Glossary of mental disorders and guide to their classification

WORLD HEALTH ORGANIZATION GENEVA

GLOSSARY OF MENTAL DISORDERS AND GUIDE TO THEIR CLASSIFICATION

for use in conjunction with the International Classification of Diseases, 8th Revision

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FOREWORD

Compiling glossaries has been a respectable profession since the 2nd century B.C., as the article in the Encyclopaedia Britannica makes abundantly clear. This is not surprising when the multifarious needs for classification and interpretation are considered. But there is a reverse side to the coin : to " gloss over ", or " to gloze ", a term derived from the same root as glossary, denotes a disreputable activity. " Classification " likewise has a pejorative as well as a respectable flavour. Psychiatric usage of the relevant terms attests their ambiguity : " mere labelling ", " the neat complacency of classification ", " nosological stamp collecting ", " a medical hortus siccus ". Such damning phrases arise in part from revulsion against the excesses to which classification was pushed in the late 18th and early 19th century.

A modern psychiatric glossarist has to cope basically with the same uncertainties and pitfalls as beset the compilers of other medical classifications, but they are aggravated by hazards arising from the paucity of the objective data on which definition and diagnosis must depend. He has to contrive appropriate criteria for differentiating one disease from another ; ideally he aims at constructing a consistent schema into which they will all fit. Such a schema may be based on clinical patterns (syndromes) or on clinical course ; it may be psychodynamic, etiological (genetic), or pathological. And, since diseases are in any case abstract concepts, it is no wonder that the disease constructs which psychiatrists work with have shimmering outlines and overlap. Observer variation is disconcertingly in evidence ; reliability is too low for scientific comfort ; discrepancies may be in some cases lessened, in others minimized, depending on whether they arise from inexact perception, personal bias, or divergency of the nosological systems or terms used.

The picture is no longer black. The glossary put forward here, when faithfully applied, reduces the scope of error. It would seem, however, that accurate observation is still the gate that needs the closest guard. A. R. Feinstein put it bluntly : " the current psychiatric debates about systems of classification, the many hypothetical and unconfirmed schemas of ' psychodynamic mechanisms ', and the concern with etiological inference rather than observational evidence are nosologic activities sometimes reminiscent of those conducted by the mediaeval taxonomists." Since the disorders listed in this glossary are identified by criteria that are predominantly descriptive, its use should encourage an emphasis on careful observation.

This glossary still contains some compromises and anomalies, but the emergence of an agreed version from an international group of collaborators and advisers of such diversity of background and outlook was possible only because of a generous spirit of cooperation and common recognition of an urgent need for better means of communication.

Sir Aubrey J. Lewis, M.D., F.R.C.P.

PREFACE

This volume has been put together for the guidance and convenience of both diagnosticians and coders of psychiatric conditions. The main part of the volume is the Glossary, which consists of internationally agreed descriptions of the diagnostic terms appearing in Section V (Mental Disorders) of the International Classification of Diseases, *8th revision*[1] *(ICD-8). A number of other sections have been included to provide further guidance on the classification of mental disorders in accordance with the ICD-8. The Introduction makes some general points about the problems of classification and about the nature and purposes of the Glossary and the ICD. It is followed by Notes on the use of the Glossary and by a list of the 3-digit categories in the psychiatric section of the ICD-8, which serves to show the reader at a glance how that section, and hence the Glossary itself, is arranged. Annexes 1 and 2 give an introduction to and an outline of the whole ICD so as to encourage all users of Section V to remember the possibilities of recording associated conditions outside this section. Annex 3 consists of an additional list of conditions outside Section V that are often associated with or causative of psychiatric disorders; this list should allow the coder to deal with the great majority of instances where two codes are required, and he should only occasionally need to refer to the full ICD lists. Finally, an alphabetical index of the headings of the Section V categories and subcategories and other recommended terms is provided for quick reference.*

Many individuals and groups have contributed to this publication, both officially and informally, but a special debt of gratitude is owed to Sir Aubrey Lewis, who has been the main consultant to WHO in this project and whose continuous interest, hard work, and international prestige were of essential importance in producing this volume. Sir Aubrey drafted the first version of the Glossary, which was discussed in 1967 in Geneva and then sent to members of the Mental Health Expert Advisory Panel for comments and suggestions. Sir Aubrey used these suggestions and the material contained in a number of national glossaries to produce a second draft of the Glossary; this was again circulated to experts in many countries whose comments were brought to the attention of a working party that met in Geneva in 1969. A further draft was produced after that meeting, again circulated, commented upon, and further revised. It was discussed in detail at the meeting held in London in 1970. In the following year the members of this working party and other experts put the Glossary to trial use in their country, often with the collaboration of other psychiatrists,

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[1] World Health Organization (1967) *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death*, 1965 revision, Geneva.

and Mr M. Nicole reviewed the draft from the terminological point of view. Dr J. E. Cooper helped to incorporate the resulting comments and experience in the final version, which was agreed upon at the meeting in London in 1972. The same year, the participants in the Eighth Seminar on the Standardization of Psychiatric Diagnosis, Classification and Statistics held in Geneva again reviewed the Glossary, expressed satisfaction with its contents and form, and recommended its publication. They also recommended the addition of the three Annexes and the introductory sections. Dr M. Kramer provided the text for Annex 1, Miss E. Brooke the list of associated conditions outside Section V (Annex 3), and Dr Cooper the text for the Introduction, Notes on the use of the Glossary, and the alphabetical index. Dr Cooper also gave invaluable assistance in the editorial organization and finalization of the volume.

This volume is thus the product of an international collaborative effort in the true sense of the word. It is hoped that its users will find it helpful and will continue to assist WHO in the further improvement of the Glossary by providing their comments and suggestions.

INTRODUCTION

Relationships between a nomenclature, a classification, and a glossary

To obtain the maximum benefit from using the ICD-8 and the present Glossary, and to apply it with the greatest possible consistency, it is necessary to understand some basic points about systems of classification of diseases. The classification of diseases cannot begin without a list of agreed names of diseases in which each name stands for only one disease ; such a list is called a *nomenclature*. Since a nomenclature is merely a list carrying no implications about the relationships between its constituent terms, agreed names of new illnesses can simply be added as they are identified without affecting the terms already present.

The next step is to group together these names according to stated criteria so that diseases with properties in common are brought together in classes ; such a grouping is called a *classification*. The nature of the criteria upon which the classes are formed will depend upon the purposes of the classification—there is no one single type of classification that suits all purposes. In general medicine a classification by cause is very useful for many purposes, but in psychiatry the causes of the majority of mental illnesses are not known. Consequently, other criteria have to be relied upon, such as similarity of symptoms and behaviour, or course of illness. When a new illness is added to an already established classification, care must be taken to ensure that it is placed in correct relationship to other similar conditions, depending upon the criteria being used in that particular classification. (This is in contrast to a nomenclature, to which one can simply add new illnesses without having to consider such relationships.) An additional complication in classifications designed primarily for statistical purposes, such as the ICD, is that each section is initially allotted a fixed number of categories. When a statistical classification is first set up, all the terms in the existing nomenclature have to be fitted into these categories. Since it is often impossible to leave spaces for future changes or additions, the insertion of a new term may require the rearrangement of already accepted parts of the classification. It is therefore often necessary to adopt a comparatively conservative attitude to suggestions for changes in a statistical classification.

No classification of diseases can be used satisfactorily unless some indication is given of the meaning of its constituent terms. A set of descriptions, and if possible definitions, of the terms making up a classification is a *glossary*. Again, there are special problems in psychiatry. The present Glossary is necessarily composed of descriptions of symptom patterns and syndromes rather than clear-cut or mutually exclusive definitions. This is because diagnosis by means of a few pathognomonic

signs or symptoms is uncommon in psychiatry; in most instances, psychiatric disorders are differentiated from one another by the recognition of different patterns of emphasis among a comparatively small number of symptoms.

The ICD

The various revisions of the ICD have always had as their primary aim the classification of morbidity and mortality information on a national and international scale. The ICD is thus a classification of *diseases*, rather than *patients*. However, most physicians think in terms of classifying patients. Since one patient may have more than one disease, there must be rules of procedure indicating how the several conditions should be recorded; these rules will vary with the purposes for which the data are being collected. (Several possible sets of rules that might be used in connexion with this Glossary are summarized in the Notes on the use of the Glossary, page 14.)

Although the axes of classification in the ICD-8 vary from one section to the next (see Annex 1, page 60), the psychiatric section is itself a compromise in that the criteria upon which it is based are not uniform throughout, owing to the special problems of psychiatry. Section V follows predominantly descriptive lines, but etiological and prognostic criteria are also used in some categories. While this complicates its use, some difficulties of this type are inevitable given the present state of psychiatric knowledge and the need to make the ICD acceptable to as many different countries and schools of thought as possible.

Glossary for use with the psychiatric section of the ICD-8

All the previous revisions of the ICD have been published without any indication of the meanings of the constituent terms. Guidance to Section V of the ICD-8 has now been added in the form of a glossary because it has become increasingly obvious that many key psychiatric terms are acquiring very different meanings in different countries. Unless some attempt is made to encourage uniformity of usage of descriptive and diagnostic terms, very little meaning can be attributed to the diagnostic side of statistics of mental illness based upon the ICD, and in many other ways communication between psychiatrists will become increasingly difficult.[1] Because the Glossary is designed to accompany

[1] WHO has undertaken two important programmes to assist in the establishment of a common language within psychiatry. The first is the programme on the standardization of psychiatric diagnosis, classification, and statistics, in which psychiatrists from 35 countries have already taken part. The present volume is in fact a product of this programme. The second programme involves comparative studies of specific mental disorders and has as one of its principal aims the development of transculturally applicable and acceptable instruments and methods for reliable assessment of the mentally ill. Further details may be found in Sartorius, N. (1974) The programme of the World Health Organization on the epidemiology of mental disorders. In: *Psychiatry (Part 1), Proceedings of the V World Congress of Psychiatry, Mexico, D. F., 25 November–4 December, 1971*, Amsterdam, Excerpta Medica, pp. 13-17 *(International Congress Series No. 274)*.

Section V of the ICD-8, it inevitably reflects any inconsistencies or difficulties present in this section, which, as already noted, itself represents a compromise.

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

Apart from its primary purpose of fostering communication the Glossary can also serve as an educational stimulus, since it was compiled by psychiatrists representing many different countries and points of view. It is unlikely that any one psychiatrist will find that all the terms and descriptions coincide with his own personal views or usage. Disagreements naturally arise from the existence of different viewpoints, each of which has some support. For purposes of communication, however, it is necessary to arrive at a working compromise, and this is what the Glossary represents. The Glossary undoubtedly contains some inconsistencies. However, their very presence, and the retention of vague terms such as " neurosis " and " psychosis ", are rooted in important points of psychiatric custom and history. It is hoped that discussion of these difficult and controversial points will serve to highlight the problems underlying all systems of medical and psychiatric classification, and will emphasize the need to acknowledge and try to understand the opinions of others.

NOTES ON THE USE OF THE GLOSSARY

The Glossary has been prepared to give guidance to psychiatrists in selecting the diagnostic code that most nearly describes the clinical characteristics of the patient. It is also designed to be used, either alone or together with the ICD-8, by coders responsible for assigning diagnoses to the proper ICD-8 categories.

1. As far as the terms in the ICD-8 permit, the Glossary consists merely of descriptions of symptoms or syndromes ; etiological statements and assumptions have been avoided. The major exceptions to this principle are in sections 290–294, where an organic etiology is implicit in the ICD-8 headings, and in the subdivisions of the mental retardation categories 310–315.

2. When using this Glossary for statistical purposes, the user should avoid making a firm diagnosis in his own terms and then merely searching through the Glossary for the nearest equivalent among the ICD headings. He should familiarize himself with the Glossary descriptions in advance and then choose the description that most nearly fits the patient's illness, even if this means selecting a term not personally familiar to the diagnostician or in use in his country.

3. It is inevitable that many psychiatrists will find that some of the descriptions and rules of the Glossary are in conflict with their own diagnostic preferences. Where they cannot reconcile the Glossary descriptions and rules with their own convictions and practice, it is open to them when, for example, reporting their own special research or clinical interests, to modify, enlarge, or regroup the ICD terms—and modify this Glossary accordingly—provided that they make it clear how their terms can be converted into those of the Glossary and the ICD. In some cases a national glossary can be used with the same proviso, so as to encourage consistency within a given country.

4. Users of the ICD are urged always to use the exact terms specified as the heading of each category, whether 3-digit or 4-digit. In many cases, other terms are also listed under the subheading " inclusion term ". This implies that the term is recognized as an acceptable and frequently used name for a disease or condition falling into that category, or as an acceptable synonym for the category heading. All 3- and 4-digit headings and inclusion terms appearing in the Glossary have been assembled in an alphabetical index (pages 79–86) for quick reference and assistance in assigning diagnoses to the appropriate code. (The Alphabetical Index in Volume 2 of the ICD-8 should be consulted for guidance on how to code terms not found in the present index.) Terms

considered obsolete or confusing have been purposely excluded from the Glossary, however interesting or important their history.

5. Before the ICD can be used satisfactorily for classifying patients, some provision has to be made for those patients who have more than one diagnosis. The rules of procedure adopted will depend upon the purposes for which the patients are being classified; no single system can be suitable for all purposes. Some examples are given below of commonly used systems of different degrees of complexity. Diagnosticians and other users of the ICD-8 and Glossary should always be aware of the requirements and purposes of the recording system to which they are contributing a diagnosis.

(*a*) Where only one diagnosis can be recorded for each patient, it is often stipulated that the diagnosis most relevant to the reason for admission or contact should be the one recorded. If the reason for admission or contact is not the main interest, then it may be preferable to give one type of diagnosis precedence over others according to a set of hierarchical rules. These rules may be applied by the psychiatrist or by those responsible for analysing the diagnoses. For instance, all organically based psychiatric illnesses may be given precedence over functional ones, and within the functional group the order then may be psychoses, neuroses, personality disorders, and others.

(*b*) If the recording system can handle more than one diagnosis, as should nowadays be the case, a set of rules of precedence is again needed to determine the order in which the diagnoses should be recorded. The hierarchical rules cited in the previous paragraph are often found to be satisfactory for psychiatric diagnoses. In addition, however, underlying or associated physical conditions may need to be recorded.

Some parts of Section V of the ICD-8 already contain so-called "combination categories" for coding combined mental and physical disorders, particularly for organic mental disorders and mental retardation. In certain cases, the category designates a mental condition associated with a *specific* physical condition (e.g., 293.0, Psychosis with cerebral arteriosclerosis). In other instances the category consists of a specified mental condition and a *general* class of associated physical disorders (e.g., 312.0, Moderate mental retardation following infections and intoxications). Clearly, such arrangements are inconsistent and unsatisfactory and may result in the omission of important information. This situation will be corrected in ICD-9, where "combination categories" will be eliminated and only separate conditions will be coded. In the meantime it is recommended that, whenever an associated physical condition appears in the diagnosis of a mental disorder, it be

specified and coded *separately*. The following examples illustrate codings of some combination diagnoses:

Diagnosis	*Code from Section V*	*Associated condition*
Organic psychosis with general paralysis	292.0	094.1
Organic psychosis with cerebral arteriosclerosis	293.0	437
Organic psychosis with multiple sclerosis	293.4	340
Organic psychosis with epilepsy	293.2	345
Non-psychotic mental disorders (e.g., personality changes) with epilepsy	309.4	345
Psychogenic duodenal ulcer	305.5	532.9
Mental retardation, moderate, associated with rubella, congenital	312.0	761.3
Mental retardation, severe, associated with lead poisoning	313.0	N984
Suicide attempt, barbiturate poisoning, as a result of depressive neurosis	300.4	E950

One further point should be made regarding the coding of combination diagnoses. It will be seen that all the psychoses listed in categories 290–294 are characterized by a basic " organic " clinical syndrome associated with a variety of physical conditions. These categories should *not* be used for coding a psychosis that is associated with one of the physical conditions listed when it fails to show the characteristic " organic " features. Instead, such a psychosis should be classified under the type of mental disorder present and the associated physical condition should be recorded under its own ICD code. For example, a postpartum schizophrenic psychosis exhibiting none of the specified organic features should be classified under 295, the category for schizophrenia, and a separate entry should be made for the associated physical condition (childbirth).

Annex 3 lists the conditions outside of Section V of the ICD-8 that are often associated with or causative of mental disorders; this list should allow the coder to deal with the great majority of instances where a separate code is required for an associated physical condition.

(*c*) If a recording system is required that allows some indication of diagnostic certainties and uncertainties, then a great deal of information can be contained in a triple system in which Main, Subsidiary, and Alternative Diagnoses are recorded. In such a system, the Main Diagnosis is the one most relevant to the purpose of collection of the statistics. This may be all that is necessary, particularly in clear-cut and severe mental illnesses. If another psychiatric condition is present in addition to the main diagnosis, a Subsidiary Diagnosis is recorded; this does not conflict with the Main Diagnosis but describes additional features