

# Classifications of Mental Disorders

17 Wikipedia Articles

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# List of diagnostic classification and rating scales used in psychiatry

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The following diagnostic systems and rating scales are used in psychiatry and clinical psychology.

## Diagnostic Classification

### Diagnostic Criteria

- Diagnostic and Statistical Manual of Mental Disorders (DSM)
- ICD-10 Chapter V: Mental and behavioural disorders
- Chinese Classification of Mental Disorders
- Feighner Criteria
- Research Diagnostic Criteria (RDC), a 1970s-era criteria that served as a basis for DSM-III
- Research Domain Criteria (RDoC), a on-going framework being developed by the National Institute of Mental Health

### Interview instruments using the above criteria

- Structured Clinical Interview for DSM-IV (SCID)
- Schedule for Affective Disorders and Schizophrenia (SADS)
- Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS)
- Mini-international neuropsychiatric interview (MINI)
- World Health Organisation Composite International Diagnostic Interview (CIDI)
- Schedules for Clinical Assessment in Neuropsychiatry (SCAN)
- Diagnostic Interview for Genetic Studies (DIGS)

## Rating Scales

### ADHD

*For further information see ADHD*

- Adult ADHD Self-Report Scale (ASRS v1.1)
- Brown Attention-Deficit Disorder Scales<sup>[1]</sup>

### Autism Spectrum

*For further information see Autism Spectrum*

- Adult Asperger Assessment<sup>[2]</sup>
- ASAS (Australian scale for Asperger's syndrome)<sup>[3]</sup>
- Autism Spectrum Quotient (AQ)
- Childhood Autism Spectrum Test (CAST)<sup>[4]</sup>
- Q-CHAT (Quantitative Checklist for Autism in Toddlers)<sup>[5]</sup>

## Anxiety

*For further information see Anxiety disorders*

- Beck Anxiety Inventory
- Clinician Administered PTSD Scale (CAPS)
- Hamilton Anxiety Scale (HAM-A)
- Hospital Anxiety and Depression Scale
- Generalized Anxiety Disorder 7 (GAD-7)
- Panic and Agoraphobia Scale (PAS)
- Panic Disorder Severity Scale (PDSS)
- PTSD Symptom Scale – Self-Report Version
- Social Phobia Inventory (SPIN)
- Trauma Screening Questionnaire
- Yale–Brown Obsessive Compulsive Scale (Y-BOCS)
- Zung Self-Rating Anxiety Scale

## Dementia and Cognitive Impairment

*For more further information see Dementia*

- Abbreviated mental test score
- Clinical Dementia Rating
- General Practitioner Assessment Of Cognition
- Informant Questionnaire on Cognitive Decline in the Elderly
- Mini-mental state examination

## Depression

*For further information see Rating scales for depression*

- Beck Depression Inventory (BDI)
- Beck Hopelessness Scale
- Centre for Epidemiological Studies - Depression Scale (CES-D)
- Edinburgh Postnatal Depression Scale (EPDS)
- Geriatric Depression Scale (GDS)
- Hamilton Rating Scale for Depression (HAM-D)
- Hospital Anxiety and Depression Scale
- Kutcher Adolescent Depression Scale (KADS)
- Major Depression Inventory (MDI)
- Montgomery-Åsberg Depression Rating Scale (MADRS)
- Zung Self-Rating Depression Scale

## **Eating Disorders**

*For further information see Eating disorders*

- Anorectic Behavior Observation Scale
- Binge Eating Scale (BES)
- Eating Attitudes Test (EAT-26)
- Eating Disorder Inventory (EDI)

## **Mania and Bipolar Disorder**

*For more further information see Mania and Bipolar Disorder*

- Altman Self-Rating Mania Scale (ASRM)
- Young Mania Rating Scale (YMRS)

## **Personality and Personality Disorders**

*For more further information see Personality and Personality Disorder*

- Buss-Perry Aggression Questionnaire (AGQ)
- Hare Psychopathy Checklist
- Minnesota Multiphasic Personality Inventory
- Narcissistic Personality Inventory

## **Schizophrenia and Psychosis**

*For further information see Schizophrenia, Psychosis*

- Brief Psychiatric Rating Scale (BPRS)
- Positive and Negative Syndrome Scale (PANSS)
- Scale for the Assessment of Positive Symptoms (SAPS)
- Scale for the Assessment of Negative Symptoms (SANS)

## **Other**

- Barnes Akathisia Scale
- CAGE Questionnaire

## **Global Scales**

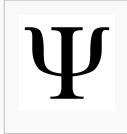
- Clinical Global Impression
- Comprehensive Psychopathological Rating Scale (CPRS)
- Global Assessment of Functioning (GAF)
- Children's Global Assessment Scale

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- [1] <https://psychcorp.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=015-8029-240>
- [2] [http://www.autismresearchcentre.com/arc\\_tests](http://www.autismresearchcentre.com/arc_tests)
- [3] <http://www.aspennj.org/pdf/information/articles/australian-scale-for-asperger-syndrome.pdf>
- [4] <http://www.ncbi.nlm.nih.gov/pubmed/11918111>
- [5] <http://www.ncbi.nlm.nih.gov/pubmed/18240013>

# Classification of mental disorders

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<b>Psychology</b>

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<b>Basic types</b>
<ul style="list-style-type: none"> <li>• Abnormal</li> <li>• Biological</li> <li>• Cognitive</li> <li>• Comparative</li> <li>• Cultural</li> <li>• Differential</li> <li>• Developmental</li> <li>• Evolutionary</li> <li>• Experimental</li> <li>• Mathematical</li> <li>• Personality</li> <li>• Positive</li> <li>• Quantitative</li> <li>• Social</li> </ul>
<b>Applied psychology</b>
<ul style="list-style-type: none"> <li>• Applied behavior analysis</li> <li>• Clinical</li> <li>• Community</li> <li>• Consumer</li> <li>• Educational</li> <li>• Environmental</li> <li>• Forensic</li> <li>• Health</li> <li>• Industrial and organizational</li> <li>• Legal</li> <li>• Military</li> <li>• Occupational health</li> <li>• Political</li> <li>• Religion</li> </ul>

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The **classification of mental disorders**, also known as psychiatric nosology or taxonomy, is a key aspect of psychiatry and other mental health professions and an important issue for people who may be diagnosed. There are currently two widely established systems for classifying mental disorders—Chapter V of the International Classification of Diseases (ICD-10) produced by the World Health Organization (WHO) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) produced by the American Psychiatric Association (APA). Both list categories of disorders thought to be distinct types, and have deliberately converged their codes in recent revisions so that the manuals are often broadly comparable, although significant differences remain. Other classification schemes may be in use more locally, for example the Chinese Classification of Mental Disorders. Other manuals have some limited use by those of alternative theoretical persuasions, such as the Psychodynamic Diagnostic Manual.

The widely used DSM and ICD classifications employ operational definitions.<sup>[1]</sup> There is a significant scientific debate about the relative validity of a "categorical" versus a "dimensional" system of classification, as well as significant controversy about the role of science and values in classification schemes and the professional, legal and social uses to which they are put.

## Definitions

In the scientific and academic literature on the definition or categorization of mental disorders, one extreme argues that it is entirely a matter of value judgements (including of what is normal) while another proposes that it is or could be entirely objective and scientific (including by reference to statistical norms);<sup>[2]</sup> other views argue that the concept refers to a "fuzzy prototype" that can never be precisely defined, or that the definition will always involve a mixture of scientific facts (e.g. that a natural or evolved function isn't working properly) and value judgements (e.g. that it is harmful or undesired).<sup>[3]</sup> Lay concepts of mental disorder vary considerably across different cultures and countries, and may refer to different sorts of individual and social problems.<sup>[4]</sup>

The WHO and national surveys report that there is no single consensus on the definition of mental disorder/illness, and that the phrasing used depends on the social, cultural, economic and legal context in different contexts and in different societies.<sup>[5][4]</sup> The WHO reports that there is intense debate about which conditions should be included under the concept of mental disorder; a broad definition can cover mental illness, mental retardation, personality disorder and substance dependence, but inclusion varies by country and is reported to be a complex and debated issue.<sup>[6]</sup> There may be a criterion that a condition should not be expected to occur as part of a person's usual culture or religion. However, despite the term "mental", there is not necessarily a clear distinction drawn between mental (dys)functioning and brain (dys)functioning, or indeed between the brain and the rest of the body.<sup>[5]</sup>

Most international clinical documents avoid the term "mental illness", preferring the term "mental disorder".<sup>[7]</sup> However, some use "mental illness" as the main overarching term to encompass mental disorders.<sup>[6]</sup> Some

consumer/survivor movement organizations oppose use of the term "mental illness" on the grounds that it supports the dominance of a medical model.<sup>[1]</sup> The term "serious mental illness" (SMI) is sometimes used to refer to more severe and long-lasting disorders while "mental health problems" may be used as a broader term, or to refer only to milder or more transient issues.<sup>[7][8]</sup> Confusion often surrounds the ways and contexts in which these terms are used.<sup>[9]</sup>

Mental disorders are generally classified separately to neurological disorders, learning disabilities or mental retardation.

## ICD-10

The International Classification of Diseases (ICD) is an international standard diagnostic classification for a wide variety of health conditions. Chapter V focuses on "mental and behavioural disorders" and consists of 10 main groups:

- F0: Organic, including symptomatic, mental disorders
- F1: Mental and behavioural disorders due to use of psychoactive substances
- F2: Schizophrenia, schizotypal and delusional disorders
- F3: Mood [affective] disorders
- F4: Neurotic, stress-related and somatoform disorders
- F5: Behavioural syndromes associated with physiological disturbances and physical factors
- F6: Disorders of personality and behaviour in adult persons
- F7: Mental retardation
- F8: Disorders of psychological development
- F9: Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
- In addition, a group of "unspecified mental disorders".

Within each group there are more specific subcategories. The ICD includes personality disorders on the same domain as other mental disorders, unlike the DSM. The ICD-10 states that mental disorder is "not an exact term", although is generally used "...to imply the existence of a clinically recognisable set of symptoms or behaviours associated in most cases with distress and with interference with personal functions." (WHO, 1992).

The WHO is revising their classifications in this section as part of the development of the ICD-11 (scheduled for 2014) and an "International Advisory Group" has been established to guide this.<sup>[10]</sup>

## DSM-IV

The DSM-IV, produced by the American Psychiatric Association, characterizes mental disorder as "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual,...is associated with present distress...or disability...or with a significant increased risk of suffering" but that "...no definition adequately specifies precise boundaries for the concept of 'mental disorder'...different situations call for different definitions" (APA, 1994 and 2000). The DSM also states that "there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder."

The DSM-IV-TR (Text Revision, 2000) consists of five axes (domains) on which disorder can be assessed. The five axes are:

**Axis I:** Clinical Disorders (all mental disorders except Personality Disorders and Mental Retardation)

**Axis II:** Personality Disorders and Mental Retardation

**Axis III:** General Medical Conditions (must be connected to a Mental Disorder)

**Axis IV:** Psychosocial and Environmental Problems (for example limited social support network)

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**Axis V:** Global Assessment of Functioning (Psychological, social and job-related functions are evaluated on a continuum between mental health and extreme mental disorder)

The main categories of disorder in the DSM are:

DSM Group	Examples
Disorders usually first diagnosed in infancy, childhood or adolescence. *Disorders such as ADHD and epilepsy have also been referred to as <i>developmental disorders</i> and <i>developmental disabilities</i> .	Mental retardation, ADHD
Delirium, dementia, and amnesia and other cognitive disorders	Alzheimer's disease
Mental disorders due to a general medical condition	AIDS-related psychosis
Substance-related disorders	Alcohol abuse
Schizophrenia and other psychotic disorders	Delusional disorder
Mood disorders	Major depressive disorder, Bipolar disorder
Anxiety disorders	Generalized anxiety disorder, Social anxiety disorder
Somatoform disorders	Somatization disorder
Factitious disorders	Münchausen syndrome
Dissociative disorders	Dissociative identity disorder
Sexual and gender identity disorders	Dyspareunia, Gender identity disorder
Eating disorders	Anorexia nervosa, Bulimia nervosa
Sleep disorders	Insomnia
Impulse control disorders not elsewhere classified	Kleptomania
Adjustment disorders	Adjustment disorder
Personality disorders	Narcissistic personality disorder
Other conditions that may be a focus of clinical attention	Tardive dyskinesia, Child abuse

## Other schemes

- The Chinese Society of Psychiatry's Chinese Classification of Mental Disorders (currently CCMD-3)
- The Latin American Guide for Psychiatric Diagnosis (GLDP).<sup>[11]</sup>
- The Research Domain Criteria (RDoC), a framework being developed by the National Institute of Mental Health

## Childhood diagnosis

Child and adolescent psychiatry sometimes uses specific manuals in addition to the DSM and ICD. The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3) was first published in 1994 by Zero to Three to classify mental health and developmental disorders in the first four years of life. It has been published in 9 languages.<sup>[12][13]</sup> The Research Diagnostic criteria-Preschool Age (RDC-PA) was developed between 2000 and 2002 by a task force of independent investigators with the goal of developing clearly specified diagnostic criteria to facilitate research on psychopathology in this age group.<sup>[14][15]</sup> The French Classification of Child and Adolescent Mental Disorders (CFTMEA), operational since 1983, is the classification of reference for French child psychiatrists.<sup>[16]</sup>

## Usage

The ICD and DSM classification schemes have achieved widespread acceptance in psychiatry. A survey of 205 psychiatrists, from 66 different countries across all continents, found that ICD-10 was more frequently used and more valued in clinical practice and training, while the DSM-IV was more valued for research, with accessibility to either being limited, and usage by other mental health professionals, policy makers, patients and families less clear.<sup>[17]</sup> A primary care (e.g. general or family physician) version of the mental disorder section of ICD-10 has been developed (ICD-10-PHC) which has also been used quite extensively internationally.<sup>[18]</sup> A survey of journal articles indexed in various biomedical databases between 1980 and 2005 indicated that 15,743 referred to the DSM and 3,106 to the ICD.<sup>[19]</sup>

In Japan, most university hospitals use either the ICD or DSM. ICD appears to be the somewhat more used for research or academic purposes, while both were used equally for clinical purposes. Other traditional psychiatric schemes may also be used.<sup>[20]</sup>

## Types of classification schemes

### Categorical schemes

The classification schemes in common usage are based on separate (but may be overlapping) categories of disorder schemes sometimes termed "neo-Kraepelinian" (after the psychiatrist Kraepelin)<sup>[21]</sup> which is intended to be atheoretical with regard to etiology (causation). These classification schemes have achieved some widespread acceptance in psychiatry and other fields, and have generally been found to have improved inter-rater reliability, although routine clinical usage is less clear. Questions of validity and utility have been raised, both scientifically<sup>[1]</sup> and in terms of social, economic and political factors—notably over the inclusion of certain controversial categories, the influence of the pharmaceutical industry,<sup>[22]</sup> or the stigmatizing effect of being categorized or labelled.

### Non-categorical schemes

Some approaches to classification do not use categories with single cut-offs separating the ill from the healthy or the abnormal from the normal (a practice sometimes termed "threshold psychiatry" or "dichotomous classification"<sup>[23]</sup>).

Classification may instead be based on broader underlying "spectra", where each spectrum links together a range of related categorical diagnoses and nonthreshold symptom patterns.<sup>[24]</sup>

Some approaches go further and propose continuously-varying dimensions that are not grouped into spectra or categories; each individual simply has a profile of scores across different dimensions.<sup>[25]</sup> DSM-5 planning committees are currently seeking to establish a research basis for a hybrid dimensional classification of personality disorders.<sup>[26]</sup> However, the problem with entirely dimensional classifications is they are said to be of limited practical value in clinical practice where yes/no decisions often need to be made, for example whether a person requires treatment, and moreover the rest of medicine is firmly committed to categories, which are assumed to reflect discrete disease entities.<sup>[27]</sup> While the Psychodynamic Diagnostic Manual has an emphasis on dimensionality and the context of mental problems, it has been structured largely as an adjunct to the categories of the DSM.

Nevertheless, non-categorical clinical formulation approaches are commonly employed in clinical psychology and some areas of psychiatry, where there may be limited or no reference to diagnostic categories. One such approach advocates taking each specific complaint reported by an individual on its own merits, treated as a phenomenon with its own causes.<sup>[28]</sup>

## Descriptive vs Somatic

Descriptive classifications are based almost exclusively on either descriptions of behavior as reported by various observers, such as parents, teachers, and medical personnel; or symptoms as reported by individuals themselves. As such, they are quite subjective, not amenable to verification by third parties, and not readily transferable across chronologic and/or cultural barriers.

Somatic nosology, on the other hand, is based almost exclusively on the objective histologic and chemical abnormalities which are characteristic of various diseases and can be identified by appropriately trained pathologists. While not all pathologists will agree in all cases, the degree of uniformity allowed is orders of magnitude greater than that enabled by the constantly changing classification embraced by the DSM system.

## Cultural differences

Classification schemes may not apply to all cultures. The DSM is based on predominantly American research studies and has been said to have a decidedly American outlook, meaning that differing disorders or concepts of illness from other cultures (including personalistic rather than naturalistic explanations) may be neglected or misrepresented, while Western cultural phenomena may be taken as universal.<sup>[29]</sup> Culture-bound syndromes are those hypothesized to be specific to certain cultures (typically taken to mean non-Western or non-mainstream cultures); while some are listed in an appendix of the DSM-IV they are not detailed and there remain open questions about the relationship between Western and non-Western diagnostic categories and sociocultural factors, which are addressed from different directions by, for example, cross-cultural psychiatry or anthropology.

## Historical development

### Antiquity

In Ancient Greece, Hippocrates and his followers are generally credited with the first classification system for mental illnesses, including mania, melancholia, paranoia, phobias and Scythian disease (transvestism). They held that they were due to different kinds of imbalance in four humors.

### Middle ages to Renaissance

An elaborate classification of mental disorders was developed in the 10th century by Arabian psychologist Najab ud-din Unhammad. His nosology included nine major categories of mental disorders, with 30 different mental illnesses in total. Some of the categories he described resembled obsessive-compulsive disorders, delusional disorders, degenerative diseases, involutional melancholia, and states of abnormal excitement.<sup>[30]</sup> Avicenna (980–1037 CE) in the Canon of Medicine listed a number of mental disorders, including "passive male homosexuality".

Laws generally distinguished between "idiots" and "lunatics".

Thomas Sydenham (1624–1689), the "English Hippocrates", emphasized careful clinical observation and diagnosis and developed the concept of a syndrome, a group of associated symptoms having a common course, which would later influence psychiatric classification.

## 18th century

Evolution in the scientific concepts of psychopathology (literally referring to diseases of the mind) took hold in the late 18th and 19th centuries following the Renaissance and Enlightenment. Individual behaviors that had long been recognized came to be grouped into syndromes.

Boissier de Sauvages developed an extremely extensive psychiatric classification in the mid-18th century, influenced by the medical nosology of Thomas Sydenham and the biological taxonomy of Carl Linnaeus. It was only part of his classification of 2400 medical diseases. These were divided into 10 "classes", one of which comprised the bulk of the mental diseases, divided into four "orders" and 23 "genera". One genus, melancholia, was subdivided into 14 "species".

William Cullen advanced an influential medical nosology which included four classes of neuroses: coma, adynamias, spasms, and vesanias. The vesanias included amentia, melancholia, mania, and oneirodynia.

Towards the end of the 18th century and into the 19th, Pinel, influenced by Cullen's scheme, developed his own, again employing the terminology of genera and species. His simplified revision of this reduced all mental illnesses to four basic types. He argued that mental disorders are not separate entities but stem from a single disease that he called "mental alienation".

Attempts were made to merge the ancient concept of delirium with that of insanity, the latter sometimes described as delirium without fever.

On the other hand, Pinel had started a trend for diagnosing forms of insanity 'without delirium' (meaning hallucinations or delusions) - a concept of partial insanity. Attempts were made to distinguish this from total insanity by criteria such as intensity, content or generalization of delusions.<sup>[1]</sup>

## 19th century

Pinel's successor, Esquirol, extended Pinel's categories to five. Both made a clear distinction between insanity (including mania and dementia) as opposed to mental retardation (including idiocy and imbecility). Esquirol developed a concept of monomania—a periodic delusional fixation or undesirable disposition on one theme—that became a broad and common diagnosis and a part of popular culture for much of the 19th century.<sup>[31]</sup> The diagnosis of "moral insanity" coined by James Prichard also became popular; those with the condition did not seem delusional or intellectually impaired but seemed to have disordered emotions or behavior.

The botanical taxonomic approach was abandoned in the 19th century, in favor of an anatomical-clinical approach that became increasingly descriptive. There was a focus on identifying the particular psychological faculty involved in particular forms of insanity, including through phrenology, although some argued for a more central "unitary" cause.<sup>[1]</sup> French and German psychiatric nosology was in the ascendency. The term "psychiatry" ("Psychiatrie") was coined by German physician Johann Christian Reil in 1808, from the Greek " $\psi\chi\lambda$ " (*psυχή*: "soul or mind") and " $\iota\alpha\tauρός$ " (*iatros*: "healer or doctor"). The term "alienation" took on a psychiatric meaning in France, later adopted into medical English. The terms psychosis and neurosis came into use, the former viewed psychologically and the latter neurologically.<sup>[1]</sup>

In the second half of the century, Karl Kahlbaum and Ewald Hecker developed a descriptive categorization of syndromes, employing terms such as dysthymia, cyclothymia, catatonia, paranoia and hebephrenia. Wilhelm Griesinger (1817–1869) advanced a unitary scheme based on a concept of brain pathology. French psychiatrists Jules Baillarger described "folie à double forme" and Jean-Pierre Falret described "la folie circulaire"—alternating mania and depression.

The concept of adolescent insanity or developmental insanity was advanced by Scottish psychiatrist Thomas Coulston in 1873, describing a psychotic condition which generally afflicted those aged 18–24 years, particularly males, and in 30% of cases proceeded to "a secondary dementia".<sup>[32]</sup>

The concept of hysteria (wandering womb) had long been used, perhaps since ancient Egyptian times, and was later adopted by Freud. Descriptions of a specific syndrome now known as somatization disorder were first developed by the French physician, Paul Briquet in 1859.

An American physician, Beard, described "neurasthenia" in 1869. German neurologist Westphal, coined the term "obsessional neurosis" now termed obsessive-compulsive disorder, and agoraphobia. Alienists created a whole new series of diagnoses that highlighted single, impulsive behavior, such as kleptomania, dipsomania, pyromania, and nymphomania. The diagnosis of drapetomania was also developed in the Southern United States to explain the perceived irrationality of black slaves trying to escape what was thought to be a suitable role.

The scientific study of homosexuality began in the 19th century, informally viewed either as natural or as a disorder. Kraepelin included it as a disorder in his *Compendium der Psychiatrie* that he published in successive editions from 1883.<sup>[33]</sup>

In the late 19th century, Koch referred to "psychopathic inferiority" as a new term for moral insanity. In the 20th century the term became known as "psychopathy" or "sociopathy", related specifically to antisocial behavior. Related studies led to the DSM-III category of antisocial personality disorder.

## 20th century

Influenced by the approach of Kahlbaum and others, and developing his concepts in publications spanning the turn of the century, German psychiatrist Emil Kraepelin advanced a new system. He grouped together a number of existing diagnoses that appeared to all have a deteriorating course over time—such as catatonia, hebephrenia and dementia paranoides—under another existing term "dementia praecox" (meaning "early senility", later renamed schizophrenia). Another set of diagnoses that appeared to have a periodic course and better outcome were grouped together under the category of manic-depressive insanity (mood disorder). He also proposed a third category of psychosis, called paranoia, involving delusions but not the more general deficits and poor course attributed to dementia praecox. In all he proposed 15 categories, also including psychogenic neurosis, psychopathic personality, and syndromes of defective mental development (mental retardation). He eventually included homosexuality in the category of "mental conditions of constitutional origin".

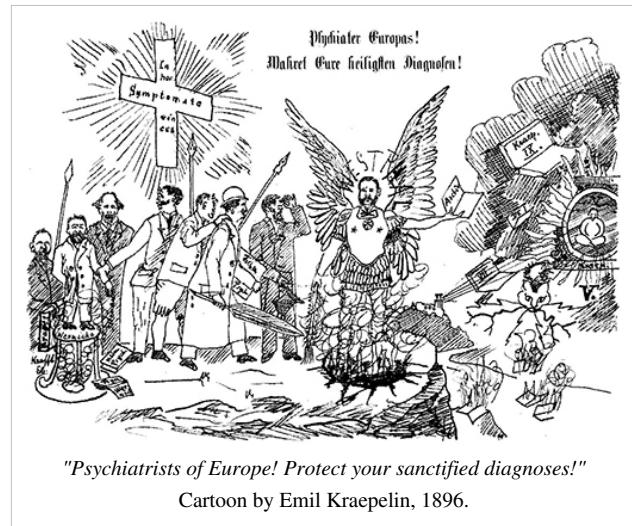
The neuroses were later split into anxiety disorders and other disorders.

Freud wrote extensively on hysteria and also coined the term, "anxiety neurosis", which appeared in DSM-I and DSM-II. Checklist criteria for this led to studies that were to define panic disorder for DSM-III.

Early 20th century schemes in Europe and the United States reflected a brain disease (or degeneration) model that had emerged during the 19th century, as well as some ideas from Darwin's theory of evolution and/or Freud's psychoanalytic theories.

Psychoanalytic theory did not rest on classification of distinct disorders, but pursued analyses of unconscious conflicts and their manifestations within an individual's life. It dealt with neurosis, psychosis, and perversion. The concept of borderline personality disorder and other personality disorder diagnoses were later formalized from such psychoanalytic theories, though such ego psychology-based lines of development diverged substantially from the paths taken elsewhere within psychoanalysis.

The philosopher and psychiatrist Karl Jaspers made influential use of a "biographical method" and suggested ways to diagnose based on the form rather than content of beliefs or perceptions. In regard to classification in general he



prophetically remarked that: "When we design a diagnostic schema, we can only do so if we forego something at the outset ... and in the face of facts we have to draw the line where none exists... A classification therefore has only provisional value. It is a fiction which will discharge its function if it proves to be the most apt for the time".<sup>[27]</sup>

Adolph Meyer advanced a mixed biosocial scheme that emphasized the reactions and adaptations of the whole organism to life experiences.

In 1945, William C. Menninger advanced a classification scheme for the US army, called Medical 203, synthesizing ideas of the time into five major groups. This system was adopted by the Veterans Administration in the United States and strongly influenced the DSM.

The term stress, having emerged out of endocrinology work in the 1930s, was popularized with an increasingly broad biopsychosocial meaning, and was increasingly linked to mental disorders. The diagnosis of post-traumatic stress disorder was later created.<sup>[1]</sup>

Mental disorders were first included in the sixth revision of the International Classification of Diseases (ICD-6) in 1949.<sup>[1]</sup> Three years later, in 1952, the American Psychiatric Association created its own classification system, DSM-I.<sup>[1]</sup>

The Feighner Criteria group described fourteen major psychiatric disorders for which careful research studies were available, including homosexuality. These developed as the Research Diagnostic Criteria, adopted and further developed by the DSM-III.

The DSM and ICD developed, partly in sync, in the context of mainstream psychiatric research and theory. Debates continued and developed about the definition of mental illness, the medical model, categorical vs dimensional approaches, and whether and how to include suffering and impairment criteria.<sup>[34]</sup> There is some attempt to construct novel schemes, for example from an attachment perspective where patterns of symptoms are construed as evidence of specific patterns of disrupted attachment, coupled with specific types of subsequent trauma.<sup>[citation needed]</sup>

## 21st century

The ICD-11 and DSM-5 are being developed at the start of the 21st century. Any radical new developments in classification are said to be more likely to be introduced by the APA than by the WHO, mainly because the former only has to persuade its own board of trustees whereas the latter has to persuade the representatives of over 200 different countries at a formal revision conference. In addition, while the DSM is a bestselling publication that makes huge profits for APA, the WHO incurs major expense in determining international consensus for revisions to the ICD. Although there is an ongoing attempt to reduce trivial or accidental differences between the DSM and ICD, it is thought that the APA and the WHO are likely to continue to produce new versions of their manuals and, in some respects, to compete with one another.<sup>[27]</sup>

## Criticism

There is some ongoing scientific doubt concerning the construct validity and reliability of psychiatric diagnostic categories and criteria<sup>[35][36][37]</sup> even though they have been increasingly standardized to improve inter-rater agreement in controlled research. In the United States, there have been calls and endorsements for a congressional hearing to explore the nature and extent of harm potentially caused by this "minimally investigated enterprise".<sup>[38][39]</sup>

Other specific criticisms of the current schemes include: attempts to demonstrate natural boundaries between related syndromes, or between a common syndrome and normality, have failed; the disorders of current classification are probably surface phenomena that can have many different interacting causes, yet "the mere fact that a diagnostic concept is listed in an official nomenclature and provided with a precise operational definition tends to encourage us to assume that it is a "quasi-disease entity" that can be invoked to explain the patient's symptoms"; and that the diagnostic manuals have led to an unintended decline in careful evaluation of each individual person's experiences

and social context.<sup>[27]</sup>

Psychodynamic schemes have traditionally given the latter phenomenological aspect more consideration, but in psychoanalytic terms that have been long criticized on numerous grounds.

Some have argued that reliance on operational definition demands that intuitive concepts, such as depression, need to be operationally defined before they become amenable to scientific investigation. However, John Stuart Mill pointed out the dangers of believing that anything that could be given a name must refer to a thing and Stephen Jay Gould and others have criticized psychologists for doing just that. One critic states that "Instead of replacing 'metaphysical' terms such as 'desire' and 'purpose', they used it to legitimize them by giving them operational definitions. Thus in psychology, as in economics, the initial, quite radical operationalist ideas eventually came to serve as little more than a 'reassurance fetish' (Koch 1992, 275) for mainstream methodological practice."<sup>[40]</sup> According to Tadafumi Kato, since the era of Kraepelin, psychiatrists have been trying to differentiate mental disorders by using clinical interviews. Kato argues there has been little progress over the last century and that only modest improvements are possible in this way; he suggests that only neurobiological studies using modern technology could form the basis for a new classification.<sup>[1]</sup>

According to Heinz Katsching, expert committees have combined phenomenological criteria in variable ways into categories of mental disorders, repeatedly defined and redefined over the last half century. The diagnostic categories are termed "disorders" and yet, despite not being validated by biological criteria as most medical diseases are, are framed as medical diseases identified by medical diagnoses. He describes them as top-down classification systems similar to the botanic classifications of plants in the 17th and 18th centuries, when experts decided a priori which visible aspects of plants were relevant. Katsching notes that while psychopathological phenomena are certainly observed and experienced, the conceptual basis of psychiatric diagnostic categories is questioned from various ideological perspectives.<sup>[1]</sup>

Psychiatrist Joel Paris argues that psychiatry is sometimes susceptible to diagnostic fads. Some have been based on theory (overdiagnosis of schizophrenia), some based on etiological (causation) concepts (overdiagnosis of post-traumatic stress disorder), and some based on the development of treatments. Paris points out that psychiatrists like to diagnose conditions they can treat, and gives examples of what he sees as prescribing patterns paralleling diagnostic trends, for example an increase in bipolar diagnosis once lithium came into use, and similar scenarios with the use of electroconvulsive therapy, neuroleptics, tricyclic antidepressants, and SSRIs. He notes that there was a time when every patient seemed to have "latent schizophrenia" and another time when everything in psychiatry seemed to be "masked depression", and he fears that the boundaries of the bipolar spectrum concept, including in application to children, are similarly expanding.<sup>[41]</sup> Allen Frances has suggested fad diagnostic trends regarding autism and Attention deficit hyperactivity disorder.<sup>[42]</sup>

Since the 1980s, psychologist Paula Caplan has had concerns about psychiatric diagnosis, and people being arbitrarily "slapped with a psychiatric label". Caplan says psychiatric diagnosis is unregulated, so doctors aren't required to spend much time understanding patients situations or to seek another doctor's opinion. The criteria for allocating psychiatric labels are contained in the Diagnostic and Statistical Manual of Mental Disorders, which can "lead a therapist to focus on narrow checklists of symptoms, with little consideration for what is causing the patient's suffering". So, according to Caplan, getting a psychiatric diagnosis and label often hinders recovery.<sup>[43]</sup>

The DSM and ICD approach remains under attack both because of the implied causality model<sup>[44]</sup> and because some researchers believe it better to aim at underlying brain differences which can precede symptoms by many years.<sup>[45][46]</sup>

## External links

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# Diagnostic and Statistical Manual of Mental Disorders

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association provides a common language and standard criteria for the classification of mental disorders. The DSM is used in the United States and to various degrees around the world. It is used or relied upon by clinicians, researchers, psychiatric drug regulation agencies, health insurance companies, pharmaceutical companies, the legal system, and policy makers. The current version, published on May 18, 2013, is the DSM-5 (fifth edition).

The DSM evolved from systems for collecting census and psychiatric hospital statistics, and from a United States Army manual. Revisions since its first publication in 1952 have incrementally added to the total number of mental disorders, although also removing those no longer considered to be mental disorders.

The International Statistical Classification of Diseases and Related Health Problems (ICD), produced by the World Health Organization (WHO), is another commonly used manual which includes criteria for mental disorders. This is in fact the official diagnostic system for mental disorders in the US, but is used more widely in Europe and other parts of the world. The coding system used in the DSM is designed to correspond with the codes used in the ICD, although not all codes may match at all times because the two publications are not revised synchronously.

The DSM has attracted praise for standardizing psychiatric diagnostic categories and criteria. It has also attracted controversy and criticism. Some critics argue that the DSM represents an unscientific and subjective system. There are ongoing issues concerning the validity and reliability of the diagnostic categories; the reliance on superficial symptoms; the use of artificial dividing lines between categories and from 'normality'; possible cultural bias; medicalization of human distress".<sup>[1][2][3][4]</sup> The publication of the DSM, with tightly guarded copyrights, now makes APA over \$5 million a year, historically adding up to over \$100 million.<sup>[5]</sup>

## Uses and definition

Many mental health professionals use the manual to determine and help communicate a patient's diagnosis after an evaluation; hospitals, clinics, and insurance companies in the US also generally require a DSM diagnosis for all patients treated. The DSM can be used clinically in this way, and also to categorize patients using diagnostic criteria for research purposes. Studies done on specific disorders often recruit patients whose symptoms match the criteria listed in the DSM for that disorder. An international survey of psychiatrists in 66 countries comparing use of the ICD-10 and DSM-IV found the former was more often used for clinical diagnosis while the latter was more valued for research.<sup>[6]</sup>

DSM-5, and all previous editions, are registered trademarks owned by the American Psychiatric Association (APA).<sup>[1]</sup>

The current version of the DSM characterizes a mental disorder as "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual [which] is associated with present distress...or disability...or with a significant increased risk of suffering." It also notes that "...no definition adequately specifies precise boundaries for the concept of 'mental disorder'...different situations call for different definitions". It states that "there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder" (APA, 1994 and 2000). There are attempts to adjust the wording for the upcoming DSM-V.<sup>[7][8]</sup>

## History

The initial impetus for developing a classification of mental disorders in the United States was the need to collect statistical information. The first official attempt was the 1840 census which used a single category, "idiocy/insanity". In 1917, a Committee on Statistics from what is now known as the American Psychiatric Association (APA), together with the National Commission on Mental Hygiene, developed a new guide for mental hospitals called the "Statistical Manual for the Use of Institutions for the Insane", which included 22 diagnoses. This was subsequently revised several times by APA over the years. APA, along with the New York Academy of Medicine, also provided the psychiatric nomenclature subsection of the US medical guide, the *Standard Classified Nomenclature of Disease*, referred to as the "Standard".<sup>[9]</sup>

### DSM-I (1952)

World War II saw the large-scale involvement of US psychiatrists in the selection, processing, assessment and treatment of soldiers. This moved the focus away from mental institutions and traditional clinical perspectives. A committee that was headed by psychiatrist Brigadier General William C. Menninger developed a new classification scheme called Medical 203 that was issued in 1943 as a War Department Technical Bulletin under the auspices of the Office of the Surgeon General.<sup>[1]</sup> The foreword to the DSM-I states the US Navy had itself made some minor revisions but "the Army established a much more sweeping revision, abandoning the basic outline of the Standard and attempting to express present day concepts of mental disturbance. This nomenclature eventually was adopted by all Armed Forces", and "assorted modifications of the Armed Forces nomenclature [were] introduced into many clinics and hospitals by psychiatrists returning from military duty." The Veterans Administration also adopted a slightly modified version of Medical 203.

In 1949, the World Health Organization published the sixth revision of the International Statistical Classification of Diseases (ICD) which included a section on mental disorders for the first time. The foreword to DSM-I states this "categorized mental disorders in rubrics similar to those of the Armed Forces nomenclature." An APA Committee on Nomenclature and Statistics was empowered to develop a version specifically for use in the United States, to standardize the diverse and confused usage of different documents. In 1950 the APA committee undertook a review and consultation. It circulated an adaptation of Medical 203, the VA system and the Standard's Nomenclature, to approximately 10% of APA members. 46% replied, of which 93% approved, and after some further revisions (resulting in it being called DSM-I), the *Diagnostic and Statistical Manual of Mental Disorders* was approved in 1951 and published in 1952. The structure and conceptual framework were the same as in Medical 203 and many passages of text identical.<sup>[1]</sup> The manual was 130 pages long and listed 106 mental disorders.<sup>[10]</sup> This included several categories of 'personality disturbance', generally distinguished from 'neurosis' (nervousness, 'egodystonic').<sup>[1]</sup>

In 1952, the APA listed homosexuality in the DSM as a sociopathic personality disturbance. *Homosexuality: A Psychoanalytic Study of Male Homosexuals*, a large-scale 1962 study of homosexuality, was used to justify inclusion of the disorder as a supposed pathological hidden fear of the opposite sex caused by traumatic parent-child relationships. This view was widely influential in the medical profession.<sup>[11]</sup> In 1956, however, the psychologist Evelyn Hooker performed a study that compared the happiness and well-adjusted nature of self-identified homosexual men with heterosexual men and found no difference.<sup>[12]</sup> Her study stunned the medical community and made her a hero to many gay men and lesbians,<sup>[13]</sup> but homosexuality remained in the DSM until 1973.

### DSM-II (1968)

In the 1960s there were many challenges to the concept of mental illness itself. These challenges came from psychiatrists like Thomas Szasz who argued that mental illness was a myth used to disguise moral conflicts; from sociologists such as Erving Goffman who said that mental illness was merely another example of how society labels and controls non-conformists; from behavioural psychologists who challenged psychiatry's fundamental reliance on unobservable phenomena; and from gay rights activists who criticised the APA's listing of homosexuality as a

mental disorder. A study published in *Science* by Rosenhan received much publicity and was viewed as an attack on the efficacy of psychiatric diagnosis.<sup>[14]</sup>

Although the APA was closely involved in the next significant revision of the mental disorder section of the ICD (version 8 in 1968), it decided to go ahead with a revision of the DSM. It was published in 1968, listed 182 disorders, and was 134 pages long. It was quite similar to the DSM-I. The term "reaction" was dropped, but the term "neurosis" was retained. Both the DSM-I and the DSM-II reflected the predominant psychodynamic psychiatry,<sup>[1]</sup> although they also included biological perspectives and concepts from Kraepelin's system of classification. Symptoms were not specified in detail for specific disorders. Many were seen as reflections of broad underlying conflicts or maladaptive reactions to life problems, rooted in a distinction between neurosis and psychosis (roughly, anxiety/depression broadly in touch with reality, or hallucinations/delusions appearing disconnected from reality). Sociological and biological knowledge was incorporated, in a model that did not emphasize a clear boundary between normality and abnormality.<sup>[1]</sup> The idea that personality disorders did not involve emotional distress was discarded.<sup>[1]</sup>

An influential 1974 paper by Robert Spitzer and Joseph L. Fleiss demonstrated that the second edition of the DSM (DSM-II) was an unreliable diagnostic tool.<sup>[1]</sup> They found that different practitioners using the *DSM-II* were rarely in agreement when diagnosing patients with similar problems. In reviewing previous studies of 18 major diagnostic categories, Fleiss and Spitzer concluded that "there are no diagnostic categories for which reliability is uniformly high. Reliability appears to be only satisfactory for three categories: mental deficiency, organic brain syndrome (but not its subtypes), and alcoholism. The level of reliability is no better than fair for psychosis and schizophrenia and is poor for the remaining categories".<sup>[1]</sup>

### **Seventh printing of the DSM-II, 1974**

As described by Ronald Bayer, a psychiatrist and gay rights activist, specific protests by gay rights activists against the APA began in 1970 when the organization held its convention in San Francisco. The activists disrupted the conference by interrupting speakers and shouting down and ridiculing psychiatrists who viewed homosexuality as a mental disorder. In 1971, gay rights activist Frank Kameny worked with the Gay Liberation Front collective to demonstrate against the APA's convention. At the 1971 conference, Kameny grabbed the microphone and yelled, "Psychiatry is the enemy incarnate. Psychiatry has waged a relentless war of extermination against us. You may take this as a declaration of war against you."<sup>[15]</sup>

This activism occurred in the context of a broader anti-psychiatry movement that had come to the fore in the 1960s and was challenging the legitimacy of psychiatric diagnosis. Anti-psychiatry activists protested at the same APA conventions, with some shared slogans and intellectual foundations.<sup>[16][17]</sup>

Presented with data from researchers such as Alfred Kinsey and Evelyn Hooker, the seventh printing of the DSM-II, in 1974, no longer listed homosexuality as a category of disorder. After a vote by the APA trustees in 1973, and confirmed by the wider APA membership in 1974, the diagnosis was replaced with the category of "sexual orientation disturbance".<sup>[18]</sup>

### **DSM-III (1980)**

In 1974, the decision to create a new revision of the DSM was made, and Robert Spitzer was selected as chairman of the task force. The initial impetus was to make the DSM nomenclature consistent with the International Statistical Classification of Diseases and Related Health Problems (ICD), published by the World Health Organization. The revision took on a far wider mandate under the influence and control of Spitzer and his chosen committee members.<sup>[19]</sup> One goal was to improve the uniformity and validity of psychiatric diagnosis in the wake of a number of critiques, including the famous Rosenhan experiment. There was also a need to standardize diagnostic practices within the US and with other countries after research showed that psychiatric diagnoses differed markedly between Europe and the USA.<sup>[1]</sup> The establishment of these criteria was an attempt to facilitate the pharmaceutical regulatory

process.

The criteria adopted for many of the mental disorders were taken from the Research Diagnostic Criteria (RDC) and Feighner Criteria, which had just been developed by a group of research-orientated psychiatrists based primarily at Washington University in St. Louis and the New York State Psychiatric Institute. Other criteria, and potential new categories of disorder, were established by consensus during meetings of the committee, as chaired by Spitzer. A key aim was to base categorization on colloquial English descriptive language (which would be easier to use by federal administrative offices), rather than assumptions of etiology, although its categorical approach assumed each particular pattern of symptoms in a category reflected a particular underlying pathology (an approach described as "neo-Kraepelinian"). The psychodynamic or physiologic view was abandoned, in favor of a regulatory or legislative model. A new "multiaxial" system attempted to yield a picture more amenable to a statistical population census, rather than just a simple diagnosis. Spitzer argued that "mental disorders are a subset of medical disorders" but the task force decided on the DSM statement: "Each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome."<sup>[1]</sup> The personality disorders were placed on axis II along with mental retardation.<sup>[1]</sup>

The first draft of the DSM-III was prepared within a year. Many new categories of disorder were introduced, while some were deleted or changed. A number of the unpublished documents discussing and justifying the changes have recently come to light.<sup>[20]</sup> Field trials sponsored by the U.S. National Institute of Mental Health (NIMH) were conducted between 1977 and 1979 to test the reliability of the new diagnoses. A controversy emerged regarding deletion of the concept of neurosis, a mainstream of psychoanalytic theory and therapy but seen as vague and unscientific by the DSM task force. Faced with enormous political opposition, so the DSM-III was in serious danger of not being approved by the APA Board of Trustees unless "neurosis" was included in some capacity, a political compromise reinserted the term in parentheses after the word "disorder" in some cases. Additionally, the diagnosis of ego-dystonic homosexuality replaced the DSM-II category of "sexual orientation disturbance".

Finally published in 1980, the DSM-III was 494 pages and listed 265 diagnostic categories. It rapidly came into widespread international use and has been termed a revolution or transformation in psychiatry.<sup>[1][2]</sup> However Robert Spitzer later criticized his own work on it in an interview with Adam Curtis saying it led to the medicalization of 20-30 percent of the population who may not have had any serious mental problems.

When DSM-III was published, the developers made extensive claims about the reliability of the radically new diagnostic system they had devised, which relied on data from special field trials. However, according to a 1994 article by Stuart A. Kirk:

Twenty years after the reliability problem became the central focus of DSM-III, there is still not a single multi-site study showing that DSM (any version) is routinely used with high reliability by regular mental health clinicians. Nor is there any credible evidence that any version of the manual has greatly increased its reliability beyond the previous version. There are important methodological problems that limit the generalisability of most reliability studies. Each reliability study is constrained by the training and supervision of the interviewers, their motivation and commitment to diagnostic accuracy, their prior skill, the homogeneity of the clinical setting in regard to patient mix and base rates, and the methodological rigor achieved by the investigator...<sup>[21]</sup>

## DSM-III-R (1987)

In 1987 the DSM-III-R was published as a revision of DSM-III, under the direction of Spitzer. Categories were renamed, reorganized, and significant changes in criteria were made. Six categories were deleted while others were added. Controversial diagnoses such as pre-menstrual dysphoric disorder and masochistic personality disorder were considered and discarded. "Sexual orientation disturbance" was also removed and was largely subsumed under "sexual disorder not otherwise specified" which can include "persistent and marked distress about one's sexual orientation."<sup>[1][22]</sup> Altogether, DSM-III-R contained 292 diagnoses and was 567 pages long. Further efforts were

made for the diagnoses to be purely descriptive, although the introductory text stated that for at least some disorders, "particularly the Personality Disorders, the criteria require much more inference on the part of the observer" (p. xxiii).<sup>[1]</sup>

### **DSM-IV (1994)**

In 1994, DSM-IV was published, listing 297 disorders in 886 pages. The task force was chaired by Allen Frances. A steering committee of 27 people was introduced, including four psychologists. The steering committee created 13 work groups of 5–16 members. Each work group had approximately 20 advisers. The work groups conducted a three-step process. First, each group conducted an extensive literature review of their diagnoses. Then they requested data from researchers, conducting analyses to determine which criteria required change, with instructions to be conservative. Finally, they conducted multicenter field trials relating diagnoses to clinical practice.<sup>[23][24]</sup> A major change from previous versions was the inclusion of a clinical significance criterion to almost half of all the categories, which required symptoms cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning". Some personality disorder diagnoses were deleted or moved to the appendix.<sup>[1]</sup>

### **DSM-IV-TR (2000)**

A "text revision" of the DSM-IV, known as the DSM-IV-TR, was published in 2000. The diagnostic categories and the vast majority of the specific criteria for diagnosis were unchanged.<sup>[25]</sup> The text sections giving extra information on each diagnosis were updated, as were some of the diagnostic codes to maintain consistency with the ICD. The DSM-IV-TR was organized into a five-part axial system. The first axis incorporated clinical disorders. The second axis covered personality disorders and intellectual disabilities. The remaining axes covered medical, psychosocial, environmental, and childhood factors functionally necessary to provide diagnostic criteria for health care assessments.

## **DSM-IV-TR**

The term "psychosis" has many meanings, and the definitions that have been put forward are controversial. Even the DSM-IV-TR, says that "the term psychosis has historically received a number of definitions, none of which has achieved universal acceptance".<sup>[26]</sup>

### **Categorization**

The DSM-IV is a categorical classification system. The categories are prototypes, and a patient with a close approximation to the prototype is said to have that disorder. DSM-IV states, "there is no assumption each category of mental disorder is a completely discrete entity with absolute boundaries" but isolated, low-grade and noncriterion (unlisted for a given disorder) symptoms are not given importance.<sup>[27]</sup> Qualifiers are sometimes used, for example mild, moderate or severe forms of a disorder. For nearly half the disorders, symptoms must be sufficient to cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning," although DSM-IV-TR removed the distress criterion from tic disorders and several of the paraphilic due to their egosyntonic nature. Each category of disorder has a numeric code taken from the ICD coding system, used for health service (including insurance) administrative purposes.

## Multi-axial system

The DSM-IV organizes each psychiatric diagnosis into five dimensions (axes) relating to different aspects of disorder or disability:

- **Axis I:** All diagnostic categories except mental retardation and personality disorder
- **Axis II:** Personality disorders and mental retardation
- **Axis III:** General medical condition; acute medical conditions and physical disorders
- **Axis IV:** Psychosocial and environmental factors contributing to the disorder
- **Axis V:** Global Assessment of Functioning or Children's Global Assessment Scale for children and teens under the age of 18

**Common Axis I disorders** include depression, anxiety disorders, bipolar disorder, ADHD, autism spectrum disorders, anorexia nervosa, bulimia nervosa, and schizophrenia.

**Common Axis II disorders** include personality disorders: paranoid personality disorder, schizoid personality disorder, schizotypal personality disorder, borderline personality disorder, antisocial personality disorder, narcissistic personality disorder, histrionic personality disorder, avoidant personality disorder, dependent personality disorder, obsessive-compulsive personality disorder; and intellectual disabilities.

**Common Axis III disorders** include brain injuries and other medical/physical disorders which may aggravate existing diseases or present symptoms similar to other disorders.

## Cautions

The **DSM-IV-TR** states, because it is produced for the completion of federal legislative mandates, its use by people without clinical training can lead to inappropriate application of its contents. Appropriate use of the diagnostic criteria is said to require extensive clinical training, and its contents "cannot simply be applied in a cookbook fashion".<sup>[28]</sup> The APA notes diagnostic labels are primarily for use as a "convenient shorthand" among professionals. The DSM advises laypersons should consult the DSM only to obtain information, not to make diagnoses, and people who may have a mental disorder should be referred to psychological counseling or treatment. Further, a shared diagnosis or label may have different causes or require different treatments; for this reason the DSM contains no information regarding treatment or cause. The range of the DSM represents an extensive scope of psychiatric and psychological issues or conditions, and it is not exclusive to what may be considered "illnesses".

## Sourcebooks

The DSM-IV does not specifically cite its sources, but there are four volumes of "sourcebooks" intended to be APA's documentation of the guideline development process and supporting evidence, including literature reviews, data analyses and field trials.<sup>[29][30][31][32]</sup> The Sourcebooks have been said to provide important insights into the character and quality of the decisions that led to the production of DSM-IV, and hence the scientific credibility of contemporary psychiatric classification.<sup>[33][34]</sup>

## DSM-5

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the DSM-5, was approved by the Board of Trustees of the American Psychiatric Association (APA) on December 1, 2012.<sup>[35]</sup> Published on May 18, 2013,<sup>[36]</sup> the DSM-5 contains extensively revised diagnoses and, in some cases, broadens diagnostic definitions while narrowing definitions in other cases.<sup>[37]</sup> The DSM-5 is the first major edition of the manual in twenty years<sup>[38]</sup> and the Roman numerals numbering system has been changed to allow for greater clarity in regard to revision numbers. A significant change in the fifth edition is the proposed deletion of the subtypes of schizophrenia.<sup>[39][40]</sup> During the revision process, the APA website periodically listed several sections of the DSM-5 for review and discussion.<sup>[41]</sup>

## Criticism

### Reliability and validity concerns

The revisions of the DSM from the 3rd Edition forward have been mainly concerned with diagnostic reliability--the degree to which different diagnosticians agree on a diagnosis. It was argued that a science of psychiatry can only advance if diagnosis is reliable. If clinicians and researchers frequently disagree about a diagnosis with a patient, then research into the causes and effective treatments of those disorders cannot advance. Hence, diagnostic reliability was a major concern of DSM-III. When the diagnostic reliability problem was thought to be solved, subsequent editions of the DSM were concerned mainly with "tweaking" the diagnostic criteria. Unfortunately, neither the issue of reliability (accurate measurement) or validity (do these disorders really exist) was settled. However, most psychiatric education post DSM-III focused on issues of treatment--especially drug treatment--and less on diagnostic concerns. In fact, Thomas R. Insel, M.D., Director of the NIMH, has recently stated the agency would no longer fund research projects that rely exclusively on DSM criteria due to its lack of validity.

### Superficial symptoms

By design, the DSM is primarily concerned with the signs and symptoms of mental disorders, rather than the underlying causes. It claims to collect them together based on statistical or clinical patterns. As such, it has been compared to a naturalist's field guide to birds, with similar advantages and disadvantages.<sup>[42]</sup> The lack of a causative or explanatory basis, however, is not specific to the DSM, but rather reflects a general lack of pathophysiological understanding of psychiatric disorders. As DSM-III chief architect Robert Spitzer and DSM-IV editor Michael First outlined in 2005, "little progress has been made toward understanding the pathophysiological processes and etiology of mental disorders. If anything, the research has shown the situation is even more complex than initially imagined, and we believe not enough is known to structure the classification of psychiatric disorders according to etiology."<sup>[43]</sup>

The DSM's focus on superficial symptoms is claimed to be largely a result of necessity (assuming such a manual is nevertheless produced), since there is no agreement on a more explanatory classification system.<sup>[citation needed]</sup> Reviewers note, however, that this approach is undermining research, including in genetics, because it results in the grouping of individuals who have very little in common except superficial criteria as per DSM or ICD diagnosis.<sup>[1]</sup>

Despite the lack of consensus on underlying causation, advocates for specific psychopathological paradigms have nonetheless faulted the current diagnostic scheme for not incorporating evidence-based models or findings from other areas of science. A recent example is evolutionary psychologists' criticism that the DSM does not differentiate between genuine cognitive malfunctions and those induced by psychological adaptations, a key distinction within evolutionary psychology, but one widely challenged within general psychology.<sup>[44][45][46]</sup> Another example is a strong operationalist viewpoint, which contends that reliance on operational definitions, as purported by the DSM, necessitates that intuitive concepts such as depression be replaced by specific measurable concepts before they are scientifically meaningful. One critic states of psychologists that "Instead of replacing 'metaphysical' terms such as 'desire' and 'purpose', they used it to legitimize them by giving them operational definitions...the initial, quite radical operationalist ideas eventually came to serve as little more than a 'reassurance fetish' (Koch 1992) for mainstream methodological practice."<sup>[47]</sup>

### Dividing lines

Despite caveats in the introduction to the DSM, it has long been argued that its system of classification makes unjustified categorical distinctions between disorders, and uses arbitrary cut-offs between normal and abnormal. A 2009 psychiatric review noted that attempts to demonstrate natural boundaries between related DSM syndromes, or between a common DSM syndrome and normality, have failed.<sup>[1]</sup> Some argue that rather than a categorical approach, a fully dimensional, spectrum or complaint-oriented approach would better reflect the evidence.<sup>[48][49][50][51]</sup>

In addition, it is argued that the current approach based on exceeding a threshold of symptoms does not adequately take into account the context in which a person is living, and to what extent there is internal disorder of an individual versus a psychological response to adverse situations.<sup>[52][53]</sup> The DSM does include a step ("Axis IV") for outlining "Psychosocial and environmental factors contributing to the disorder" once someone is diagnosed with that particular disorder.

Because an individual's degree of impairment is often not correlated with symptom counts, and can stem from various individual and social factors, the DSM's standard of distress or disability can often produce false positives.<sup>[54]</sup> On the other hand, individuals who do not meet symptom counts may nevertheless experience comparable distress or disability in their life.

## Cultural bias

Some psychiatrists also argue that current diagnostic standards rely on an exaggerated interpretation of neurophysiological findings and so underestimate the scientific importance of social-psychological variables.<sup>[5]</sup> Advocating a more culturally sensitive approach to psychology, critics such as Carl Bell and Marcello Maviglia contend that the cultural and ethnic diversity of individuals is often discounted by researchers and service providers.<sup>[55]</sup> In addition, current diagnostic guidelines have been criticized as having a fundamentally Euro-American outlook. Although these guidelines have been widely implemented, opponents argue that even when a diagnostic criteria set is accepted across different cultures, it does not necessarily indicate that the underlying constructs have any validity within those cultures; even reliable application can only demonstrate consistency, not legitimacy.<sup>[5]</sup> Cross-cultural psychiatrist Arthur Kleinman contends that the Western bias is ironically illustrated in the introduction of cultural factors to the DSM-IV: the fact that disorders or concepts from non-Western or non-mainstream cultures are described as "culture-bound", whereas standard psychiatric diagnoses are given no cultural qualification whatsoever, is to Kleinman revelatory of an underlying assumption that Western cultural phenomena are universal.<sup>[56]</sup> Kleinman's negative view towards the culture-bound syndrome is largely shared by other cross-cultural critics, common responses included both disappointment over the large number of documented non-Western mental disorders still left out, and frustration that even those included were often misinterpreted or misrepresented.<sup>[57]</sup> Many mainstream psychiatrists have also been dissatisfied with these new culture-bound diagnoses, although not for the same reasons. Robert Spitzer, a lead architect of the DSM-III, has held the opinion that the addition of cultural formulations was an attempt to placate cultural critics, and that they lack any scientific motivation or support. Spitzer also posits that the new culture-bound diagnoses are rarely used in practice, maintaining that the standard diagnoses apply regardless of the culture involved. In general, the mainstream psychiatric opinion remains that if a diagnostic category is valid, cross-cultural factors are either irrelevant or are only significant to specific symptom presentations.<sup>[5]</sup>

## Medicalization and financial conflicts of interest

It has also been alleged that the way the categories of the DSM are structured, as well as the substantial expansion of the number of categories, are representative of an increasing medicalization of human nature, which may be attributed to disease mongering by psychiatrists and pharmaceutical companies, the power and influence of the latter having grown dramatically in recent decades.<sup>[58]</sup> Of the authors who selected and defined the DSM-IV psychiatric disorders, roughly half have had financial relationships with the pharmaceutical industry at one time, raising the prospect of a direct conflict of interest.<sup>[59]</sup> The same article concludes that the connections between panel members and the drug companies were particularly strong in those diagnoses where drugs are the first line of treatment, such as schizophrenia and mood disorders, where 100% of the panel members had financial ties with the pharmaceutical industry.<sup>[59]</sup> In 2005, then American Psychiatric Association President Steven Sharfstein released a statement in which he conceded that psychiatrists had "allowed the biopsychosocial model to become the bio-bio-bio model".<sup>[60]</sup>

However, although the number of identified diagnoses has increased by more than 200% (from 106 in DSM-I to 365 in DSM-IV-TR), psychiatrists such as Zimmerman and Spitzer argue it almost entirely represents greater specification of the forms of pathology, thereby allowing better grouping of more similar patients.<sup>[1]</sup> William Glasser, however, refers to the DSM as "phony diagnostic categories", arguing that "it was developed to help psychiatrists – to help them make money".<sup>[61]</sup> In addition, the publishing of the DSM, with tightly guarded copyrights, has in itself earned over \$100 million for the American Psychiatric Association.<sup>[62]</sup>

## Consumers and survivors

A *consumer* is a person who accesses psychiatric services and may have been given a diagnosis from the *Diagnostic and Statistical Manual of Mental Disorders*, while a *survivor* self-identifies as having survived psychiatric intervention and the mental health system (which may have involved involuntary commitment and involuntary treatment). Some are relieved to find that they have a recognized condition to which they can give a name. Indeed, many people self-diagnose. Others, however, feel they have been given a "label" that invites social stigma and discrimination (i.e. mentalism), or one that they simply do not feel is accurate. Diagnoses can become internalized and affect an individual's self-identity, and some psychotherapists find that this can worsen symptoms and inhibit the healing process.<sup>[63]</sup> Some in the Psychiatric survivors movement (more broadly the consumer/survivor/ex-patient movement) actively campaign against their diagnosis, or its assumed implications, and/or against the DSM system in general. It has been noted that the DSM often uses definitions and terminology that are inconsistent with a recovery model, and that can erroneously imply excess psychopathology (e.g. multiple "comorbid" diagnoses) or chronicity.<sup>[64]</sup>

## DSM-5 Critiques

Psychiatrist Allen Frances has been critical of proposed revisions to the DSM-5. In a 2012 article, Frances warned that if this DSM version is issued unamended by the APA, it will "medicalize normality and result in a glut of unnecessary and harmful drug prescription."<sup>[65]</sup> In a December 2, 2012 blog post in *Psychology Today*, Frances lists the ten "most potentially harmful changes" to DSM-5:<sup>[1]</sup>

- Disruptive Mood Dysregulation Disorder, for temper tantrums
- Major Depressive Disorder, includes normal grief
- Minor Neurocognitive Disorder, for normal forgetting in old age
- Adult Attention Deficit Disorder, encouraging psychiatric prescriptions of stimulants
- Binge Eating Disorder, for excessive eating
- Autism change, reducing the numbers diagnosed
- First time drug users will be lumped in with addicts
- Behavioral Addictions, making a "mental disorder of everything we like to do a lot."
- Generalized Anxiety Disorder, includes everyday worries
- Post-traumatic stress disorder, changes opening "the gate even further to the already existing problem of misdiagnosis of PTSD in forensic settings."

Frances and others have published debates on what they see as the six most essential questions in psychiatric diagnosis:<sup>[1]</sup>

- are they more like theoretical constructs or more like diseases
- how to reach an agreed definition
- whether the DSM-5 should take a cautious or conservative approach
- the role of practical rather than scientific considerations
- the issue of use by clinicians or researchers
- whether an entirely different diagnostic system is required.

In 2011, psychologist Brent Robbins co-authored a national letter for the Society for Humanistic Psychology that has brought thousands into the public debate about the DSM. Approximately 14,000 individuals and mental health professionals have signed a petition in support of the letter. Thirteen other American Psychological Association divisions have endorsed the petition.<sup>[66]</sup> Robbins has noted that under the new guidelines, certain responses to grief could be labeled as pathological disorders, instead of being recognized as being normal human experiences.<sup>[67]</sup>

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## External links

- Official DSM-5 development website (<http://www.dsm5.org/pages/default.aspx>)
- Topic Center from the Psychiatric Times: DSM-5 (<http://www.psychiatrictimes.com/DSM-5>)
- DSM-IV-TR Official Site (<http://www.psychiatry.org/practice/dsm/dsm-iv-tr>) - American Psychiatric Association
- Diagnostic Criteria from DSM-IV-TR (<http://www.behavenet.com/capsules/disorders/dsm4TRclassification.htm>)
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- DSM-IV-TR In Action (<http://www.spiritualmentoring.com/page2/page46/page46.html>) Powerpoint slide handouts by G. Scott Sparrow

# American Psychiatric Association

American Psychiatric Association	
Logo of the APA	
<b>Formation</b>	1844
<b>Headquarters</b>	1000 Wilson Boulevard, Suite 1825 Arlington, Virginia, United States
<b>Membership</b>	36,000 members <sup>[1]</sup>
<b>May 2013–2014 President</b>	Jeffrey Lieberman, M.D.
<b>Website</b>	<a href="http://www.psychiatry.org">www.psychiatry.org</a> <sup>[1]</sup>

The **American Psychiatric Association (APA)** is the main professional organization of psychiatrists and trainee psychiatrists in the United States, and the largest psychiatric organization in the world.<sup>[1]</sup> Its some 36,000<sup>[1]</sup> members are mainly American but some are international. The association publishes various journals and pamphlets, as well as the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The DSM codifies psychiatric conditions and is used worldwide as a key guide for diagnosing disorders.

The organization has its headquarters in Arlington County, Virginia.<sup>[2]</sup>

## History

At a meeting in 1844 in Philadelphia, 13 superintendents and organizers of insane asylums and hospitals formed the Association of Medical Superintendents of American Institutions for the Insane (AMSAII). The group included Thomas Kirkbride, creator of the asylum model which was used throughout the United States. At the meeting they passed the first proposition of the new organization: "It is the unanimous sense of this convention that the attempt to abandon entirely the use of all means of personal restraint is not sanctioned by the true interests of the insane."<sup>[3]</sup>

The name of the organization was changed in 1892 to The American Medico-Psychological Association to allow assistant physicians working in mental hospitals to become members.

In 1921, the name was changed to the present American Psychiatric Association. The APA emblem, dating to 1890, became more officially adopted from that year. It was a round medallion with a purported facial likeness of Benjamin Rush and 13 stars over his head to represent the 13 founders of the organization. The outer ring contains the words "American Psychiatric Association 1844." Rush's name and an M.D.<sup>[4]</sup> The Association was Incorporated in the District of Columbia in 1927.

In 1948, APA formed a small task force to create a new standardized psychiatric classification system. This resulted in the 1952 publication of the first DSM. In 1965 a new task force of 10 people developed DSM-II, published in 1968. DSM-III was published in 1980, after a larger process involving some 600 clinicians. The book was now 500 pages long, including many more disorders, and it sold nearly half a million copies. APA published a revised DSM-III-R in 1987 and DSM-IV in 1994, the latter selling nearly a million copies by the end of 2000. DSM-IV-TR with minor revisions was published in 2000. APA is currently developing and consulting on DSM-V, which will be published in May 2013.

In the early 1970s, activists campaigned against the DSM classification of homosexuality as a mental disorder, protesting at APA offices and at annual meetings from 1970 to 1973. In 1973 the Board of Trustees voted to remove homosexuality as a disorder category from the DSM, a decision ratified by a majority (58%) of the general APA membership the following year. A category of "sexual orientation disturbance" was introduced in its place in 1974,

and then replaced in the 1980 DSM-III with Ego-dystonic sexual orientation. That was removed in 1987.

In 2002, amidst increasing concern to differentiate themselves from clinical psychologists, the APA assembly membership voted against a proposed name change to the American Psychiatric Medical Association.<sup>[5]</sup>

Dr. Saul Levin was named on May 15th, 2013 as the new chief executive officer and medical director of the APA, making him the first known openly gay person to head the APA.<sup>[6]</sup>

## Organization and membership

APA is led by the President of the American Psychiatric Association and a Board of Trustees with an Executive Committee.

APA reports<sup>[7]</sup> that its membership is primarily medical specialists who are qualified, or in the process of becoming qualified, as psychiatrists. The basic eligibility requirement is completion of a residency program in psychiatry accredited by the Residency Review Committee for Psychiatry of the Accreditation Council for Graduate Medical Education (ACGME), the Royal College of Physicians and Surgeons of Canada (RCPS(C)), or the American Osteopathic Association (AOA). Applicants for membership must also hold a valid medical license (with the exception of medical students and residents) and provide one reference who is an APA member.

APA holds an annual conference attended by a US and international audience.

APA is made up of some 76 district associations throughout the US.<sup>[8]</sup>

## Theoretical position

The APA reflects and represents mainstream psychiatry in the United States. Reflecting larger trends, the APA members and leaders had been largely psychodynamic in their approaches until recent decades, when the field became more "biopsychosocial."

The DSM is currently intended to be less theoretical than prior editions, having moved away from psychodynamic theories to be more widely accepted, and is proposed to not be committed to a particular theorized etiology for mental disorders. The criteria for many of the mental disorders have been expanded and involve a checklist of so-called 'Feighner Criteria' to try and capture the varying sets of features which would be necessary to diagnose a particular disorder.

## Publications and campaigns

APA position statements,<sup>[9]</sup> Psych.org and practice guidelines<sup>[10]</sup> and description of its core diagnostic manual the DSM<sup>[11]</sup> are published.

APA publishes several journals<sup>[12]</sup> focused on different areas of psychiatry, for example, academic, clinical practice, or news.

APA recently launched a health campaign<sup>[13]</sup> with a new PR approach<sup>[14]</sup>

## Notable figures

- Adolf Meyer rose to prominence as the president of the American Psychiatric Association and was one of the most influential figures in psychiatry in the first half of the twentieth century.
- Robert Spitzer was a key figure in the development of later editions of the DSM.
- Donald Ewen Cameron is best known for his MK-ULTRA-related mind-control and behavior modification research for the CIA. Cameron was President of the APA in 1952-1953.
- Current president Jeffrey Lieberman was principal investigator for the NIMH CATIE study.<sup>[15]</sup>

## Drug company ties

In his book *Anatomy of an Epidemic* (2010), Robert Whitaker described the partnership that has developed between the APA and pharmaceutical companies since the 1980s.<sup>[1]</sup> APA has come to depend on pharmaceutical money.<sup>[1]</sup> The drug companies endowed continuing education and psychiatric "grand rounds" at hospitals. They funded a political action committee (PAC) in 1982 to lobby Congress.<sup>[1]</sup> The industry helped to pay for the APA's media training workshops.<sup>[1]</sup> It was able to turn psychiatrists at top schools into speakers, and although the doctors felt they were independents, they rehearsed their speeches and likely would not be invited back if they discussed drug side effects.<sup>[1]</sup> "Thought leaders" became the experts quoted in the media.<sup>[1]</sup> As Marcia Angell wrote in *The New England Journal of Medicine* (2000), "thought leaders" could agree to be listed as an author of ghostwritten articles,<sup>[16]</sup> and she cites Thomas Bodenheimer and David Rothman who describe the extent of the drug industry's involvement with doctors.<sup>[17][18]</sup> *The New York Times* published a summary about antipsychotic medications in October 2010.<sup>[19]</sup>

In 2008, for the first time, Senator Charles Grassley asked the APA to disclose how much of its annual budget came from drug industry funds. The APA said that industry contributed 28% of its budget (\$14 million at that time), mainly through paid advertising in APA journals and funds for continuing medical education.<sup>[1]</sup>

## Controversies

Controversies have related to anti-psychiatry and disability rights campaigners, who regularly protest at American Psychiatric Association offices or meetings. In 1971, members of the Gay Liberation Front organization sabotaged an APA conference in San Francisco. In 2003 activists from MindFreedom International staged a 21-day hunger strike, protesting at a perceived unjustified biomedical focus and challenging APA to provide evidence of the widespread claim that mental disorders are due to chemical imbalances in the brain. APA published a position statement in response<sup>[20]</sup> and the two organizations exchanged views on the evidence.

There was controversy when it emerged that US psychologists and psychiatrists were helping interrogators in Guantanamo and other US facilities. The American Psychiatric Association released a policy statement that psychiatrists should not take a direct part in interrogation of particular prisoners<sup>[21]</sup> but could "offer general advice on the possible medical and psychological effects of particular techniques and conditions of interrogation, and on other areas within their professional expertise."

After previous controversy over APA's classification of homosexuality as a mental illness, there is also controversy regarding the remaining category of "sexual disorder not otherwise specified" which can include a state of distress about one's sexual orientation, as well as the diagnosis of "gender identity disorder" or gender dysphoria.<sup>[22]</sup>

The APA's Standard Diagnostic Manual came under criticism from autism specialists Tony Attwood and Simon Baron-Cohen for proposing the elimination of Asperger's syndrome as a disorder and replacing it with an autism severity scale. Professor Roy Richard Grinker wrote a controversial editorial for the New York Times expressing support for the proposal.

The APA president in 2005, Steven Sharfstein, caused controversy when, although praising the pharmaceutical industry, he argued that American psychiatry had "allowed the biopsychosocial model to become the bio-bio-bio model" and accepted "kickbacks and bribes" from pharmaceutical companies leading to the over-use of medication

and neglect of other approaches.<sup>[23]</sup> In 2008 APA became a focus of congressional investigations regarding the way that money from the pharmaceutical industry can shape the practices of nonprofit organizations that purport to be independent in their viewpoints and actions. The drug industry accounted in 2006 for about 30 percent of the association's \$62.5 million in financing, half through drug advertisements in its journals and meeting exhibits, and the other half sponsoring fellowships, conferences and industry symposiums at its annual meeting. APA is considering its response to increasingly intense scrutiny and questions about conflicts of interest.<sup>[24]</sup> The APA president of 2009-2010, Alan Schatzberg, has also come under fire after it came to light that he was principal investigator on a federal study into a drug being developed by Corcept Therapeutics, a company Schatzberg had himself set up and in which he had several millions of dollars' worth of stock.<sup>[25]</sup>

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- [11] Diagnostic and Statistical Manual (<http://www.psych.org/MainMenu/Research/DSMIV.aspx>)
- [12] psychiatryonline.org (<http://www.psychiatryonline.org/>)
- [13] HealthyMinds.org (<http://www.healthyminds.org/>)
- [21] Psychiatric participation in interrogation of detainees ([http://web.archive.org/web/20060622063118/http://www.psych.org/edu/other\\_res/lib\\_archives/archives/200601.pdf](http://web.archive.org/web/20060622063118/http://www.psych.org/edu/other_res/lib_archives/archives/200601.pdf))
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## External links

- Official website (<http://www.psychiatry.org>)

# DSM-5

**DSM-5** (formerly known as **DSM-V**) is the fifth edition of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders*. In the United States the DSM serves as a universal authority for the diagnosis of psychiatric disorders. Treatment recommendations, as well as payment by health care providers, are often determined by DSM classifications, so the appearance of a new version has significant practical importance.

The DSM-5 was published on May 18, 2013, superseding the DSM-IV-TR, which was published in 2000. The development of the new edition began with a conference in 1999, and proceeded with the formation of a Task Force in 2007, which developed and field-tested a variety of new classifications. In most respects DSM-5 is not greatly changed from DSM-IV-TR. Notable innovations include dropping Asperger syndrome as a distinct classification; loss of subtype classifications for variant forms of schizophrenia; dropping the "bereavement exclusion" for depressive disorders; a revised treatment and naming of gender identity disorder to Gender dysphoria, and a new gambling disorder.

The fifth edition has been criticized by a number of authorities before it was formally published. The main thrust of criticism has been that changes in the DSM have not kept pace with advances in scientific understanding of psychiatric dysfunction. Another criticism is that the development of DSM-5 was unduly influenced by input from the psychiatric drug industry. A number of scientists have objected that the DSM forces clinicians to make distinctions that are not supported by solid evidence, distinctions that have major treatment implications, including drug prescriptions and the availability of health insurance coverage. General criticism of the DSM-5 ultimately resulted in a petition signed by 13,000, and sponsored by many mental health organizations, which called for outside review of the document.

## Changes in DSM-5

### Section I

Section I describes DSM-5 chapter organization, its multiaxial system, and Section III's dimensional assessments.<sup>[1]</sup> The DSM-5 deleted the chapter that includes disorders usually first diagnosed in infancy, childhood, or adolescence" opting to list them in other chapters.<sup>[1]</sup> A note under Anxiety Disorders says that the "sequential order" of at least some DSM-5 chapters has significance that reflects the relationships between diagnoses.<sup>[1]</sup>

This introductory section describes the process of DSM revision, including field trials, public and professional review, and expert review. It states its goal is to harmonize with the ICD systems and share organizational structures as much as is feasible. Concern about the categorical system of diagnosis is expressed, but the conclusion is the reality that alternative definitions for most disorders is scientifically premature.

The new version replaces the NOS categories with two options: *other specified disorder* and *unspecified disorder* to increase the utility to the clinician. The first allows the clinician to specify the reason that the criteria for a specific disorder are not met; the second allows the clinician the option to forgo specification.

DSM-5 has discarded the multiaxial system of diagnosis (formerly Axis I, Axis II, Axis III), listing all disorders in Section II. It has replaced Axis IV with significant psychosocial and contextual features and dropped Axis V (Global Assessment of Functioning, known as GAF). The World Health Organization's (WHO) Disability Assessment Schedule is added to Section III (Emerging measures and models) under Assessment Mesures.<sup>[1]</sup>

## Section II: diagnostic criteria and codes

### Neurodevelopmental disorders

- "Mental retardation" has a new name: "intellectual disability (intellectual developmental disorder)"<sup>[1]</sup>
- Phonological disorder and stuttering are now called communication disorders—which include language disorder, speech sound disorder, childhood-onset fluency disorder, and a new condition characterized by impaired social verbal and nonverbal communication called social (pragmatic) communication disorder<sup>[1]</sup>
- Autism spectrum disorder incorporates Asperger disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified (PDD-NOS) - see Diagnosis of Asperger syndrome#Proposed changes to DSM-5<sup>[1]</sup>

### Schizophrenia spectrum and other psychotic disorders

- All subtypes of schizophrenia were deleted (paranoid, disorganized, catatonic, undifferentiated, and residual).<sup>[1]</sup>
- A major mood episode is required for schizoaffective disorder (for a majority of the disorder's duration after criterion A is met).<sup>[1]</sup>
- Criteria for delusional disorder changed, and, in DSM-5, delusional disorder is no longer separate from shared delusional disorder.<sup>[1]</sup>
- In DSM-5, catatonia in all contexts requires 3 of a total of 12 symptoms. Catatonia may be a specifier for depressive, bipolar, and psychotic disorders; part of another medical condition; or an other specified diagnosis.<sup>[1]</sup>

### Bipolar and related disorders

- New specifier "with mixed features" can be applied to bipolar I disorder, bipolar II disorder, bipolar disorder NED (previously called "NOS") and MDD<sup>[2]</sup>
- Allows other specified bipolar and related disorder for particular conditions.<sup>[1]</sup>
- Anxiety symptoms are a specifier added to bipolar disorder and to depressive disorders (but are not part of the bipolar diagnostic criteria).<sup>[1]</sup>

### Depressive disorders

- The bereavement exclusion in DSM-IV was removed from depressive disorders in DSM-5.<sup>[3]</sup>
- New disruptive mood dysregulation disorder (DMDD)<sup>[4]</sup> for children up to age 18 years<sup>[1]</sup>
- Premenstrual dysphoric disorder moved from an appendix for further study, and became a disorder.<sup>[1]</sup>
- Specifiers were added for mixed symptoms and for anxiety, along with guidance to physicians for suicidality.<sup>[1]</sup>

### Anxiety disorders

- For the various forms of phobias and anxiety disorders, DSM-5 removes the requirement that the subject (formerly, over 18 years old) "must recognize that their fear and anxiety are excessive or unreasonable". Also, the duration of at least 6 months now applies to everyone (not only to children).<sup>[1]</sup>
- Panic attack became a specifier for all DSM-5 disorders.<sup>[1]</sup>
- Panic disorder and agoraphobia became two separate disorders in DSM-5.<sup>[1]</sup>
- Specific types of phobias became specifiers but are otherwise unchanged.<sup>[1]</sup>
- The generalized specifier for social anxiety disorder (formerly, social phobia) changed in favor of a performance only (i.e., public speaking or performance) specifier.<sup>[1]</sup>
- Separation anxiety disorder and selective mutism are now classified as anxiety disorders (rather than disorders of early onset).<sup>[1]</sup>

### **Obsessive-compulsive and related disorders**

- A new chapter on obsessive-compulsive and related disorders includes four new disorders: excoriation (skin-picking) disorder, hoarding disorder, substance-/medication-induced obsessive-compulsive and related disorder, and obsessive-compulsive and related disorder due to another medical condition.<sup>[1]</sup>
- Trichotillomania (hair-pulling disorder) moved from "impulse-control disorders not elsewhere classified" in DSM-IV, to an obsessive-compulsive disorder in DSM-5.<sup>[1]</sup>
- A specifier was expanded (and added to body dysmorphic disorder and hoarding disorder) to allow for good or fair insight, poor insight, and "absent insight/delusional" (i.e., complete conviction that obsessive-compulsive disorder beliefs are true).<sup>[1]</sup>
- Criteria were added to body dysmorphic disorder to describe repetitive behaviors or mental acts that may arise with perceived defects or flaws in physical appearance.<sup>[1]</sup>
- The DSM-IV specifier "with obsessive-compulsive symptoms" moved from anxiety disorders to this new category for obsessive-compulsive and related disorders.<sup>[1]</sup>
- In DSM-5, other specified obsessive-compulsive and related disorder can include body-focused repetitive behavior disorder (behaviors like nail biting, lip biting, and cheek chewing, other than hair pulling and skin picking), obsessional jealousy, and unspecified obsessive-compulsive and related disorder.<sup>[1]</sup>

### **Trauma- and stressor-related disorders**

- Posttraumatic stress disorder (PTSD) is now included in a new section titled "Trauma- and Stressor-Related Disorders."<sup>[5]</sup>
- The PTSD diagnostic clusters were reorganized and expanded from a total of three clusters to four based on the results of confirmatory factor analytic research conducted since the publication of DSM-IV.<sup>[1]</sup>
- Separate criteria were added for children six years old or younger.<sup>[1]</sup>
- For the diagnosis of acute stress disorder and PTSD, the stressor criteria (Criterion A1 in DSM-IV) was modified to some extent, and the requirement for specific subjective emotional reactions (Criterion A2 in DSM-IV) was eliminated because it lacked empirical support for its utility and predictive validity<sup>[1]</sup> and resulted in certain groups, e.g., military personnel involved in combat, law enforcement officers and other first responders, lacking only the A2 criteria for a PTSD diagnosis because their training prepared them to not react emotionally to traumatic events.<sup>[6] [7] [8]</sup>
- Two new disorders that were formerly subtypes were named: reactive attachment disorder and disinhibited social engagement disorder.<sup>[1]</sup>
- Adjustment disorders were moved to this new section and reconceptualized as stress-response syndromes. DSM-IV subtypes for depressed mood, anxious symptoms, and disturbed conduct are unchanged.<sup>[1]</sup>

### **Dissociative disorders**

- Depersonalization disorder is now called depersonalization/derealization disorder.<sup>[1]</sup>
- Dissociative fugue became a specifier for dissociative amnesia.<sup>[1]</sup>
- In DSM-5, criteria were expanded in dissociative identity disorder to include "possession-form phenomena and functional neurological symptoms" and to say that "transitions in identity may be observable by others or self-reported".<sup>[1]</sup> Criterion B was also modified for people who can't recall everyday events (not only trauma).<sup>[1]</sup>

### Somatic symptom and related disorders

- Somatoform disorders are now called somatic symptom and related disorders. Diagnoses of somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder were deleted in DSM-5. In DSM-5, people with chronic pain could be diagnosed with somatic symptom disorder with predominant pain; or psychological factors that affect other medical conditions; or with an adjustment disorder.<sup>[1]</sup>
- Somatization disorder and undifferentiated somatoform disorder were combined to become somatic symptom disorder, a diagnosis which no longer requires a specific number of somatic symptoms.<sup>[1]</sup>
- In DSM-5, somatic symptom and related disorders are defined by positive symptoms, and minimize the use of medically unexplained symptoms except in the cases of conversion disorder and pseudocyesis specifically.<sup>[1]</sup>
- "Psychological factors affecting other medical conditions" (formerly found in the DSM-IV chapter "Other Conditions That May Be a Focus of Clinical Attention") is termed a new mental disorder.<sup>[1]</sup>
- Criteria for conversion disorder (functional neurological symptom disorder) were changed.<sup>[1]</sup>

### Feeding and eating disorders

- Criteria for pica and rumination disorder were changed and can now refer to people of any age.<sup>[1]</sup>
- Binge eating disorder graduated from DSM-IV's "Appendix B -- Criteria Sets and Axes Provided for Further Study".<sup>[9]</sup>
- Requirements for bulimia nervosa and binge eating disorder were changed from "at least twice weekly for 6 months to at least once weekly over the last 3 months".
- Anorexia nervosa no longer has a requirement of amenorrhea and its criteria were changed.
- What in DSM-IV was called "feeding disorder of infancy or early childhood" and rarely used, is now called avoidant/restrictive food intake disorder with expanded criteria.<sup>[1]</sup>

### Sleep-wake disorders

- "Sleep disorders related to another mental disorder, and sleep disorders related to a general medical condition" were deleted from DSM-IV.<sup>[1]</sup>
- Primary insomnia became insomnia disorder in DSM-5, and narcolepsy is separate from other hypersomnolence.<sup>[1]</sup>
- In DSM-5, there are three breathing-related sleep disorders: obstructive sleep apnea hypopnea, central sleep apnea, and sleep-related hypoventilation.<sup>[1]</sup>
- Circadian rhythm sleep-wake disorders were expanded to include advanced sleep phase syndrome, irregular sleep-wake type, and non-24-hour sleep-wake type.<sup>[1]</sup> Jet lag was removed.<sup>[1]</sup>
- Listed under "dyssomnia not otherwise specified" in DSM-IV, rapid eye movement sleep behavior disorder and restless legs syndrome are each a disorder in DSM-5.<sup>[1]</sup>

### Sexual dysfunctions

- DSM-5 has gender-specific sexual dysfunctions.<sup>[1]</sup>
- For females, sexual desire and arousal disorders are combined into female sexual interest/arousal disorder.<sup>[1]</sup>
- DSM-5 sexual dysfunctions (except substance-/medication-induced sexual dysfunction) now require a duration of approximately 6 months and more exact severity criteria.<sup>[1]</sup>
- New in DSM-5 is genito-pelvic pain/penetration disorder which combines vaginismus and dyspareunia from DSM-IV.<sup>[1]</sup>
- Sexual aversion disorder was deleted.<sup>[1]</sup>
- DSM-5 subtypes for all disorders includes only "lifelong versus acquired" and "generalized versus situational" (one subtype was deleted from DSM-IV).<sup>[1]</sup>
- In DSM-5, two subtypes were deleted: "sexual dysfunction due to a general medical condition" and "due to psychological versus combined factors".<sup>[1]</sup>

### Gender dysphoria

- DSM-IV gender identity disorder is similar to, but not the same as, gender dysphoria in DSM-5. Separate criteria for children, adolescents and adults that are appropriate for varying developmental states are added.
- Subtypes of gender identity disorder based on sexual orientation were deleted.<sup>[1]</sup>
- Among other wording changes, criterion A and criterion B (cross-gender identification, and aversion toward one's gender) were combined.<sup>[1]</sup> Along with these changes comes the creation of a separate gender dysphoria in children as well as one for adults and adolescents. The grouping has been moved out of the sexual disorders category and into its own. The name change was made in part due to stigmatization of the term "disorder" and the relatively common use of "gender dysphoria" in the GID literature and among specialists in the area.<sup>[10]</sup> The creation of a specific diagnosis for children reflects the lesser ability of children to have insight into what they are experiencing and ability to express it in the event that they have insight.<sup>[11]</sup>

### Disruptive, impulse-control, and conduct disorders

Some of these disorders were formerly part of the chapter on early diagnosis, oppositional defiant disorder; conduct disorder; and disruptive behavior disorder not otherwise specified became other specified and unspecified disruptive disorder, impulse-control disorder, and conduct disorders.<sup>[1]</sup> Intermittent explosive disorder, pyromania, and kleptomania moved to this chapter from the DSM-IV chapter "Impulse-Control Disorders Not Otherwise Specified".<sup>[1]</sup>

- Antisocial personality disorder is listed here *and* in the chapter on personality (neurocognitive) disorders (but ADHD is listed under neurodevelopmental disorders).<sup>[1]</sup>
- Symptoms for oppositional defiant disorder are of three types: angry/irritable mood, argumentative/defiant behavior, and vindictiveness. The conduct disorder exclusion is deleted. The criteria were also changed with a note on frequency requirements and a measure of severity.<sup>[1]</sup>
- Criteria for conduct disorder are unchanged for the most part from DSM-IV.<sup>[1]</sup> A specifier was added for people with limited "prosocial emotion".<sup>[1]</sup>
- People over the disorder's minimum age of 6 may be diagnosed with intermittent explosive disorder without outbursts of physical aggression.<sup>[1]</sup> Criteria were added for frequency and to specify "impulsive and/or anger based in nature, and must cause marked distress, cause impairment in occupational or interpersonal functioning, or be associated with negative financial or legal consequences".<sup>[1]</sup>

### Substance-related and addictive disorders

- Gambling disorder and tobacco use disorder are new.<sup>[1]</sup>
- Substance abuse and substance dependence have been combined into single substance use disorders specific to each substance of abuse within a new "addictions and related disorders" category.<sup>[12]</sup> "Recurrent legal problems" was deleted and "craving or a strong desire or urge to use a substance" was added to the criteria.<sup>[1]</sup> The threshold of the number of criteria that must be met was changed.<sup>[1]</sup> Severity from mild to severe is based on the number of criteria endorsed.<sup>[1]</sup> Criteria for cannabis and caffeine withdrawal were added.<sup>[1]</sup> New specifiers were added for early and sustained remission along with new specifiers for "in a controlled environment" and "on maintenance therapy".<sup>[1]</sup>

## Neurocognitive disorders

- Dementia and amnestic disorder became major or mild neurocognitive disorder (major NCD, or mild NCD).<sup>[1][13]</sup> DSM-5 has a new list of neurocognitive domains.<sup>[1]</sup> "New separate criteria are now presented" for major or mild NCD due to various conditions.<sup>[1]</sup> Substance/medication-induced NCD and unspecified NCD are new diagnoses.<sup>[1]</sup>

## Paraphilic disorders

- New specifiers "in a controlled environment" and "in remission" were added to criteria for all paraphilic disorders.<sup>[1]</sup>
- Distinguishes between paraphilic behaviors, or paraphilias, and paraphilic disorders.<sup>[14]</sup> All criteria sets were changed to add the word disorder to all of the paraphilias, for example, pedophilia is now pedophilic disorder.<sup>[1]</sup> There is no change in the basic diagnostic structure since DSM-III-R, however, people now must meet both qualitative (criterion A) and negative consequences (criterion B) criteria to be diagnosed with a paraphilic disorder. Otherwise they have a paraphilia (and no diagnosis).<sup>[1]</sup>

## Section III: emerging measures and models

### Alternative DSM-5 model for personality disorders

An alternative hybrid dimensional-categorical model for personality disorders is included to stimulate further research on this modified classification system.<sup>[1]</sup>

## Conditions for further study in DSM-5

These conditions and criteria are set forth to encourage future research and are not meant for clinical use.

- Attenuated psychosis syndrome
- Depressive episodes with short-duration hypomania
- Persistent complex bereavement disorder
- Caffeine use disorder
- Internet gaming disorder
- Neurobehavioral disorder associated with prenatal alcohol exposure
- Suicidal behavior disorder
- Non-suicidal self-injury<sup>[1]</sup>

## Development

In 1999, a DSM-5 Research Planning Conference; sponsored jointly by APA and the National Institute of Mental Health (NIMH), was held to set the research priorities. Research Planning Work Groups produced "white papers" on the research needed to inform and shape the DSM-5<sup>[15]</sup> and the resulting work and recommendations were reported in an APA monograph<sup>[16]</sup> and peer-reviewed literature.<sup>[17]</sup> There were six workgroups, each focusing on a broad topic: Nomenclature, Neuroscience and Genetics, Developmental Issues and Diagnosis, Personality and Relational Disorders, Mental Disorders and Disability, and Cross-Cultural Issues. Three additional white papers were also due by 2004 concerning gender issues, diagnostic issues in the geriatric population, and mental disorders in infants and young children.<sup>[1]</sup> The white papers have been followed by a series of conferences to produce recommendations relating to specific disorders and issues, with attendance limited to 25 invited researchers.<sup>[1]</sup>

On July 23, 2007, the APA announced the task force that would oversee the development of DSM-5. The DSM-5 Task Force consisted of 27 members, including a chair and vice chair, who collectively represent research scientists from psychiatry and other disciplines, clinical care providers, and consumer and family advocates. Scientists working on the revision of the DSM have experience in research, clinical care, biology, genetics, statistics, epidemiology, public health, and consumer advocacy. They have interests ranging from cross-cultural medicine and

genetics to geriatric issues, ethics and addiction. The APA Board of Trustees required that all task force nominees disclose any competing interests or potentially conflicting relationships with entities that have an interest in psychiatric diagnoses and treatments as a precondition to appointment to the task force. The APA made all task force members' disclosures available during the announcement of the task force. Several individuals were ruled ineligible for task force appointments due to their competing interests. Future announcements will include naming the workgroups on specific categories of disorders and their research-based recommendations on updating various disorders and definitions.<sup>[18]</sup>

The DSM-5 field trials included test-retest reliability which involved different clinicians doing independent evaluations of the same patient—a common approach to the study of diagnostic reliability.<sup>[19]</sup>

## Criticism

Robert Spitzer, the head of the DSM-III task force, has publicly criticized the APA for mandating that DSM-5 task force members sign a nondisclosure agreement, effectively conducting the whole process in secret: "When I first heard about this agreement, I just went bonkers. Transparency is necessary if the document is to have credibility, and, in time, you're going to have people complaining all over the place that they didn't have the opportunity to challenge anything."<sup>[1]</sup> Allen Frances, chair of the DSM-IV task force, expressed a similar concern.<sup>[20]</sup>

Although the APA has since instituted a disclosure policy for DSM-5 task force members, many still believe the Association has not gone far enough in its efforts to be transparent and to protect against industry influence.<sup>[1]</sup> In a 2009 Point/Counterpoint article, Lisa Cosgrove, PhD and Harold J. Bursztajn, MD noted that "the fact that 70% of the task force members have reported direct industry ties—an increase of almost 14% over the percentage of DSM-IV task force members who had industry ties—shows that disclosure policies alone, especially those that rely on an honor system, are not enough and that more specific safeguards are needed."<sup>[21]</sup>

David Kupfer, chair of the DSM-5 task force, and Darrel A. Regier, MD, MPH, vice chair of the task force, whose industry ties are disclosed with those of the task force,<sup>[22]</sup> countered that "collaborative relationships among government, academia, and industry are vital to the current and future development of pharmacological treatments for mental disorders." They asserted that the development of DSM-5 is the "most inclusive and transparent developmental process in the 60-year history of DSM." The developments to this new version can be viewed on the APA website.<sup>[23]</sup> Public input was requested for the first time in the history of the manual.<sup>[citation needed]</sup> During periods of public comment, members of the general public could sign up at the DSM-5 website<sup>[24]</sup> and provide feedback on the various proposed changes.<sup>[25]</sup>

In June 2009 Allen Frances issued strongly worded criticisms of the processes leading to DSM-5 and the risk of "serious, subtle, (...) ubiquitous" and "dangerous" unintended consequences such as new "false 'epidemics'". He writes that "the work on DSM-V has displayed the most unhappy combination of soaring ambition and weak methodology" and is concerned about the task force's "inexplicably closed and secretive process."<sup>[26]</sup> His and Spitzer's concerns about the contract that the APA drew up for consultants to sign, agreeing not to discuss drafts of the fifth edition beyond the task force and committees, have also been aired and debated.<sup>[27]</sup>

The appointment, in May 2008, of two of the taskforce members, Kenneth Zucker and Ray Blanchard, led to an internet petition to remove them.<sup>[28]</sup> According to MSNBC, "The petition accuses Zucker of having engaged in 'junk science' and promoting 'hurtful theories' during his career, especially advocating the idea that children who are unambiguously male or female anatomically, but seem confused about their gender identity, can be treated by encouraging gender expression in line with their anatomy."<sup>[1]</sup> According to *The Gay City News*, "Dr. Ray Blanchard, a psychiatry professor at the University of Toronto, is deemed offensive for his theories that some types of transsexuality are paraphilias, or sexual urges. In this model, transsexuality is not an essential aspect of the individual, but a misdirected sexual impulse."<sup>[29]</sup> Blanchard responded, "Naturally, it's very disappointing to me there seems to be so much misinformation about me on the Internet. [They didn't distort] my views, they completely reversed my views."<sup>[29]</sup> Zucker "rejects the junk-science charge, saying there 'has to be an empirical basis to modify

anything' in the DSM. As for hurting people, 'in my own career, my primary motivation in working with children, adolescents and families is to help them with the distress and suffering they are experiencing, whatever the reasons they are having these struggles. I want to help people feel better about themselves, not hurt them.'<sup>[1]</sup>

In 2011, psychologist Brent Robbins co-authored a national letter for the Society for Humanistic Psychology that brought thousands into the public debate about the DSM. Approximately 13,000 individuals and mental health professionals signed a petition in support of the letter. Thirteen other American Psychological Association divisions endorsed the petition.<sup>[30]</sup> In a November 2011 article about the debate in the *San Francisco Chronicle*, Robbins notes that under the new guidelines, certain responses to grief could be labeled as pathological disorders, instead of being recognized as being normal human experiences.<sup>[31]</sup> In 2012, a footnote was added to the draft text which explains the distinction between grief and depression.<sup>[1]</sup>

DSM-5, has been criticized for purportedly saying nothing about the biological underpinnings of mental disorders.<sup>[32]</sup>

## **Borderline personality disorder controversy**

In 2003, the Treatment and Research Advancements National Association for Personality Disorders (TARA-APD) campaigned to change the name and designation of borderline personality disorder in DSM-5.<sup>[33]</sup> The paper *How Advocacy is Bringing BPD into the Light*<sup>[34]</sup> reported that "the name BPD is confusing, imparts no relevant or descriptive information, and reinforces existing stigma...". Instead, it proposed the name "emotional regulation disorder" or "emotional dysregulation disorder". There was also discussion about changing borderline personality disorder, an Axis II diagnosis (personality disorders and mental retardation), to an Axis I diagnosis (clinical disorders).<sup>[35]</sup>

## **More radical criticisms**

Some authors believe that the problem is not simply of a few criteria to be deleted or modified. For example, a Kuhnian reformulation of the diagnostic debate suggested that apparently trivial problems of the DSM, like the extremely high rates of comorbidity, might fruitfully be analysed as Kuhnian anomalies leading the DSM system to a scientific crisis.<sup>[36]</sup> As a consequence, a radical rethinking of the concept of mental disorder was proposed, addressing its constructive nature.<sup>[37]</sup> Based on similar views, several revolutionary approaches were proposed, ranging from dimensional diagnosis to various forms of etiopathogenetic diagnosis.<sup>[38]</sup>

The financial association of DSM-5 panel members with industry continues to be a concern for financial conflict of interest.<sup>[59]</sup> Of the DSM-5 task force members, 69% report having ties to the pharmaceutical industry, an increase from the 57% of DSM-IV task force members.<sup>[59]</sup>

## **British Psychological Society response**

The British Psychological Society in the United Kingdom stated in its June 2011 response that it had "more concerns than plaudits".<sup>[39]</sup> It criticized proposed diagnoses as "*clearly based largely on social norms, with 'symptoms' that all rely on subjective judgements... not value-free, but rather reflect[ing] current normative social expectations*", noting doubts over the reliability, validity, and value of existing criteria, that personality disorders were not normed on the general population, and that "not otherwise specified" categories covered a "huge" 30% of all personality disorders.

It also expressed a major concern that "*clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences... which demand helping responses, but which do not reflect illnesses so much as normal individual variation*".

The Society suggested as its primary specific recommendation, a change from using "diagnostic frameworks" to a description based on an individual's specific experienced problems, and that mental disorders are better explored as part of a spectrum shared with normality:

[We recommend] a revision of the way mental distress is thought about, starting with recognition of the overwhelming evidence that it is on a spectrum with 'normal' experience, and that psychosocial factors such as poverty, unemployment and trauma are the most strongly-evidenced causal factors. Rather than applying preordained diagnostic categories to clinical populations, we believe that any classification system should begin from the bottom up – starting with specific experiences, problems or 'symptoms' or 'complaints'..... We would like to see the base unit of measurement as specific problems (e.g. hearing voices, feelings of anxiety etc)? These would be more helpful too in terms of epidemiology.

While some people find a name or a diagnostic label helpful, our contention is that this helpfulness results from a knowledge that their problems are recognised (in both senses of the word) understood, validated, explained (and explicable) and have some relief. Clients often, unfortunately, find that diagnosis offers only a spurious promise of such benefits. Since – for example – two people with a diagnosis of 'schizophrenia' or 'personality disorder' may possess no two symptoms in common, it is difficult to see what communicative benefit is served by using these diagnoses. We believe that a description of a person's real problems would suffice. Moncrieff and others have shown that diagnostic labels are less useful than a description of a person's problems for predicting treatment response, so again diagnoses seem positively unhelpful compared to the alternatives.

—British Psychological Society June 2011 response

## National Institute of Mental Health

National Institute of Mental Health director Thomas R. Insel, MD,<sup>[40]</sup> wrote in an April 29, 2013 blog post:<sup>[41]</sup>

The goal of this new manual, as with all previous editions, is to provide a common language for describing psychopathology. While DSM has been described as a "Bible" for the field, it is, at best, a dictionary, creating a set of labels and defining each. The strength of each of the editions of DSM has been "reliability" – each edition has ensured that clinicians use the same terms in the same ways. The weakness is its lack of validity. ... Patients with mental disorders deserve better.

Insel also discussed an NIMH effort to develop a new classification system, Research Domain Criteria (RDoC), currently for research purposes only.<sup>[42]</sup> Insel's post sparked a flurry of reaction, some of which might be termed sensationalistic, with headlines such as "Goodbye to the DSM-V",<sup>[43]</sup> "Federal institute for mental health abandons controversial 'bible' of psychiatry",<sup>[44]</sup> "National Institute of Mental Health abandoning the DSM",<sup>[45]</sup> and "Psychiatry divided as mental health 'bible' denounced."<sup>[46]</sup> Other responses provided a more nuanced analysis of the NIMH Director's post.<sup>[47]</sup>

In May 2013, Insel, on behalf of NIMH, issued a joint statement with Jeffrey A. Lieberman, MD, president of the American Psychiatric Association,<sup>[48]</sup> that emphasized that DSM-5, "...represents the best information currently available for clinical diagnosis of mental disorders. Patients, families, and insurers can be confident that effective treatments are available and that the DSM is the key resource for delivering the best available care. The National Institute of Mental Health (NIMH) has not changed its position on DSM-5." Insel and Lieberman say that DSM-5 and RDoC "represent complementary, not competing, frameworks" for characterizing diseases and disorders.<sup>[49]</sup>

## References

- [19] Reliability and Prevalence in the DSM-5 Field Trials, January 12, 2012 [http://www.dsm5.org/Documents/Reliability\\_and\\_Prevalence\\_in\\_DSM-5\\_Field\\_Trials\\_1-12-12.pdf](http://www.dsm5.org/Documents/Reliability_and_Prevalence_in_DSM-5_Field_Trials_1-12-12.pdf)
- [20] Psychiatrists Propose Revisions to Diagnosis Manual. ([http://www.pbs.org/newshour/bb/health/jan-june10/mentalillness\\_02-10.html](http://www.pbs.org/newshour/bb/health/jan-june10/mentalillness_02-10.html)) via PBS Newshour, Feb 10, 2010 (interviews Frances and Alan Schatzberg on some of the main changes proposed to the DSM-5)
- [21] Cosgrove L, Bursztajn HJ, Kupfer DJ, Regier DA. "Toward Credible Conflict of Interest Policies in Clinical Psychiatry" (<http://www.psychiatrictimes.com/dsm-v/article/10168/1364672?pageNumber=1>) Psychiatric Times 26:1.
- [22] and
- [23] DSM-5 Overview: The Future Manual | APA DSM-5 (<http://www.psych.org/MainMenu/Research/DSMIV/DSMV.aspx>)
- [24] Registration page for DSM-5 public comment (<http://www.dsm5.org/Pages/Registration.aspx>), page found 2011-06-05.
- [25] "Suggestions and ideas for members of the work groups were also solicited through the DSM-5 website. The proposed draft revisions to DSM-5 are posted on the website, and anyone can provide feedback to the work groups during periods of public comment." Question 4 on the DSM-5 FAQ (<http://www.dsm5.org/about/Pages/faq.aspx#4>), page found 2011-06-05.
- [32] *New DSM-5 Ignores Biology of Mental Illness* (<http://www.scientificamerican.com/article.cfm?id=new-dsm5-ignores-biology-mental-illness>); "The latest edition of psychiatry's standard guidebook neglects the biology of mental illness. New research may change that." May 5, 2013 Scientific American
- [33] Treatment and Research Advancements National Association for Personality Disorders (TARA-APD) (<http://www.tara4bpd.org>)
- [34] How Advocacy is Bringing BPD into the Light (<http://www.tara4bpd.org/dyn/index.php?option=content&task=view&id=32&Itemid=35>)
- [36] Aragona M. (2009). The role of comorbidity in the crisis of the current psychiatric classification system ([http://muse.jhu.edu/journals/philosophy\\_psychiatry\\_and\\_psychology/v016/16.1.aragona.pdf](http://muse.jhu.edu/journals/philosophy_psychiatry_and_psychology/v016/16.1.aragona.pdf)) PDF. *Philosophy, Psychiatry, & Psychology* 16: 1-11
- [37] Aragona M. (2009) The concept of mental disorder and the DSM-V (<http://www.crossingdialogues.com/Ms-A08-02.pdf>) *Dialogues in Philosophy, Mental and Neuro Sciences* 2: 1-14
- [38] (an example from a cognitive point of view) Sirgiovanni E. (2009) The Mechanistic Approach to Psychiatric Classification (<http://www.crossingdialogues.com/Ms-C09-02.pdf>) *Dialogues in Philosophy, Mental and Neuro Sciences* 2: 45-49
- [39] British Psychological Society Response, June 2011 ([http://apps.bps.org.uk/\\_publicationfiles/consultation-responses/DSM-5 2011 - BPS response.pdf](http://apps.bps.org.uk/_publicationfiles/consultation-responses/DSM-5 2011 - BPS response.pdf))

## External links

- Official DSM-5 Development Website (<http://www.dsm5.org/pages/default.aspx>)

# DSM-5 codes

This article gives an overview of diagnostic codes from DSM-5, the fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*.

## Neurodevelopmental disorders

Disorders with onset in the developmental period, often before starting school, and characterized by a range of developmental deficits that impair normal functioning.<sup>[1]</sup>

- **Intellectual developmental disorder**

Deficits in intellectual functioning and every day adaptive functioning with onset during the developmental period.

*Specifiers*

Mild

Moderate

Severe

Profound

- **315.8 Global developmental delay**

Pertains to those under 5 years old whose intellectual functioning can not be systematically assessed.

- **319 Unspecified intellectual disability (Intellectual developmental disorder)**

Used in exceptional circumstances for individuals over 5 years old whose intellectual disability cannot be assessed because of sensory or physical impairments.

- **Communication disorders**

Deficits in language, speech, or in any behaviors affecting verbal and nonverbal communications

- **315.39 Language disorder**

Persistent deficits in comprehension or production of language (e.g. spoken, written, sign language) substantially below age level, beginning in the early developmental period, and not due to other disorders or conditions

- **315.39 Speech sound disorder**

Persistent deficits in speech sound production, below that expected of age and developmental level, not due to other impairments such as a physical, neurological or hearing disorders or conditions

- **315.35 Childhood-onset fluency disorder (stuttering)**

Disturbance in normal speech patterns and fluency that interferes with normal achievement

- **315.39 Social (Pragmatic) communication disorder**

Primary deficits in understanding and following social practices of verbal and nonverbal communication in normal settings that functionally impair the individual; not better explained by other deficits

- **307.9 Unspecified communication disorder**

Clinically significant symptoms of a communication disorder, but fails to meet the full criteria for any of the communication or neurodevelopmental disorders and the clinician does not specify the reason

- **299.00 Autism spectrum disorder**

Persistent communication and social interaction deficits in multiple situations; restricted, repetitive behavior and interests, originally manifested in the early developmental period and causing significant impairment

*Specify if:*

- With or without accompanying intellectual impairment
- With or without accompanying language impairment
- Associated with a known medical or genetic condition or environmental factor
- Associated with another neurodevelopmental, mental, or behavioral disorder
- With catatonia

- **Attention-deficit/Hyperactivity disorder (ADHD)**

"Persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development" beginning in childhood, and present across more than one setting<sup>[1]</sup>

*Specify whether:*

- **314.01 Combined presentation**
- **314.00 Predominantly inattentive presentation**
- **314.01 Predominantly hyperactive/impulsive presentation**

*Specify if:*

- In partial remission

*Specify current severity:*

- Mild
- Moderate
- Severe

- **314.01 Other specified attention-deficit/Hyperactivity disorder**

Symptoms of ADHD are present and cause significant impairment in important functional areas, but do not meet the full criteria, and where the reason for failing the criteria is specified.

- **314.01 Unspecified attention-deficit/Hyperactivity disorder**

Same as 314.01 above but with no reason specified or insufficient information is available to provide one

- **Specific learning disorder**

A neurodevelopmental disorder of biological origin manifested in learning difficulty and problems in acquiring academic skills markedly below age level and manifested in the early school years, lasting for at least 6 months; not attributed to intellectual disabilities, developmental disorders, or neurological or motor disorders

*Specify if:*

- **315.00 With impairment in reading**
- **315.2 With impairment in written expression**
- **315.1 With impairment in mathematics**

*Specify current severity:*

- Mild
- Moderate
- Severe

- **Motor disorders.<sup>[1]</sup>**

- **315.4 Developmental coordination disorder**

Motor skill development substantially below age group, interfere with normal activities, and begin in "early developmental period". Not better accounted for by intellectual disabilities, visual problems, or a neurological

condition such as cerebral palsy, or a degenerative disorder.

- **307.3 Stereotypic movement disorder**

Repetitive, seemingly purposeless, often rhythmical motor behavior that interferes with normal activities, with onset in the "early developmental period".

*Specify if:*

With self-injurious behavior

With-out self-injurious behavior

*Specify if:*

Associated with a known medical or genetic condition, neurodevelopmental disorder, or environmental factor

*Specify current severity:*

Mild

Moderate

Severe

- **Tic disorders**

"A tic is a sudden, rapid, recurrent, nonrhythmic motor movement or vocalization". Tic disorders are not due to use of a substance or to another medical condition; the diagnosis depends on the lack of any known cause.<sup>[1]</sup>

- **307.23 Tourette's disorder**

Multiple motor tics and at least one vocal tic present for more than one year, though not necessarily at the same time, with onset before age 18.

- **307.22 Persistent (Chronic) motor or vocal tic disorder**

At least one motor or vocal tic, but not both; must be present for more than one year with onset before age 18.

*Specify if:*

With motor tics only

With vocal tics only

- **307.21 Provisional tic disorder**

One or more motor and/or vocal tics, present for less than one year; onset before age 18.

- **307.20 Other specified tic disorder**

Characteristic tic disorder symptoms causing distress or impairment but not meeting the "criteria for a tic disorder or any specific neurodevelopmental disorder"; the specific reason given e.g. onset over the age of 18

- **307.20 Unspecified tic disorder<sup>[1]</sup>**

Same as "307.20 Other specified tic disorder", but the reason is not specified

- Other neurodevelopmental disorders

- **315.8 Other specified neurodevelopmental disorder**

A category that pertains to characteristic symptoms of a neurodevelopmental disorder causing significant impairment but does not fulfill the criteria of a specific diagnostic class.

*Specify:* Specific reason, such as "associated with prenatal alcohol exposure"

- **315.9 Unspecified neurodevelopmental disorder**

A category similar to 315.8, but without a specified reason.

## Schizophrenia spectrum and other psychotic disorders

Key features that define the psychotic disorders in DSM-5 are:<sup>[1]</sup>

Delusions - fixed beliefs not open to change even when evidence contradicts them; termed *bizarre* if implausible and not derived from ordinary experience

Hallucinations - involuntary sensory experiences not related to external stimuli

Disorganized thinking (speech) - derailment of focal topic or loose associations, incoherence

Grossly disorganized or abnormal motor behavior (including catatonia)

Negative symptoms - reduced emotional expression, avolition, alogia, anhedonia, asociality

- **297.1 Delusional disorder** - presence of one or more fixed delusions, but otherwise functioning usually is not noticeably impaired.<sup>[1]</sup>

*Specify whether:*

Eerotomaniac type

Grandiose type

Jealous type

Persecutory type

Somatic type

Mixed type

Unspecified type

*Specify if:*

With bizarre content

*Specify if:*

First episode, currently in acute episode

First episode, currently in partial remission

First episode, currently in full remission

Multiple episodes, currently in acute episode

Multiple episodes, currently in partial remission

Multiple episodes, currently in full remission

Unspecified

*Specify current severity:*

- **298.8 Brief psychotic disorder** - sudden onset of at least one positive psychotic symptom, such as delusions, hallucinations, disorganized speech, lasting at least one day but less than one month

*Specify if:*

With marked stressor(s)

Without marked stressor(s)

With postpartum onset

*Specify if:*

With catatonia

*Specify current severity:*

- **295.40 Schizoaffective disorder**

Symptoms identical to schizophrenia but lasting less than 6 months

*Specify if:*

With good prognostic features

Without good prognostic features

*Specify if:*

With catatonia

*Specify current severity:*

- **295.90 Schizophrenia**

At least two of the following: (one of which must be delusions, hallucinations or disorganized speech), grossly disorganized or catatonic behavior, negative symptoms

*Specify if:*

First episode, currently in acute episode

First episode, currently in partial remission

First episode, currently in full remission

Multiple episodes, currently in acute episode

Multiple episodes, currently in partial remission

Multiple episodes, currently in full remission

Unspecified

*Specify if:*

With catatonia

*Specify current severity*

- **Schizoaffective disorder**

Major depressive or manic mood disorder concurrent with primary symptoms of schizophrenia

*Specify whether:*

295.70 Bipolar type

295.70 Depressive type

*Specify if:*

With catatonia

*Specify if:*

First episode, currently in acute episode

First episode, currently in partial remission

First episode, currently in full remission

Multiple episodes, currently in acute episode

Multiple episodes, currently in partial remission

Multiple episodes, currently in full remission

Continuous

Unspecified

*Specify current severity*

- **Substance/Medication-induced psychotic disorder**

- **Psychotic disorder due to another medical condition**

**293.81 With delusion as the predominant symptom**

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**293.82 With hallucinations as the predominant symptom****Catatonia**

Marked psychomotor disturbance including decreased motor activity, or excessive and peculiar motor activity, ranging from unresponsiveness to agitation. Can include stupor, catlepsy and waxy flexibility, mutism and other puzzling behaviors. Rather than being a separate diagnosis, catatonia is associated with other mental disorders, other medical conditions, or can be unspecified.

- **293.89 Catatonia associated with another mental disorder (Catatonia specifier)**

Specifier is defined by three or more of 12 listed symptoms

- **293.89 Catatonic disorder due to another medical condition**

Criteria include three or more of 12 listed symptoms

- **293.89 Unspecified catatonia**

Characteristic symptoms of catatonia are present but the underlying disorder is unclear, the full criteria are not met, or the information available is insufficient

**Coding note:** Code first **781.99 "Other symptoms involving nervous and musculoskeletal systems"**, followed by 293.89

- **298.8 Other specified schizophrenia spectrum and other psychotic disorder**

Characteristic symptoms of schizophrenia spectrum and other psychotic disorder are present but full criteria for a diagnostic class are not met. The *other specified* is used to describe the presentation.

- **298.9 Unspecified schizophrenia spectrum and other psychotic disorder**

Characteristic symptoms of schizophrenia spectrum and other psychotic disorder are present but full criteria for a diagnostic class are not met, but the clinician does not specify the reason.

## Trauma- and stressor-related disorders

A new category has been created for those disorders that explicitly list in their criteria exposure to a traumatic or catastrophic event, emphasizing the close connection between disorders listed in this category and those in the categories of anxiety disorders, obsessive-compulsive disorders, and dissociative disorders. However, in this category's disorders the dominating characteristics are symptoms of anhedonia and dysphoria, anger and aggression, or symptoms of dissociation, or some combination of these, and vary considerably with heterogeneous presentations.<sup>[1]</sup>

- **313.89 Reactive attachment disorder**

A disorder of infancy or early childhood in which the child, though thought to be capable of forming selective attachments, does not seek comfort, protection or other nurturance associated with attachment to caregiving adults, and does not respond adequately to nurturing behaviors from caregivers when it is offered.

*Specify if:*

Persistent (more than 12 months)

*Specify current severity:*

- **313.89 Disinhibited social engagement disorder**

A behavioral pattern in children of overly familiar and culturally inappropriate interactions with relatives and strangers that violated social boundaries.

*Specify if:*

Persistent (over 12 months)

*Specify current severity:*

- **309.81 Posttraumatic stress disorder<sup>[1]</sup>**

There is a separate section for **Posttraumatic stress disorder for children 6 years and younger**

*Specify whether:*

With dissociative symptoms

1. Depersonalization
2. Derealization

*Specify if:*

With delayed expression (full criteria not expressed at least 6 months after traumatic event)

- **308.3 Acute stress disorder**

- **Adjustment disorder**

*Specify whether:*

**309.0 With depressed mood**

**309.24 With anxiety**

**309.28 With mixed anxiety and depressed mood**

**309.3 With disturbance of conduct**

**309.4 With mixed disturbance of emotions and conduct**

**309.9 Unspecified**

- **309.89 Other specified Trauma- and stressor-related disorder**

- **309.9 Unspecified trauma- and stressor-related disorder<sup>[1]</sup>**

## Dissociative disorders in DSM-5.<sup>[1]</sup>

Common to these disorders are disruptions or gaps in the normal integration of subjective experience resulting in discontinuities in affect, memory, behavior.

- **300.14 Dissociative identity disorder**

The primary feature is the presence of two or more distinct personalities, self-reported or observed by others, resulting in failure to recall everyday events and/or important autobiographical information, and impairing continuity in the sense of self. The "experience of possession" is included as a "personality".

- **300.12 Dissociative amnesia**

The primary feature is the inability to remember important life history information, usually traumatic, that has been successfully stored but is inaccessible to the individual, causing significant distress or impairment in life functioning.

*Specify if:*

**300.13 With dissociative fugue:** Travel or wandering associated with amnesia for identity or important autobiographical information

- **300.6 Depersonalization/Derealization disorder**

The primary feature is recurrent episodes of depersonalization and/or derealization that have functional consequences.

- **300.15 Other specified dissociative disorder**

Symptoms of a dissociative disorder are present but do not meet the full criteria for a specific disorder. The clinician specifies the reason.

- **300.15 Unspecified dissociative disorder**

As 300.15 above, but the clinician does not specify the reason

## Elimination disorders

- The elimination disorders, included in the chapter on early diagnosis in DSM-IV, is an independent class in DSM-5.
- **307.6 Enuresis**

*Specify if:*

- Nocturnal only
- Diurnal only
- Nocturnal and diurnal

- **307.7 Encopresis**

*Specify if:*

- With constipation and overflow incontinence
- Without constipation and overflo incontinence

- Other specified elimination disorder<sup>[1]</sup>

## Gender dysphoria in DSM-5<sup>[1]</sup>

- **302.6 Gender dysphoria in children**

*Specify if:*

- With a disorder of sex development (e.g. such as congenital adrenogenital disorder)

- **302.85 Gender dysphoria in adolescents and adults**

*Specify if:*

- With a disorder of sex development (e.g. congenital medial conditions such as congenital adrenogenital disorder)

- Posttransitional (the specifics of the person's degree of transition, medical procedures undergone or planned etc. to attain the desired gender)<sup>[1]</sup>

Comment on subtypes and specifiers

The sexual orientation subtyping has been removed as unrelated to gender dysphoria and therefore not useful clinically.

The posttransition specifier has been added because after gender transition, although many people no longer meet criteria for gender dysphoria they still remain in need of treatments to improve life in the desired gender and this specifier recognizes that need.<sup>[1]</sup>

## Disruptive, impulse-control, and conduct disorders in DSM-5

DSM-5 has a new chapter on disruptive, impulse-control, and conduct disorders to bring under one unique category those behavioral conditions that violate the rights of others and/or cause significant conflict with society or draw the attention of authority figures.<sup>[1]</sup> This DSM-5 category contains the following:<sup>[1]</sup>

- **313.81 Oppositional defiant disorder**

Frequent, persistent pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness exhibited over the course of at least six months, and with at least one non-sibling, and should exceed normal behavior for the individual's age, gender and culture.

*Specify current severity:*

Mild - symptoms occur in one setting only, such as home or school or work

Moderate - some symptoms present in at least two settings

Severe - some symptoms present in three or more settings

- **312.34 Intermittent explosive disorder**

Rapid onset of recurrent impulsive, verbally or physically aggressive outbursts typically lasting less than 30 minutes, usually in response to minimal provocation by an intimate or associate, and causing marked impairment in functioning or legal consequences.

- Conduct disorder

Repetitive pattern of behavior that violates the basic rights of others, falling in to four categories:

Aggressive behavior causing or threatening harm to people or animals

Non-aggressive behavior causing property damage or loss

Deceitfulness or theft

Serious violations of rules, such as running away from home

*Specify whether:*

**312.81 Childhood-onset type** - before age 10

**312.82 Adolescent-onset type** - no symptoms before age 10

**312.89 Unspecified onset** - not enough information available

*Specify if:*

With limited prosocial emotions:

Lack of remorse or guilt

Callous - lack of empathy

Unconcerned about performance

Shallow or deficient affect

*Specify current severity:*

Mild - causes relatively minor harm to others, such as lying, staying out late, etc.

Moderate - intermediate harm such as stealing without confrontation, vandalism

Severe - cause considerable harm to others (e.g. forced sex, physical cruelty, use of a weapon, breaking and entering, stealing while confronting victim)

- **301.7 Antisocial personality disorder**

Coded here as well as in "Personality disorders" because of this disorder's close connected with the "externalizing" conduct disorders in this chapter.<sup>[1]</sup>

- **312.33 Pyromania**

- **312.32 Kleptomania**
- **312.89 Other specified disruptive, impulse-control, and conduct disorder**
- **312.9 Unspecified disruptive, impulse-control, and conduct disorder**<sup>[1]</sup>

## Personality disorders in DSM-5

Criteria for a General personality disorder is provided with an emphasis on personality traits and relationship of the specific personality disorder criteria to other mental disorders in which those behaviors also occur. The criteria for the specific personality disorders in Section II of DSM-5 have not changed from DSM-IV.

The ten personality disorders in DSM-IV remain:<sup>[1]</sup>

- Cluster A personality disorders
  - **301.0 Paranoid personality disorder**
  - **301.2 Schizoid personality disorder**
  - **301.22 Schizotypal personality disorder**
- Cluster B personality disorders
  - **301.7 Antisocial personality disorder**
  - **301.83 Borderline personality disorder**
  - **301.50 Histrionic personality disorder**
  - **301.81 Narcissistic personality disorder**
- Cluster C personality disorders
  - **301.82 Avoidant personality disorder**
  - **301.6 Dependent personality disorder**
  - **301.4 Obsessive-compulsive personality disorder**

The multiaxial system has been dropped in favor of a system evaluating psychosocial and contextual factors, although the category classification remains. Under consideration is a new trait-specific diagnostic method that views personality traits on a continuum. The relationship of personality traits to general personality dysfunction is under active investigation in another section of DSM-5, entitled "Alternative DSM-5 Model for Personality Disorders".<sup>[1]</sup>

## Paraphilic disorders in DSM-5

Eight disorders were chosen for listing in DSM-5 because of their frequency and because some of them are listed as criminal offenses due to their potential for public harm. It is recognized that many more paraphilic disorders than those listed have been identified and described, and could be considered as paraphilic disorders because of their negative impact on the individual and others. The eight paraphilic disorders described in DSM-5 are the following:<sup>[1]</sup>

- **302.82 Voyeuristic disorder**
- **302.4 Exhibitionistic disorder**
- **302.89 Frotteuristic disorder**
- **302.83 Sexual masochism disorder**
- **302.84 Sexual sadism disorder**
- **302.2 Pedophilic disorder**
- **302.81 Fetishistic disorder**
- **302.3 Transvestic disorder**

*Specify if:*

With fetishism

With autogynephilia

*Specify if:*

In a controlled environment

In full remission

- **302.89 Other specified paraphilic disorder**
- **302.9 Unspecified paraphilic disorder**

## References

- [1] "Highlights of changes from DSM-IV-TR to DSM-5" (PDF). (<http://www.psychiatry.org/File Library/Practice/DSM/DSM-5/Changes-from-DSM-IV-TR--to-DSM-5.pdf>) American Psychiatric Association. 2013. Retrieved on June 8, 2013.

## DSM-IV codes

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**DSM-IV Codes** are the classification found in the **Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision**, also known as *DSM-IV-TR*, a manual published by the American Psychiatric Association (APA) that includes all currently recognized mental health disorders. The DSM-IV codes are thus used by mental health professionals to describe the features of a given mental disorder and indicate how the disorder can be distinguished from other, similar problems.<sup>[1]</sup>

The coding system utilized by the DSM-IV is designed to correspond with codes from the International Classification of Diseases, commonly referred to as the ICD. Since early versions of the DSM did not correlate with ICD codes and updates of the publications for the ICD and the DSM are not simultaneous, some distinctions in the coding systems may still be present. For this reason, it is recommended that users of these manuals consult the appropriate reference when accessing diagnostic codes

Note that **NOS** is an abbreviation for *Not Otherwise Specified*, indicating a cluster of symptoms that do not clearly fit in any single diagnostic category. NOS is often a provisional diagnosis pending additional information or testing.

For an alphabetical list, see **DSM-IV Codes (alphabetical)**.

## Disorders usually first diagnosed in infancy, childhood, or adolescence

### Mental Retardation

- 317 Mild mental retardation
- 318.0 Moderate mental retardation
- 318.1 Severe mental retardation
- 318.2 Profound mental retardation
- 319 Mental retardation; severity unspecified

**Learning disorders**

- 315.00 Reading disorder
- 315.1 Mathematics disorder
- 315.2 Disorder of written expression
- 315.9 Learning disorder NOS

**Motor skills disorders**

- 315.4 Developmental coordination disorder

**Communication disorders**

- 315.31 Expressive language disorder
- 315.32 Mixed receptive-expressive language disorder
- 315.39 Phonological disorder
- 307.0 Stuttering
- 307.9 Communication disorder NOS

**Pervasive developmental disorders**

- 299.00 Autistic Disorder
- 299.80 Rett's Disorder
- 299.10 Childhood Disintegrative Disorder
- 299.80 Asperger's Disorder
- 299.80 Pervasive Developmental Disorder NOS

**Attention-deficit and disruptive behavior disorders**

- Attention-Deficit Hyperactivity Disorder
  - 314.01 Combined subtype
  - 314.01 Predominantly hyperactive-impulsive subtype
  - 314.00 Predominantly inattentive subtype
  - 314.9 Attention-Deficit Hyperactivity Disorder NOS
- Conduct disorder
  - 312.81 Childhood onset
  - 312.82 Adolescent onset
  - 312.89 Unspecified onset
- 313.81 Oppositional Defiant Disorder
- 312.9 Disruptive Behavior Disorder NOS

**Feeding and eating disorders of infancy or early childhood**

- 307.52 Pica
- 307.53 Rumination disorder
- 307.59 Feeding disorder of infancy or early childhood

**Tic disorders**

- 307.23 Tourette's Disorder
- 307.22 Chronic motor or vocal tic disorder
- 307.21 Transient tic disorder
- 307.20 Tic disorder NOS

**Elimination disorders**

- 307.6 Enuresis (not due to a general medical condition)
- 307.7 Encopresis, without constipation and overflow incontinence
- 787.6 Encopresis, with constipation and overflow incontinence

**Other disorders of infancy, childhood, or adolescence**

- 309.21 Separation anxiety disorder
- 313.23 Selective mutism
- 313.89 Reactive attachment disorder of infancy or early childhood
- 307.3 Stereotypic movement disorder
- 313.9 Disorder of infancy, childhood, or adolescence NOS

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**Delirium, dementia, and amnestic and other cognitive disorders****Delirium**

- 293.0 Delirium due to... [indicate the general medical condition]
- 780.09 Delirium NOS

**Dementia**

- Dementia of the Alzheimer's Type, with early onset
  - 294.10 Without behavioral disturbance
  - 294.11 With behavioral disturbance
- Dementia of the Alzheimer's Type, with late onset
  - 294.10 Without behavioral disturbance
  - 294.11 With behavioral disturbance
- Vascular dementia
  - 290.40 Uncomplicated
  - 290.41 With delirium
  - 290.42 With delusions
  - 290.43 With depressed mood
- Dementia due to HIV disease
  - 294.10 Without behavioral disturbance

- 294.11 With behavioral disturbance
- Dementia due to head trauma
  - 294.10 Without behavioral disturbance
  - 294.11 With behavioral disturbance
- Dementia due to Parkinson's disease
  - 294.10 Without behavioral disturbance
  - 294.11 With behavioral disturbance
- Dementia due to Huntington's disease
  - 294.10 Without behavioral disturbance
  - 294.11 With behavioral disturbance
- Dementia due to Pick's disease
  - 294.10 Without behavioral disturbance
  - 294.11 With behavioral disturbance
- Dementia due to Creutzfeldt-Jakob Disease
  - 294.10 Without behavioral disturbance
  - 294.11 With behavioral disturbance
- Dementia due to... [indicate other general medical condition]
  - 294.10 Without behavioral disturbance
  - 294.11 With behavioral disturbance
- 294.8 Dementia NOS

### **Amnestic disorders**

- 294.0 Amnestic disorder due to... [indicate the general medical condition]
- 294.8 Amnestic disorder NOS

### **Other cognitive disorders**

- 294.9 Cognitive disorder NOS

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## **Mental disorders due to a general medical condition not elsewhere classified**

- 293.89 Catatonic disorder due to... [indicate the general medical condition]
- 310.1 Personality change due to... [indicate the general medical condition]
  - (Subtypes: Labile, Disinhibited, Aggressive, Apathetic, Paranoid, Other, Combined, Unspecified)
- 293.9 Mental disorder NOS due to... [indicate the general medical condition]

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## Substance-related disorders

### Alcohol-related disorders

- Alcohol
  - 305.00 Abuse
  - 303.90 Dependence
  - 291.89 -Induced anxiety disorder
  - 291.89 -Induced mood disorder
  - 291.1 -Induced persisting amnestic disorder
  - 291.2 -Induced persisting dementia
  - 291.5 -Induced psychotic disorder, with delusions
  - 291.3 -Induced psychotic disorder, with hallucinations
  - 291.89 -Induced sexual dysfunction
  - 291.89 -Induced sleep disorder
  - 303.00 Intoxication
  - 291.0 Intoxication delirium
  - 291.9 -Related disorder NOS
  - 291.81 Withdrawal
  - 291.0 Withdrawal delirium

### Amphetamine (or amphetamine-like) related disorders

- Amphetamine (or amphetamine-like)
  - 305.70 Abuse
  - 304.40 Dependence
  - 292.89 -Induced anxiety disorder
  - 292.84 -Induced mood disorder
  - 292.11 -Induced psychotic disorder, with delusions
  - 292.12 -Induced psychotic disorder, with hallucinations
  - 292.89 -Induced sexual dysfunction
  - 292.89 -Induced sleep disorder
  - 292.89 Intoxication
  - 292.81 Intoxication delirium
  - 292.9 -Related disorder NOS (includes Amphetamine Withdrawal Psychosis)
  - 292.0 Withdrawal

### Caffeine-related disorders

- Caffeine
  - 292.89 -Induced anxiety disorder
  - 292.89 -Induced sleep disorder
  - 305.90 Intoxication
  - 292.9 -Related disorder NOS

## Cannabis-related disorders

- Cannabis
  - 305.20 Abuse
  - 304.30 Dependence
  - 292.89 -Induced anxiety disorder
  - 292.11 -Induced psychotic disorder, with delusions
  - 292.12 -Induced psychotic disorder, with hallucinations
  - 292.89 Intoxication
  - 292.81 Intoxication delirium
  - 292.9 -Related disorder NOS

## Cocaine-related disorders

- Cocaine
  - 305.60 Abuse
  - 304.20 Dependence
  - 292.89 -Induced anxiety disorder
  - 292.84 -Induced mood disorder
  - 292.11 -Induced psychotic disorder, with delusions
  - 292.12 -Induced psychotic disorder, with hallucinations
  - 292.89 -Induced sexual dysfunction
  - 292.89 -Induced sleep disorder
  - 292.89 Intoxication
  - 292.81 Intoxication delirium
  - 292.9 -Related disorder NOS
  - 292.0 Withdrawal

## Hallucinogen-related disorders

- Hallucinogen
  - 305.30 Abuse
  - 304.50 Dependence
  - 292.89 -Induced anxiety disorder
  - 292.84 -Induced mood disorder
  - 292.11 -Induced psychotic disorder, with delusions
  - 292.12 -Induced psychotic disorder, with hallucinations
  - 292.89 Intoxication
  - 292.81 Intoxication delirium
  - 292.89 -persisting perception disorder
  - 292.9 -Related disorder NOS

## Inhalant-related disorders

- Inhalant
  - 305.90 Abuse
  - 304.60 Dependence
  - 292.89 -Induced anxiety disorder
  - 292.84 -Induced mood disorder
  - 292.82 -Induced persisting dementia
  - 292.11 -Induced psychotic disorder, with delusions
  - 292.12 -Induced psychotic disorder, with hallucinations
  - 292.89 Intoxication
  - 292.81 Intoxication delirium
  - 292.9 -Related disorder NOS

## Nicotine-related disorders

- Nicotine
  - 305.1 Dependence
  - 292.9 -Related disorder NOS
  - 292.0 Withdrawal

## Opioid-related disorders

- Opioid
  - 305.50 Abuse
  - 304.00 Dependence
  - 292.84 -Induced mood disorder
  - 292.11 -Induced psychotic disorder, with delusions
  - 292.12 -Induced psychotic disorder, with hallucinations
  - 292.89 -Induced sexual dysfunction
  - 292.89 -Induced sleep disorder
  - 292.89 Intoxication
  - 292.81 Intoxication delirium
  - 292.9 -Related disorder NOS
  - 292.0 Withdrawal

## Phencyclidine (or phencyclidine-like) related disorders

- Phencyclidine (or phencyclidine-like)
  - 305.90 Abuse
  - 304.60 Dependence
  - 292.89 -Induced anxiety disorder
  - 292.84 -Induced mood disorder
  - 292.11 -Induced psychotic disorder, with delusions
  - 292.12 -Induced psychotic disorder, with hallucinations
  - 292.89 Intoxication
  - 292.81 Intoxication delirium
  - 292.9 -Related disorder NOS

**Sedative-, hypnotic-, or anxiolytic-related disorders**

- Sedative, hypnotic, or anxiolytic
  - 305.40 Abuse
  - 304.10 Dependence
  - 292.89 -Induced anxiety disorder
  - 292.84 -Induced mood disorder
  - 292.83 -Induced persisting amnestic disorder
  - 292.82 -Induced persisting dementia
  - 292.11 -Induced psychotic disorder, with delusions
  - 292.12 -Induced psychotic disorder, with hallucinations
  - 292.89 -Induced sexual dysfunction
  - 292.89 -Induced sleep disorder
  - 292.89 Intoxication
  - 292.81 Intoxication delirium
  - 292.9 -Related disorder NOS
  - 292.0 Withdrawal
  - 292.81 Withdrawal delirium

**Polysubstance-related disorder**

- 304.80 Polysubstance dependence

**Other (or unknown) substance-related disorder**

- Other (or unknown) substance
  - 305.90 Abuse
  - 304.90 Dependence
  - 292.89 -Induced anxiety disorder
  - 292.81 -Induced delirium
  - 292.84 -Induced mood disorder
  - 292.83 -Induced persisting amnestic disorder
  - 292.82 -Induced persisting dementia
  - 292.11 -Induced psychotic disorder, with delusions
  - 292.12 -Induced psychotic disorder, with hallucinations
  - 292.89 -Induced sexual dysfunction
  - 292.89 -Induced sleep disorder
  - 292.89 Intoxication
  - 292.9 -Related disorder NOS
  - 292.0 Withdrawal
  - 293.0 Delirium Due to ... [Indicate the General Medical Condition]

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## Schizophrenia and other psychotic disorders

- Schizophrenia
  - 295.20 Catatonic type
  - 295.10 Disorganized type
  - 295.30 Paranoid type
  - 295.60 Residual type
  - 295.90 Undifferentiated type
- 295.40 Schizophreniform disorder
- 295.70 Schizoaffective disorder
- 297.1 Delusional disorder
  - Erotomanic subtype
  - Grandiose subtype
  - Jealous subtype
  - Persecutory subtype
  - Somatic subtype
  - Mixed type
- 298.8 Brief psychotic disorder
- 297.3 Shared psychotic disorder
- Psychotic disorder due to... [indicate the general medical condition]
  - 293.81 With delusions
  - 293.82 With hallucinations
- 298.9 Psychotic disorder NOS

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## Mood disorders

### Depressive disorders

- 300.4 Dysthymic disorder
- Major depressive disorder
  - Major depressive disorder, recurrent
    - 296.36 In full remission
    - 296.35 In partial remission
    - 296.31 Mild
    - 296.32 Moderate
    - 296.33 Severe without psychotic features
    - 296.34 Severe with psychotic features
    - 296.30 Unspecified
  - Major depressive disorder, single episode
    - 296.26 In full remission
    - 296.25 In partial remission
    - 296.21 Mild
    - 296.22 Moderate
    - 296.23 Severe without psychotic features
    - 296.24 Severe with psychotic features
    - 296.20 Unspecified

- 311 Depressive disorder NOS

## Bipolar disorders

- Bipolar disorders
  - 296.80 Bipolar disorder NOS
  - Bipolar I disorder, most recent episode depressed
    - 296.56 In full remission
    - 296.55 In partial remission
    - 296.51 Mild
    - 296.52 Moderate
    - 296.53 Severe without psychotic features
    - 296.54 Severe with psychotic features
    - 296.50 Unspecified
  - 296.40 Bipolar I disorder, most recent episode hypomanic
  - Bipolar I disorder, most recent episode manic
    - 296.46 In full remission
    - 296.45 In partial remission
    - 296.41 Mild
    - 296.42 Moderate
    - 296.43 Severe without psychotic features
    - 296.44 Severe with psychotic features
    - 296.40 Unspecified
  - Bipolar I disorder, most recent episode mixed
    - 296.66 In full remission
    - 296.65 In partial remission
    - 296.61 Mild
    - 296.62 Moderate
    - 296.63 Severe without psychotic features
    - 296.64 Severe with psychotic features
    - 296.60 Unspecified
  - 296.7 Bipolar I disorder, most recent episode unspecified
  - Bipolar I disorder, single manic episode
    - 296.06 In full remission
    - 296.05 In partial remission
    - 296.01 Mild
    - 296.02 Moderate
    - 296.03 Severe without psychotic features
    - 296.04 Severe with psychotic features
    - 296.00 Unspecified
  - 296.89 Bipolar II disorder
- 301.13 Cyclothymic disorder
- 293.83 Mood disorder due to... [indicate the general medical condition]
- 296.90 Mood disorder NOS

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## Anxiety disorders

- 300.02 Generalized anxiety disorder
- Panic disorder
  - 300.21 With agoraphobia
  - 300.01 Without agoraphobia
- 300.22 Agoraphobia without history of panic disorder
- 300.29 Specific phobia
- 300.23 Social phobia
- 300.3 Obsessive-compulsive disorder
- 309.81 Posttraumatic stress disorder
- 308.3 Acute stress disorder
  - 293.84 Anxiety disorder due to a general medical condition
  - 293.89 Anxiety disorder due to... [indicate the general medical condition]
  - 300.00 Anxiety disorder NOS

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## Somatoform disorders

- 300.81 Somatization disorder
- 300.82 Undifferentiated somatoform disorder
- 300.11 Conversion disorder
- Pain disorder
  - 307.89 Associated with both psychological factors and a general medical condition
  - 307.80 Associated with psychological factors
- 300.7 Hypochondriasis
- 300.7 Body dysmorphic disorder
- 300.82 Somatoform disorder NOS

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## Factitious disorders

- Factitious disorder
  - 300.19 With combined psychological and physical signs and symptoms
  - 300.19 With predominantly physical signs and symptoms
  - 300.16 With predominantly psychological signs and symptoms
  - 300.19 Factitious disorder NOS

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## Dissociative disorders

- 300.6 Depersonalization disorder
- 300.12 Dissociative amnesia
- 300.14 Dissociative identity disorder
- 300.15 Dissociative disorder not otherwise specified

## Sexual and gender identity disorders

### Sexual dysfunctions

- 625.8 Female hypoactive sexual desire disorder due to... [indicate the general medical condition]
- 608.89 Male hypoactive sexual desire disorder due to... [indicate the general medical condition]
- 302.71 Hypoactive sexual desire disorder
- 302.79 Sexual aversion disorder
- 302.72 Female sexual arousal disorder
- 302.72 Male erectile disorder
- 607.84 Male erectile disorder due to... [indicate the general medical condition]
- 302.73 Female orgasmic disorder
- 302.74 Male orgasmic disorder
- 302.75 Premature ejaculation
- 302.76 Dyspareunia (not due to a general medical condition)
- 625.0 Female dyspareunia due to... [indicate the general medical condition]
- 608.89 Male dyspareunia due to... [indicate the general medical condition]
- 306.51 Vaginismus (not due to a general medical condition)
- 625.8 Other female sexual dysfunction due to... [indicate the general medical condition]
- 608.89 Other male sexual dysfunction due to... [indicate the general medical condition]
- 302.70 Sexual dysfunction NOS

### Paraphilic disorders

- 302.4 Exhibitionism
- 302.81 Fetishism
- 302.89 Frotteurism
- 302.2 Pedophilia
- 302.83 Sexual masochism
- 302.84 Sexual sadism
- 302.3 Transvestic fetishism
- 302.82 Voyeurism
- 302.9 Paraphilia NOS (not otherwise specified)

## Gender identity disorders

- Gender identity disorder
  - 302.85 In adolescents or adults
  - 302.6 In children
  - 302.6 Gender identity disorder NOS
- 302.9 Sexual disorder NOS

## Eating disorders

- 307.1 Anorexia nervosa
- 307.51 Bulimia nervosa
- 307.50 Eating disorder not otherwise specified (EDNOS)

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## Sleep disorders

### Primary sleep disorders

- 307.44 Primary hypersomnia
- 307.42 Primary insomnia
- 347 Narcolepsy
- 780.59 Breathing-related sleep disorder
- 307.45 Circadian rhythm sleep disorder
- 307.47 Dyssomnia NOS
- 327.03 Insomnia Related to Mood Disorder (ICD 9)

### Parasomnias

- 307.47 Nightmare disorder
- 307.46 Sleep terror disorder
- 307.46 Sleepwalking disorder
- 307.47 Parasomnia NOS

### Other sleep disorders

- Sleep disorder
  - Sleep disorder due to... [indicate the general medical condition]
    - 780.54 Hypersomnia type
    - 780.52 Insomnia type
    - 780.59 Mixed type
    - 780.59 Parasomnia type
  - 307.42 Insomnia related to... [indicate the Axis I or Axis II disorder]
  - 307.44 Hypersomnia related to... [indicate the Axis I or Axis II disorder]

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## **Impulse-Control Disorders Not Elsewhere Classified**

- 312.34 Intermittent Explosive Disorder
- 312.32 Kleptomania
- 312.31 Pathological Gambling
- 312.33 Pyromania
- 312.39 Trichotillomania
- 312.30 Impulse-Control Disorder NOS

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## **Adjustment disorders**

- Adjustment disorders
  - 309.9 Unspecified
  - 309.24 With anxiety
  - 309.0 With depressed mood
  - 309.3 With disturbance of conduct
  - 309.28 With mixed anxiety and depressed mood
  - 309.4 With mixed disturbance of emotions and conduct

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## **Personality disorders (Axis II)**

Cluster A (odd or eccentric)

- 301.0 Paranoid personality disorder
- 301.20 Schizoid personality disorder
- 301.22 Schizotypal personality disorder

Cluster B (dramatic, emotional, or erratic)

- 301.7 Antisocial personality disorder
- 301.83 Borderline personality disorder
- 301.50 Histrionic personality disorder
- 301.81 Narcissistic personality disorder

Cluster C (anxious or fearful)

- 301.82 Avoidant personality disorder
- 301.6 Dependent personality disorder
- 301.4 Obsessive-compulsive personality disorder

NOS

- 301.9 Personality disorder not otherwise specified

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## Additional codes

- V62.3 Academic problem
- V62.4 Acculturation problem
- 995.2 Adverse effects of medication NOS
- 780.9 Age-related cognitive decline
- Antisocial behavior
  - V71.01 Adult antisocial behavior
  - V71.02 Child or adolescent antisocial behavior
- V62.82 Bereavement
- V62.89 Borderline intellectual functioning
- 313.82 Identity problem
- Medication-induced
- Movement disorder
  - 333.90 Movement disorder NOS
  - 333.1 Postural tremor
- Neglect of child
  - V61.21 Neglect of child
  - 995.5 Neglect of child (if focus of attention is on victim)
- Neuroleptic-induced
  - 333.99 Acute akathisia
  - 333.7 Acute dystonia
  - 332.1 Parkinsonism
  - 333.82 Tardive dyskinesia
  - 333.92 Neuroleptic malignant syndrome
- V71.09 No diagnosis on Axis II
- V71.09 No diagnosis or condition on Axis I
- V15.81 Noncompliance with treatment
- V62.2 Occupational problem
- V61.20 Parent-child relational problem
- V61.10 Partner relational problem
- V62.89 Phase of life problem
- Physical abuse
  - V61.1 Physical abuse of adult
  - 995.81 Physical abuse of adult (if focus of attention is on victim)
  - V61.21 Physical abuse of child
  - 995.5 Physical abuse of child (if focus of attention is on victim)
- 316 Psychological factors affecting medical condition
- Relational problem
  - V62.81 Relational problem NOS
  - V61.9 Relational problem related to a mental disorder or general medical condition
- V62.89 Religious or spiritual problem
  - V61.1 Sexual abuse of adult
  - V61.21 Sexual abuse of child
- V61.8 Sibling relational problem
- 300.9 Unspecified mental disorder (nonpsychotic)

- 799.9 Diagnosis deferred on Axis II
- 799.9 Diagnosis or condition deferred on Axis I
- V65.2 Malingering

## External links

- The Diagnostic and Statistical Manual of Mental Disorders (DSM) <sup>[2]</sup>, published by the American Psychiatric Association (APA, via archive.org).
- American Academy of Family Physicians ICD-9 Coding Tools <sup>[3]</sup>
- The Multiaxial System of Diagnosis in DSM IV Criteria <sup>[4]</sup>

## References

- [1] Schacter, Gilbert, Wegner (2011)*Psychology* (2nd Edition), page 552, Worth Publishers
- [2] <http://web.archive.org/web/20070630225823/http://dsmivtr.org/index.cfm>
- [3] <http://www.aafp.org/online/en/home/publications/journals/fpm/icd9.html>
- [4] [http://www.psyweb.com/DSM\\_IV/jsp/dsm\\_iv.jsp](http://www.psyweb.com/DSM_IV/jsp/dsm_iv.jsp)

# International Statistical Classification of Diseases and Related Health Problems

The *International Classification of Diseases* (also known by the abbreviation **ICD**) is the United Nations-sponsored World Health Organization's "standard diagnostic tool for epidemiology, health management and clinical purposes."<sup>[1]</sup> The ICD is designed as a health care classification system, providing a system of diagnostic codes for classifying diseases, including nuanced classifications of a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease. This system is designed to map health conditions to corresponding generic categories together with specific variations, assigning for these a designated code, up to six characters long. Thus, major categories are designed to include a set of similar diseases.

The International Classification of Diseases is published by the World Health Organization (WHO) and used worldwide for morbidity and mortality statistics, reimbursement systems, and automated decision support in health care. This system is designed to promote international comparability in the collection, processing, classification, and presentation of these statistics. As in the case of the analogous (but limited to mental and behavioral disorders) Diagnostic and Statistical Manual of Mental Disorders (DSM, currently in version 5), the ICD is a major project to statistically classify health disorders, and provide diagnostic assistance. The ICD is a core statistically-based classificatory diagnostic system for health care related issues of the WHO Family of International Classifications (WHO-FIC).<sup>[2]</sup>

The ICD is revised periodically and is currently in its tenth revision. The ICD-10, as it is therefore known, was developed in 1992 to track health statistics. ICD-11<sup>[3]</sup> is planned for 2015<sup>[1]</sup> and will be revised using Web 2.0 principles.<sup>[1]</sup> Annual minor updates and triennial major updates are published by the WHO.<sup>[4]</sup> The ICD is part of a "family" of guides that can be used to complement each other, including also the International Classification of Functioning, Disability and Health which focuses on the domains of functioning (disability) associated with health conditions, from both medical and social perspectives.

## Historical synopsis

In 1893, a French physician, Jacques Bertillon, introduced the *Bertillon Classification of Causes of Death* at a congress of the International Statistical Institute in Chicago.<sup>[5]</sup> A number of countries and cities adopted Dr. Bertillon's system, which was based on the principle of distinguishing between general diseases and those localized to a particular organ or anatomical site, as used by the City of Paris for classifying deaths. Subsequent revisions represented a synthesis of English, German and Swiss classifications, expanding from the original 44 titles to 161 titles. In 1898, the American Public Health Association (APHA) recommended that the registrars of Canada, Mexico, and the United States also adopt it. The APHA also recommended revising the system every ten-years to ensure the system remained current with medical practice advances. As a result, the first international conference to revise the International Classification of Causes of Death convened in 1900; with revisions occurring every ten-years thereafter. At that time the classification system was contained in one book, which included an Alphabetic Index as well as a Tabular List. The book was small compared with current coding texts.

The revisions that followed contained minor changes, until the sixth revision of the classification system. With the sixth revision, the classification system expanded to two volumes. The sixth revision included morbidity and mortality conditions, and its title was modified to reflect the changes: *International Statistical Classification of Diseases, Injuries and Causes of Death (ICD)*. Prior to the sixth revision, responsibility for ICD revisions fell to the Mixed Commission, a group composed of representatives from the International Statistical Institute and the Health Organization of the League of Nations. In 1948, the World Health Organization (WHO) assumed responsibility for preparing and publishing the revisions to the ICD every ten-years. WHO sponsored the seventh and eighth revisions in 1957 and 1968, respectively. It later became clear that the established ten-year interval between revisions was too short.<sup>[5]</sup>

The ICD is currently the most widely used statistical classification system for diseases in the world. International health statistics using this system are available at the Global Health Observatory (GHO)<sup>[6]</sup><sup>[7]</sup>

In addition, some countries—including Australia, Canada and the United States—have developed their own adaptations of ICD, with more procedure codes for classification of operative or diagnostic procedures.

## Versions of ICD

### ICD-6

The ICD-6, published in 1949, was the first to be shaped to become suitable for morbidity reporting. Accordingly the name changed from International List of Causes of Death to International Statistical Classification of Diseases. The combined code section for injuries and their associated accidents was split into two, a chapter for injuries, and a chapter for their external causes. With use for morbidity there was a need for coding mental conditions, and for the first time a section on mental disorders was added.<sup>[8]</sup>

## **ICD-7**

The International Conference for the Seventh Revision of the International Classification of Diseases was held in Paris under the auspices of WHO in February 1955. In accordance with a recommendation of the WHO Expert Committee on Health Statistics, this revision was limited to essential changes and amendments of errors and inconsistencies.<sup>[8]</sup>

## **ICD-8**

The Eighth Revision Conference convened by WHO met in Geneva, from 6 to 12 July 1965. This revision was more radical than the Seventh but left unchanged the basic structure of the Classification and the general philosophy of classifying diseases, whenever possible, according to their etiology rather than a particular manifestation. During the years that the Seventh and Eighth Revisions of the ICD were in force, the use of the ICD for indexing hospital medical records increased rapidly and some countries prepared national adaptations which provided the additional detail needed for this application of the ICD. In the USA, a group of consultants was asked to study the 8th revision of ICD (ICD-8) for its applicability to various users in the United States. This group recommended that further detail be provided for coding hospital and morbidity data. The American Hospital Association's "Advisory Committee to the Central Office on ICDA" developed the needed adaptation proposals, resulting in the publication of the International Classification of Diseases, Adapted (ICDA). In 1968, the United States Public Health Service published the International Classification of Diseases, Adapted, 8th Revision for use in the United States (ICDA-8). Beginning in 1968, ICDA-8 served as the basis for coding diagnostic data for both official morbidity [and mortality] statistics in the United States.<sup>[8][9]</sup>

## **ICD-9**

The International Conference for the Ninth Revision of the International Classification of Diseases, convened by WHO, met in Geneva from 30 September to 6 October 1975. In the discussions leading up to the conference, it had originally been intended that there should be little change other than updating of the classification. This was mainly because of the expense of adapting data processing systems each time the classification was revised.

There had been an enormous growth of interest in the ICD and ways had to be found of responding to this, partly by modifying the classification itself and partly by introducing special coding provisions. A number of representations was made by specialist bodies which had become interested in using the ICD for their own statistics. Some subject areas in the classification were regarded as inappropriately arranged and there was considerable pressure for more detail and for adaptation of the classification to make it more relevant for the evaluation of medical care, by classifying conditions to the chapters concerned with the part of the body affected rather than to those dealing with the underlying generalized disease.

At the other end of the scale, there were representations from countries and areas where a detailed and sophisticated classification was irrelevant, but which nevertheless needed a classification based on the ICD in order to assess their progress in health care and in the control of disease. A field test with a bi-axial classification approach - one axis for anatomy, another for etiology - showed the impracticability of such approach for routine use.

The final proposals presented to and accepted by the Conference retained the basic structure of the ICD, although with much additional detail at the level of the four digit subcategories, and some optional five digit subdivisions. For the benefit of users not requiring such detail, care was taken to ensure that the categories at the three digit level were appropriate.

For the benefit of users wishing to produce statistics and indexes oriented towards medical care, the Ninth Revision included an optional alternative method of classifying diagnostic statements, including information about both an underlying general disease and a manifestation in a particular organ or site. This system became known as the dagger and asterisk system and is retained in the Tenth Revision. A number of other technical innovations were included in the Ninth Revision, aimed at increasing its flexibility for use in a variety of situations. It was eventually replaced by

ICD-10, the version currently in use by the WHO and most countries. Given the widespread expansion in the tenth revision, it is not possible to convert ICD-9 data sets directly into ICD-10 data sets, although some tools are available to help guide users.<sup>[10]</sup> Publication of ICD-9 without IP restrictions in a world with evolving electronic data systems led to a range of products based on ICD-9, such as MeDRA or the Read directory.<sup>[8][9]</sup>

## **ICPM**

When ICD-9 was published by the World Health Organization (WHO), the International Classification of Procedures in Medicine (ICPM) was also developed (1975) and published (1978). The ICPM surgical procedures fascicle was originally created by the United States, based on its adaptations of ICD (called ICDA), which had contained a procedure classification since 1962. ICPM is published separately from the ICD disease classification as a series of supplementary documents called fascicles (bundles or groups of items). Each fascicle contains a classification of modes of laboratory, radiology, surgery, therapy, and other diagnostic procedures. Many countries have adapted and translated the ICPM in parts or as a whole and are using it with amendments since then.<sup>[8][9]</sup>

## **ICD-9-CM**

*International Classification of Diseases, Clinical Modification* (ICD-9-CM) is an adaption created by the U.S. National Center for Health Statistics (NCHS) and used in assigning diagnostic and procedure codes associated with inpatient, outpatient, and physician office utilization in the United States. The ICD-9-CM is based on the ICD-9 but provides for additional morbidity detail. It is updated annually on October 1.<sup>[11][12]</sup>

It consists of two or three volumes:

- Volumes 1 and 2 contain diagnosis codes. (Volume 1 is a tabular listing, and volume 2 is an index.) Extended for ICD-9-CM
- Volume 3 contains procedure codes. ICD-9-CM only

The NCHS and the Centers for Medicare and Medicaid Services are the U.S. governmental agencies responsible for overseeing all changes and modifications to the ICD-9-CM.

## **ICD-10**

Work on ICD-10 began in 1983, and the new revision was endorsed by the Forty-third World Health Assembly in May 1990. The latest version came into use in WHO Member States starting in 1994.<sup>[13]</sup> The classification system allows more than 155,000 different codes and permits tracking of many new diagnoses and procedures, a significant expansion on the 17,000 codes available in ICD-9.<sup>[1]</sup> Adoption was relatively swift in most of the world. Several materials are made available online by WHO to facilitate its use, including a manual, training guidelines, a browser, and files for download.<sup>[2]</sup> Some countries have adapted the international standard, such as the "ICD-10-AM" published in Australia in 1998 (also used in New Zealand),<sup>[14]</sup> and the "ICD-10-CA" introduced in Canada in 2000.<sup>[15]</sup>

## **ICD-10-CM**

Adoption of ICD-10 has been slow in the United States. Since 1979,<sup>[16]</sup> the USA had required ICD-9-CM codes for Medicare and Medicaid claims, and most of the rest of the American medical industry followed suit. On 1 January 1999 the ICD-10 (without clinical extensions) was adopted for reporting mortality, but ICD-9-CM was still used for morbidity. Meanwhile, NCHS received permission from the WHO to create a clinical modification of the ICD-10, and has production of all these systems:

- ICD-10-CM, for diagnosis codes, is intended to replace volumes 1 and 2. Annual updates are provided.
- ICD-10-PCS, for procedure codes, is intended to replace volume 3. Annual updates are provided.

On August 21, 2008, the US Department of Health and Human Services (HHS) proposed new code sets to be used for reporting diagnoses and procedures on health care transactions. Under the proposal, the ICD-9-CM code sets

would be replaced with the ICD-10-CM code sets, effective October 1, 2013. On April 17, 2012 the Department of Health and Human Services (HHS) published a proposed rule that would delay, from October 1, 2013 to October 1, 2014, the compliance date for the ICD-10-CM and PCS.<sup>[17]</sup>

### **ICD-10-CA**

ICD-10-CA is an clinical modification of ICD-10 developed by the Canadian Institute for Health Information for morbidity classification in Canada. ICD-10-CA applies beyond acute hospital care, and includes conditions and situations that are not diseases but represent risk factors to health, such as occupational and environmental factors, lifestyle and psycho-social circumstances.<sup>[15]</sup>

### **ICD-11**

The World Health Organization is currently revising the International Classification of Diseases (ICD) towards the ICD-11. The development is taking place on an internet-based workspace, called iCAT (Collaborative Authoring Tool) Platform, somewhat similar to Wikipedia – yet it requires more structure and peer review process. The WHO collaborates through this platform with all interested parties.

The final draft of the ICD-11 system is expected to be submitted to WHO's World Health Assembly (WHA) for official endorsement by 2015. The beta draft<sup>[18]</sup> was made available online in May 2012 for initial consultation and commenting.<sup>[19]</sup>

In ICD-11 each disease entity will have definitions that give key descriptions and guidance on what the meaning of the entity/category is in human readable terms - to guide users. This is an advancement over ICD-10, which had only title headings. The Definitions have a standard structure according to a template with standard definition templates and further features exemplified in a “Content Model”. The Content Model is a structured framework that captures the knowledge that underpins the definition of an ICD entity. The Content Model therefore allows computerization (with links to ontologies and SNOMED CT). Each ICD entity can be seen from different dimensions or “parameters”. For example, there are currently 13 defined main parameters in the Content Model (see below) to describe a category in ICD.

1. ICD Entity Title - *Fully Specified Name*
2. Classification Properties - *disease, disorder, injury, etc.*
3. Textual Definitions - *short standard description*
4. Terms - *synonyms, other inclusion and exclusions*
5. Body System/Structure Description - *anatomy and physiology*
6. Temporal Properties - *acute, chronic or other*
7. Severity of Subtypes Properties - *mild, moderate, severe, or other scales*
8. Manifestation Properties - *signs, symptoms*
9. Causal Properties - *etiology: infectious, external cause, etc.*
10. Functioning Properties - *impact on daily life: activities and participation*
11. Specific Condition Properties - *relates to pregnancy etc.*
12. Treatment Properties - *specific treatment considerations: e.g. resistance*
13. Diagnostic Criteria - *operational definitions for assessment*

ICD exists in 41 Languages in electronic versions and its expression in multiple languages will be systematically pursued in ICD11.

## Usage and current topics

### History and usage in the United States

In the United States, the U.S. Public Health Service published *The International Classification of Diseases, Adapted for Indexing of Hospital Records and Operation Classification (ICDA)*, completed in 1962 and expanding the ICD-7 in a number of areas to more completely meet the indexing needs of hospitals. The U.S. Public Health Service later published the *Eighth Revision, International Classification of Diseases, Adapted for Use in the United States*, commonly referred to as ICDA-8, for official national morbidity and mortality statistics. This was followed by the *ICD, 9th Revision, Clinical Modification*, known as ICD-9-CM, published by the U.S. Department of Health and Human Services and used by hospitals and other healthcare facilities to better describe the clinical picture of the patient. The diagnosis component of ICD-9-CM is completely consistent with ICD-9 codes, and remains the data standard for reporting morbidity. National adaptations of the ICD-10 progressed to incorporate both clinical code (ICD-10-CM) and procedure code (ICD-10-PCS) with the revisions completed in 2003. In 2009, the U.S. Centers for Medicare and Medicaid Services announced that it would begin using ICD-10 on April 1, 2010, with full compliance by all involved parties by 2013.<sup>[1]</sup>

The years for which causes of death in the United States have been classified by each revision as follows:

• ICD-1 – 1900	• ICD-6 – 1949
• ICD-2 – 1910	• ICD-7 – 1958
• ICD-3 – 1921	• ICD-8A – 1968
• ICD-4 – 1930	• ICD-9 – 1979
• ICD-5 – 1939	• ICD-10 – 1999

### Mental and behavioral disorders

The ICD includes a section classifying mental and behavioral disorders (Chapter V). This has developed alongside the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the two manuals seek to use the same codes. There are significant differences, however, such as the ICD including personality disorders in the same way as other mental disorders, while the DSM lists them on a separate 'axis'. The WHO is revising their classifications in these sections as part the development of the ICD-11 (scheduled for 2015), and an "International Advisory Group" has been established to guide this.<sup>[20]</sup> An international survey of psychiatrists in 66 countries comparing use of the ICD-10 and DSM-IV found that the former was more often used for clinical diagnosis while the latter was more valued for research.<sup>[21]</sup> The ICD is actually the official system for the US, although many mental health professionals do not realize this due to the dominance of the DSM. The US is due to adopt a modified version of the ICD-10 in 2013. Psychologists note that, "Serious problems with the clinical utility of both the ICD and the DSM are widely acknowledged."<sup>[22]</sup>

## References

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- [19] World Health Organization. "The International Classification of Diseases 11th Revision is due by 2015." (<http://www.who.int/classifications/icd/revision/en/>) Accessed 21 June 2012.
- [20] [http://www.who.int/mental\\_health/evidence/en/](http://www.who.int/mental_health/evidence/en/)

## External links

- ICD Homepage (<http://www.who.int/classifications/icd/en/>) at World Health Organization (WHO)
- ICD-10 online browser (<http://apps.who.int/classifications/icd10>) (WHO)
- ICD-10 online training direct access (<http://apps.who.int/classifications/apps/icd/ICD10Training>) (WHO)
- ICD-10 online training support (<http://sites.google.com/site/icd10onlinetraining>) (WHO)
- ICD-10-CM (<http://www.cdc.gov/nchs/icd/icd10cm.htm>) (USA – modification) at Centers for Disease Control and Prevention
- ICD-11 Revision (<http://sites.google.com/site/icd11revision/home>) (WHO)
- Code Browser for ICD-9-CM, ICD-10-CM, ICD-10-PCS, HCPCS, DRGs (<http://www.findacode.com/tools/browse-a-code.php>)
- ICD-9-CM to ICD-10-CM code conversions (<http://www.ecodingnow.com/OnlineCodes/OnlineCodes/i9toi10.html>)
- ICD-9-CM and DRG on-line coding engine (<http://www.icd9coding.com>)
- Free ICD-9-CM Code search ([https://drchrono.com/public\\_billing\\_code\\_search/](https://drchrono.com/public_billing_code_search/))
- ICD-10 and ICD-10 PCS (<http://www.med-code.info/?country=us&locale=us>)
- ICD-9 and ICD-10 code lookup (<http://icdx.org>)

# World Health Organization

 <p>World Health Organization منظمة الصحة العالمية 世界卫生组织 Organisation mondiale de la Santé Всемирная организация здравоохранения Organización Mundial de la Salud</p>	
	
Flag of the World Health Organization	
<b>Org type</b>	Specialized agency of the United Nations
<b>Acronyms</b>	WHO OMS
<b>Head</b>	Margaret Chan
<b>Status</b>	Active
<b>Established</b>	7 April 1948
<b>Headquarters</b>	Geneva, Switzerland
<b>Website</b>	<a href="http://www.who.int">www.who.int</a> [1]
<b>Parent org</b>	United Nations Economic and Social Council (ECOSOC)

The **World Health Organization (WHO)** is a specialized agency of the United Nations (UN) that is concerned with international public health. It was established on 7 April 1948, with headquarters in Geneva, Switzerland, and is a member of the United Nations Development Group. Its predecessor, the Health Organization, was an agency of the League of Nations.

The constitution of the World Health Organization had been signed by all 61 countries of the United Nations by 22 July 1946, with the first meeting of the World Health Assembly finishing on 24 July 1948. It incorporated the *Office International d'Hygiène Publique* and the League of Nations Health Organization. Since its creation, WHO has been responsible for playing a leading role in the eradication of smallpox. Its current priorities include communicable diseases, in particular, HIV/AIDS, malaria and tuberculosis; the mitigation of the effects of non-communicable diseases; sexual and reproductive health, development, and aging; nutrition, food security and healthy eating; occupational health; substance abuse; and drive the development of reporting, publications, and networking. WHO is responsible for the *World Health Report*, a leading international publication on health, the worldwide World Health Survey, and World Health Day (7th-April of every Year).

Its links with the International Atomic Energy Agency and distribution of contraception have both proved controversial, as have guidelines on healthy eating and the 2009 flu pandemic.

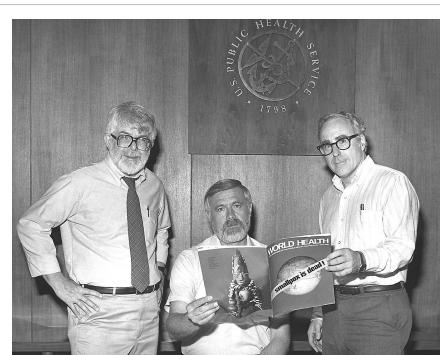
## History

### Establishment

The use of the word "world", rather than "international", emphasized the truly global nature of what the organization was seeking to achieve.<sup>[1]</sup> The constitution of the World Health Organization had been signed by all 61 countries of the United Nations by 22 July 1946. It thus became the first specialised agency of the United Nations to which every member subscribed.<sup>[1]</sup> Its constitution formally came into force on the first World Health Day on 7 April 1948, when it was ratified by the 26th member state.<sup>[2]</sup> The first meeting of the World Health Assembly finished on 24 July 1948, having secured a budget of US\$5 million (then GBP£1,250,000) for the 1949 year. Andrija Stampar was the Assembly's first president, and G. Brock Chisholm was appointed Director-General of WHO, having served as Executive Secretary during the planning stages.<sup>[1]</sup> Its first priorities were to control the spread of malaria, tuberculosis and sexually transmitted infections, and to improve maternal and child health, nutrition and environmental hygiene. Its first legislative act was concerning the compilation of accurate statistics on the spread and morbidity of disease.<sup>[1]</sup> The logo of the World Health Organization features the Rod of Asclepius as a symbol for healing.<sup>[3]</sup>

### Operational history

WHO established an epidemiological information service via telex in 1947, and by 1950 a mass tuberculosis inoculation drive (using the BCG vaccine) was under way. In 1955, the malaria eradication programme was launched, although it was later altered in objective. 1965 saw the first report on diabetes mellitus and the creation of the International Agency for Research on Cancer. WHO moved into its headquarters building in 1966. The Expanded Programme on Immunization was started in 1974, as was the control programme into onchocerciasis – an important partnership between the Food and Agriculture Organization (FAO), the United Nations Development Programme (UNDP), and World Bank. In the following year, the Special Programme for Research and Training in Tropical Diseases was also launched. In 1976, the World Health Assembly voted to enact a resolution on Disability Prevention and Rehabilitation, with a focus on community-driven care. The first list of essential medicines was drawn up in 1977, and a year later the ambitious goal of "health for all" was declared. In 1986, WHO started its global programme on the growing problem of HIV/AIDS, followed two years later by additional attention on preventing discrimination against sufferers and UNAIDS was formed in 1996. The Global Polio Eradication Initiative was established in 1988.<sup>[1]</sup>



Three former directors of the Global Smallpox Eradication Programme read the news that smallpox had been globally eradicated, 1980

In 1958, Viktor Zhdanov, Deputy Minister of Health for the USSR, called on the World Health Assembly to undertake a global initiative to eradicate smallpox, resulting in Resolution WHA11.54.<sup>[1]</sup> At this point, 2 million people were dying from smallpox every year. In 1967, the World Health Organization intensified the global smallpox eradication by contributing \$2.4 million annually to the effort and adopted a new disease surveillance method.<sup>[4][5]</sup> The initial problem the WHO team faced was inadequate reporting of smallpox cases. WHO established a network of consultants who assisted countries in setting up surveillance and containment activities.<sup>[6]</sup> The WHO also helped contain the last European outbreak in Yugoslavia in 1972.<sup>[7]</sup> After over two decades of fighting smallpox, the WHO declared in 1980 that the disease had been eradicated – the first disease in history to be eliminated by human effort.<sup>[8]</sup>

In 1998, WHO's Director General highlighted gains in child survival, reduced infant mortality, raised life expectancy and reduced rates of "scourges" such as smallpox and polio on the fiftieth anniversary of WHO's founding. He, did, however, accept that more had to be done to assist maternal health and that progress in this area had been slow.<sup>[9]</sup>

Cholera and malaria have remained problems since WHO's founding, although in decline for a large part of that period.<sup>[10]</sup> In the twenty-first century, the Stop TB Partnership was created in 2000, along with the UN's formulation of the Millennium Development Goals. The Measles initiative was formed in 2001, and credited with reducing global deaths from the disease by 68% by 2007. In 2002, The Global Fund to Fight AIDS, Tuberculosis and Malaria was drawn up to improve the resources available.<sup>[11]</sup> In 2006, the organization endorsed the world's first official HIV/AIDS Toolkit for Zimbabwe, which formed the basis for a global prevention, treatment and support plan to fight the AIDS pandemic.<sup>[11]</sup>

## Current projects

### Overall focus

The WHO's Constitution states that its objective "is the attainment by all peoples of the highest possible level of health".<sup>[12]</sup>

WHO fulfils its objective through its functions as defined in its Constitution: (a) to act as the directing and co-ordinating authority on international health work; (b) to establish and maintain effective collaboration with the United Nations, specialized agencies, governmental health administrations, professional groups and such other organizations as may be deemed appropriate; (c) to assist Governments, upon request, in strengthening health services; (d) to furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments; (e) to provide or assist in providing, upon the request of the United Nations, health services and facilities to special groups, such as the peoples of trust territories; (f) to establish and maintain such administrative and technical services as may be required, including epidemiological and statistical services; (g) to stimulate and advance work to eradicate epidemic, endemic and other diseases; (h) to promote, in co-operation with other specialized agencies where necessary, the prevention of accidental injuries; (i) to promote, in co-operation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene; (j) to promote co-operation among scientific and professional groups which contribute to the advancement of health; (k) to propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform.

WHO currently defines its role in public health as follows:<sup>[13]</sup>

- providing leadership on matters critical to health and engaging in partnerships where joint action is needed;
- shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
- setting norms and standards and promoting and monitoring their implementation;
- articulating ethical and evidence-based policy options;
- providing technical support, catalyzing change, and building sustainable institutional capacity; and
- monitoring the health situation and assessing health trends.

The 2012–2013 budget further identified thirteen areas among which funding was distributed.<sup>[1]</sup>

### Communicable diseases

Two of those thirteen areas related to communicable diseases: the first, to reduce the "health, social and economic burden" of communicable diseases in general; the second to combat HIV/AIDS, malaria and tuberculosis in particular.<sup>[1]</sup>

In terms of HIV/AIDS, WHO works within the UNAIDS network and considers it important that it works in alignment with UNAIDS objectives and strategies. It also strives to involve sections of society other than health to help deal with the economic and social effects of the disease.<sup>[14]</sup> In line with UNAIDS, WHO has set itself the interim task between 2009 and 2015 of reducing the number of those aged 15–24 years who are infected by 50%; reducing new HIV infections in children by 90%; and reducing HIV-related deaths by 25%.<sup>[15]</sup>

Although WHO dropped its commitment to a global malaria eradication campaign in the 1970s as too ambitious, it retains a strong commitment to malaria control. WHO's Global Malaria Programme works to keep track of malaria cases, and future problems in malaria control schemes. WHO is to report, likely in 2015, as to whether RTS,S/AS01, currently in research, is a viable malaria vaccine. For the time being, insecticide-treated mosquito nets and insecticide sprays are used to prevent the spread of malaria, as are antimalarial drugs – particularly to vulnerable people such as pregnant women and young children.<sup>[16]</sup>

WHO's help has contributed to a 40% fall in the number of deaths from tuberculosis between 1990 and 2010, and since 2005, it claims that over 46 million people have been treated and an estimated 7 million lives saved through practices advocated by WHO. These include engaging national governments and their financing, early diagnosis, standardising treatment, monitoring of the spread and impact of tuberculosis and stabilising the drug supply. It has also recognised the vulnerability of victims of HIV/AIDS to tuberculosis.<sup>[17]</sup>

WHO aims to eradicate polio. It has also been successful in helping to reduce cases by 99% since the Global Polio Eradication Initiative was launched in 1988, which partnered WHO with Rotary International, the US Centers for Disease Control and Prevention (CDC) and the United Nations Children's Fund (UNICEF), as well as smaller organizations. It works to immunize young children and prevent the re-emergence of cases in countries declared "polio-free".<sup>[18]</sup>

## Non-communicable diseases

Another of the thirteen areas is aimed at the prevention and reduction of "disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment".<sup>[19]</sup>

## Life and lifestyle

WHO also works to "reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy aging for all individuals".<sup>[20]</sup>

It also tries to prevent or reduce risk factors for "health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets and physical inactivity and unsafe sex".<sup>[21][22]</sup>

WHO works to improve nutrition, food safety and food security and to ensure this has a positive effect on public health and sustainable development.<sup>[23]</sup>

## Emergency work in the world

When any sort of disaster or emergency occurs, it is WHO's stated objective to reduce any consequences it may have on world health and its social and economic implications.<sup>[24]</sup>

## Health policy

WHO also addresses government health policy with two aims: firstly, "to address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, genderresponsive, and human rights-based approaches" and secondly "to promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health".<sup>[25]</sup>

In terms of health services, WHO looks to improve "governance, financing, staffing and management" and the availability and quality of evidence and research to guide policy making. It also strives to "ensure improved access, quality and use of medical products and technologies".<sup>[26]</sup>

## Governance and support

The remaining two of WHO's thirteen identified policy areas relate to the role of WHO itself: firstly, "to provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfill the mandate of WHO in advancing the global health agenda" and secondly "to develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively".<sup>[1]</sup>

## Other work

The WHO and the World Bank constitute the core team responsible for administering the International Health Partnership (IHP+). The IHP+ is a group of partner governments, development agencies, civil society and others committed to improving the health of citizens in developing countries. Partners work together to put international principles for aid effectiveness and development cooperation into practice in the health sector.<sup>[23]</sup>

In addition, the WHO has also promoted road safety.<sup>[24]</sup> Each year, the organization marks World Health Day focusing on a specific health promotion topic, timed to match the anniversary of WHO's founding. Recent themes have been drug resistance (2011) and ageing (2012).<sup>[25]</sup> As part of the United Nations, the World Health Organization supports work towards the Millennium Development Goals.<sup>[26]</sup> Of the eight Millennium Development Goals, three – reducing child mortality by two-thirds, to reduce maternal deaths by three-quarters, and to halt and begin to reduce the spread of HIV/AIDS – relate directly to WHO's scope; the other five inter-relate and have an impact on world health.<sup>[27]</sup>

## Data handling and publications

The organization relies on contributions from renowned scientists and professionals to inform its work, such as the WHO Expert Committee on Biological Standardization,<sup>[28]</sup> the WHO Expert Committee on Leprosy,<sup>[29]</sup> and the WHO Study Group on Interprofessional Education & Collaborative Practice.<sup>[30]</sup> WHO has also worked on global initiatives in surgery, including emergency and essential surgical care,<sup>[31]</sup> trauma care,<sup>[32]</sup> and safe surgery.<sup>[33]</sup> The WHO Surgical Safety Checklist is in current use worldwide in the effort to improve patient safety.<sup>[34]</sup>

WHO runs the Alliance for Health Policy and Systems Research, targeted at improving health policy and systems.<sup>[35]</sup> WHO aims to improve access to health research and literature in developing countries such as through the HINARI network.<sup>[36]</sup> The organization has published tools for monitoring the capacity of national health systems<sup>[37]</sup> and health workforces.<sup>[38]</sup> The Global Health Observatory (GHO) has been the WHO's main portal which provides access to data and analyses for key health themes by monitoring health situations around the globe.<sup>[39]</sup> The World Health Organization works to provide the needed health and well-being evidence through a variety of data collection platforms, including the World Health Survey covering almost 400,000 respondents from 70 countries,<sup>[40]</sup> and the *Study on Global Ageing and Adult Health* (SAGE) covering over 50,000 persons over 50 years old in 23 countries.<sup>[41]</sup> The Country Health Intelligence Portal (CHIP), has also been developed to provide an access point to information about the health services that are available in different countries.<sup>[42]</sup> The information gathered in this portal is utilized by the countries to set priorities for future strategies or plans, implement, monitor, and evaluate it. The *WHO Assessment Instrument for Mental Health Systems* (WHO-AIMS), the *WHO Quality of Life Instrument* (WHOQOL), and the *Service Availability and Readiness Assessment* (SARA) provide guidance for data collection.<sup>[43]</sup> Collaborative efforts between WHO and other agencies, such as through the Health Metrics Network, also aim to provide sufficient high-quality information to assist governmental decision making.<sup>[44]</sup> WHO promotes the development of capacities in member states to use and produce research that addresses their national needs, including through the Evidence-Informed Policy Network (EVIPNet).<sup>[45]</sup> The Pan American Health Organization (PAHO/AMRO) became the first region to develop and pass a policy on research for health approved in September 2009.<sup>[46]</sup>

The organization develops and promotes the use of evidence-based tools, norms and standards to support member states to inform health policy options. It oversees the implementation of the International Health Regulations, and publishes a series of medical classifications; of these, three are overreaching "reference classifications": the International Statistical Classification of Diseases (ICD), the International Classification of Functioning, Disability and Health (ICF) and the International Classification of Health Interventions (ICHI).<sup>[47]</sup> Other international policy frameworks produced by WHO include the International Code of Marketing of Breast-milk Substitutes (adopted in 1981),<sup>[48]</sup> Framework Convention on Tobacco Control (adopted in 2003)<sup>[49]</sup> and the Global Code of Practice on the International Recruitment of Health Personnel (adopted in 2010).<sup>[50]</sup> The WHO regularly publishes a *World Health Report*, its leading publication, including an expert assessment of a specific global health topic.<sup>[51]</sup> Other publications of WHO include the *Bulletin of the World Health Organization*,<sup>[52]</sup> the *Eastern Mediterranean Health Journal* (overseen by EMRO),<sup>[53]</sup> the *Human Resources for Health* (published in collaboration with BioMed Central),<sup>[54]</sup> and the *Pan American Journal of Public Health* (overseen by PAHO/AMRO).<sup>[55]</sup>

## Structure

The World Health Organization is a member of the United Nations Development Group.<sup>[56]</sup>

## Membership

As of 2013[57], the WHO has 194 member states: all Member States of the United Nations except Liechtenstein, as well as the Cook Islands and Niue.<sup>[1]</sup> (A state becomes a full member of WHO by ratifying the treaty known as the Constitution of the World Health Organization.) As of 2013[57], it also had two associate members, Puerto Rico and Tokelau.<sup>[58]</sup> Non-members of the WHO include Liechtenstein and other states with limited diplomatic recognition.<sup>[1]</sup> Several other entities have been granted observer status. Palestine is an observer as a "national liberation movement" recognised by the League of Arab States under United Nations Resolution 3118. The Holy See also attends as an observer, as does the Order of Malta.<sup>[1]</sup> In 2010, Taiwan was invited under the name of "Chinese Taipei".<sup>[59]</sup>



WHO Member States appoint delegations to the World Health Assembly, WHO's supreme decision-making body. All UN Member States are eligible for WHO membership, and, according to the WHO web site, "other countries may be admitted as members when their application has been approved by a simple majority vote of the World Health Assembly".<sup>[1]</sup>

In addition, the UN observer organizations International Committee of the Red Cross and International Federation of Red Cross and Red Crescent Societies have entered into "official relations" with WHO and are invited as observers. In the World Health Assembly they are seated along the other NGOs.<sup>[1]</sup>

## Assembly and Executive Board

The World Health Assembly is the legislative and supreme body of WHO. Based in Geneva, it typically meets yearly in May. It appoints the Director-General every five years, and votes on matters of policy and finance of WHO, including the proposed budget. It also reviews reports of the Executive Board and decides whether there are areas of work requiring further examination. The Assembly elects 34 members, technically qualified in the field of health, to the Executive Board for three-year terms. The main functions of the Board are to carry out the decisions and policies of the Assembly, to advise it and to facilitate its work.<sup>[60]</sup>

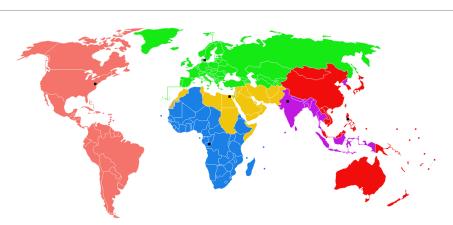


WHO Headquarters in Geneva

## Regional offices

The regional divisions of WHO were created between 1949 and 1952, and are based on article 44 of WHO's constitution, which allowed the WHA to "establish a [single] regional organization to meet the special needs of [each defined] area". Many decisions are made at regional level, including importance discussions over WHO's budget, and in deciding the members of the next assembly, which are designated by the regions.<sup>[60]</sup>

Each region has a Regional Committee, which generally meets once a year, normally in the autumn. Representatives attend from each member or associative member in each region, including those states that are not fully recognised. For example, Palestine attends meetings of the Eastern Mediterranean Regional office. Each region also has a regional office.<sup>[60]</sup> Each Regional Office is headed by a Regional Director, who is elected by the Regional Committee. The Board must approve such appointments, although as of 2004, it had never overruled the preference of a regional committee. The exact role of the board in the process has been a subject of debate, but the practical effect has always been small.<sup>[60]</sup> Since 1999, Regional Directors serve for a once-renewable five-year term.<sup>[61]</sup>



Regional offices and regions of the WHO:  
Africa; HQ: Brazzaville, Republic of Congo  
Americas; HQ: Washington, DC, United States of America  
Eastern Mediterranean; HQ: Cairo, Egypt  
Europe; HQ: Copenhagen, Denmark  
South East Asia; HQ: New Delhi, India  
Western Pacific; HQ: Manila, Philippines

Each Regional Committee of the WHO consists of all the Health Department heads, in all the governments of the countries that constitute the Region. Aside from electing the Regional Director, the Regional Committee is also in charge of setting the guidelines for the implementation, within the region, of the health and other policies adopted by the World Health Assembly. The Regional Committee also serves as a progress review board for the actions of WHO within the Region.

The Regional Director is effectively the head of WHO for his or her Region. The RD manages and/or supervises a staff of health and other experts at the regional offices and in specialized centers. The RD is also the direct supervising authority—concomitantly with the WHO Director-General—of all the heads of WHO country offices, known as WHO Representatives, within the Region.

## Regional Offices of WHO

Region	Headquarters	Notes	Website
Africa	Brazzaville, Republic of Congo	AFRO includes most of Africa, with the exception of Egypt, Sudan, South Sudan, Tunisia, Libya, Somalia and Morocco (all fall under EMRO). <sup>[62]</sup>	AFRO [63]
Europe	Copenhagen, Denmark.	EURO includes most of Europe and Israel. <sup>[64]</sup>	EURO [64]
South-East Asia	New Delhi, India	North Korea is served by SEARO. <sup>[65]</sup>	SEARO [66]
Eastern Mediterranean	Cairo, Egypt	Eastern Mediterranean Regional office includes the countries of Africa that are not included in AFRO, as well as the countries of the Middle East, except for Israel. Pakistan is served by EMRO. <sup>[67]</sup>	EMRO [68]
Western Pacific	Manila, Philippines.	WPRO covers all the Asian countries not served by SEARO and EMRO, and all the countries in Oceania. South Korea is served by WPRO. <sup>[69]</sup>	WPRO [70]
The Americas	Washington D.C., USA.	Also known as the Pan American Health Organization (PAHO), and covers the Americas. <sup>[71]</sup>	AMRO [72]

## People

### Former Directors-General of WHO<sup>[73]</sup>

Name	Years of tenure
Brock Chisholm	1948–1953
Marcolino Gomes Candau	1953–1973
Halfdan T. Mahler	1973–1988
Hiroshi Nakajima	1988–1998
Gro Harlem Brundtland	1998–2003
Lee Jong-wook	2003–2006
Anders Nordström*	2006

\*Acting Director-General following the death of Lee Jong-wook while in office

The head of the organization is the Director-General, appointed by the World Health Assembly.<sup>[74]</sup> The current Director-General is Margaret Chan, who was appointed on 9 November 2006.<sup>[74]</sup> On 18 January 2012, Chan was nominated by the WHO's Executive Board for a second term. If confirmed by the World Health Assembly in May 2012, Dr Chan will remain Director-General until the end of June 2017.<sup>[75]</sup>

WHO employs 8,500 people in 147 countries.<sup>[76]</sup> In support of the principle of a tobacco-free work environment the WHO does not recruit cigarette smokers.<sup>[77]</sup> The organization has previously instigated the Framework Convention on Tobacco Control in 2003.<sup>[78]</sup>

The WHO operates "Goodwill Ambassadors", members of the arts, sport or other fields of public life aimed at drawing attention to WHO's initiatives and projects. There are currently five Goodwill Ambassadors (Jet Li, Nancy Brinker, Peng Liyuan, Yohei Sasakawa and the Vienna Philharmonic Orchestra) and a further ambassador associated with a partnership project (Craig David).<sup>[79]</sup>

## Country and liaison offices

The World Health Organization operates 147 country offices in all its regions.<sup>[1]</sup> It also operates several liaison offices, including those with the European Union, United Nations and a single office covering the World Bank and International Monetary Fund. It also operates the International Agency for Research on Cancer in Lyon, France, and the WHO Centre for Health Development in Kobe, Japan.<sup>[80]</sup> Additional offices include those in Pristina; the West Bank and Gaza; the US–Mexican Border Field Office in El Paso; the Office of the Caribbean Program Coordination in Barbados; and Northern Micronesia office.<sup>[1]</sup> There will generally be one WHO country office in the capital, occasionally accompanied by satellite-offices in the provinces or sub-regions of the country in question.

The country office is headed by a WHO Representative (WR). As of 2010[57], the only WHO Representative outside Europe to be a national of that country was for the Libyan Arab Jamahiriya ("Libya"); all other staff were international. Those in the Region for the Americas, they are referred to as PAHO/WHO Representatives. In Europe, WHO Representatives also serve as Head of Country Office, and are nationals with the exception of Serbia; there are also Heads of Country Office in Albania, the Russian Federation, Tajikistan, Turkey, and Uzbekistan.<sup>[1]</sup> The WR is member of the UN system country team which is coordinated by the UN System Resident Coordinator.

The country office consists of the WR, and several health and other experts, both foreign and local, as well as the necessary support staff.<sup>[1]</sup> The main functions of WHO country offices include being the primary adviser of that country's government in matters of health and pharmaceutical policies.<sup>[81]</sup>

## Financing and partnerships

The WHO is financed by contributions from member states and outside donors. As of 2012[57], the largest annual assessed contributions from member states came from the United States (\$110 million), Japan (\$58 million), Germany (\$37 million), United Kingdom (\$31 million) and France (\$31 million).<sup>[82]</sup> The combined 2012–2013 budget has proposed a total expenditure of \$3,959 million, of which \$944 million (24%) will come from assessed contributions. This represented a significant fall in outlay compared to the previous 2009–2010 budget, adjusting to take account of previous underspends. Assessed contributions were kept the same. Voluntary contributions will account for \$3,015 million (76%), of which \$800 million is regarded as highly or moderately flexible funding, with the remainder tied to particular programmes or objectives.<sup>[83]</sup>

In recent years, the WHO's work has involved increasing collaboration with external bodies.<sup>[84]</sup> As of 2002[57], a total of 473 NGOs had some form of partnership with WHO. There were 189 partnerships with international non-governmental organization (NGO) in formal "official relations" – the rest being considered informal in character.<sup>[85]</sup> Partners include the Bill and Melinda Gates Foundation<sup>[86]</sup> and the Rockefeller Foundation.<sup>[87]</sup>

## Controversies

### IAEA – Agreement WHA 12–40

In 1959, the WHO signed Agreement WHA 12–40 with the International Atomic Energy Agency (IAEA). The agreement states that the WHO recognises the IAEA as having responsibility for peaceful nuclear energy without prejudice to the roles of the WHO of promoting health. However, the following paragraph adds: "whenever either organization proposes to initiate a programme or activity on a subject in which the other organization has or may have a substantial interest, the first party shall consult the other with a view to adjusting the matter by mutual agreement".<sup>[88]</sup> The nature of this statement has led some pressure groups and activists (including Women in Europe for a Common Future) to believe that the WHO is restricted in its ability to investigate the effects on human health of radiation caused by the use of nuclear power and the continuing effects of nuclear disasters in Chernobyl and Fukushima. They believe WHO must regain what they see as "independence".<sup>[89][90][91]</sup>



Demonstration on Chernobyl disaster day near WHO in Geneva

### Roman Catholic Church and AIDS

In 2003, the WHO denounced the Roman Curia's health department's opposition to the use of condoms, saying: "These incorrect statements about condoms and HIV are dangerous when we are facing a global pandemic which has already killed more than 20 million people, and currently affects at least 42 million."<sup>[92]</sup> As of 2009[57], the Catholic Church remains opposed to increasing the use of contraception to combat HIV/AIDS.<sup>[93]</sup> At the time, the World Health Assembly President, Guyana's Health Minister Leslie Ramsammy, condemned Pope Benedict's opposition to contraception, saying he was trying to "create confusion" and "impede" proven strategies in the battle against the disease.<sup>[94]</sup>

### Intermittent preventive therapy

The aggressive support of the Bill & Melinda Gates Foundation for intermittent preventive therapy of malaria which included the commissioning of a report from the Institute of Medicine triggered a memo from the former WHO malaria chief Akira Kochi.<sup>[95]</sup>

### Diet and sugar intake

Some of the research undertaken or supported by WHO to determine how people's lifestyles and environments are influencing whether they live in better or worse health can be controversial, as illustrated by a 2003 joint WHO/FAO report on nutrition and the prevention of chronic non-communicable disease,<sup>[96]</sup> which recommended that sugar should form no more than 10% of a healthy diet. This report led to lobbying by the sugar industry against the recommendation, to which the WHO/FAO responded by including in the report the statement "The Consultation recognized that a population goal for free sugars of less than 10% of total energy is controversial", but also stood by its recommendation based upon its own analysis of scientific studies.<sup>[97]</sup>

## 2009 influenza pandemic

In 2007, the WHO organized work on pandemic influenza vaccine development through clinical trials in collaboration with many experts. A pandemic involving the H1N1 influenza virus was declared by Director-General Margaret Chan in April 2009.

By the post-pandemic period critics claimed the WHO had exaggerated the danger, spreading "fear and confusion" rather than "immediate information".<sup>[98]</sup> Industry experts countered that the 2009 pandemic had led to "unprecedented collaboration between global health authorities, scientists and manufacturers, resulting in the most comprehensive pandemic response ever undertaken, with a number of vaccines approved for use three months after the pandemic declaration. This response was only possible because of the extensive preparations undertaken in during the last decade".<sup>[99]</sup>

## References

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- [43] See respectively: \* \* \*
- [57] [http://en.wikipedia.org/w/index.php?title=World\\_Health\\_Organization&action=edit](http://en.wikipedia.org/w/index.php?title=World_Health_Organization&action=edit)
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## External links

- [www.who.int](http://www.who.int) (<http://www.who.int/>) - Website
- World Health Organization (<https://plus.google.com/+who/posts>) on Google+

# List of ICD-9 codes

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The following is a list of codes for International Statistical Classification of Diseases and Related Health Problems.

- List of ICD-9 codes 001–139: infectious and parasitic diseases
- List of ICD-9 codes 140–239: neoplasms
- List of ICD-9 codes 240–279: endocrine, nutritional and metabolic diseases, and immunity disorders
- List of ICD-9 codes 280–289: diseases of the blood and blood-forming organs
- List of ICD-9 codes 290–319: mental disorders
- List of ICD-9 codes 320–359: diseases of the nervous system
- List of ICD-9 codes 360–389: diseases of the sense organs
- List of ICD-9 codes 390–459: diseases of the circulatory system
- List of ICD-9 codes 460–519: diseases of the respiratory system
- List of ICD-9 codes 520–579: diseases of the digestive system
- List of ICD-9 codes 580–629: diseases of the genitourinary system
- List of ICD-9 codes 630–679: complications of pregnancy, childbirth, and the puerperium
- List of ICD-9 codes 680–709: diseases of the skin and subcutaneous tissue
- List of ICD-9 codes 710–739: diseases of the musculoskeletal system and connective tissue
- List of ICD-9 codes 740–759: congenital anomalies
- List of ICD-9 codes 760–779: certain conditions originating in the perinatal period
- List of ICD-9 codes 780–799: symptoms, signs, and ill-defined conditions
- List of ICD-9 codes 800–999: injury and poisoning
- List of ICD-9 codes E and V codes: external causes of injury and supplemental classification

## ICD-9-CM Volume 3

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**ICD-9-CM Volume 3** is a system of procedural codes. It is a subset of the International Statistical Classification of Diseases and Related Health Problems (ICD) 9-CM. Volumes 1 and 2 are used for diagnostic codes.

### (00) Procedures and interventions, not elsewhere classified

- (00<sup>[1]</sup>) Procedures and interventions, not elsewhere classified
  - (00.6<sup>[2]</sup>) Procedures on blood vessels
    - (00.61<sup>[3]</sup>) Percutaneous angioplasty or atherectomy of precerebral (extracranial) vessel(s)

### (01–05) Operations on the nervous system

- (01<sup>[4]</sup>) Incision and excision of skull, brain, and cerebral meninges
  - (01.2<sup>[5]</sup>) Craniotomy and craniectomy
  - (01.3<sup>[6]</sup>) Incision of brain and cerebral meninges
    - (01.32<sup>[7]</sup>) Lobotomy and tractotomy
  - (01.5<sup>[8]</sup>) Other excision or destruction of brain and meninges
    - (01.52<sup>[9]</sup>) Hemispherectomy
- (02<sup>[10]</sup>) Other operations on skull, brain, and cerebral meninges
  - (02.2<sup>[11]</sup>) Ventriculostomy
- (03<sup>[12]</sup>) Operations on spinal cord and spinal canal structures

- (03.0<sup>[13]</sup>) Exploration and decompression of spinal canal structures
  - (03.09<sup>[14]</sup>) Other exploration and decompression of spinal canal
    - Laminectomy
- (03.1<sup>[15]</sup>) Division of intraspinal nerve root
  - Rhizotomy
- (03.2<sup>[16]</sup>) Chordotomy
- (03.3<sup>[17]</sup>) Diagnostic procedures on spinal cord and spinal canal structures
  - (03.31<sup>[18]</sup>) Spinal tap
- (04<sup>[19]</sup>) Operations on cranial and other nerves
  - (04.0<sup>[20]</sup>) Incision, division, and excision of cranial and other nerves
    - (04.05<sup>[21]</sup>) Gasserian ganglionectomy
    - (04.06<sup>[22]</sup>) Other cranial or peripheral ganglionectomy
  - (04.8<sup>[23]</sup>) Injection into a nerve
    - (04.81<sup>[24]</sup>) Injection of anesthetic into a nerve for analgesia
- (05<sup>[25]</sup>) Operations on sympathetic nerves or ganglia
  - (05.2<sup>[26]</sup>) Sympathectomy
    - (05.21<sup>[27]</sup>) Sphenopalatine ganglionectomy
    - (05.29<sup>[28]</sup>) Other sympathectomy and ganglionectomy

## (06–07) Operations on the endocrine system

- (06<sup>[29]</sup>) Operations on thyroid and parathyroid glands
  - (06.0<sup>[30]</sup>) Incision of thyroid field
  - (06.1<sup>[31]</sup>) Diagnostic procedures on thyroid and parathyroid glands
  - (06.2<sup>[32]</sup>) Unilateral thyroid lobectomy
  - (06.3<sup>[33]</sup>) Other partial thyroidectomy
  - (06.4<sup>[34]</sup>) Complete thyroidectomy
  - (06.5<sup>[35]</sup>) Substernal thyroidectomy
  - (06.6<sup>[36]</sup>) Excision of lingual thyroid
  - (06.7<sup>[37]</sup>) Excision of thyroglossal duct or tract
  - (06.8<sup>[38]</sup>) Parathyroidectomy
  - (06.9<sup>[39]</sup>) Other operations on thyroid (region) and parathyroid
- (07<sup>[40]</sup>) Operations on other endocrine glands
  - (07.0<sup>[41]</sup>) Exploration of adrenal field
  - (07.1<sup>[42]</sup>) Diagnostic procedures on adrenal glands, pituitary gland, pineal gland, and thymus
  - (07.2<sup>[43]</sup>) Partial adrenalectomy
  - (07.3<sup>[44]</sup>) Bilateral adrenalectomy
  - (07.4<sup>[45]</sup>) Other operations on adrenal glands, nerves, and vessels
  - (07.5<sup>[46]</sup>) Operations on pineal gland
  - (07.6<sup>[47]</sup>) Hypophysectomy
  - (07.7<sup>[48]</sup>) Other operations on hypophysis
  - (07.8<sup>[49]</sup>) Thymectomy
  - (07.9<sup>[50]</sup>) Other operations on thymus

## (08–16) Operations on the eye

- (08<sup>[51]</sup>) Operations on eyelids
- (09<sup>[52]</sup>) Operations on lacrimal system
- (10<sup>[53]</sup>) Operations on conjunctiva
- (11<sup>[54]</sup>) Operations on cornea
  - (11.6<sup>[55]</sup>) Corneal transplant
  - (11.7<sup>[56]</sup>) Other reconstructive and refractive surgery on cornea
    - Keratomileusis
    - Mini asymmetric radial keratotomy
    - (11.75<sup>[57]</sup>) Radial keratotomy
- (12<sup>[58]</sup>) Operations on iris, ciliary body, sclera, and anterior chamber
- (13<sup>[59]</sup>) Operations on lens
  - Cataract surgery
  - (13.41<sup>[60]</sup>) Phacoemulsification and aspiration of cataract
- (14<sup>[61]</sup>) Operations on retina, choroid, vitreous, and posterior chamber
  - (14.0<sup>[62]</sup>) Removal of foreign body from posterior segment of eye
  - (14.1<sup>[63]</sup>) Diagnostic procedures on retina, choroid, vitreous, and posterior chamber
  - (14.2<sup>[64]</sup>) Destruction of lesion of retina and choroid
  - (14.3<sup>[65]</sup>) Repair of retinal tear
  - (14.4<sup>[66]</sup>) Repair of retinal detachment with scleral buckling and implant
  - (14.5<sup>[67]</sup>) Other repair of retinal detachment
  - (14.6<sup>[68]</sup>) Removal of surgically implanted material from posterior segment of eye
  - (14.7<sup>[69]</sup>) Operations on vitreous
  - (14.9<sup>[70]</sup>) Other operations on retina, choroid, and posterior chamber
- (15<sup>[71]</sup>) Operations on extraocular muscles
- (16<sup>[72]</sup>) Operations on orbit and eyeball
  - (16.4<sup>[73]</sup>) Enucleation of the Eye

## (18–20) Operations on the ear

- (18<sup>[74]</sup>) Operations on external ear
  - (18.0<sup>[75]</sup>) Incision of external ear
  - (18.1<sup>[76]</sup>) Diagnostic procedures on external ear
  - (18.2<sup>[77]</sup>) Excision or destruction of lesion of external ear
  - (18.3<sup>[78]</sup>) Other excision of external ear
  - (18.4<sup>[79]</sup>) Suture of laceration of external ear
  - (18.5<sup>[80]</sup>) Surgical correction of prominent ear
  - (18.6<sup>[81]</sup>) Reconstruction of external auditory canal
  - (18.7<sup>[82]</sup>) Other plastic repair of external ear
    - (18.71<sup>[83]</sup>) Construction of auricle of ear
    - (18.72<sup>[84]</sup>) Reattachment of amputated ear
    - (18.79<sup>[85]</sup>) Other plastic repair of external ear
      - Otoplasty NOS
  - (18.9<sup>[86]</sup>) Other operations on external ear

- (19<sup>[87]</sup>) Reconstructive operations on middle ear
  - (19.0<sup>[88]</sup>) Stapes mobilization
  - (19.1<sup>[89]</sup>) Stapedectomy
  - (19.2<sup>[90]</sup>) Revision of stapedectomy
  - (19.3<sup>[91]</sup>) Other operations on ossicular chain
  - (19.4<sup>[92]</sup>) Myringoplasty
  - (19.5<sup>[93]</sup>) Other tympanoplasty
  - (19.6<sup>[94]</sup>) Revision of tympanoplasty
  - (19.9<sup>[95]</sup>) Other repair of middle ear
- (20<sup>[96]</sup>) Other operations on middle and inner ear
  - (20.0<sup>[97]</sup>) Myringotomy
  - (20.1<sup>[98]</sup>) Removal of tympanostomy tube
  - (20.2<sup>[99]</sup>) Incision of mastoid and middle ear
  - (20.3<sup>[100]</sup>) Diagnostic procedures on middle and inner ear
  - (20.4<sup>[101]</sup>) Mastoidectomy
  - (20.5<sup>[102]</sup>) Other excision of middle ear
  - (20.6<sup>[103]</sup>) Fenestration of inner ear
  - (20.7<sup>[104]</sup>) Incision, excision, and destruction of inner ear
  - (20.8<sup>[105]</sup>) Operations on Eustachian tube
  - (20.9<sup>[106]</sup>) Other operations on inner and middle ear

## (21-29) Operations on the nose, mouth and pharynx

- (21<sup>[107]</sup>) Operations on nose
  - (21.0<sup>[108]</sup>) Control of epistaxis
  - (21.1<sup>[109]</sup>) Incision of nose
  - (21.2<sup>[110]</sup>) Diagnostic procedures on nose
  - (21.3<sup>[111]</sup>) Local excision or destruction of lesion of nose
  - (21.4<sup>[112]</sup>) Resection of nose
  - (21.5<sup>[113]</sup>) Submucous resection of nasal septum
  - (21.6<sup>[114]</sup>) Turbinectomy
  - (21.7<sup>[115]</sup>) Reduction of nasal fracture
  - (21.8<sup>[116]</sup>) Repair and plastic operations on the nose
    - (21.81<sup>[117]</sup>) Suture of laceration of nose
    - (21.82<sup>[118]</sup>) Closure of nasal fistula
    - (21.83<sup>[119]</sup>) Total nasal reconstruction
    - (21.84<sup>[120]</sup>) Revision rhinoplasty
    - (21.85<sup>[121]</sup>) Augmentation rhinoplasty
    - (21.86<sup>[122]</sup>) Limited rhinoplasty
    - (21.87<sup>[123]</sup>) Other rhinoplasty
    - (21.88<sup>[124]</sup>) Other septoplasty
    - (21.89<sup>[125]</sup>) Other repair and plastic operations on nose
  - (21.9<sup>[126]</sup>) Other operations on nose
- (22<sup>[127]</sup>) Operations on nasal sinuses
- (23<sup>[128]</sup>) Removal and restoration of teeth
  - (23.0<sup>[129]</sup>) Forceps extraction of tooth

- (23.1 [130]) Surgical removal of tooth
- (23.2 [131]) Restoration of tooth by filling
- (23.3 [132]) Restoration of tooth by inlay
- (23.4 [133]) Other dental restoration
- (23.5 [134]) Implantation of tooth
- (23.6 [135]) Prosthetic dental implant
- (23.7 [136]) Apicoectomy and root canal therapy
- (24 [137]) Other operations on teeth, gums, and alveoli
  - (24.0 [138]) Incision of gum or alveolar bone
  - (24.1 [139]) Diagnostic procedures on teeth, gums, and alveoli
  - (24.2 [140]) Gingivoplasty
  - (24.3 [141]) Other operations on gum
  - (24.4 [142]) Excision of dental lesion of jaw
  - (24.5 [143]) Alveoloplasty
  - (24.6 [144]) Exposure of tooth
  - (24.7 [145]) Application of orthodontic appliance
  - (24.8 [146]) Other orthodontic operation
  - (24.9 [147]) Other dental operations
- (25 [148]) Operations on tongue
  - (25.0 [149]) Diagnostic procedures on tongue
  - (25.1 [150]) Excision or destruction of lesion or tissue of tongue
  - (25.2 [151]) Partial glossectomy
  - (25.3 [152]) Complete glossectomy
  - (25.4 [153]) Radical glossectomy
  - (25.5 [154]) Repair of tongue and glossoplasty
  - (25.9 [155]) Other operations on tongue
    - (25.91 [156]) Lingual frenotomy
    - (25.92 [157]) Lingual frenectomy
    - (25.93 [158]) Lysis of adhesions of tongue
    - (25.94 [159]) Other glossotomy
    - (25.99 [160]) Other
- (26 [161]) Operations on salivary glands and ducts
- (27 [162]) Other operations on mouth and face
  - (27.0 [163]) Drainage of face and floor of mouth
  - (27.1 [164]) Incision of palate
  - (27.2 [165]) Diagnostic procedures on oral cavity
  - (27.3 [166]) Excision of lesion or tissue of bony palate
  - (27.4 [167]) Excision of other parts of mouth
    - (27.41 [168]) Labial frenectomy
    - (27.42 [169]) Wide excision of lesion of lip
    - (27.43 [170]) Other excision of lesion or tissue of lip
    - (27.49 [171]) Other excision of mouth
  - (27.5 [172]) Plastic repair of mouth
  - (27.6 [173]) Palatoplasty
  - (27.7 [174]) Operations on uvula

- (27.9<sup>[175]</sup>) Other operations on mouth and face
- (28<sup>[176]</sup>) Operations on tonsils and adenoids
  - (28.2<sup>[177]</sup>) Tonsillectomy without adenoidectomy
  - (28.3<sup>[178]</sup>) Tonsillectomy with adenoidectomy
  - (28.6<sup>[179]</sup>) Adenoidectomy without tonsillectomy
- (29<sup>[180]</sup>) Operations on pharynx

## (30–34) Operations on the respiratory system

- (30<sup>[181]</sup>) Excision of larynx
  - (30.0<sup>[182]</sup>) Excision or destruction of lesion or tissue of larynx
  - (30.1<sup>[183]</sup>) Hemilaryngectomy
  - (30.2<sup>[184]</sup>) Other partial laryngectomy
  - (30.3<sup>[185]</sup>) Complete laryngectomy
  - (30.4<sup>[186]</sup>) Radical laryngectomy
- (31<sup>[187]</sup>) Other operations on larynx and trachea
  - (31.0<sup>[188]</sup>) Injection of larynx
  - (31.1<sup>[189]</sup>) Temporary tracheostomy
  - (31.2<sup>[190]</sup>) Permanent tracheostomy
  - (31.3<sup>[191]</sup>) Other incision of larynx or trachea
  - (31.4<sup>[192]</sup>) Diagnostic procedures on larynx and trachea
  - (31.5<sup>[193]</sup>) Local excision or destruction of lesion or tissue of trachea
  - (31.6<sup>[194]</sup>) Repair of larynx
  - (31.7<sup>[195]</sup>) Repair and plastic operations on trachea
  - (31.9<sup>[196]</sup>) Other operations on larynx and trachea
- (32<sup>[197]</sup>) Excision of lung and bronchus
  - (32.0<sup>[198]</sup>) Local excision or destruction of lesion or tissue of bronchus
  - (32.1<sup>[199]</sup>) Other excision of bronchus
  - (32.2<sup>[200]</sup>) Local excision or destruction of lesion or tissue of lung
  - (32.3<sup>[201]</sup>) Segmental resection of lung
  - (32.4<sup>[202]</sup>) Lobectomy of lung
  - (32.5<sup>[203]</sup>) Complete pneumonectomy
  - (32.6<sup>[204]</sup>) Radical dissection of thoracic structures
  - (32.9<sup>[205]</sup>) Other excision of lung
- (33<sup>[206]</sup>) Other operations on lung and bronchus
  - (33.0<sup>[207]</sup>) Incision of bronchus
  - (33.1<sup>[208]</sup>) Incision of lung
  - (33.2<sup>[209]</sup>) Diagnostic procedures on lung and bronchus
    - (33.21<sup>[210]</sup>) Bronchoscopy through artificial stoma
    - (33.22<sup>[211]</sup>) Fiber-optic bronchoscopy
    - (33.23<sup>[212]</sup>) Other bronchoscopy
    - (33.24<sup>[213]</sup>) Closed (endoscopic) biopsy of bronchus
    - (33.25<sup>[214]</sup>) Open biopsy of bronchus
    - (33.26<sup>[215]</sup>) Closed (percutaneous) (needle) biopsy of lung
    - (33.27<sup>[216]</sup>) Closed endoscopic biopsy of lung
    - (33.28<sup>[217]</sup>) Open biopsy of lung

- (33.29 [218]) Other diagnostic procedures on lung and bronchus
- (33.3 [219]) Surgical collapse of lung
- (33.4 [220]) Repair and plastic operation on lung and bronchus
- (33.5 [221]) Lung transplant
- (33.6 [222]) Combined heart-lung transplantation
- (33.9 [223]) Other operations on lung and bronchus
- (34 [224]) Operations on chest wall, pleura, mediastinum, and diaphragm
  - (34.0 [225]) Incision of chest wall and pleura
    - (34.02 [226]) Exploratory thoracotomy
  - (34.1 [227]) Incision of mediastinum
  - (34.2 [228]) Diagnostic procedures on chest wall, pleura, mediastinum, and diaphragm
    - (34.21 [229]) Transpleural thoracoscopy
    - (34.22 [230]) Mediastinoscopy
    - (34.23 [231]) Biopsy of chest wall
    - (34.24 [232]) Pleural biopsy
    - (34.25 [233]) Closed (percutaneous) (needle) biopsy of mediastinum
    - (34.26 [234]) Open mediastinal biopsy
    - (34.27 [235]) Biopsy of diaphragm
    - (34.28 [236]) Other diagnostic procedures on chest wall, pleura, and diaphragm
    - (34.29 [237]) Other diagnostic procedures on mediastinum
  - (34.3 [238]) Excision or destruction of lesion or tissue of mediastinum
  - (34.4 [239]) Excision or destruction of lesion of chest wall
  - (34.5 [240]) Pleurectomy
  - (34.6 [241]) Scarification of pleura
  - (34.7 [242]) Repair of chest wall
    - (34.74 [243]) Repair of pectus deformity
  - (34.8 [244]) Operations on diaphragm
  - (34.9 [245]) Other operations on thorax
    - (34.91 [246]) Thoracentesis
    - (34.92 [247]) Injection into thoracic cavity
      - Chemical pleurodesis

## (35–39) Operations on the cardiovascular system

### Heart

- (35 [248]) Operations on valves and septa of heart
  - (35.0 [249]) Closed heart valvotomy
  - (35.1 [250]) Open heart valvuloplasty without replacement
  - (35.2 [251]) Replacement of heart valve
  - (35.3 [252]) Operations on structures adjacent to heart valves
  - (35.4 [253]) Production of septal defect in heart
  - (35.5 [254]) Repair of atrial and ventricular septa with prosthesis
  - (35.6 [255]) Repair of atrial and ventricular septa with tissue graft
  - (35.7 [256]) Other and unspecified repair of atrial and ventricular septa
  - (35.8 [257]) Total repair of certain congenital cardiac anomalies

- (35.9<sup>[258]</sup>) Other operations on valves and septa of heart
  - (35.94<sup>[259]</sup>) Creation of conduit between atrium and pulmonary artery
    - Fontan procedure
- (36<sup>[260]</sup>) Operations on vessels of heart
  - (36.0<sup>[261]</sup>) Removal of coronary artery obstruction and insertion of stent(s)
  - (36.1<sup>[262]</sup>) Bypass anastomosis for heart revascularization
  - (36.2<sup>[263]</sup>) Heart revascularization by arterial implant
  - (36.3<sup>[264]</sup>) Other heart revascularization
  - (36.9<sup>[265]</sup>) Other operations on vessels of heart
- (37<sup>[266]</sup>) Other operations on heart and pericardium
  - (37.0<sup>[267]</sup>) Pericardiocentesis
  - (37.1<sup>[268]</sup>) Cardiotomy and pericardiotomy
  - (37.2<sup>[269]</sup>) Diagnostic procedures on heart and pericardium
  - (37.3<sup>[270]</sup>) Pericardectomy and excision of lesion of heart
    - (37.31<sup>[271]</sup>) Pericardectomy
    - (37.32<sup>[272]</sup>) Excision of aneurysm of heart
    - (37.33<sup>[273]</sup>) Excision or destruction of other lesion or tissue of heart, open approach
      - Maze procedure
    - (37.34<sup>[274]</sup>) Excision or destruction of other lesion or tissue of heart, other approach
    - (37.35<sup>[275]</sup>) Partial ventriculectomy
      - Ventricular reduction surgery
  - (37.4<sup>[276]</sup>) Repair of heart and pericardium
  - (37.5<sup>[277]</sup>) Heart replacement procedures
    - (37.51<sup>[278]</sup>) Heart transplantation
    - (37.52<sup>[279]</sup>) Implantation of total replacement heart system
      - Artificial heart
  - (37.6<sup>[280]</sup>) Implantation of heart and circulatory assist system
  - (37.7<sup>[281]</sup>) Insertion, revision, replacement, and removal of pacemaker leads; insertion of temporary pacemaker system; or revision of cardiac device pocket
  - (37.8<sup>[282]</sup>) Insertion, replacement, removal, and revision of pacemaker device
  - (37.9<sup>[283]</sup>) Other operations on heart and pericardium

## Vessels

- (38<sup>[284]</sup>) Incision, excision, and occlusion of vessels
  - (38.0<sup>[285]</sup>) Incision of vessel
    - Thrombectomy
    - (38.1<sup>[286]</sup>) Endarterectomy
    - (38.2<sup>[287]</sup>) Diagnostic procedures on blood vessels
    - (38.3<sup>[288]</sup>) Resection of vessel with anastomosis
    - (38.4<sup>[289]</sup>) Resection of vessel with replacement
    - (38.5<sup>[290]</sup>) Ligation and stripping of varicose veins
    - (38.6<sup>[291]</sup>) Other excision of vessel
    - (38.7<sup>[292]</sup>) Interruption of the vena cava
    - (38.8<sup>[293]</sup>) Other surgical occlusion of vessels

- (38.9 [294]) Puncture of vessel
  - (38.91 [295]) Arterial catheterization
  - (38.92 [296]) Umbilical vein catheterization
  - (38.93 [297]) Venous catheterization, not elsewhere classified
  - (38.94 [298]) Venous cutdown
  - (38.95 [299]) Venous catheterization for renal dialysis
  - (38.98 [300]) Other puncture of artery
  - (38.99 [301]) Other puncture of vein
- (39 [302]) Other operations on vessels
  - (39.0 [303]) Systemic to pulmonary artery shunt
  - (39.1 [304]) Intra-abdominal venous shunt
    - transjugular intrahepatic portosystemic shunt (TIPS)
  - (39.2 [305]) Other shunt or vascular bypass
  - (39.3 [306]) Suture of vessel
  - (39.4 [307]) Revision of vascular procedure
  - (39.5 [308]) Other repair of vessels
  - (39.6 [309]) Extracorporeal circulation and procedures auxiliary to heart surgery
    - (39.61 [310]) Extracorporeal circulation auxiliary to open heart surgery
      - Cardiopulmonary bypass
      - (39.62 [311]) Hypothermia (systemic) incidental to open heart surgery
      - (39.63 [312]) Cardioplegia
      - (39.64 [313]) Intraoperative cardiac pacemaker
      - (39.65 [314]) Extracorporeal membrane oxygenation (ECMO)
      - (39.66 [315]) Percutaneous cardiopulmonary bypass
    - (39.7 [316]) Endovascular repair of vessel
    - (39.8 [317]) Operations on carotid body and other vascular bodies
    - (39.9 [318]) Other operations on vessels
      - (39.90 [319]) Insertion of non-drug-eluting peripheral vessel stent(s)
      - (39.91 [320]) Freeing of vessel
      - (39.92 [321]) Injection of sclerosing agent into vein
      - (39.93 [322]) Insertion of vessel-to-vessel cannula
      - (39.94 [323]) Replacement of vessel-to-vessel cannula
      - (39.95 [324]) Hemodialysis
        - Artificial kidney
        - Hemodiafiltration
        - Hemofiltration
        - Renal dialysis
      - (39.96 [325]) Total body perfusion
      - (39.97 [326]) Other perfusion, not otherwise specified
      - (39.98 [327]) Control of hemorrhage, not otherwise specified
      - (39.99 [328]) Other operations on vessels

## (40–41) Operations on the hemic and lymphatic system

- (40<sup>[329]</sup>) Operations on lymphatic system
  - (40.0<sup>[330]</sup>) Incision of lymphatic structures
  - (40.1<sup>[331]</sup>) Diagnostic procedures on lymphatic structures
  - (40.2<sup>[332]</sup>) Simple excision of lymphatic structure
    - (40.21<sup>[333]</sup>) Excision of deep cervical lymph node
    - (40.22<sup>[334]</sup>) Excision of internal mammary lymph node
    - (40.23<sup>[335]</sup>) Excision of axillary lymph node
    - (40.24<sup>[336]</sup>) Excision of inguinal lymph node
    - (40.29<sup>[337]</sup>) Simple excision of other lymphatic structure
      - Simple lymphadenectomy
  - (40.3<sup>[338]</sup>) Regional lymph node excision
  - (40.4<sup>[339]</sup>) Radical excision of cervical lymph nodes
    - (40.40<sup>[340]</sup>) Radical neck dissection, not otherwise specified
    - (40.41<sup>[341]</sup>) Radical neck dissection, unilateral
    - (40.42<sup>[342]</sup>) Radical neck dissection, bilateral
  - (40.5<sup>[343]</sup>) Radical excision of other lymph nodes
  - (40.6<sup>[344]</sup>) Operations on thoracic duct
  - (40.9<sup>[345]</sup>) Other operations on lymphatic structures
- (41<sup>[346]</sup>) Operations on bone marrow and spleen
  - (41.0<sup>[347]</sup>) Bone marrow or hematopoietic stem cell transplant
  - (41.1<sup>[348]</sup>) Puncture of spleen
  - (41.2<sup>[349]</sup>) Splenotomy
  - (41.3<sup>[350]</sup>) Diagnostic procedures on bone marrow and spleen
  - (41.4<sup>[351]</sup>) Excision or destruction of lesion or tissue of spleen
    - (41.41<sup>[352]</sup>) Marsupialization of splenic cyst
    - (41.42<sup>[353]</sup>) Excision of lesion or tissue of spleen
    - (41.43<sup>[354]</sup>) Partial splenectomy
  - (41.5<sup>[355]</sup>) Total splenectomy
  - (41.9<sup>[356]</sup>) Other operations on spleen and bone marrow

## (42–54) Operations on the digestive system

- (42<sup>[357]</sup>) Operations on esophagus
  - (42.4<sup>[358]</sup>) Excision of esophagus
    - (42.40<sup>[359]</sup>) Esophagectomy, not otherwise specified
- (43<sup>[360]</sup>) Incision and excision of stomach
  - (43.0<sup>[361]</sup>) Gastrotomy
  - (43.1<sup>[362]</sup>) Gastrostomy
    - (43.11<sup>[363]</sup>) Percutaneous (endoscopic) gastrostomy (PEG)
  - (43.3<sup>[364]</sup>) Pyloromyotomy
  - (43.4<sup>[365]</sup>) Local excision or destruction of lesion or tissue of stomach
  - (43.5<sup>[366]</sup>) Partial gastrectomy with anastomosis to esophagus
  - (43.6<sup>[367]</sup>) Partial gastrectomy with anastomosis to duodenum
  - (43.7<sup>[368]</sup>) Partial gastrectomy with anastomosis to jejunum

- (43.8<sup>[369]</sup>) Other partial gastrectomy
- (43.9<sup>[370]</sup>) Total gastrectomy
- (44<sup>[371]</sup>) Other operations on stomach
  - (44.0<sup>[372]</sup>) Vagotomy
  - (44.3<sup>[373]</sup>) Gastroenterostomy without gastrectomy
    - (44.31<sup>[374]</sup>) High gastric bypass
    - (44.32<sup>[375]</sup>) Percutaneous (endoscopic) gastrojejunostomy
    - (44.38<sup>[376]</sup>) Laparoscopic gastroenterostomy
    - (44.39<sup>[377]</sup>) Other gastroenterostomy
- (45<sup>[378]</sup>) Incision, excision, and anastomosis of intestine
  - (45.1<sup>[379]</sup>) Diagnostic procedures on small intestine
    - (45.11<sup>[380]</sup>) Transabdominal endoscopy of small intestine
    - (45.12<sup>[381]</sup>) Endoscopy of small intestine through artificial stoma
    - (45.13<sup>[382]</sup>) Other endoscopy of small intestine
      - Esophagogastroduodenoscopy (EGD)
      - (45.14<sup>[383]</sup>) Closed (endoscopic) biopsy of small intestine
      - (45.15<sup>[384]</sup>) Open biopsy of small intestine
      - (45.16<sup>[385]</sup>) Esophagogastroduodenoscopy (EGD) with closed biopsy
      - (45.19<sup>[386]</sup>) Other diagnostic procedures on small intestine
  - (45.2<sup>[387]</sup>) Diagnostic procedures on large intestine
    - (45.23<sup>[388]</sup>) Colonoscopy
  - (45.7<sup>[389]</sup>) Partial excision of large intestine
    - (45.73<sup>[390]</sup>) Right hemicolectomy
  - (45.8<sup>[391]</sup>) Total intra-abdominal colectomy
- (46<sup>[392]</sup>) Other operations on intestine
  - (46.1<sup>[393]</sup>) Colostomy
  - (46.2<sup>[394]</sup>) Ileostomy
  - (46.3<sup>[395]</sup>) Other enterostomy
  - (46.4<sup>[396]</sup>) Revision of intestinal stoma
  - (46.5<sup>[397]</sup>) Closure of intestinal stoma
  - (46.6<sup>[398]</sup>) Fixation of intestine
  - (46.7<sup>[399]</sup>) Other repair of intestine
  - (46.8<sup>[400]</sup>) Dilatation and manipulation of intestine
  - (46.9<sup>[401]</sup>) Other operations on intestines
    - (46.91<sup>[402]</sup>) Myotomy of sigmoid colon
    - (46.92<sup>[403]</sup>) Myotomy of other parts of colon
    - (46.93<sup>[404]</sup>) Revision of anastomosis of small intestine
      - jejunileal bypass
      - (46.94<sup>[405]</sup>) Revision of anastomosis of large intestine
      - (46.95<sup>[406]</sup>) Local perfusion of small intestine
      - (46.96<sup>[407]</sup>) Local perfusion of large intestine
      - (46.97<sup>[408]</sup>) Transplant of intestine
      - (46.99<sup>[409]</sup>) Other
- (47<sup>[410]</sup>) Operations on appendix

- (47.0 <sup>[411]</sup>) Appendectomy
- (48 <sup>[412]</sup>) Operations on rectum, rectosigmoid and perirectal tissue
  - (48.2 <sup>[413]</sup>) Diagnostic procedures on rectum, rectosigmoid and perirectal tissue
    - (48.21 <sup>[414]</sup>) Transabdominal proctosigmoidoscopy
    - (48.22 <sup>[415]</sup>) Proctosigmoidoscopy through artificial stoma
    - (48.23 <sup>[416]</sup>) Rigid proctosigmoidoscopy
    - (48.24 <sup>[417]</sup>) Closed (endoscopic) biopsy of rectum
    - (48.25 <sup>[418]</sup>) Open biopsy of rectum
    - (48.26 <sup>[419]</sup>) Biopsy of perirectal tissue
    - (48.29 <sup>[420]</sup>) Other diagnostic procedures on rectum, rectosigmoid and perirectal tissue
  - (49 <sup>[421]</sup>) Operations on anus
    - (49.0 <sup>[422]</sup>) Incision or excision of perianal tissue
    - (49.1 <sup>[423]</sup>) Incision or excision of anal fistula
    - (49.2 <sup>[424]</sup>) Diagnostic procedures on anus and perianal tissue
    - (49.3 <sup>[425]</sup>) Local excision or destruction of other lesion or tissue of anus
    - (49.4 <sup>[426]</sup>) Procedures on hemorrhoids
      - (49.46 <sup>[427]</sup>) Excision of hemorrhoids
        - Hemorrhoidectomy NOS
    - (49.5 <sup>[428]</sup>) Division of anal sphincter
      - (49.51 <sup>[429]</sup>) Left lateral anal sphincterotomy
      - (49.52 <sup>[430]</sup>) Posterior anal sphincterotomy
      - (49.59 <sup>[431]</sup>) Other anal sphincterotomy
    - (49.6 <sup>[432]</sup>) Excision of anus
    - (49.7 <sup>[433]</sup>) Repair of anus
    - (49.9 <sup>[434]</sup>) Other operations on anus
  - (50 <sup>[435]</sup>) Operations on liver
    - (50.0 <sup>[436]</sup>) Hepatotomy
    - (50.1 <sup>[437]</sup>) Diagnostic procedures on liver
    - (50.2 <sup>[438]</sup>) Local excision or destruction of liver tissue or lesion
      - (50.21 <sup>[439]</sup>) Marsupialization of lesion of liver
      - (50.22 <sup>[440]</sup>) Partial hepatectomy
      - (50.29 <sup>[441]</sup>) Other destruction of lesion of liver
    - (50.3 <sup>[442]</sup>) Lobectomy of liver
    - (50.4 <sup>[443]</sup>) Total hepatectomy
    - (50.5 <sup>[444]</sup>) Liver transplant
    - (50.6 <sup>[445]</sup>) Repair of liver
    - (50.9 <sup>[446]</sup>) Other operations on liver
  - (51 <sup>[447]</sup>) Operations on gallbladder and biliary tract
    - (51.0 <sup>[448]</sup>) Cholecystotomy and cholecystostomy
    - (51.1 <sup>[449]</sup>) Diagnostic procedures on biliary tract
      - (51.10 <sup>[450]</sup>) Endoscopic retrograde cholangiopancreatography (ERCP)
    - (51.2 <sup>[451]</sup>) Cholecystectomy
    - (51.3 <sup>[452]</sup>) Anastomosis of gallbladder or bile duct
    - (51.4 <sup>[453]</sup>) Incision of bile duct for relief of obstruction

- (51.5<sup>[454]</sup>) Other incision of bile duct
- (51.6<sup>[455]</sup>) Local excision or destruction of lesion or tissue of biliary ducts and sphincter of Oddi
- (51.7<sup>[456]</sup>) Repair of bile ducts
- (51.8<sup>[457]</sup>) Other operations on biliary ducts and sphincter of Oddi
- (51.9<sup>[458]</sup>) Other operations on biliary tract
- (52<sup>[459]</sup>) Operations on pancreas
  - (52.0<sup>[460]</sup>) Pancreatotomy
  - (52.1<sup>[461]</sup>) Diagnostic procedures on pancreas
  - (52.2<sup>[462]</sup>) Local excision or destruction of pancreas and pancreatic duct
  - (52.3<sup>[463]</sup>) Marsupialization of pancreatic cyst
  - (52.4<sup>[464]</sup>) Internal drainage of pancreatic cyst
  - (52.5<sup>[465]</sup>) Partial pancreatectomy
  - (52.6<sup>[466]</sup>) Total pancreatectomy
  - (52.7<sup>[467]</sup>) Radical pancreaticoduodenectomy
  - (52.8<sup>[468]</sup>) Transplant of pancreas
  - (52.9<sup>[469]</sup>) Other operations on pancreas
    - (52.96<sup>[470]</sup>) Anastomosis of pancreas
- (53<sup>[471]</sup>) Repair of hernia
  - hernia repair
- (54<sup>[472]</sup>) Other operations on abdominal region
  - (54.1<sup>[473]</sup>) Laparotomy
  - (54.9<sup>[474]</sup>) Other operations of abdominal region
    - (54.91<sup>[475]</sup>) Percutaneous abdominal drainage
      - Paracentesis

## (55–59) Operations on the urinary system

- (55<sup>[476]</sup>) Operations on kidney
  - (55.0<sup>[477]</sup>) Nephrotomy and nephrostomy
    - (55.02<sup>[478]</sup>) Nephrostomy
  - (55.1<sup>[479]</sup>) Pyelotomy and pyelostomy
  - (55.2<sup>[480]</sup>) Diagnostic procedures on kidney
  - (55.3<sup>[481]</sup>) Local excision or destruction of lesion or tissue of kidney
  - (55.4<sup>[482]</sup>) Partial nephrectomy
  - (55.5<sup>[483]</sup>) Complete nephrectomy
  - (55.6<sup>[484]</sup>) Transplant of kidney
  - (55.7<sup>[485]</sup>) Nephropexy
  - (55.8<sup>[486]</sup>) Other repair of kidney
  - (55.9<sup>[487]</sup>) Other operations on kidney
- (56<sup>[488]</sup>) Operations on ureter
  - (56.0<sup>[489]</sup>) Transurethral removal of obstruction from ureter and renal pelvis
  - (56.1<sup>[490]</sup>) Ureteral meatotomy
  - (56.2<sup>[491]</sup>) Ureterotomy
  - (56.3<sup>[492]</sup>) Diagnostic procedures on ureter
    - (56.31<sup>[493]</sup>) Ureteroscopy

- (56.4<sup>[494]</sup>) Ureterectomy
- (56.5<sup>[495]</sup>) Cutaneous uretero-ileostomy
- (56.6<sup>[496]</sup>) Other external urinary diversion
  - (56.61<sup>[497]</sup>) Formation of other cutaneous ureterostomy
    - Ureterostomy NOS
- (56.7<sup>[498]</sup>) Other anastomosis or bypass of ureter
  - (56.71<sup>[499]</sup>) Urinary diversion to intestine
    - Internal urinary diversion NOS
- (56.8<sup>[500]</sup>) Repair of ureter
- (56.9<sup>[501]</sup>) Other operations on ureter
- (57<sup>[502]</sup>) Operations on urinary bladder
  - (57.0<sup>[503]</sup>) Transurethral clearance of bladder
  - (57.1<sup>[504]</sup>) Cystotomy and cystostomy
  - (57.2<sup>[505]</sup>) Vesicostomy
  - (57.3<sup>[506]</sup>) Diagnostic procedures on bladder
  - (57.4<sup>[507]</sup>) Transurethral excision or destruction of bladder tissue
  - (57.5<sup>[508]</sup>) Other excision or destruction of bladder tissue
  - (57.6<sup>[509]</sup>) Partial cystectomy
  - (57.7<sup>[510]</sup>) Total cystectomy
  - (57.8<sup>[511]</sup>) Other repair of urinary bladder
  - (57.9<sup>[512]</sup>) Other operations on bladder
- (58<sup>[513]</sup>) Operations on urethra
  - (55.81<sup>[514]</sup>) Suture of laceration of kidney
  - (55.82<sup>[515]</sup>) Closure of nephrostomy and pyelostomy
  - (55.83<sup>[516]</sup>) Closure of other fistula of kidney
  - (55.84<sup>[517]</sup>) Reduction of torsion of renal pedicle
  - (55.85<sup>[518]</sup>) Symphysiotomy for horseshoe kidney
  - (55.86<sup>[519]</sup>) Anastomosis of kidney
  - (55.87<sup>[520]</sup>) Correction of ureteropelvic junction
  - (55.89<sup>[521]</sup>) Other
- (59<sup>[522]</sup>) Other operations on urinary tract

## (60–64) Operations on the male genital organs

- (60<sup>[523]</sup>) Operations on prostate and seminal vesicles
  - (60.0<sup>[524]</sup>) Incision of prostate
  - (60.1<sup>[525]</sup>) Diagnostic procedures on prostate and seminal vesicles
  - (60.2<sup>[526]</sup>) Transurethral prostatectomy
    - (60.21<sup>[527]</sup>) Transurethral (ultrasound) guided laser induced prostatectomy (TULIP)
    - (60.29<sup>[528]</sup>) Other transurethral prostatectomy
      - Transurethral resection of prostate (TURP)
  - (60.3<sup>[529]</sup>) Suprapubic prostatectomy
  - (60.4<sup>[530]</sup>) Retropubic prostatectomy
  - (60.5<sup>[531]</sup>) Radical prostatectomy
  - (60.6<sup>[532]</sup>) Other prostatectomy

- (60.7 [533]) Operations on seminal vesicles
- (60.8 [534]) Incision or excision of periprostatic tissue
- (60.9 [535]) Other operations on prostate
- (61 [536]) Operations on scrotum and tunica vaginalis
- (62 [537]) Operations on testes
- (63 [538]) Operations on spermatic cord, epididymis, and vas deferens
  - (63.7 [539]) Vasectomy and ligation of vas deferens
    - (63.73 [540]) Vasectomy
  - (63.8 [541]) Repair of vas deferens and epididymis
    - (63.82 [542]) Reconstruction of surgically divided vas deferens
- (64 [543]) Operations on penis
  - (64.0 [544]) Circumcision
  - (64.1 [545]) Diagnostic procedures on the penis
  - (64.2 [546]) Local excision or destruction of lesion of penis
  - (64.3 [547]) Amputation of penis
  - (64.4 [548]) Repair and plastic operation on penis
  - (64.5 [549]) Operations for sex transformation, not elsewhere classified
  - (64.9 [550]) Other operations on male genital organs
    - (64.91 [551]) Dorsal or lateral slit of prepuce
    - (64.92 [552]) Incision of penis
    - (64.93 [553]) Division of penile adhesions
    - (64.94 [554]) Fitting of external prosthesis of penis
      - Penile prosthesis NOS
    - (64.95 [555]) Insertion or replacement of non-inflatable penile prosthesis
    - (64.96 [556]) Removal of internal prosthesis of penis
    - (64.97 [557]) Insertion or replacement of inflatable penile prosthesis
    - (64.98 [558]) Other operations on penis
    - (64.99 [559]) Other

## (65–71) Operations on the female genital organs

- (65 [560]) Operations on ovary
  - (65.0 [561]) Oophorotomy
  - (65.1 [562]) Diagnostic procedures on ovaries
  - (65.2 [563]) Local excision or destruction of ovarian lesion or tissue
  - (65.3 [564]) Unilateral oophorectomy
  - (65.4 [565]) Unilateral salpingo-oophorectomy
  - (65.5 [566]) Bilateral oophorectomy
  - (65.6 [567]) Bilateral salpingo-oophorectomy
  - (65.7 [568]) Repair of ovary
  - (65.8 [569]) Lysis of adhesions of ovary and fallopian tube
  - (65.9 [570]) Other operations on ovary
- (66 [571]) Operations on fallopian tubes
  - (66.0 [572]) Salpingotomy and salpingostomy
  - (66.1 [573]) Diagnostic procedures on fallopian tubes

- (66.2 [574]) Bilateral endoscopic destruction or occlusion of fallopian tubes
- (66.3 [575]) Other bilateral destruction or occlusion of fallopian tubes
- (66.4 [576]) Total unilateral salpingectomy
- (66.5 [577]) Total bilateral salpingectomy
- (66.6 [578]) Other salpingectomy
- (66.7 [579]) Repair of fallopian tube
- (66.8 [580]) Insufflation of fallopian tube
- (66.9 [581]) Other operations on fallopian tubes
- (67 [582]) Operations on cervix
  - (67.0 [583]) Dilation of cervical canal, excludes Dilatation and curettage
  - (67.1 [584]) Diagnostic procedures on cervix
  - (67.2 [585]) Conization of cervix excluding electrical/cryo
  - (67.3 [586]) Other excision or destruction of lesion or tissue of cervix
- (68 [587]) Other incision and excision of uterus
  - (68.0 [588]) Hysterotomy
  - (68.1 [589]) Diagnostic procedures on uterus and supporting structures
    - (68.12 [590]) Hysteroscopy
  - (68.2 [591]) Excision or destruction of lesion or tissue of uterus
  - (68.3 [592]) Subtotal abdominal hysterectomy
  - (68.4 [593]) Total abdominal hysterectomy
  - (68.5 [594]) Vaginal hysterectomy
  - (68.6 [595]) Radical abdominal hysterectomy
  - (68.7 [596]) Radical vaginal hysterectomy
  - (68.8 [597]) Pelvic exenteration
  - (68.9 [598]) Other and unspecified hysterectomy
- (69 [599]) Other operations on uterus and supporting structures
  - (69.0 [600]) Dilatation and curettage of uterus
  - (69.1 [601]) Excision or destruction of lesion or tissue of uterus and supporting structures
  - (69.2 [602]) Repair of uterine supporting structures
  - (69.3 [603]) Paracervical uterine denervation
  - (69.4 [604]) Uterine repair
  - (69.5 [605]) Aspiration curettage of uterus
  - (69.6 [606]) Menstrual extraction or regulation
  - (69.7 [607]) Insertion of intrauterine contraceptive device
  - (69.9 [608]) Other operations on uterus, cervix, and supporting structures
- (70 [609]) Operations on vagina and rectouterine pouch
  - (70.0 [610]) Culdocentesis
  - (70.1 [611]) Incision of vagina and rectouterine pouch
    - (70.11 [612]) Hymenotomy
    - (70.12 [613]) Culdotomy
    - (70.13 [614]) Lysis of intraluminal adhesions of vagina
    - (70.14 [615]) Other vaginotomy
  - (70.2 [616]) Diagnostic procedures on vagina and rectouterine pouch
  - (70.3 [617]) Local excision or destruction of vagina and rectouterine pouch
  - (70.4 [618]) Obliteration and total excision of vagina

- Vaginectomy
- (70.5 [619]) Repair of cystocele and rectocele
- (70.6 [620]) Vaginal construction and reconstruction
- (70.7 [621]) Other repair of vagina
- (70.8 [622]) Obliteration of vaginal vault
- (70.9 [623]) Other operations on vagina and rectouterine pouch
- (71 [624]) Operations on vulva and perineum
  - (71.0 [625]) Incision of vulva and perineum
  - (71.1 [626]) Diagnostic procedures on vulva
  - (71.2 [627]) Operations on Bartholin's gland
  - (71.3 [628]) Other local excision or destruction of vulva and perineum
  - (71.4 [629]) Operations on clitoris
  - (71.5 [630]) Radical vulvectomy
  - (71.6 [631]) Other vulvectomy
  - (71.7 [632]) Repair of vulva and perineum
  - (71.8 [633]) Other operations on vulva
  - (71.9 [634]) Other operations on female genital organs

## (72–75) Obstetrical procedures

- (72 [635]) Forceps, vacuum, and breech delivery
- (73 [636]) Other procedures inducing or assisting delivery
  - (73.0 [637]) Artificial rupture of membranes
    - (73.01 [638]) Induction of labor by artificial rupture of membranes
    - (73.09 [639]) Other artificial rupture of membranes
      - Amniotomy
  - (73.1 [640]) Other surgical induction of labor
  - (73.2 [641]) Internal and combined version and extraction
  - (73.3 [642]) Failed forceps
  - (73.4 [643]) Medical induction of labor
  - (73.5 [644]) Manually assisted delivery
  - (73.6 [645]) Episiotomy
  - (73.8 [646]) Operations on fetus to facilitate delivery
  - (73.9 [647]) Other operations assisting delivery
  - (73.91 [648]) External version
  - (73.92 [649]) Replacement of prolapsed umbilical cord
  - (73.93 [650]) Incision of cervix to assist delivery
  - (73.94 [651]) Pubiotomy to assist delivery
    - Obstetrical symphysiotomy
  - (73.99 [652]) Other
- (74 [653]) Cesarean section and removal of fetus
- (75 [654]) Other obstetric operations
  - (75.0 [655]) Intra-amniotic injection for abortion
  - (75.1 [656]) Diagnostic amniocentesis
  - (75.2 [657]) Intrauterine transfusion
  - (75.3 [658]) Other intrauterine operations on fetus and amnion

- (75.31<sup>[659]</sup>) Amnioscopy
  - Fetoscopy
  - Laparoamnioscopy
- (75.32<sup>[660]</sup>) Fetal EKG (scalp)
- (75.33<sup>[661]</sup>) Fetal blood sampling and biopsy
  - Chorionic villus sampling
- (75.34<sup>[662]</sup>) Other fetal monitoring
- (75.35<sup>[663]</sup>) Other diagnostic procedures on fetus and amnion
- (75.36<sup>[664]</sup>) Correction of fetal defect
- (75.37<sup>[665]</sup>) Amnioinfusion
- (75.38<sup>[666]</sup>) Fetal pulse oximetry
- (75.4<sup>[667]</sup>) Manual removal of retained placenta
- (75.5<sup>[668]</sup>) Repair of current obstetric laceration of uterus
- (75.6<sup>[669]</sup>) Repair of other current obstetric laceration
- (75.7<sup>[670]</sup>) Manual exploration of uterine cavity, postpartum
- (75.8<sup>[671]</sup>) Obstetric tamponade of uterus or vagina
- (75.9<sup>[672]</sup>) Other obstetric operations

## (76–84) Operations on the musculoskeletal system

- (76<sup>[673]</sup>) Operations on facial bones and joints
  - (76.0<sup>[674]</sup>) Incision of facial bone without division
  - (76.1<sup>[675]</sup>) Diagnostic procedures on facial bones and joints
  - (76.2<sup>[676]</sup>) Local excision or destruction of lesion of facial bone
  - (76.3<sup>[677]</sup>) Partial ostectomy of facial bone
  - (76.4<sup>[678]</sup>) Excision and reconstruction of facial bones
  - (76.5<sup>[679]</sup>) Temporomandibular arthroplasty
  - (76.6<sup>[680]</sup>) Other facial bone repair and orthognathic surgery
    - (76.68<sup>[681]</sup>) Augmentation genioplasty
      - Mentoplasty NOS
    - (76.7<sup>[682]</sup>) Reduction of facial fracture
    - (76.9<sup>[683]</sup>) Other operations on facial bones and joints
- (77<sup>[684]</sup>) Incision, excision, and division of other bones
  - (77.0<sup>[685]</sup>) Sequestrectomy
  - (77.1<sup>[686]</sup>) Other incision of bone without division
  - (77.2<sup>[687]</sup>) Wedge osteotomy
  - (77.3<sup>[688]</sup>) Other division of bone
  - (77.4<sup>[689]</sup>) Biopsy of bone
  - (77.5<sup>[690]</sup>) Excision and repair of bunion and other toe deformities
  - (77.6<sup>[691]</sup>) Local excision of lesion or tissue of bone
  - (77.7<sup>[692]</sup>) Excision of bone for graft
  - (77.8<sup>[693]</sup>) Other partial ostectomy
  - (77.9<sup>[694]</sup>) Total ostectomy
- (78<sup>[695]</sup>) Other operations on bones, except facial bones
  - (78.0<sup>[696]</sup>) Bone graft
  - (78.1<sup>[697]</sup>) Application of external fixator device

- (78.2 [698]) Limb shortening procedures
- (78.3 [699]) Limb lengthening procedures
- (78.4 [700]) Other repair or plastic operations on bone
- (78.5 [701]) Internal fixation of bone without fracture reduction
- (78.6 [702]) Removal of implanted devices from bone
- (78.7 [703]) Osteoclasis
- (78.8 [704]) Diagnostic procedures on bone, not elsewhere classified
- (78.9 [705]) Insertion of bone growth stimulator
- (79 [706]) Reduction of fracture and dislocation
  - (79.0 [707]) Closed reduction of fracture without internal fixation
  - (79.1 [708]) Closed reduction of fracture with internal fixation
  - (79.2 [709]) Open reduction of fracture without internal fixation
  - (79.3 [710]) Open reduction of fracture with internal fixation
  - (79.4 [711]) Closed reduction of separated epiphysis
  - (79.5 [712]) Open reduction of separated epiphysis
  - (79.6 [713]) Debridement of open fracture site
  - (79.7 [714]) Closed reduction of dislocation
  - (79.8 [715]) Open reduction of dislocation
  - (79.9 [716]) Unspecified operation on bone injury
- (80 [717]) Incision and excision of joint structures
  - (80.2 [718]) Arthroscopy
  - (80.5 [719]) Excision or destruction of intervertebral disc
    - (80.51 [720]) Excision of intervertebral disc
      - Diskectomy
- (81 [721]) Repair and plastic operations on joint structures
  - (81.0 [722]) Spinal fusion
  - (81.1 [723]) Arthrodesis and arthroereisis of foot and ankle
  - (81.2 [724]) Arthrodesis of other joint
  - (81.3 [725]) Refusion of spine
  - (81.4 [726]) Other repair of joint of lower extremity
  - (81.5 [727]) Joint replacement of lower extremity
    - (81.51 [728]) Total hip replacement
    - (81.52 [729]) Partial hip replacement
    - (81.53 [730]) Revision of hip replacement, not otherwise specified
    - (81.54 [731]) Total knee replacement
    - (81.55 [732]) Revision of knee replacement, not otherwise specified
    - (81.56 [733]) Total ankle replacement
    - (81.57 [734]) Replacement of joint of foot and toe
    - (81.59 [735]) Revision of joint replacement of lower extremity, not elsewhere classified
  - (81.6 [736]) Other procedures on spine
  - (81.7 [737]) Arthroplasty and repair of hand, fingers and wrist
  - (81.8 [738]) Arthroplasty and repair of shoulder and elbow
    - (81.80 [739]) Total shoulder replacement
    - (81.81 [740]) Partial shoulder replacement
    - (81.82 [741]) Repair of recurrent dislocation of shoulder

- (81.83 [742]) Other repair of shoulder
- (81.84 [743]) Total elbow replacement
- (81.85 [744]) Other repair of elbow
- (81.9 [745]) Other operations on joint structures
- (82 [746]) Operations on muscle, tendon, and fascia of hand
  - (82.0 [747]) Incision of muscle, tendon, fascia, and bursa of hand
  - (82.1 [748]) Division of muscle, tendon, and fascia of hand
  - (82.2 [749]) Excision of lesion of muscle, tendon, and fascia of hand
  - (82.3 [750]) Other excision of soft tissue of hand
  - (82.4 [751]) Suture of muscle, tendon, and fascia of hand
  - (82.5 [752]) Transplantation of muscle and tendon of hand
  - (82.6 [753]) Reconstruction of thumb
  - (82.7 [754]) Plastic operation on hand with graft or implant
  - (82.8 [755]) Other plastic operations on hand
  - (82.9 [756]) Other operations on muscle, tendon, and fascia of hand
- (83 [757]) Operations on muscle, tendon, fascia, and bursa, except hand
  - (83.0 [758]) Incision of muscle, tendon, fascia, and bursa
    - (83.01 [759]) Exploration of tendon sheath
    - (83.02 [760]) Myotomy
    - (83.03 [761]) Burstomy
    - (83.09 [762]) Other incision of soft tissue
  - (83.1 [763]) Division of muscle, tendon, and fascia
    - (83.11 [764]) Achillotenotomy
    - (83.12 [765]) Adductor tenotomy of hip
    - (83.13 [766]) Other tenotomy
    - (83.14 [767]) Fasciotomy
    - (83.19 [768]) Other division of soft tissue
  - (83.2 [769]) Diagnostic procedures on muscle, tendon, fascia, and bursa, including that of hand
  - (83.3 [770]) Excision of lesion of muscle, tendon, fascia, and bursa
  - (83.4 [771]) Other excision of muscle, tendon, and fascia
  - (83.5 [772]) Bursectomy
  - (83.6 [773]) Suture of muscle, tendon, and fascia
  - (83.7 [774]) Reconstruction of muscle and tendon
  - (83.8 [775]) Other plastic operations on muscle, tendon, and fascia
  - (83.9 [776]) Other operations on muscle, tendon, fascia, and bursa
- (84 [777]) Other procedures on musculoskeletal system
  - (84.0 [778]) Amputation of upper limb
  - (84.1 [779]) Amputation of lower limb
    - (84.10 [780]) Lower limb amputation, not otherwise specified
    - (84.11 [781]) Amputation of toe
    - (84.12 [782]) Amputation through foot
    - (84.13 [783]) Disarticulation of ankle
    - (84.14 [784]) Amputation of ankle through malleoli of tibia and fibula
    - (84.15 [785]) Other amputation below knee
    - (84.16 [786]) Disarticulation of knee

- (84.17 [787]) Amputation above knee
- (84.18 [788]) Disarticulation of hip
- (84.19 [789]) Abdominopelvic amputation
  - Hemipelvectomy
- (84.2 [790]) Reattachment of extremity
- (84.3 [791]) Revision of amputation stump
- (84.4 [792]) Implantation or fitting of prosthetic limb device
- (84.5 [793]) Implantation of other musculoskeletal devices and substances
  - (84.51 [794]) Insertion of interbody spinal fusion device
  - (84.52 [795]) Insertion of recombinant bone morphogenetic protein
  - (84.53 [796]) Implantation of internal limb lengthening device with kinetic distraction
  - (84.54 [797]) Implantation of other internal limb lengthening device
  - (84.55 [798]) Insertion of bone void filler
  - (84.56 [799]) Insertion of (cement) spacer[800]
  - (84.57 [801]) Removal of (cement) spacer[800]
  - (84.58 [802]) Implantation of interspinous process decompression device
  - (84.59 [803]) Insertion of other spinal devices
- (84.6 [804]) Replacement of spinal disc
- (84.7 [805]) Adjunct codes for external fixator devices
- (84.9 [806]) Other operations on musculoskeletal system

## (85–86) Operations on the integumentary system

- (85 [807]) Operations on the breast
  - (85.0 [808]) Mastotomy
  - (85.1 [809]) Diagnostic procedures on breast
  - (85.2 [810]) Excision or destruction of breast tissue
    - (85.21 [811]) Local excision of lesion of breast
      - Lumpectomy
    - (85.3 [812]) Reduction mammoplasty and subcutaneous mammectomy
    - (85.4 [813]) Mastectomy
    - (85.5 [814]) Augmentation mammoplasty
    - (85.6 [815]) Mastopexy
    - (85.7 [816]) Total reconstruction of breast
    - (85.8 [817]) Other repair and plastic operations on breast
    - (85.9 [818]) Other operations on the breast
- (86 [819]) Operations on skin and subcutaneous tissue
  - (86.0 [820]) Incision of skin and subcutaneous tissue
    - (86.01 [821]) Aspiration of skin and subcutaneous tissue
    - (86.02 [822]) Injection or tattooing of skin lesion or defect
    - (86.03 [823]) Incision of pilonidal sinus or cyst
    - (86.04 [824]) Other incision with drainage of skin and subcutaneous tissue
    - (86.05 [825]) Incision with removal of foreign body or device from skin and subcutaneous tissue
    - (86.06 [826]) Insertion of totally implantable infusion pump
    - (86.07 [827]) Insertion of totally implantable vascular access device (VAD)
    - (86.09 [828]) Other incision of skin and subcutaneous tissue

- Escharotomy
- (86.1 <sup>[829]</sup>) Diagnostic procedures on skin and subcutaneous tissue
- (86.2 <sup>[830]</sup>) Excision or destruction of lesion or tissue of skin and subcutaneous tissue
- (86.3 <sup>[831]</sup>) Other local excision or destruction of lesion or tissue of skin and subcutaneous tissue
- (86.4 <sup>[832]</sup>) Radical excision of skin lesion
- (86.5 <sup>[833]</sup>) Suture or other closure of skin and subcutaneous tissue
- (86.6 <sup>[834]</sup>) Free skin graft
  - (86.60 <sup>[835]</sup>) Free skin graft, not otherwise specified
  - (86.61 <sup>[836]</sup>) Full-thickness skin graft to hand
  - (86.62 <sup>[837]</sup>) Other skin graft to hand
  - (86.63 <sup>[838]</sup>) Full-thickness skin graft to other sites
  - (86.64 <sup>[839]</sup>) Hair transplant
  - (86.65 <sup>[840]</sup>) Heterograft to skin
  - (86.66 <sup>[841]</sup>) Homograft to skin
- (86.7 <sup>[842]</sup>) Pedicle grafts or flaps
- (86.8 <sup>[843]</sup>) Other repair and reconstruction of skin and subcutaneous tissue
- (86.9 <sup>[844]</sup>) Other operations on skin and subcutaneous tissue

## (87–99) Miscellaneous diagnostic and therapeutic procedures

### Diagnostic radiology

- (87 <sup>[845]</sup>) Diagnostic radiology
  - (87.3 <sup>[846]</sup>) Soft tissue x-ray of thorax
  - (87.4 <sup>[847]</sup>) Other x-ray of thorax
  - (87.7 <sup>[848]</sup>) X-ray of urinary system
    - (87.71 <sup>[849]</sup>) Computerized axial tomography of kidney
      - CAT scan of kidney
      - (87.72 <sup>[850]</sup>) Other nephrotomogram
      - (87.73 <sup>[851]</sup>) Intravenous pyelogram
        - Diuretic infusion pyelogram
        - (87.74 <sup>[852]</sup>) Retrograde pyelogram
        - (87.75 <sup>[853]</sup>) Percutaneous pyelogram
        - (87.76 <sup>[854]</sup>) Retrograde cystourethrogram
        - (87.77 <sup>[855]</sup>) Other cystogram
        - (87.78 <sup>[856]</sup>) Ileal conduitogram
        - (87.79 <sup>[857]</sup>) Other x-ray of the urinary system
          - KUB x-ray
- (88 <sup>[858]</sup>) Other diagnostic radiology and related techniques
  - (88.0 <sup>[859]</sup>) Soft tissue x-ray of abdomen
  - (88.1 <sup>[860]</sup>) Other x-ray of abdomen
  - (88.2 <sup>[861]</sup>) Skeletal x-ray of extremities and pelvis
  - (88.3 <sup>[862]</sup>) Other x-ray
  - (88.4 <sup>[863]</sup>) Arteriography using contrast material
  - (88.5 <sup>[864]</sup>) Angiography using contrast material
  - (88.6 <sup>[865]</sup>) Phlebography

- (88.7 [866]) Diagnostic ultrasound
- (88.8 [867]) Thermography
- (88.9 [868]) Other diagnostic imaging
  - (88.90 [869]) Diagnostic imaging, not elsewhere classified
  - (88.91 [870]) Magnetic resonance imaging of brain and brain stem
  - (88.92 [871]) Magnetic resonance imaging of chest and myocardium
  - (88.93 [872]) Magnetic resonance imaging of spinal canal
  - (88.94 [873]) Magnetic resonance imaging of musculoskeletal
  - (88.95 [874]) Magnetic resonance imaging of pelvis, prostate, and bladder
  - (88.96 [875]) Other intraoperative magnetic resonance imaging
  - (88.97 [876]) Magnetic resonance imaging of other and unspecified sites
  - (88.98 [877]) Bone mineral density studies

## Interview, evaluation, consultation, and examination

- (89 [878]) Interview, evaluation, consultation, and examination
- (89.0 [879]) Diagnostic interview, consultation, and evaluation
- (89.1 [880]) Anatomic and physiologic measurements and manual examinations—nervous system and sense organs
  - (89.14 [881]) Electroencephalogram
- (89.2 [882]) Anatomic and physiologic measurements and manual examinations -- genitourinary system
  - (89.21 [883]) Urinary manometry
  - (89.22 [884]) Cystometrogram
  - (89.23 [885]) Urethral sphincter electromyogram
  - (89.24 [886]) Uroflowmetry (UFR)
  - (89.25 [887]) Urethral pressure profile (UPP)
  - (89.26 [888]) Gynecological examination
  - (89.29 [889]) Other nonoperative genitourinary system measurements
- (89.3 [890]) Other anatomic and physiologic measurements and manual examinations
- (89.4 [891]) Cardiac stress tests, pacemaker and defibrillator checks
- (89.5 [892]) Other nonoperative cardiac and vascular diagnostic procedures
- (89.6 [893]) Circulatory monitoring
- (89.7 [894]) General physical examination
- (89.8 [895]) Autopsy
- (90 [896]-91 [897]) Microscopic examination
  - fourth-digit codes:
  - 1 bacterial smear
  - 2 culture
  - 3 culture and sensitivity
  - 4 parasitology
  - 5 toxicology
  - 6 cell block and Papanicolaou smear
  - 9 other microscopic examination
  - (90.0 [898]) specimen from nervous system and of spinal fluid
  - (90.1 [899]) specimen from endocrine gland, not elsewhere classified
  - (90.2 [900]) specimen from eye
  - (90.3 [901]) specimen from ear, nose, throat, and larynx

- (90.4 [902]) specimen from trachea, bronchus, pleura, lung, and other thoracic specimen, and of sputum
- (90.5 [903]) blood
- (90.6 [904]) specimen from spleen and of bone marrow
- (90.7 [905]) specimen from lymph node and of lymph
- (90.8 [906]) specimen from upper gastrointestinal tract and of vomitus
- (90.9 [907]) specimen from lower gastrointestinal tract and of stool
- (91.0 [908]) specimen from liver, biliary tract, and pancreas
- (91.1 [909]) peritoneal and retroperitoneal specimen
- (91.2 [910]) specimen from kidney, ureter, perirenal and periureteral tissue
- (91.3 [911]) specimen from bladder, urethra, prostate, seminal vesicle, perivesical tissue, and of urine and semen
- (91.4 [912]) specimen from female genital tract
- (91.5 [913]) specimen from musculoskeletal system and of joint fluid
- (91.6 [914]) specimen from skin and other integument
- (91.7 [915]) specimen from operative wound
- (91.8 [916]) specimen from other site
- (91.9 [917]) specimen from unspecified site

## Nuclear medicine

- (92 [918]) Nuclear medicine
  - (92.0 [919]) Radioisotope scan and function study
  - (92.1 [920]) Other radioisotope scan
  - (92.2 [921]) Therapeutic radiology and nuclear medicine
  - (92.3 [922]) Stereotactic radiosurgery

## Physical therapy, respiratory therapy, rehabilitation, and related procedures

- (93 [923]) Physical therapy, respiratory therapy, rehabilitation, and related procedures
  - (93.0 [924]) Diagnostic physical therapy
  - (93.1 [925]) Physical therapy exercises
  - (93.2 [926]) Other physical therapy musculoskeletal manipulations
  - (93.3 [927]) Other physical therapy therapeutic procedures
    - (93.31 [928]) Assisted exercise in pool
    - (93.32 [929]) Whirlpool treatment
    - (93.33 [930]) Other hydrotherapy
    - (93.34 [931]) Diathermy
    - (93.35 [932]) Other heat therapy
    - (93.36 [933]) Cardiac retraining
    - (93.37 [934]) Prenatal training
    - (93.38 [935]) Combined physical therapy without mention of the components
    - (93.39 [936]) Other physical therapy
  - (93.4 [937]) Skeletal traction and other traction
  - (93.5 [938]) Other immobilization, pressure, and attention to wound
    - (93.52 [939]) Application of neck support
      - Application of cervical collar
      - Application of Minerva jacket
    - (93.6 [940]) Osteopathic manipulative treatment

- (93.7 [941]) Speech and reading rehabilitation and rehabilitation of the blind
- (93.8 [942]) Other rehabilitation therapy
  - (93.81 [943]) Recreation therapy
  - (93.82 [944]) Educational therapy
  - (93.83 [945]) Occupational therapy
  - (93.84 [946]) Music therapy
  - (93.85 [947]) Vocational rehabilitation
  - (93.89 [948]) Rehabilitation, not elsewhere classified
- (93.9 [949]) Respiratory therapy

## Procedures related to the psyche

- (94 [950]) Procedures related to the psyche
- (94.0 [951]) Psychologic evaluation and testing
  - (94.01 [952]) Administration of intelligence test
    - Administration of Stanford-Binet
    - Administration of Wechsler Adult Intelligence Scale
    - Administration of Wechsler Intelligence Scale for Children
  - (94.02 [953]) Administration of psychologic test
    - Administration of Bender Visual-Motor Gestalt Test
    - Administration of Benton Visual Retention Test
    - Administration of Minnesota Multiphasic Personality Inventory
    - Administration of Wechsler Memory Scale
  - (94.03 [954]) Character analysis
  - (94.08 [955]) Other psychologic evaluation and testing
  - (94.09 [956]) Psychologic mental status determination, not otherwise specified
- (94.1 [957]) Psychiatric interviews, consultations, and evaluations
  - (94.11 [958]) Psychiatric mental status determination
  - (94.12 [959]) Routine psychiatric visit, not otherwise specified
  - (94.13 [960]) Psychiatric commitment evaluation
  - (94.19 [961]) Other psychiatric interview and evaluation
- (94.2 [962]) Psychiatric somatotherapy
  - (94.21 [963]) Narcoanalysis
  - (94.22 [964]) Lithium therapy
  - (94.23 [965]) Neuroleptic therapy
  - (94.24 [966]) Chemical shock therapy
  - (94.25 [967]) Other psychiatric drug therapy
  - (94.26 [968]) Subconvulsive electroshock therapy
  - (94.27 [969]) Other electroshock therapy
    - Electroconvulsive therapy (ECT)
  - (94.29 [970]) Other psychiatric somatotherapy
- (94.3 [971]) Individual psychotherapy
  - (94.31 [972]) Psychoanalysis
  - (94.32 [973]) Hypnotherapy
  - (94.33 [974]) Behavior therapy
    - Aversion therapy

- Behavior modification
- Desensitization therapy
- Extinction therapy
- Relaxation training
- Token economy
- (94.39 [975]) Other individual psychotherapy
- Biofeedback
- (94.4 [976]) Other psychotherapy and counselling
  - (94.41 [977]) Group therapy for psychosexual dysfunction
  - (94.42 [978]) Family therapy
  - (94.43 [979]) Psychodrama
  - (94.44 [980]) Other group therapy
  - (94.45 [981]) Drug addiction counselling
  - (94.46 [982]) Alcoholism counselling
  - (94.49 [983]) Other counselling
- (94.5 [984]) Referral for psychologic rehabilitation
- (94.6 [985]) Alcohol and drug rehabilitation and detoxification

## Ophthalmologic and otologic diagnosis and treatment

- (95 [986]) Ophthalmologic and otologic diagnosis and treatment
  - (95.0 [987]) General and subjective eye examination
    - (95.01 [988]) Limited eye examination
    - (95.02 [989]) Comprehensive eye examination
    - (95.03 [990]) Extended ophthalmologic work-up
    - (95.04 [991]) Eye examination under anesthesia
    - (95.05 [992]) Visual field study
    - (95.06 [993]) Color vision study
    - (95.07 [994]) Dark adaptation study
    - (95.09 [995]) Eye examination, not otherwise specified
  - (95.1 [996]) Examinations of form and structure of eye
    - (95.11 [997]) Fundus photography
    - (95.12 [998]) Fluorescein angiography or angioscopy of eye
    - (95.13 [999]) Ultrasound study of eye
    - (95.14 [1000]) X-ray study of eye
    - (95.15 [1001]) Ocular motility study
    - (95.16 [1002]) P32 and other tracer studies of eye
  - (95.2 [1003]) Objective functional tests of eye
    - (95.21 [1004]) Electroretinogram (ERG)
    - (95.22 [1005]) Electro-oculogram (EOG)
    - (95.23 [1006]) Visual evoked potential (VEP)
    - (95.24 [1007]) Electronystagmogram (ENG)
    - (95.25 [1008]) Electromyogram of eye (EMG)
    - (95.26 [1009]) Tonography, provocative tests, and other glaucoma testing
  - (95.3 [1010]) Special vision services
  - (95.4 [1011]) Nonoperative procedures related to hearing
    - (95.41 [1012]) Audiometry

- (95.42 <sup>[1013]</sup>) Clinical test of hearing
- (95.43 <sup>[1014]</sup>) Audiological evaluation
- (95.44 <sup>[1015]</sup>) Clinical vestibular function tests
- (95.45 <sup>[1016]</sup>) Rotation tests
- (95.49 <sup>[1017]</sup>) Other nonoperative procedures related to hearing

## Nonoperative intubation and irrigation

- (96 <sup>[1018]</sup>) Nonoperative intubation and irrigation
  - (96.0 <sup>[1019]</sup>) Nonoperative intubation of gastrointestinal and respiratory tracts
    - (96.01 <sup>[1020]</sup>) Insertion of nasopharyngeal airway
    - (96.02 <sup>[1021]</sup>) Insertion of oropharyngeal airway
    - (96.03 <sup>[1022]</sup>) Insertion of esophageal obturator airway
    - (96.04 <sup>[1023]</sup>) Insertion of endotracheal tube
    - (96.05 <sup>[1024]</sup>) Other intubation of respiratory tract
    - (96.06 <sup>[1025]</sup>) Insertion of Sengstaken tube
      - Esophageal tamponade
    - (96.07 <sup>[1026]</sup>) Insertion of other (naso-)gastric tube
    - (96.08 <sup>[1027]</sup>) Insertion of (naso-)intestinal tube
      - Miller-Abbott tube (for decompression)
    - (96.09 <sup>[1028]</sup>) Insertion of rectal tube
  - (96.1 <sup>[1029]</sup>) Other nonoperative insertion
  - (96.2 <sup>[1030]</sup>) Nonoperative dilation and manipulation
  - (96.3 <sup>[1031]</sup>) Nonoperative alimentary tract irrigation, cleaning, and local instillation
    - (96.31 <sup>[1032]</sup>) Gastric cooling
    - (96.32 <sup>[1033]</sup>) Gastric freezing
    - (96.33 <sup>[1034]</sup>) Gastric lavage
    - (96.34 <sup>[1035]</sup>) Other irrigation of (naso-)gastric tube
    - (96.35 <sup>[1036]</sup>) Gastric gavage
    - (96.36 <sup>[1037]</sup>) Irrigation of gastrostomy or enterostomy
    - (96.37 <sup>[1038]</sup>) Proctoclysis
    - (96.38 <sup>[1039]</sup>) Removal of impacted feces
  - (96.4 <sup>[1040]</sup>) Nonoperative irrigation, cleaning, and local instillation of other digestive and genitourinary organs
    - (96.41 <sup>[1041]</sup>) Irrigation of cholecystostomy and other biliary tube
    - (96.42 <sup>[1042]</sup>) Irrigation of pancreatic tube
    - (96.43 <sup>[1043]</sup>) Digestive tract instillation, except gastric gavage
    - (96.44 <sup>[1044]</sup>) Vaginal douche
    - (96.45 <sup>[1045]</sup>) Irrigation of nephrostomy and pyelostomy
    - (96.46 <sup>[1046]</sup>) Irrigation of ureterostomy and ureteral catheter
    - (96.47 <sup>[1047]</sup>) Irrigation of cystostomy
    - (96.48 <sup>[1048]</sup>) Irrigation of other indwelling urinary catheter
    - (96.49 <sup>[1049]</sup>) Other genitourinary instillation
  - (96.5 <sup>[1050]</sup>) Other nonoperative irrigation and cleaning
  - (96.6 <sup>[1051]</sup>) Enteral infusion of concentrated nutritional substances
  - (96.7 <sup>[1052]</sup>) Other continuous invasive mechanical ventilation

**Replacement and removal of therapeutic appliances/nonoperative removal of foreign body or calculus**

- (97 [1053]) Replacement and removal of therapeutic appliances
  - (97.0 [1054]) Nonoperative replacement of gastrointestinal appliance
  - (97.1 [1055]) Nonoperative replacement of musculoskeletal and integumentary system appliance
  - (97.2 [1056]) Other nonoperative replacement
  - (97.3 [1057]) Nonoperative removal of therapeutic device from head and neck
  - (97.4 [1058]) Nonoperative removal of therapeutic device from thorax
  - (97.5 [1059]) Nonoperative removal of therapeutic device from digestive system
  - (97.6 [1060]) Nonoperative removal of therapeutic device from urinary system
  - (97.7 [1061]) Nonoperative removal of therapeutic device from genital system
  - (97.8 [1062]) Other nonoperative removal of therapeutic device
- (98 [1063]) Nonoperative removal of foreign body or calculus
  - (98.0 [1064]) Removal of intraluminal foreign body from digestive system without incision
  - (98.1 [1065]) Removal of intraluminal foreign body from other sites without incision
  - (98.2 [1066]) Removal of other foreign body without incision
  - (98.5 [1067]) Extracorporeal shockwave lithotripsy (ESWL)

**Other nonoperative procedures**

- (99 [1068]) Other nonoperative procedures
  - (99.0 [1069]) Transfusion of blood and blood components
  - (99.1 [1070]) Injection or infusion of therapeutic or prophylactic substance
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    - (99.29 [1081]) Injection or infusion of other therapeutic or prophylactic substance
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  - (99.4 [1083]) Prophylactic vaccination and inoculation against certain viral diseases
  - (99.5 [1084]) Other vaccination and inoculation
  - (99.6 [1085]) Conversion of cardiac rhythm
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- (99.81<sup>[1094]</sup>) Hypothermia (central) (local)
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- (99.85<sup>[1098]</sup>) Hyperthermia for treatment of cancer
- (99.86<sup>[1099]</sup>) Non-invasive placement of bone growth stimulator
- (99.88<sup>[1100]</sup>) Therapeutic photopheresis
- (99.9<sup>[1101]</sup>) Other miscellaneous procedures

## External links

- Tabular index of codes<sup>[1102]</sup>

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# ICD-10

**ICD-10** is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). It codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.<sup>[1]</sup>

The code set allows more than 14,400 different codes and permits the tracking of many new diagnoses. The codes can be expanded to over 16,000 codes by using optional sub-classifications. The detail reported by ICD can be further increased, with a simplified multi-axial approach, by using codes meant to be reported in a separate data field.

The WHO provides detailed information about ICD online, and makes available a set of materials online, such as an ICD-10 online browser,<sup>[1]</sup> ICD-10 Training, ICD-10 online training,<sup>[2]</sup> ICD-10 online training support,<sup>[3]</sup> and study guide materials for download.

The International version of ICD should not be confused with national Clinical Modifications of ICD that frequently include much more detail, and sometimes have separate sections for procedures. The US ICD-10 CM, for instance, has some 68,000 codes. The US also has ICD-10 PCS, a procedure code system not used by other countries that contains 76,000 codes.<sup>[1]</sup>

Work on ICD-10 began in 1983 and was completed in 1992.<sup>[1]</sup>

## List

The following is a **List of ICD-10 codes**.<sup>[1]</sup>

### International Statistical Classification of Diseases and Related Health Problems 10th Revision

Chapter	Blocks	Title
I	A00–B99	Certain infectious and parasitic diseases
II	C00–D48	Neoplasms
III	D50–D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
IV	E00–E90	Endocrine, nutritional and metabolic diseases
V	F00–F99	Mental and behavioural disorders
VI	G00–G99	Diseases of the nervous system
VII	H00–H59	Diseases of the eye and adnexa
VIII	H60–H95	Diseases of the ear and mastoid process
IX	I00–I99	Diseases of the circulatory system
X	J00–J99	Diseases of the respiratory system
XI	K00–K93	Diseases of the digestive system
XII	L00–L99	Diseases of the skin and subcutaneous tissue
XIII	M00–M99	Diseases of the musculoskeletal system and connective tissue
XIV	N00–N99	Diseases of the genitourinary system
XV	O00–O99	Pregnancy, childbirth and the puerperium
XVI	P00–P96	Certain conditions originating in the perinatal period
XVII	Q00–Q99	Congenital malformations, deformations and chromosomal abnormalities

XVIII	R00–R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
XIX	S00–T98	Injury, poisoning and certain other consequences of external causes
XX	V01–Y98	External causes of morbidity and mortality
XXI	Z00–Z99	Factors influencing health status and contact with health services
XXII	U00–U99	Codes for special purposes

## National adoption for clinical use

Some 25 countries use ICD-10 for reimbursement and resource allocation in their health system. A few of them made modifications to ICD to better accommodate this use of ICD-10. The article below makes reference to some of these modifications. The unchanged international version of ICD-10 is used in about 110 countries ICD-10 for cause of death reporting and statistics.

### South Africa

1 January 2005 Pretoria, Johannesburg, Cape town

### Australia

1 July 1998 Victoria, New South Wales, Australian Capital Territory and Northern Territory implemented ICD-10-AM.

1 July 1999 Queensland, South Australia, Tasmania and Western Australia implemented ICD-10-AM.<sup>[4]</sup>

### Canada

Canada introduced ICD-10-CA in 2000.<sup>[5]</sup>

### China

China now using ICD-10 as diagnosis reference and ICD-9 as procedure reference. [citation needed]

### France

France introduced a clinical addendum to ICD-10 in 2005. See also website of the ATIH.

### Germany

Germany: ICD-10-GM (German Modification)

### Korea

A Korean modification has existed since 2008.

### Netherlands

The Dutch translation of ICD-10 is ICD10-nl, which was created by the WHO-FIC Netwerk in 1994.<sup>[6]</sup> There is an online dictionary<sup>[7]</sup>.

### Sweden

The current Swedish translation of ICD-10 was created in 1997. A clinical modification has added more detail and omits codes of the international version in the context of clinical use of ICD:

The codes F64.1 (Dual-role transvestism), F64.2 (Gender identity disorder of childhood), F65.0 (Fetishism), F65.1 (Fetishistic transvestism), F65.5 (Sadomasochism), F65.6 (Multiple disorders of sexual preference) are not used in Sweden since 1 January 2009 according to a decision by the present Director General of The National Board of Health and Welfare, Sweden. The code O60.0 (Preterm labor without delivery) is not used in Sweden; instead, since 1 January 2009, the Swedish extension codes to O47 (False labor) are recommended for use.

## Thailand

A Thai modifications exists since 2007.

Now Ministry of Public Health have \*\*ICD 10 TM\*\*

## United States

The deadline for the United States to begin using Clinical Modification ICD-10-CM for diagnosis coding and Procedure Coding System ICD-10-PCS for inpatient hospital procedure coding is currently October 1, 2014.<sup>[8]</sup> The deadline was previously October 1, 2013.<sup>[9][10]</sup> All HIPAA "covered entities" must make the change; a pre-requisite to ICD-10 is the adoption of EDI Version 5010 by January 1, 2012.<sup>[11]</sup> Enforcement of 5010 transition by the Centers for Medicare & Medicaid Services (CMS), however, was postponed by CMS until March 31, 2012, with the federal agency citing numerous factors, including slow software upgrades.<sup>[12]</sup> The implementation of ICD-10 has been subject to previous delays. In January 2009, the date was pushed back by two years, to October 1, 2013 rather than a prior proposal of October 1, 2011.<sup>[13]</sup>

Even though the deadline for ICD-10 has been pushed back repeatedly, CMS recommends that medical practices take several years to prepare for implementation of the new code set.<sup>[14]</sup> The basic structure of the ICD-10 code is the following: Characters 1-3 (the category of disease); 4 (etiology of disease); 5 (body part affected), 6 (severity of illness) and 7 (placeholder for extension of the code to increase specificity).<sup>[15]</sup> Not only must new software be installed and tested, but medical practices must provide training for physicians, staff members, and administrators. They will also need to develop new practice policies and guidelines, and update paperwork and forms. Practices should also create crosswalks that will convert their most frequently used ICD-9 codes to the ICD-10 equivalents.

Although the undertaking can seem overwhelming, especially to small practices,<sup>[16]</sup> technology can be a big help. Practices should check with their EHR vendors to make sure they understand the data storage requirements for the new code set; seek online training available through association websites and software-based instruction; and invest in additional technology, such as patient kiosks, to boost productivity.<sup>[17]</sup>

## Language versions

Language versions should not be confused with clinical versions. ICD has been translated into 42 languages.

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## Structured Clinical Interview for DSM-IV

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The **Structured Clinical Interview for DSM-IV** Axis I Disorders (**SCID-I**) is a diagnostic exam used to determine DSM-IV Axis I disorders (major mental disorders) and Axis II disorders (personality disorders). There are at least 700 published studies in which the SCID was the diagnostic instrument used. Major parts of the SCID have been translated into other languages, including Danish, French, German, Greek, Hebrew, Italian, Portuguese, Spanish, Swedish, Turkish, and Zulu.

An Axis I SCID assessment with a psychiatric patient usually takes between 1 and 2 hours, depending on the complexity of the past psychiatric history and the subject's ability to clearly describe episodes of current and past symptoms. A SCID with a non-psychiatric patient takes 1/2 hour to 1-1/2 hours. (See editions below.) A **SCID-II** personality assessment takes about 1/2 to 1 hour.

The instrument was designed to be administered by a clinician or trained mental health professional, for example a psychologist or medical doctor. This must be someone who has relevant professional training and has had experience performing unstructured, open-ended question, diagnostic evaluations. However, for the purposes of some research studies, non-clinician research assistants, who have extensive experience with the study population in question, and who have demonstrated competence, have been trained to use the SCID. The less clinical experience and specific education the potential interviewer has had, the more training is required.

### DSM-IV editions of SCID-I and SCID-II

There are several editions of the SCID-I addressed to different audiences.<sup>[1]</sup>

- Three Research Versions:
  - Patient Edition (SCID-I/P)<sup>[2]</sup>
  - Patient Edition, with psychotic screen (SCID-I/P W/ PSY SCREEN)<sup>[3]</sup>
  - Non-patient Edition (SCID-I/NP),<sup>[4]</sup>
- A Clinical Trials Version (SCID-CT)<sup>[5]</sup>
- Clinician Version (SCID-CV)<sup>[6]</sup>

The SCID-II for DSM-IV comes in a single edition.<sup>[7]</sup>

## DSM-III editions of SCID-I and SCID-II

The DSM-III SCID had one edition per axis: SCID-P/SCID-NP<sup>[8]</sup> and SCID-II.<sup>[9]</sup>

The reliability and validity of the SCID for DSM-III-R has been reported in several published studies. With regard to reliability, the range in reliability is enormous, depending on the type of the sample and research methodology (i.e., joint vs. test-retest, multi-site vs. single site with raters who have worked together, etc.)

## SCID-D

The *Structured Clinical Interview for DSM-IV* Dissociative disorders (SCID-D)<sup>[10]</sup> is widely used to diagnose dissociative disorders, especially in research settings. This interview takes about 30 minutes to 1.5 hours, depending on individual's experiences. The SCID-D has been translated into Dutch and used in the Netherlands.<sup>[1]</sup>

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## External links

- scid4.org: official site (<http://www.scid4.org/>)

# Research Domain Criteria

The **Research Domain Criteria (RDoC)** project is an initiative being developed by US National Institute of Mental Health. In contrast to the Diagnostic and Statistical Manual of Mental Disorders maintained by the American Psychiatric Association, RDoC aims to be a biologically-valid framework for the understanding mental disorders: "RDoC is an attempt to create a new kind of taxonomy for mental disorders by bringing the power of modern research approaches in genetics, neuroscience, and behavioral science to the problem of mental illness."<sup>[1]</sup>



## Call for creation

The NIMH Strategic Plan<sup>[2]</sup> (2008) calls for NIMH to "Develop, for research purposes, new ways of classifying mental disorders based on dimensions of observable behavior and neurobiological measures."<sup>[3]</sup> The strategic plan continues:

Currently, the diagnosis of mental disorders is based on clinical observation—identifying symptoms that tend to cluster together, determining when the symptoms appear, and determining whether the symptoms resolve, recur, or become chronic. However, the way that mental disorders are defined in the present diagnostic system does not incorporate current information from integrative neuroscience research, and thus is not optimal for making scientific gains through neuroscience approaches. It is difficult to deconstruct clusters of complex behaviors and attempt to link these to underlying neurobiological systems. Many mental disorders may be considered as falling along multiple dimensions (e.g., cognition, mood, social interactions), with traits that exist on a continuum ranging from normal to extreme. Co-occurrence of multiple mental disorders might reflect different patterns of symptoms that result from shared risk factors and perhaps the same underlying disease processes.

To clarify the underlying causes of mental disorders, it will be necessary to define, measure, and link basic biological and behavioral components of normal and abnormal functioning. This effort will require integration of genetic, neuroscience, imaging, behavioral, and clinical studies. By linking basic biological and behavioral components, it will become possible to construct valid, reliable phenotypes (measurable traits or characteristics) for mental disorders. This will help us elucidate the causes of the disorder, while clarifying the boundaries and overlap between mental disorders. In order to understand mental disorders in terms of dimensions and/or components of neurobiology and behaviors, it will be important to:

- Initiate a process for bringing together experts in clinical and basic sciences to jointly identify the fundamental behavioral components that may span multiple disorders (e.g., executive functioning, affect regulation, person perception) and that are more amenable to neuroscience approaches.
- Develop reliable and valid measures of these fundamental components of mental disorders for use in basic studies and in more clinical settings.
- Determine the full range of variation, from normal to abnormal, among the fundamental components to improve understanding of what is typical versus pathological.
- Integrate the fundamental genetic, neurobiological, behavioral, environmental, and experiential components that comprise these mental disorders.<sup>[4]</sup>

## Contrast with DSM

On April 29, 2013, a few weeks before the publication of the DSM-5, NIMH director Thomas Insel published an article critical of the DSM methodology and highlighting the improvement offered by the RDoC project.<sup>[5]</sup>

Wrote Insel:

"While DSM has been described as a 'Bible' for the field, it is, at best, a dictionary, creating a set of labels and defining each."<sup>[6]</sup>

"The strength of each of the editions of DSM has been "reliability" – each edition has ensured that clinicians use the same terms in the same ways. The weakness is its lack of validity.

"Unlike our definitions of ischemic heart disease, lymphoma, or AIDS, the DSM diagnoses are based on a consensus about clusters of clinical symptoms, not any objective laboratory measure."

In that article, Insel wrote: "Patients with mental disorders deserve better." He would later elaborate on this point, saying "I look at the data and I'm concerned. I don't see a reduction in the rate of suicide or prevalence of mental illness or any measure of morbidity. I see it in other areas of medicine and I don't see it for mental illness. That was the basis for my comment that people with mental illness deserve better."<sup>[6]</sup>

In their effort to resolve their issues with the new DSM, the NIMH launched the Research Domain Criteria Project (RDoC), based on four assumptions:

- A diagnostic approach based on the biology as well as the symptoms must not be constrained by the current DSM categories,
- Mental disorders are biological disorders involving brain circuits that implicate specific domains of cognition, emotion, or behavior,
- Each level of analysis needs to be understood across a dimension of function,
- Mapping the cognitive, circuit, and genetic aspects of mental disorders will yield new and better targets for treatment.

Insel stressed that the RDoC is not designed as diagnostic criteria to replace the DSM, but rather as a research framework, for future development.

Their argument is centered around the claim that, "symptom-based diagnosis, once common in other areas of medicine, has been largely replaced in the past half century as we have understood that symptoms alone rarely indicate the best choice of treatment." As a result of this position, the NIMH is no longer using the DSM as the criteria upon which they will evaluate funding of future clinic trials.

One DSM researcher was quoted as saying "I do think it does represent a lack of interest and faith on behalf of NIMH for the DSM process and an investment in alternative diagnostic systems".<sup>[7] [8]</sup>

A NIMH description of RDoC explained:

"Currently, diagnosis in mental disorders is based on clinical observation and patients' phenomenological symptom reports ... However, in antedating contemporary neuroscience research, the current diagnostic system is not informed by recent breakthroughs in genetics; and molecular, cellular and systems neuroscience."

## Research domains

The major RDoC research **domains/constructs**:

- Negative Valence Systems (Fear, Anxiety, Loss)
- Positive Valence Systems (Reward learning, Reward valuation)
- Cognitive Systems (Attention, Perception, Working Memory, Cognitive control)
- Systems for Social Processes (Attachment formation, Social Communication, Perception of self, Perception of others)
- Arousal/Modulatory Systems (Arousal, Circadian rhythm, Sleep and wakefulness)

The domains are tentative-- "It is important to emphasize that these particular domains and constructs are simply starting points that are not definitive or set in concrete"<sup>[9]</sup>

## Units of analysis

Each of the **domains/construct** can be studied using different classes of variables (or **units of analysis**). Seven classes are specified: genes, molecules, cells, neural circuits, physiology, behaviors, and self-reports.

## Methodology

The RDoC methodology distinguishes itself from traditional systems of diagnostic criteria.

Unlike conventional diagnostic systems (e.g. DSM) which use categorization, RDoc is a "dimensional system"-- it relies on dimensions that "span the range from normal to abnormal".

Unlike conventional diagnostic systems which seek to incrementally revise and build upon their pre-existing paradigms. RDoC is "agnostic about current disorder categories". Official documents explain this feature, writing: "Rather than starting with an illness definition and seeking its neurobiological underpinnings, RDoC begins with current understandings of behavior-brain relationships and links them to clinical phenomena."

Unlike conventional diagnostic systems, which typically rely on self-report and behavioral measures alone, the RDoC framework has the "explicit goal" of allowing investigators access to a wider range of data. In addition to self-report measures or measure of behavior, RDoC also incorporates units of analysis beyond those found in the DSM-- allowing RDoC to be informed by insights into genes, molecules, cells, circuits, physiology, and large-scale paradigms.<sup>[10]</sup>

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- [1] <http://www.nimh.nih.gov/news/science-news/2013/dsm-5-and-rdoc-shared-interests.shtml>
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- [9] <http://www.nimh.nih.gov/research-priorities/rdoc/nimh-research-domain-criteria-rdoc.shtml>
- [10] <http://www.nimh.nih.gov/research-priorities/rdoc/nimh-research-domain-criteria-rdoc.shtml>

## External links

- NIMH page on RDoC (<http://www.nimh.nih.gov/research-priorities/rdoc/index.shtml>)
- Detailed description of RDoC (<http://www.nimh.nih.gov/research-priorities/rdoc/nimh-research-domain-criteria-rdoc.shtml>) from NIMH
- "Toward a new understanding of mental illness" ([http://www.ted.com/talks/thomas\\_insel\\_toward\\_a\\_new\\_understanding\\_of\\_mental\\_illness.html](http://www.ted.com/talks/thomas_insel_toward_a_new_understanding_of_mental_illness.html)) a TED talk given by Director of the National Institute of Mental Health Thomas R. Insel

# Global Assessment of Functioning

The **Global Assessment of Functioning (GAF)** is a numeric scale (0 through 100) used by mental health clinicians and physicians to rate subjectively the social, occupational, and psychological functioning of adults, e.g., how well or adaptively one is meeting various problems-in-living. The scale is presented and described in the DSM-IV-TR on page 34. The score is often given as a range.

The GAF is no longer included in the DSM-5.

## Scale

**91 - 100** No symptoms. Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities.

**81 - 90** Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).

**71 - 80** If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).

**61 - 70** Some mild symptoms (e.g., depressed mood and mild insomnia) *or* some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

**51 - 60** Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) *or* moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).

**41 - 50** Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) *or* any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job, cannot work).

**31 - 40** Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) *or* major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed adult avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

**21 - 30** Behavior is considerably influenced by delusions or hallucinations *or* serious impairment, in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) *or* inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends)

**11 - 20** Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) *or* occasionally fails to maintain minimal personal hygiene (e.g., smears feces) *or* gross impairment in communication (e.g., largely incoherent or mute).

**1 - 10** Persistent danger of severely hurting self or others (e.g., recurrent violence) *or* persistent inability to maintain minimal personal hygiene *or* serious suicidal act with clear expectation of death.

**0** Inadequate information

## Use in litigation

*Montalvo v. Barnhart*, 2005 U.S. Dist. LEXIS 44133 (W.D.N.Y. 2005). (RAMS 2011)

*Montalvo* attempts to substitute "overall level of functioning and carrying out activities of daily living" with "social, occupational, or school functioning." It is possible to see the possibility of some degree of overlap because "Social functioning" is arguably a subset of overall functioning and Activities of daily living. However, some have argued that equivalence is not clearly stated in DSM-IV-TR.

GAF levels are commonly used by the Veterans Benefits Administration of the United States Department of Veterans Affairs in determining the appropriate level of disability compensation to be paid to veterans who suffer from service connected psychiatric disorders. The emphasis by the Veterans Administration on using the GAF score has, however, decreased in recent years.<sup>[1]</sup>

In disability cases before the Social Security Administration, the agency determines if the GAF is consistent with the narrative report and it is addressed as one technique for capturing the "complexity of clinical situations." American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Washington, DC 1994 (pp.25-35). The agency noted the GAF is just one tool used by clinicians to develop the clinical picture. It cannot be used in isolation from the rest of the evidence to make a disability decision. Unlike the Veteran's Administration, the Commissioner of Social Security has specifically declined to endorse the GAF scale for use in the disability programs, and has stated that the GAF scale "does not have a direct correlation to the severity requirements in our mental disorders listings." Revised Medical Criterial for Evaluating Mental Disorders and Traumatic Brain Injury, 65 Fed. Reg. 50, 746-50, 764-65 (August 21, 2000)

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- [1] ptsd1.html (<http://ptsdhelp2000.com/ptsd1.html>)
- Hall RC. Global assessment of functioning. A modified scale. *Psychosomatics*. 1995 May-Jun;36(3):267-75. PMID 7638314. The modified Global Assessment of Functioning (GAF) scale has more detailed criteria and a more structured scoring system than the original GAF.

## External links

- Modified Global Assessment of Functioning – Revised (mGAF-R) (<http://www.dcf.state.fl.us/programs/samh/mentalhealth/mgaf.pdf>) - adapted in 2004 by the Florida DCF Functional Assessment Workgroup from the original M-GAF reported by S. Caldecott-Hazard & R.C.W. Hall, 1995

# Psychodynamic Diagnostic Manual

The **Psychodynamic Diagnostic Manual (PDM)** is a diagnostic handbook similar to the International Statistical Classification of Diseases and Related Health Problems (ICD) or the Diagnostic and Statistical Manual of Mental Disorders (DSM). The PDM was published on May 28, 2006.

The information contained in the PDM was collected by a collaborative task force which includes members of the American Psychoanalytic Association, the International Psychoanalytical Association, the Division of Psychoanalysis (Division 39) of the American Psychological Association, the American Academy of Psychoanalysis and Dynamic Psychiatry, and the National Membership Committee on Psychoanalysis in Clinical Social Work.

Although it is based on current neuroscience and treatment outcome studies, Benedict (2006) points out that many of the concepts in the PDM are adapted from the classical psychoanalytic tradition of psychotherapy. For example, the PDM indicates that the anxiety disorders may be traced to the "four basic danger situations" described by Sigmund Freud (1926)<sup>[1]</sup> as the loss of a significant other; the loss of love; the loss of body integrity; and the loss of affirmation by one's own conscience.<sup>[1]</sup> It uses a new perspective on the existing diagnostic system as it enables clinicians to describe and categorize personality patterns, related social and emotional capacities, unique mental profiles, and personal experiences of the patient.<sup>[1]</sup>

The PDM is not intended to compete with the DSM or ICD. The authors report the work emphasizes "individual variations as well as commonalities" by "focusing on the full range of mental functioning" and serves as a "[complement to] the DSM and ICD efforts in cataloguing [sic] symptoms."<sup>[1]</sup> The task force intends for the PDM to augment the existing diagnostic taxonomies by providing "a multi dimensional approach to describe the intricacies of the patient's overall functioning and ways of engaging in the therapeutic process."<sup>[1]</sup>

## PDM Taxonomy

### Dimension I: Personality Patterns and Disorders

This first dimension classifies personality patterns in two domains. First, it looks at the spectrum of personality types and places the person's personality on a continuum from unhealthy and maladaptive to healthy and adaptive. Second, it classifies the how the person "organizes mental functioning and engages the world".<sup>[1]</sup>

The task force adds, "This dimension has been placed first in the PDM system because of the accumulating evidence that symptoms or problems cannot be understood, assessed, or treated in the absence of an understanding of the mental life of the person who has the symptoms".<sup>[1]</sup> In other words, a list of symptoms characteristic of a diagnosis does not adequately inform a clinician how to understand and treat the symptoms without proper context. By analogy, if a patient went to her physician complaining of watering eyes and a runny nose, the symptoms alone do not indicate the appropriate treatment. Her symptoms could be a function of seasonal allergies, a bacterial sinus infection, the common cold, or she may have just come from her grandmother's funeral. The doctor might treat allergies with an antihistamine, the sinus infection with antibiotics, the cold with zinc, and give her patient a Kleenex tissue after the funeral. All four conditions may have very similar symptoms; all four condition are treated very differently.

## Dimension II: Mental Functioning

Next, the PDM provides a "detailed description of emotional functioning" which are understood to be "the capacities that contribute to an individual's personality and overall level of psychological health or pathology".<sup>[1]</sup> This dimension provides a "microscopic" examination of the patient's mental life by systematically accounting for their functional capacity to

- Process information
- Self-regulate
- Establish and maintain relationships
- Experience, organize, and express feelings and emotions at different levels
- Represent, differentiate, and integrate experience
- Utilize appropriate coping strategies and defense mechanisms
- Accurately observe ones self and others
- Form internal values and standards

## Dimension III: Manifest Symptoms and Concerns

The third dimension starts with the DSM-IV-TR diagnostic categories; moreover, beyond simply listing symptoms, the PDM "goes on to describe the affective states, cognitive processes, somatic experiences, and relational patterns most often associated clinically" with each diagnosis.<sup>[1]</sup> In this dimension, "symptom clusters" are "useful descriptors" which presents the patient's "symptom patterns in terms of the patient's personal experience of his or her prevailing difficulties".<sup>[1]</sup> The task force concludes, "The patient may evidence a few or many patterns, which may or may not be related, and which should be seen in the context of the person's personality and mental functioning. The multi dimensional approach... provides a systematic way to describe patients that is faithful to their complexity and helpful in planning appropriate treatments".<sup>[1]</sup>

## References

### External links

- Website of the Psychodynamic Diagnostic Manual (<http://www.pdm1.org/intro.htm>)
- APA News monitor: Five psychoanalytic associations collaborate to publish a new diagnostic manual. (<http://www.apa.org/monitor/jan07/tool.aspx>)

# Chinese Classification of Mental Disorders

The **Chinese Classification of Mental Disorders (CCMD)** (中国精神疾病分类方案与诊断标准), published by the Chinese Society of Psychiatry (CSP), is a clinical guide used in China for the diagnosis of mental disorders. It is currently on a third version, the **CCMD-3**, written in Chinese and English. It is intentionally similar in structure and categorisation to the ICD and DSM, the two most well-known diagnostic manuals, though includes some variations on their main diagnoses and around 40 culturally related diagnoses.

## History

The first published Chinese psychiatric classificatory scheme appeared in 1979. A revised classification system, the CCMD-1, was made available in 1981 and further modified in 1984 (CCMD-2-R). The CCMD-3 was published in 2001.

Many Chinese psychiatrists believed the CCMD had special advantages over other manuals, such as simplicity, stability, the inclusion of culture-distinctive categories, and the exclusion of certain Western diagnostic categories. The Chinese translation of the ICD-10 was seen as linguistically complicated, containing very long sentences and awkward terms and syntax (Lee, 2001).

## Diagnostic categories

The diagnosis of depression is included in the CCMD, with many similar criteria to the ICD or DSM, with the core having been translated as 'low spirits'. However, Neurasthenia is a more central diagnosis. Although also found in the ICD, its diagnosis takes a particular form in China, called 'shenjing shuairuo', which emphasizes somatic (bodily) complaints as well as fatigue or depressed feelings. Neurasthenia is a less stigmatizing diagnosis than depression in China, being conceptually distinct from psychiatric labels, and is said to fit well with a tendency to express emotional issues in somatic terms. The concept of neurasthenia as a nervous system disorder is also said to fit well with the traditional Chinese epistemology of disease causation on the basis of disharmony of vital organs and imbalance of qi.

The diagnosis of Schizophrenia is included in the CCMD. It is applied quite readily and broadly in Chinese psychiatry.

Some of the wordings of the diagnosis are different, for example rather than borderline personality disorder as in the DSM, or emotionally unstable personality disorder (borderline type) as in the ICD, the CCMD has impulsive personality disorder.

Diagnoses that are more specific to Chinese or Asian culture, though they may also be outlined in the ICD (or DSM glossary section), include:

- **Koro or Genital retraction syndrome:** excessive fear of the genitals (and also breasts in women) shrinking or drawing back in to the body.
- **Zou huo ru mo (走火入魔) or qigong deviation (氣功偏差):** perception of uncontrolled flow of qi in the body.
- Mental disorders due to superstition or witchcraft.
- Travelling psychosis

The CCMD-3 retains a category of 'ego-dystonic homosexuality'.

## Koro

Koro or **Genital retraction syndrome** is a culture-specific syndrome from Southeast Asia in which the patient has an overpowering belief that the genitalia (or nipples in females) is shrinking and will shortly disappear. In China, it is known as shuk yang, shook yong, and suo yang (simplified Chinese: 缩阳; traditional Chinese: 縮陽). This has been associated with cultures placing a heavy emphasis on balance, or on fertility and reproduction.

## Zou huo ru mo

**Zou huo ru mo** (走火入魔) or "qigong deviation" (氣功偏差) is a mental condition characterized by the perception that there is uncontrolled flow of qi in the body. Other complaints include localized pains, headache, insomnia, and uncontrolled spontaneous movements.<sup>[1][2]</sup>

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## External links

- CSP webpage about the CCMD (<http://www.21jk.com/english/articlecontent.asp?articleId=27391>)

# Article Sources and Contributors

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