval but which is not part of any other psychiatric condition. Minor emotional disturbances may also be present. To be included, the behaviour—as judged by its frequency, severity and type of associations with other symptoms—must be abnormal in its context. Disturbances of conduct are distinguished from an adjustment reaction by a longer duration and by a lack of close relationship in time and content to some stress. They differ from a personality disorder by the absence of deeply ingrained maladaptive patterns of behaviour present from adolescence or earlier.

Excludes: adjustment reaction with disturbance of conduct (309.3)
drug dependence (304.-)
dyssocial behaviour without manifest psychiatric disorder (V71.0)
personality disorder with predominantly sociopathic or asocial manifestations (301.7)
sexual deviations (302.-)

312.0 *Unsocialized disturbance of conduct*

Disorders characterized by behaviours such as defiance, disobedience, quarrelsomeness, aggression, destructive behaviour, tantrums, solitary stealing, lying, teasing, bullying and disturbed relationships with others. The defiance may sometimes take the form of sexual misconduct.

Unsocialized aggressive disorder

312.1 *Socialized disturbance of conduct*

Disorders in individuals who have acquired the values or behaviours of a delinquent peer group to whom they are loyal and with whom they characteristically steal, play truant, and stay out late at night. There may also be promiscuity.

Group delinquency

Excludes: gang activity without manifest psychiatric disorder (V71.0)

312.2 *Compulsive conduct disorder*

Disorder of conduct or delinquent act which is specifically compulsive in origin.

Kleptomania

312.3 *Mixed disturbance of conduct and emotions*

Disorders involving behaviours listed for 312.0 and 312.1 but in which there is also *considerable* emotional distrubance as shown for example by anxiety, misery or obsessive manifestations.

Neurotic delinquency

Excludes: compulsive conduct disorder (312.2)

312.8 *Other*

312.9 *Unspecified*

313 Disturbance of emotions specific to childhood and adolescence

Less well differentiated emotional disorders characteristic of the childhood period. Where the emotional disorder takes the form of a neurotic disorder described under 300.–, the appropriate 300.– coding should be made. This category differs from category 308.– in terms of longer duration and by the lack of close relationship in time and content to some stress.

Excludes: adjustment reaction (309.-)
masturbation, nail-biting, thumb-sucking and other isolated symptoms (307.-)

313.0 *With anxiety and fearfulness*

Ill-defined emotional disorders characteristic of childhood in which the main symptoms involve anxiety and fearfulness. Many cases of school refusal or elective mutism might be included here.

Overanxious reaction of childhood or adolescence

Excludes: abnormal separation anxiety (309.2)
anxiety states (300.0)
hospitalism in children (309.8)
phobic state (300.2)

313.1 *With misery and unhappiness*

Emotional disorders characteristic of childhood in which the main symptoms involve misery and unhappiness. There may also be eating and sleep disturbances.

Excludes: depressive neurosis (300.4)

313.2 *With sensitivity, shyness and social withdrawal*

Emotional disorders characteristic of childhood in which the main symptoms involve sensitivity, shyness, or social withdrawal. Some cases of elective mutism might be included here.

Withdrawing reaction of childhood or adolescence

Excludes: infantile autism (299.0)
schizoid personality (301.2)
schizophrenia (295.-)

313.3 *Relationship problems*

Emotional disorders characteristic of childhood in which the main symptoms involve relationship problems.

Sibling jealousy

Excludes: relationship problems associated with aggression, destruction or other forms of conduct disturbance (312.-)

313.8 *Other or mixed*

Many emotional disorders of childhood include several elements but whenever possible a specific coding under .0, .1, .2 or .3 should be made according to the *preponderant* type of disturbance. The category of mixed disorders should only be used when there is such an admixture that this cannot be done.

313.9 *Unspecified*

314 Hyperkinetic syndrome of childhood

Disorders in which the essential features are short attention span and distractibility. In early childhood the most striking symptom is disinhibited, poorly organized and poorly regulated extreme overactivity but in adolescence this may be replaced by underactivity. Impulsiveness, marked mood fluctuations and aggression are also common symptoms. Delays in the development of specific skills are often present and disturbed, poor relationships are common. If the hyperkinesis is symptomatic of an underlying disorder, code the underlying disorder instead.

314.0 *Simple disturbance of activity and attention*

Cases in which short attention span, distractibility, and overactivity are the main manifestations without significant disturbance of conduct or delay in specific skills.

Overactivity NOS

314.1 *Hyperkinesis with developmental delay*

Cases in which the hyperkinetic syndrome is associated with speech delay, clumsiness, reading difficulties or other delays in specific skills.

Developmental disorder of hyperkinesis

Use additional code to identify any associated neurological disorder

314.2 *Hyperkinetic conduct disorder*

Cases in which the hyperkinetic syndrome is associated with marked conduct disturbance but not developmental delay.

Hyperkinetic conduct disorder

Excludes: hyperkinesis with significant delays in specific skills (314.1)

314.8 *Other*

314.9 *Unspecified*

Hyperkinetic reaction of childhood or adolescence NOS
Hyperkinetic syndrome NOS

315 Specific delays in development

A group of disorders in which a specific delay in development is the main feature. In each case development is related to biological maturation but it is also influenced by nonbiological factors and the coding carries no aetiological implications.

Excludes: when due to a neurological disorder (320-389)

315.0 *Specific reading retardation*

Disorders in which the main feature is a serious impairment in the development of reading or spelling skills which is not explicable in terms of general intellectual retardation or of inadequate schooling. Speech or language difficulties, impaired right-left differentiation, perceptuo-motor problems, and coding difficulties are frequently associated. Similar problems are often present in other members of the family. Adverse psychosocial factors may be present.

Developmental dyslexia
Specific spelling difficulty

315.1 *Specific arithmetical retardation*

Disorders in which the main feature is a serious impairment in the development of arithmetical skills which is not explicable in terms of general intellectual retardation or of inadequate schooling.

Dyscalculia

315.2 *Other specific learning difficulties*

Disorders in which the main feature is a serious impairment in the development of other learning skills which are not explicable in terms of general intellectual retardation or of inadequate schooling.

Excludes: specific arithmetical retardation (315.1)
specific reading retardation (315.0)

315.3 *Developmental speech or language disorder*

Disorders in which the main feature is a serious impairment in the development of speech or language [syntax or semantics] which is not explicable in terms of general intellectual retardation. Most commonly there is a delay in the development of normal word-sound production resulting in defects of articulation. Omissions or substitutions of consonants are most frequent. There may also be a delay in the production of spoken language. Rarely, there is also a developmental delay in the comprehension of sounds. Includes cases in which delay is largely due to environmental privation.

Developmental aphasia
Dyslalia

Excludes: acquired aphasia (784.3)
elective mutism (309.8, 313.0 or 313.2)
lisping and lalling (307.9)
stammering and stuttering (307.0)

315.4 *Specific motor retardation*

Disorders in which the main feature is a serious impairment in the development of motor coordination which is not explicable in terms of general intellectual retardation. The clumsiness is commonly associated with perceptual difficulties.

Clumsiness syndrome Dyspraxia syndrome

315.5 *Mixed development disorder*

A delay in the development of one specific skill [e.g., reading, arithmetic, speech or coordination] is frequently associated with lesser delays in other skills. When this occurs the coding should be made according to the skill most seriously impaired. The mixed category should be used only where the mixture of delayed skills is such that no one skill is preponderantly affected.

315.8 *Other*

315.9 *Unspecified*

Developmental disorder NOS

316 Psychic factors associated with diseases classified elsewhere

Mental disturbances or psychic factors of any type thought to have played a major part in the aetiology of physical conditions, usually involving tissue damage, classified elsewhere. The mental disturbance is usually mild and nonspecific and psychic factors [worry, fear, conflict, etc.] may be present without any overt psychiatric disorder. Use an additional code to identify the physical condition. In the rare instance that an overt psychiatric disorder is thought to have caused a physical condition, use a second additional code to record the psychiatric diagnosis.

Examples of the use of this category are:

- psychogenic:
  - asthma 316 and 493.9
  - dermatitis 316 and 692.-
  - eczema 316 and 691.- or 692.-
  - gastric ulcer 316 and 531.-
  - mucous colitis 316 and 564.1
  - ulcerative colitis 316 and 556
  - urticaria 316 and 708.-
- psychosocial dwarfism 316 and 259.4

Excludes: physical symptoms and physiological malfunctions, not involving tissue damage, of mental origin (306.-)

Mental retardation (317-319)

A condition of arrested or incomplete development of mind which is especially characterized by subnormality of intelligence. The coding should be made on the individual's *current* level of functioning *without regard to its nature* or causation—such as psychosis, cultural deprivation, Down's syndrome etc. Where there is a specific cognitive handicap—such as in speech—the four-digit coding should be based on assessments of cognition *outside the area*

of specific handicap. The assessment of intellectual level should be based on whatever information is available, including clinical evidence, adaptive behaviour and psychometric findings. The IQ levels given are based on a test with a mean of 100 and a standard deviation of 15—such as the Wechsler scales. They are provided only as a guide and should not be applied rigidly. Mental retardation often involves psychiatric disturbances and may often develop as a result of some physical disease or injury. In these cases, an additional code or codes should be used to identify any associated condition, psychiatric or physical. The Impairment and Handicap codes should also be consulted.

317 Mild mental retardation

Feeble-minded
High-grade defect
Mild mental subnormality
Moron
IQ 50-70

318 Other specific mental retardation

318.0 *Moderate mental retardation*

Imbecile
IQ 35-49
Moderate mental subnormality

318.1 *Severe mental retardation*

IQ 20-34
Severe mental subnormality

318.2 *Profound mental retardation*

Idiocy
IQ under 20
Profound mental subnormality

319 Unspecified mental retardation

Mental deficiency NOS
Mental subnormality NOS

ICD-9-CM CLASSIFICATION OF MENTAL DISORDERS
(without inclusion and exclusion terms)

From **The International Classification of Diseases, Clinical Modification, Ninth Revision (ICD-9-CM),** Commission on Professional and Hospital Activities, Edwards Bros., Ann Arbor, MI, 1979.

Italics indicate specific ICD-9-CM codes and their categories not included in DSM-III. The lozenge symbol (□) printed in the left margin preceding the disease code denotes a four-digit rubric unique to ICD-9-CM. The contents of these rubrics in ICD-9-CM are not the same as those in ICD-9.

MENTAL DISORDERS (290-319)

PSYCHOSES (290-299)

ORGANIC PSYCHOTIC CONDITIONS (290-294)

290 Senile and presenile organic psychotic conditions

290.0 Senile dementia, uncomplicated

290.1 Presenile dementia

290.10 Presenile dementia, uncomplicated

290.11 Presenile dementia with delirium

290.12 Presenile dementia with delusional features

290.13 Presenile dementia with depressive features

290.2 Senile dementia with delusional or depressive features

290.20 Senile dementia with delusional features

290.21 Senile dementia with depressive features

290.3 Senile dementia with delirium

290.4 Arteriosclerotic dementia

290.40 Arteriosclerotic dementia, uncomplicated

290.41 Arteriosclerotic dementia with delirium

290.42 Arteriosclerotic dementia with delusional features

290.43 Arteriosclerotic dementia with depressive features

290.8 Other specified senile psychotic conditions

290.9 Unspecified senile psychotic condition

291 Alcoholic psychoses

291.0 Alcohol withdrawal delirium

291.1 Alcohol amnestic syndrome

291.2 Other alcoholic dementia

291.3 Alcohol withdrawal hallucinosis

291.4 Idiosyncratic alcohol intoxication

291.5 Alcoholic jealousy

291.8 Other specified alcoholic psychosis

291.9 Unspecified alcoholic psychosis

292 Drug psychoses

292.0 Drug withdrawal syndrome

292.1 Paranoid and/or hallucinatory states induced by drugs

292.11 Drug-induced organic delusional syndrome

292.12 Drug-induced hallucinosis

292.2 *Pathological drug intoxication*

292.8 Other specified drug-induced mental disorders
- 292.81 Drug-induced delirium
- 292.82 Drug-induced dementia
- 292.83 Drug-induced amnestic syndrome
- 292.84 Drug-induced organic affective syndrome
- 292.89 Other

292.9 Unspecified drug-induced mental disorder

293 Transient organic psychotic conditions
- 293.0 Acute delirium
- *293.1 Subacute delirium*
- 293.8 Other specified transient organic mental disorders
  - 293.81 Organic delusional syndrome
  - 293.82 Organic hallucinosis syndrome
  - 293.83 Organic affective syndrome
  - 293.89 Other
- 293.9 Unspecified transient organic mental disorder

294 Other organic psychotic conditions (chronic)
- 294.0 Amnestic syndrome
- 294.1 Dementia in conditions classified elsewhere
- 294.8 Other specified organic brain syndromes (chronic)
- 294.9 Unspecified organic brain syndrome (chronic)

OTHER PSYCHOSES (295-299)

295 Schizophrenic disorders
- *295.0 Simple type*
- 295.1 Disorganized type
- 295.2 Catatonic type
- 295.3 Paranoid type
- 295.4 Acute schizophrenic episode
- *295.5 Latent schizophrenia*
- 295.6 Residual schizophrenia
- 295.7 Schizo-affective type
- 295.8 Other specified types of schizophrenia
- 295.9 Unspecified schizophrenia

296 Affective psychoses

□*296.0 Manic disorder, single episode*

□*296.1 Manic disorder, recurrent episode*

□296.2 Major depressive disorder, single episode

□296.3 Major depressive disorder, recurrent episode

□296.4 Bipolar affective disorder, manic

□296.5 Bipolar affective disorder, depressed

□296.6 Bipolar affective disorder, mixed

□296.7 Bipolar affective disorder, unspecified

□296.8 Manic-depressive psychosis, other and unspecified

296.80 Manic-depressive psychosis, unspecified

296.81 Atypical manic disorder

296.82 Atypical depressive disorder

296.89 Other

□296.9 Other and unspecified affective psychoses

296.90 Unspecified affective psychosis

296.99 Other specified affective psychoses

297 Paranoid states

297.0 Paranoid state, simple

297.1 Paranoia

297.2 Paraphrenia

297.3 Shared paranoid disorder

297.8 Other specified paranoid states

297.9 Unspecified paranoid state

298 Other nonorganic psychoses

298.0 Depressive type psychosis

298.1 Excitative type psychosis

298.2 Reactive confusion

298.3 Acute paranoid reaction

298.4 Psychogenic paranoid psychosis

298.8 Other and unspecified reactive psychosis

298.9 Unspecified psychosis

299 Psychoses with origin specific to childhood

299.0 Infantile autism

299.1 Disintegrative psychosis

299.8 Other specified early childhood psychoses

299.9 Unspecified

NEUROTIC DISORDERS, PERSONALITY DISORDERS, AND OTHER NONPSYCHOTIC MENTAL DISORDERS (300-316)

300 Neurotic disorders

300.0 Anxiety states

300.00 Anxiety state, unspecified

300.01 Panic disorder

300.02 Generalized anxiety disorder

300.09 Other

300.1 Hysteria

300.10 Hysteria, unspecified

300.11 Conversion disorder

300.12 Psychogenic amnesia

300.13 Psychogenic fugue

300.14 Multiple personality

300.15 Dissociative disorder or reaction, unspecified

300.16 Factitious illness with psychological symptoms

300.19 Other and unspecified factitious illness

300.2 Phobic disorders

300.20 Phobia, unspecified

300.21 Agoraphobia with panic attacks

300.22 Agoraphobia without mention of panic attacks

300.23 Social phobia

300.29 Other isolated or simple phobias

300.3 Obsessive-compulsive disorders

300.4 Neurotic depression

300.5 Neurasthenia

300.6 Depersonalization syndrome

300.7 Hypochondriasis

300.8 Other neurotic disorders

300.81 Somatization disorder

300.89 Other

300.9 Unspecified neurotic disorder

301 Personality disorders

- 301.0 Paranoid personality disorder
- *301.1 Affective personality disorder*
  - 301.10 Affective personality disorder, unspecified
  - *301.11 Chronic hypomanic personality disorder*
  - *301.12 Chronic depressive personality disorder*
  - 301.13 Cyclothymic disorder
- 301.2 Schizoid personality disorder
  - 301.20 Schizoid personality disorder, unspecified
  - 301.21 Introverted personality
  - 301.22 Schizotypal personality
- *301.3 Explosive personality disorder*
- 301.4 Compulsive personality disorder
- 301.5 Histrionic personality disorder
  - 301.50 Histrionic personality disorder, unspecified
  - 301.51 Chronic factitious illness with physical symptoms
  - 301.59 Other histrionic personality disorder
- 301.6 Dependent personality disorder
- 301.7 Antisocial personality disorder
- 301.8 Other personality disorders
  - 301.81 Narcissistic personality
  - 301.82 Avoidant personality
  - 301.83 Borderline personality
  - 301.84 Passive-aggressive personality
  - 301.89 Other
- 301.9 Unspecified personality disorder

302 Sexual deviations and disorders

- 302.0 Homosexuality
- 302.1 Zoophilia
- 302.2 Pedophilia
- 302.3 Tranvestism
- 302.4 Exhibitionism
- 302.5 Trans-sexualism

302.6 Disorders of psychosexual identity

302.7 Psychosexual dysfunction

302.70 Psychosexual dysfunction, unspecified

302.71 With inhibited sexual desire

302.72 With inhibited sexual excitement

302.73 With inhibited female orgasm

302.74 With inhibited male orgasm

302.75 With premature ejaculation

302.76 With functional dyspareunia

302.79 With other specified psychosexual dysfunctions

302.8 Other specified psychosexual disorders

302.81 Fetishism

302.82 Voyeurism

302.83 Sexual masochism

302.84 Sexual sadism

302.85 Gender identity disorder of adolescent or adult life

302.89 Other

302.9 Unspecified psychosexual disorder

303 Alcohol dependence syndrome

303.0 Acute alcoholic intoxication

303.9 Other and unspecified alcohol dependence

304 Drug dependence

304.0 Opioid type dependence

304.1 Barbiturate and similarly acting sedative or hypnotic dependence

304.2 Cocaine dependence

304.3 Cannabis dependence

304.4 Amphetamine and other psychostimulant dependence

304.5 Hallucinogen dependence

304.6 Other specified drug dependence

304.7 Combinations of opioid type drug with any other

304.8 Combinations of drug dependence excluding opioid type drug

304.9 Unspecified drug dependence

305 Nondependent abuse of drugs

305.0 Alcohol abuse

305.1 Tobacco use disorder

305.2 Cannabis abuse

305.3 Hallucinogen abuse

305.4 Barbiturate and similarly acting sedative or hypnotic abuse

305.5 Opioid abuse

305.6 Cocaine abuse

305.7 Amphetamine or related acting sympathomimetic abuse

305.8 Antidepressant type abuse

305.9 Other, mixed, or unspecified drug abuse

306 Physiological malfunction arising from mental factors

306.0 Musculoskeletal

306.1 Respiratory

306.2 Cardiovascular

306.3 Skin

306.4 Gastrointestinal

306.5 Genitourinary

306.50 Psychogenic genitourinary malfunction, unspecified

306.51 Psychogenic vaginismus

306.52 Psychogenic dysmenorrhea

306.53 Psychogenic dysuria

306.59 Other

306.6 Endocrine

306.7 Organs of special sense

306.8 Other specified psychophysiological malfunction

306.9 Unspecified psychophysiological malfunction

307 Special symptoms or syndromes, not elsewhere classified

307.0 Stammering and stuttering

307.1 Anorexia nervosa

307.2 Tics

- 307.20 Tic disorder, unspecified
- 307.21 Transient tic disorder of childhood
- 307.22 Chronic motor tic disorder
- 307.23 Gilles de la Tourette's disorder

307.3 Stereotyped repetitive movements

307.4 Specific disorders of sleep of nonorganic origin

- *307.40 Nonorganic sleep disorder, unspecified*
- *307.41 Transient disorder of initiating or maintaining sleep*
- *307.42 Persistent disorder of initiating or maintaining sleep*
- *307.43 Transient disorder of initiating or maintaining wakefulness*
- *307.44 Persistent disorder of initiating or maintaining wakefulness*
- *307.45 Phase-shift disruption of 24-hour sleep-wake cycle*
- 307.46 Somnambulism or night terrors
- 307.47 Other dysfunctions of sleep stages or arousal from sleep
- *307.48 Repetitive intrusions of sleep*
- 307.49 Other

307.5 Other and unspecified disorders of eating

- 307.50 Eating disorder, unspecified
- 307.51 Bulimia
- 307.52 Pica
- 307.53 Psychogenic rumination
- *307.54 Psychogenic vomiting*
- 307.59 Other

307.6 Enuresis

307.7 Encopresis

307.8 Psychalgia

- 307.80 Psychogenic pain, site unspecified
- *307.81 Tension headache*
- 307.89 Other

307.9 Other and unspecified special symptoms or syndromes, not elsewhere classified

308 Acute reaction to stress

- *308.0 Predominant disturbance of emotions*
- *308.1 Predominant disturbance of consciousness*
- *308.2 Predominant psychomotor disturbance*
- 308.3 Other acute reactions to stress
- 308.4 Mixed disorders as reaction to stress
- 308.9 Unspecified acute reaction to stress

309 Adjustment reaction

- 309.0 Brief depressive reaction
- *309.1 Prolonged depressive reaction*
- 309.2 With predominant disturbance of other emotions
  - 309.21 Separation anxiety disorder
  - *309.22 Emancipation disorder of adolescence and early adult life*
  - 309.23 Specific academic or work inhibition
  - 309.24 Adjustment reaction with anxious mood
  - 309.28 Adjustment reaction with mixed emotional features
  - 309.29 Other
- 309.3 With predominant disturbance of conduct
- 309.4 With mixed disturbance of emotions and conduct
- 309.8 Other specified adjustment reactions
  - 309.81 Prolonged posttraumatic stress disorder
  - 309.82 Adjustment reaction with physical symptoms
  - 309.83 Adjustment reaction with withdrawal
  - 309.89 Other
- 309.9 Unspecified adjustment reaction

310 Specific nonpsychotic mental disorders due to organic brain damage

- *310.0 Frontal lobe syndrome*
- 310.1 Organic personality syndrome
- *310.2 Postconcussion syndrome*
- 310.8 Other specified nonpsychotic mental disorders following organic brain damage

310.9 Unspecified nonpsychotic mental disorder following organic brain damage

311 Depressive disorder, not elsewhere classified

312 Disturbance of conduct, not elsewhere classified

□312.0 Undersocialized conduct disorder, aggressive type

□312.1 Undersocialized conduct disorder, unaggressive type

□312.2 Socialized conduct disorder

□312.3 Disorders of impulse control, not elsewhere classified

312.30 Impulse control disorder, unspecified

312.31 Pathological gambling

312.32 Kleptomania

312.33 Pyromania

312.34 Intermittent explosive disorder

312.35 Isolated explosive disorder

312.39 Other

□*312.4 Mixed disturbance of conduct and emotions*

312.8 Other specified disturbances of conduct, not elsewhere classified

312.9 Unspecified disturbance of conduct

313 Disturbance of emotions specific to childhood and adolescence

313.0 Overanxious disorder

313.1 Misery and unhappiness disorder

313.2 Sensitivity, shyness, and social withdrawal disorder

313.21 Shyness disorder of childhood

313.22 Introverted disorder of childhood

313.23 Elective mutism

313.3 Relationship problems

313.8 Other or mixed emotional disturbances of childhood or adolescence

313.81 Oppositional disorder

313.82 Identity disorder

313.83 Academic underachievement disorder

313.89 Other

313.9 Unspecified emotional disturbance of childhood or adolescence

314 Hyperkinetic syndrome of childhood

- 314.0 Attention deficit disorder
  - 314.00 Without mention of hyperactivity
  - 314.01 With hyperactivity
- *314.1 Hyperkinesis with developmental delay*
- *314.2 Hyperkinetic conduct disorder*
- 314.8 Other specified manifestations of hyperkinetic syndrome
- 314.9 Unspecified hyperkinetic syndrome

315 Specific delays in development

- 315.0 Specific reading disorder
  - 315.00 Reading disorder, unspecified
  - *315.01 Alexia*
  - *315.02 Developmental dyslexia*
  - 315.09 Other
- 315.1 Specific arithmetical disorder
- 315.2 Other specific learning difficulties
- 315.3 Developmental speech or language disorder
  - 315.31 Developmental language disorder
  - 315.39 Other
- *315.4 Coordination disorder*
- 315.5 Mixed development disorder
- 315.8 Other specified delays in development
- 315.9 Unspecified delay in development

316 Psychic factors associated with diseases classified elsewhere

MENTAL RETARDATION (317-319)

317 Mild mental retardation

318 Other specified mental retardation

- 318.0 Moderate mental retardation
- 318.1 Severe mental retardation
- 318.2 Profound mental retardation

319 Unspecified mental retardation

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Appendix E

The Diagnostic Classification of Sleep and Arousal Disorders*

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Appendix E:

The Diagnostic Classification of Sleep and Arousal Disorders*

of the
Association of Sleep Disorders Centers
and the
Association for the Psychophysiological Study of Sleep

A. DIMS: DISORDERS OF INITIATING AND MAINTAINING SLEEP (Insomnias)

1. **Psychophysiological**
   a. Transient and Situational
   b. Persistent

2. *associated with*

   Psychiatric Disorders

   a. Symptom and Personality Disorders
   b. Affective Disorders
   c. Other Functional Psychoses

3. *associated with*

   Use of Drugs and Alcohol

   a. Tolerance to or Withdrawal from CNS Depressants
   b. Sustained Use of CNS Stimulants
   c. Sustained Use of or Withdrawal from Other Drugs
   d. Chronic Alcoholism

4. *associated with*

   Sleep-Induced Respiratory Impairment

   a. Sleep Apnea DIMS Syndrome
   b. Alveolar Hypoventilation DIMS Syndrome

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* Prepared by the Sleep Disorders Classification Committee of the Association of Sleep Disorders Centers: Howard P. Roffwarg, M.D. (Chair), Robert W. Clark, M.D., Christian Guilleminault, M.D., Peter J. Hauri, Ph.D., David J. Kupfer, M.D., Laughton E. Miles, M.D., Ph.D., Helmut S. Schmidt, M.D., Vincent P. Zarcone, Jr., M.D., and Frank J. Zorick, M.D. with William C. Dement, M.D., Ph.D. and Allan Rechtschaffen, Ph.D. as consultants. This is an outline of the first diagnostic classification system endorsed by both national sleep investigator societies. It represents a major consensus in the sleep disorders field. As published in *Sleep*, Volume 2, Number 1, 1979, published by Raven Press, the classification system contains a detailed description of each condition, differential diagnosis, background material, references, and a glossary.

5. *associated with*

   Sleep-related (Nocturnal) Myoclonus and "Restless Legs" Syndromes

   a. Sleep-related (Nocturnal) Myoclonus
   b. "Restless Legs"

6. *associated with*

   Other Medical, Toxic, and Environmental Conditions

7. **Childhood Onset DIMS**

8. *associated with*

   Other DIMS Conditions

   a. Repeated REMS Interruptions
   b. Atypical Polysomnographic Features
   c. Not Otherwise Specified

9. **No DIMS Abnormality**

   a. Short Sleeper
   b. Subjective DIMS Complaints without Objective Findings
   c. Not Otherwise Specified

* * *

B. DOES: DISORDERS OF EXCESSIVE SOMNOLENCE

1. **Psychophysiological**

   a. Transient and Situational
   b. Persistent

2. *associated with*

   Psychiatric Disorders

   a. Affective Disorders
   b. Other Disorders

3. *associated with*

   Use of Drugs and Alcohol

   a. Tolerance to or Withdrawal from CNS Stimulants
   b. Sustained Use of CNS Depressants

4. **Sleep-Induced Respiratory Impairment**

   a. Sleep Apnea DOES Syndrome
   b. Alveolar Hypoventilation DOES Syndrome

5. *associated with*

   Sleep-related (Nocturnal) Myoclonus and "Restless Legs" Syndromes

   a. Sleep-related (Nocturnal) Myoclonus
   b. "Restless Legs"

6. **Narcolepsy**

7. **Idiopathic CNS Hypersomnolence**

8. *associated with*

   Other Medical, Toxic, and Environmental Conditions

9. **Other DOES Conditions**

   a. Intermittent DOES (Periodic) Syndromes
      i. Kleine-Levin Syndrome
      ii. Menstrual Associated Syndrome
   b. Insufficient Sleep
   c. Disorder of Initiating Wakefulness (Sleep Drunkenness)
   d. Not Otherwise Specified

10. **No DOES Abnormality**

    a. Long Sleeper
    b. Subjective DOES Complaint without Objective Findings
    c. Not Otherwise Specified

* * *

C. DISORDERS OF THE SLEEP-WAKE SCHEDULE

1. **Transient**

   a. Rapid Time Zone Change ("Jet Lag") Syndrome
   b. "Workshift" Change in Conventional Sleep-Wake Schedule

2. **Persistent**

   a. Frequently Changing Sleep-Wake Schedule
   b. Delayed Sleep Phase Syndrome
   c. Advanced Sleep Phase Syndrome
   d. Non-24-Hour Sleep-Wake Schedule
   e. Irregular Sleep-Wake Pattern
   f. Not Otherwise Specified

* * *

D. DYSFUNCTIONS ASSOCIATED WITH SLEEP, SLEEP STAGES, OR PARTIAL AROUSALS (PARASOMNIAS)

1. **Sleepwalking (Somnambulism)**
2. **Sleep Terror (Pavor Nocturnus, Incubus)**
3. **Sleep-related Enuresis**
4. **Other Dysfunctions**
   a. Dream Anxiety Attacks (Nightmares)
   b. Sleep-related Epileptic Seizures
   c. Sleep-related Bruxism
   d. Sleep-related Headbanging (Jactatio Capitus Nocturnus)
   e. Familial Sleep Paralysis
   f. Impaired Penile Tumescence during Sleep
   g. Sleep-related Painful Erections
   h. Sleep-related Cluster Headaches and Chronic Paroxysmal Hemicrania
   i. Sleep-related Abnormal Swallowing Syndrome
   j. Sleep-related Asthma
   k. Sleep-related Cardiovascular Symptoms
   l. Sleep-related Gastro-Esophageal Reflux
   m. Sleep-related Hemolysis (Paroxysmal Nocturnal Hemoglobinuria)
   n. Asymptomatic Polysomnographic Finding (specify condition)
   o. Not Otherwise Specified

Appendix F

DSM-III Field Trials: Interrater Reliability and List of Project Staff and Participants

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Appendix F:

DSM-III Field Trials: Interrater Reliability and List of Project Staff and Participants

NIMH-SPONSORED FIELD TRIAL: INTERRATER RELIABILITY*

An important step in the development of DSM-III has been a series of field trials using draft versions of the manual. After two pilot field trial projects in which the earliest drafts of DSM-III were used, a formal two-year field trial, using later and more definitive drafts and sponsored by the Division of Biometry and Epidemiology of the National Institute of Mental Health (NIMH), began in September 1977.

We here present a brief description of the NIMH-sponsored field trial and the interrater reliability obtained on each of the five axes. In this trial the 1/15/78 draft of DSM-III was used for Phase One supplemented by a set of revised criteria prepared for Phase Two. A list of the project staff and all the clinicians who participated in the field trials is included.

Method

Clinicians were invited to participate in the field trial through notices appearing in *Psychiatric News* and other mental health publications and by letters sent to the membership of the American Academy of Child Psychiatry. All who agreed to complete the required work were accepted as participants, either as private practitioners or as groups of clinicians working within facilities. The clinicians were from all parts of the country, from Maine to Hawaii, and worked in both rural and urban settings. Over 75% identified their main professional activity as evaluation or care of patients. The rest were engaged in administration (6%), teaching (7%), or research (6%).

Only clinicians who joined in groups participated in the reliability study. Each of these clinicians was asked to participate in at least four reliability evaluations with another clinician. (Most of the clinicians evaluated four patients each; some evaluated only one, and a few evaluated many.) These four assessments were to be done after each clinician had already had experience using the DSM-III draft to evaluate at least 15 patients selected from their patient population either as consecutive admissions or on a catch-as-catch-can basis (an approximation of the ideal of random sampling). Each individual was evaluated on each of the five axes. The reliability interviews, with only a few exceptions, were initial diagnostic evaluations before treatment was initiated.

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*Prepared by Janet B.W. Williams, M.S.W. and Robert L. Spitzer, M.D., and adapted in part from: Spitzer RL, Forman JBW, Nee J: DSM-III field trials: I. Initial interrater diagnostic reliability. Am J Psychiatry 136:815-817, 1979; and Spitzer RL, Forman JBW: DSM-III field trials: II. Initial experience with the multiaxial system. Am J Psychiatry 136:818-820, 1979.

Detailed instructions were given to the clinicians to avoid possible biases. For example, they were cautioned not to choose cases specifically because they presented no differential diagnostic problems or to discuss a case before each clinician had independently filled out the diagnostic forms. The participants were reminded that DSM-III was on trial—not they—and that they should not hesitate to send in their results, even if there was poor agreement.

The two clinicians evaluating the same individual were to have access to the same material, such as case records, letters of referral, nursing notes, and family informants. If one clinician had such information (e.g., spoke to a family member), he or she was to inform the other clinician of the additional information, but avoid communicating his or her diagnostic impression. The two clinicians could either be present at the same evaluation interview or arrange to do separate evaluations as close together in time as possible. In Phase One, approximately 60% of adult as well as child and adolescent diagnostic assessments were done in separate evaluations, and in Phase Two about two-thirds of all evaluations were done separately. Approximately 300 clinicians evaluated a total of 670 adult patients (18 years and older). Approximately 84 clinicians evaluated a total of 126 child and adolescent patients, approximately half of whom were below the age of eleven.

Results

The interrater reliability from Phase One and Phase Two, for the diagnostic classes and subclasses that were represented in the patient sample, is presented in Table 1 (adults) and Table 2 (children and adolescents). Reliability is expressed using the kappa statistic, which indexes chance-corrected agreement (1). A high kappa (generally 0.7 and above) indicates good agreement as to whether or not the patient has a disorder within that diagnostic class, even if there is disagreement about the specific disorder within the class. For example, diagnoses of Schizophrenia, Paranoid Type and Schizophrenia, Catatonic Type by two clinicians would be considered agreement on Schizophrenia. Similarly, if one clinician diagnoses Borderline Personality Disorder and the other Schizotypal Personality Disorder, this is considered agreement on whether or not there is a Personality Disorder. The overall kappa for the major classes of Axis I indicates the extent to which there is agreement across all diagnostic classes for all patients given an Axis I diagnosis by at least one of the clinicians, and is thus an overall index of diagnostic agreement.

For adult patients, the reliability for most of the classes in both phases is quite good, and in general higher than that previously achieved with DSM-I and DSM-II (2). It is particularly encouraging that the reliability for such important categories as Schizophrenia and Major Affective Disorders is so high.

It is also noteworthy that the reliability in general improved in Phase Two, perhaps due to the refinements in the criteria used in Phase Two. Although Personality Disorder as a class is evaluated more reliably than previously, with the exception of Antisocial Personality Disorder (kappa 0.87 and 0.65 in Phase One and Phase Two respectively), the kappas for the specific Personality Disorders are quite low and range from 0.26 to 0.75.

The overall reliability of the diagnostic classes for children and adolescents (Table 2) in Phase One was the same as that for adults. However, the reliabilities in Phase Two tended to be lower than in Phase One, for reasons that are not clear. This was particularly the case for Adjustment Disorder, a diagnostic category given to nearly a third of the cases. Although the reliability obtained using the DSM-III classification with children and adolescents is only fair, it is still far higher than that obtained using the classification developed for use with children by a committee of the Group for the Advancement of Psychiatry (3).

Table 3 presents the intraclass reliability coefficients for Axes IV and V for children and adolescents and for adults. The reliability of the assessment of the severity of psychosocial stressors is at least fair. The reliability of the assessment of the highest level of adaptive functioning past year is generally quite good. As with the interjudge diagnostic reliability, the coefficients of reliability are higher with the adults in Phase Two than in Phase One, but are lower with children and adolescents.

Several innovative features of DSM-III have undoubtedly contributed to the generally improved diagnostic reliability: changes in the classification itself (e.g., grouping all of the Affective Disorders together), the separation of Axis I and Axis II conditions, the systematic description of the various disorders and, finally, the inclusion of diagnostic criteria.

REFERENCES

1. Spitzer RL, Cohen J, Fleiss JL, et al: Quantification of agreement in psychiatric diagnosis: A new approach. Arch Gen Psychiatry 17:83-87, 1967
2. Spitzer RL and Fleiss JL: A re-analysis of the reliability of psychiatric diagnosis. Br J Psychiatry 125:341-347, 1974
3. Beitchman JH, Dielman TE, Landis JR, et al: Reliability of the Group for the Advancement of Psychiatry diagnostic categories in child psychiatry. Arch Gen Psychiatry 35:1461-1468, 1978

TABLE 1

KAPPA COEFFICIENTS OF AGREEMENT FOR AXES I AND II DSM-III DIAGNOSTIC CLASSES FOR ADULTS (18 AND OLDER)

	Phase One (N = 339)		Phase Two (N = 331)	
AXIS I		% of Sample		% of Sample
DISORDERS USUALLY FIRST EVIDENT IN INFANCY, CHILDHOOD OR ADOLESCENCE	.65	5.3%	.73	3.6%
Mental Retardation	.80	1.8%	.83	2.1%
Attention Deficit Disorder	..		−.003	0.6%
Conduct Disorder	..		−.003	0.6%
Other Disorders of Infancy, Childhood or Adolescence	.66	1.2%	.002	0.3%
Eating Disorders	.59	2.1%	..	
Stereotyped Movement Disorders	−.001	0.3%	..	
Other Disorders with Physical Manifestations	..		1.00	0.6%
ORGANIC MENTAL DISORDERS	.79	11.8%	.76	10.0%
Dementias arising in the senium and presenium	.85	2.4%	.91	1.8%
Substance-induced	.63	7.4%	.58	3.6%
OBS of Other or Unknown Etiology	.66	4.1%	.65	5.4%
SUBSTANCE USE DISORDERS	.86	21.2%	.80	21.2%
SCHIZOPHRENIC DISORDERS	.81	17.7%	.81	23.3%
PARANOID DISORDERS	.66	1.2%	.75	1.5%
PSYCHOTIC DISORDERS NOT ELSEWHERE CLASSIFIED	.64	11.2%	.69	6.7%
AFFECTIVE DISORDERS	.69	43.1%	.83	38.7%
Major Affective Disorders	.68	28.9%	.80	26.9%
Other Specific Affective Disorders	.49	18.3%	.69	12.4%
Atypical Affective Disorders	.29	3.2%	.49	3.6%
ANXIETY DISORDERS	.63	9.1%	.72	8.8%
SOMATOFORM DISORDERS	.54	3.8%	.42	3.3%
DISSOCIATIVE DISORDERS	.80	0.9%	−.003	0.6%
PSYCHOSEXUAL DISORDERS	.92	2.1%	.75	1.5%
Gender Identity Disorders	−.001	0.3%	−.002	0.3%
Paraphilias	1.0	0.6%	..	
Psychosexual Dysfunctions	1.0	1.5%	.86	1.2%
FACTITIOUS DISORDERS	.66	1.2%	−.005	0.9%
DISORDERS OF IMPULSE CONTROL NOT ELSEWHERE CLASSIFIED	.28	1.8%	.80	1.8%
ADJUSTMENT DISORDER	.67	12.1%	.68	8.5%
PSYCHOLOGICAL FACTORS AFFECTING PHYSICAL CONDITION	.62	3.2%	.44	2.1%
V CODES	.56	3.0%	.66	3.0%
ADDITIONAL CODES	−.003	0.6%	.28	1.8%
OVERALL KAPPA FOR AXIS I	.68		.72	
AXIS II				
Specific Developmental Disorders	..		.40	1.2%
PERSONALITY DISORDERS	.56	59.9%	.65	49.8%
OVERALL KAPPA FOR AXIS II	.56		.64	

TABLE 2

KAPPA COEFFICIENTS OF AGREEMENT FOR AXES I AND II DSM-III DIAGNOSTIC CLASSES FOR CHILDREN AND ADOLESCENTS (UNDER 18)

	Phase One (N = 71)			Phase Two (N = 55)		
AXIS I			**% of Sample**			**% of Sample**
DISORDERS USUALLY FIRST EVIDENT IN INFANCY, CHILDHOOD OR ADOLESCENCE	.69		54.9%	.63		67.3%
Mental Retardation		1.0	8.5%		1.0	3.6%
Attention Deficit Disorder		.58	15.5%		.50	14.6%
Conduct Disorder		.61	26.8%		.61	38.2%
Anxiety Disorders of Childhood or Adolescence		.25	8.5%		.44	16.4%
Other Disorders of Infancy, Childhood or Adolescence		.79	8.5%		.73	9.1%
Eating Disorders		.66	2.8%		1.0	3.6%
Stereotyped Movement Disorders		1.0	1.4%		..	
Other Disorders with Physical Manifestations		..			.48	5.5%
Pervasive Developmental Disorders		.85	5.6%		−.01	1.8%
ORGANIC MENTAL DISORDERS	..			.66		3.6%
Substance-induced		..			−.01	1.8%
OBS of Other or Unknown Etiology		..			1.0	1.8%
SUBSTANCE USE DISORDERS	1.0		5.6%	.54		9.1%
SCHIZOPHRENIC DISORDERS	1.0		5.6%	.66		3.6%
PSYCHOTIC DISORDERS NOT ELSEWHERE CLASSIFIED	.85		5.6%	..		
AFFECTIVE DISORDERS	.53		16.9%	.30		9.1%
Major Affective Disorders		.36	11.3%		−.02	3.6%
Other Specific Affective Disorders		.38	5.6%		−.02	3.6%
Atypical Affective Disorders		−.01	2.8%		1.0	1.8%
ANXIETY DISORDERS	1.0		2.8%	1.0		1.8%
SOMATOFORM DISORDERS	1.0		1.4%	−.009		1.8%
PSYCHOSEXUAL DISORDERS	1.0		1.4%	..		
Paraphilias		1.0	1.4%		..	
DISORDERS OF IMPULSE CONTROL NOT ELSEWHERE CLASSIFIED	.66		2.8%	..		
ADJUSTMENT DISORDER	.66		31.0%	.36		32.7%
PSYCHOLOGICAL FACTORS AFFECTING PHYSICAL CONDITION	−.01		1.4%	−.02		3.6%
V CODES	−.02		4.2%	.54		9.1%
ADDITIONAL CODES	1.0		1.4%	−.03		5.5%
OVERALL KAPPA FOR AXIS I	.68			.52		
AXIS II						
Specific Developmental Disorders		.77	22.5%		.51	29.1%
PERSONALITY DISORDERS	.56		26.8%	.61		18.2%
OVERALL KAPPA FOR AXIS II	.66			.55		

TABLE 3

INTRACLASS RELIABILITY COEFFICIENTS FOR DSM-III AXES IV AND V *(N in italics)*

	Adults				Children and Adolescents			
	Phase One		Phase Two		Phase One		Phase Two	
Axis IV								
Severity of Psychosocial Stressors	0.60	*(308)*	0.66	*(293)*	0.75	*(69)*	0.59	*(53)*
Axis V								
Highest Level of Adaptive Functioning Past Year	0.75	*(321)*	0.80	*(316)*	0.77	*(67)*	0.52	*(53)*

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DSM-III Index of Diagnostic Terms

This index includes names of diagnostic categories in DSM-III as well as other widely used diagnostic terms. Descriptive terms included in Appendix B: Glossary of Technical Terms, as well as in Appendix A: Decision Trees for Differential Diagnosis are not included.

Page numbers for diagnostic criteria are in parentheses.