ICD-10

The ICD-10 Classification of Mental and Behavioural Disorders

Diagnostic criteria for research

World Health Organization
Geneva

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The World Health Organization is a specialized agency of the United Nations with primary responsibility for international health matters and public health. Through this organization, which was created in 1948, the health professions of some 185 countries exchange their knowledge and experience with the aim of making possible the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

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

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

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

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

Preface

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

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

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

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Several major research efforts were undertaken to implement the recommendations of the Copenhagen conference. One of them, involving centres in 17 countries, had as its aim the development of the Composite International Diagnostic Interview, an instrument suitable for conducting epidemiological studies of mental disorders in general population groups in different countries (*5, 6*). Another major project focused on developing an assessment instrument suitable for use by clinicians (Schedules for Clinical Assessment in Neuropsychiatry) (*7*). Still another study was initiated to develop an instrument for the assessment of personality disorders in different countries (the International Personality Disorder Examination) (*8*).

In addition, several lexicons have been, or are being, prepared to provide clear definitions of terms (*9*). A mutually beneficial relationship evolved between these projects and the work on definitions of mental and behavioural disorders in the Tenth Revision of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10) (*10*). Converting diagnostic criteria into diagnostic algorithms incorporated in the assessment instruments was useful in uncovering inconsistencies, ambiguities and overlap and allowing their removal. The work on refining the ICD-10 also helped to shape the assessment instruments. The final result was a clear set of criteria for ICD-10 and assessment instruments which can produce data necessary for the classification of disorders according to the criteria included in Chapter V(F) of ICD-10.

The Copenhagen conference also recommended that the viewpoints of the different psychiatric traditions be presented in publications describing the origins of the classification in the ICD-10. This resulted in several major publications, including a volume that contains a series of presentations highlighting the origins of classification in contemporary psychiatry (*11*).

Clinical descriptions and diagnostic guidelines was the first of a series of publications developed from Chapter V(F) of ICD-10 (*12*). That publication was the culmination of the efforts of numerous people who contributed to it over many years. The work went through several major drafts, each prepared after extensive consultation with panels of experts, national and international psychiatric societies, and individual consultants. The draft in use in 1987 was the basis of field trials conducted in some 40 countries, which constituted the largest ever research effort of its type designed to improve psychiatric diagnosis (*13, 14*). The results of the trials were used in finalizing the clinical guidelines.

The text presented here has also been extensively tested (*15*). A list of the researchers and clinicians involved, in 32 countries, is given at the end of the book, together with a list of people who helped in drafting texts or commented

on them. Further texts in the series will include a version for use by general health care workers, a multiaxial presentation of the classification, a series of "fascicles" dealing in more detail with special problems (e.g. the assessment and classification of mental retardation), and "crosswalks" — allowing cross-reference between corresponding terms in ICD-10, ICD-9 and ICD-8 (*15, 16*).

Use of this publication is described in the Notes for Users (page 1). Annex 1 provides suggestions for diagnostic criteria that may be useful in research on several conditions that do not appear as such in the ICD-10 (except as index terms). The Acknowledgements section is of particular significance since it bears witness to the very many individual experts and institutions worldwide who actively participated in the production of the classification of mental and behavioural disorders and the various texts that accompany it. All the major traditions and schools of psychiatry are represented, giving this work a uniquely international character. The classification of mental and behavioural disorders and the guidelines for diagnosis were produced and tested in many languages; the arduous process of ensuring equivalence of translations has resulted in improvements in the clarity, simplicity, and logical structure of the texts in English and in other languages.

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

Further improvements and simplifications of the classification of mental disorders should become possible as our knowledge increases and experience with the current version accumulates. The task of collecting and digesting comments and results of tests of the classification will remain largely on the shoulders of the centres that collaborated with WHO in the development of the classification. These centres, and their current directors, are listed at the end of the Acknowledgements section: it is hoped that they will continue to be involved in the improvement of the WHO classifications and associated materials in the future and to assist the Organization in this work as generously as they have so far.

Numerous publications have arisen from field trial centres, describing results of their studies in connection with ICD-10. A full list of these publications and reprints of the articles can be obtained on request from Division of Mental Health, World Health Organization, 1211 Geneva 27, Switzerland.

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

Norman Sartorius
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Vol. 2: Instruction manual, 1993
Vol. 3: Index (in preparation)

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Acknowledgements

Many individuals and organizations have contributed to the production of the classification of mental and behavioural disorders in ICD-10 and to the development of the texts that accompany it. The Acknowledgements section of *Clinical descriptions and diagnostic guidelines*[1] contains a list of researchers and clinicians in some 40 countries who participated in the trials of that document. A similar list is provided on pages 192–222 of this work. Although it is clearly impossible to list all those who have helped in the production of the texts and in their testing, every effort has been made to include at least all those whose contributions were central to the creation of the documents that make up the ICD-10 "family" of classifications and guidelines (see pages 189–190).

Dr A. Jablensky, then Senior Medical Officer in the Division of Mental Health of WHO in Geneva, coordinated the first part of the programme, and thus made a major contribution to the development of the proposals for the text of the criteria. After the proposals for the classification had been assembled and circulated for comment to WHO expert panels and many other individuals, an amended version of the classification was produced for field tests. Tests were conducted according to a protocol produced by WHO staff with the help of Dr J.E. Cooper and other consultants mentioned below, and involved a large number of centres whose work was coordinated by field trial coordinating centres. The coordinating centres, listed below and on pages 192–222, also undertook the task of producing equivalent versions of *Diagnostic criteria for research* in the languages used in their countries.

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

Throughout the work on the ICD-10 documents, Dr J.E. Cooper acted as chief consultant to the project and provided invaluable guidance and help to the WHO coordinating team. Among the team members were Dr J. van Drimmelen, who has

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

worked with WHO from the beginning of the process of developing ICD-10 proposals; Dr B. Üstün, who has made particularly valuable contributions during the field trials of the criteria and the analysis of the data they produced; Mr A. L'Hours, Technical Officer, Strengthening of Epidemiological and Statistical Services, who provided generous support, ensuring compliance between the ICD-10 development in general and the production of this classification; Mrs J. Wilson, who conscientiously and efficiently handled the innumerable administrative tasks linked to the field tests and other activities related to the project; and Mrs Ruthbeth Finerman, Associate Professor in anthropology, who provided the information upon which Annex 2, Culture-specific disorders, is based.

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

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

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

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Notes for users

1. The content of *Diagnostic criteria for research* (DCR-10) is derived from Chapter V(F), Mental and behavioural disorders, of ICD-10. It provides specific criteria for the diagnoses contained in *Clinical descriptions and diagnostic guidelines* (CDDG), which was produced for general clinical and educational use by psychiatrists and other mental health professionals.[1]

2. Although completely compatible with both CDDG and Chapter V(F) of ICD-10, DCR-10 has a somewhat different style and layout. It is not designed to be used alone, and researchers should therefore make themselves familiar with CDDG. DCR-10 does not contain the descriptions of the clinical concepts upon which the research criteria are based, or any comments on commonly associated features which, although not essential for diagnosis, may well be relevant for both clinicians and researchers. These features are to be found in CDDG, the introductory chapters of which also contain information and comments that are relevant for both clinical and research uses of ICD-10. It is presumed that anyone using DCR-10 will have a copy of CDDG.

3. Certain other differences between DCR-10 and CDDG should be appreciated before DCR-10 can be used satisfactorily.

   (a) Like other published diagnostic criteria for research, the criteria of DCR-10 are deliberately restrictive: their use allows the selection of groups of individuals whose symptoms and other characteristics resemble each other in clearly stated ways. This tends to maximize the homogeneity of groups of patients but limits the generalizations that can be made. Researchers wishing to study the overlap of disorders or the best way to define boundaries between them may therefore need to supplement the criteria so as to allow the inclusion of atypical cases.

   (b) It is never appropriate to provide detailed criteria for the "unspecified" (.9) categories of the overall ICD-10 (Chapter V(F)) classification, and rarely appropriate for the "other" (.8) categories. Annex 1 (page 173) provides suggestions for criteria for some of the few exceptions; place-

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

ment of these criteria in an annex implies that their present status is somewhat controversial or tentative and that further research is to be encouraged.

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

4. As a general rule, interference with the performance of social roles has not been used as a diagnostic criterion in ICD-10. This rule has been followed in DCR-10 as far as possible, but there are a few unavoidable exceptions, the most obvious being simple schizophrenia and dissocial personality disorder. Once the decision had been made to include these disorders in the classification, it was considered best to do so without modifying the concepts; as a consequence it became necessary to include interference with social role in the diagnostic criteria for these disorders. Experience and further research should show whether these decisions were justified.

   For many of the disorders of childhood and adolescence, some form of interference with social behaviour and relationships is included among the diagnostic criteria. Initially, this appears to contravene the general ICD rule mentioned above. However, close examination of the disturbances classified in F80–F89 and F90–F98 shows that the need for social criteria is occasioned by the more complicated and interactive nature of the subject matter. Children often show general misery and frustration, but rarely produce specific complaints and symptoms equivalent to those that characterize the disorders of adults. Many of the disorders in F80–F89 and F90–F98 are joint disturbances that can be described only by indicating how roles within the family, school, or peer group are affected.

5. For the same reasons given in 3(c) above, definitions of remission, relapse, and duration of episodes have been provided in DCR-10 in only a limited number of instances. Further suggestions will be found in the lexicon of terms to Chapter V(F) of ICD-10.[1]

[1] *Lexicon of psychiatric and mental health terms*, 2nd ed. Geneva, World Health Organization (in press).

6. The criteria are labelled with letters and/or numbers to indicate their place in a hierarchy of generality and importance. General criteria, which *must* be fulfilled by all members of a group of disorders (such as the general criteria for all varieties of dementia, or for the main types of schizophrenia) are labelled with a capital G, plus a number. Obligatory criteria for individual disorders are distinguished by capital letters alone (A, B, C, etc.). Numbers (1, 2, 3, etc.) and lower case letters (a, b, etc.) are used to identify further groups and sub-groups of characteristics, of which only some are required for the diagnosis. To avoid the use of "and/or", when it is specified that *either* of two criteria is required, it is always assumed that the presence of *both* criteria also satisfies the requirement.

7. When DCR-10 is used in research on patients who also suffer from neurological disorders, researchers may also wish to use the neurological application of ICD-10 (ICD-10NA)[1] and the accompanying glossary (in preparation).

8. The two annexes to DCR-10 are concerned with disorders of uncertain or provisional status. Annex 1 deals with some affective disorders that have been the subject of recent research, and certain personality disorders. Although the concepts are regarded as clinically useful in some countries, the disorders themselves are of uncertain status from an international viewpoint; it is hoped that their inclusion here will encourage research concerning their usefulness.

   Annex 2 provides provisional descriptions of a number of disorders that are often referred to as "culture-specific". There are grounds for supposing that they might be better regarded as cultural variants of disorders already present in ICD-10 Chapter V(F), but reliable and detailed clinical information is still too scanty to allow definite conclusions to be drawn about them. The considerable practical difficulties involved in field studies of individuals with these disorders are recognized, but inclusion of the descriptions in DCR-10 may stimulate research by workers who are familiar with the languages and cultures of those affected. Information in Annex 2 will be supplemented by that in a lexicon of terms used in cross-cultural psychiatry that is expected to become available in 1994.

9. Note that "and" in category titles stands for "and/or".

[1] *Application of the International Classification of Diseases to Neurology*. Geneva, World Health Organization (in preparation).

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