ICD 10 Training Kit - (in collaboration with WHO) SECTION 4 - TRANSPARENCIES

### **ICD 10 Training Kit - (in collaboration with WHO)**

**SECTION 4** - TRANSPARENCIES

**A. Listing of transparencies, for use in the ICD-10 educational programme**

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1.2 Classification: definitions of key concepts
1.3 Requirements of an international classification
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1.6 International Statistical Classification of Diseases and Related Health Problems, 10th Revision.
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1.8 ICD-10 Composition of chapters (2)
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1.10 Examples from Chapter XXI
1.11 ICD-10 family of disease and health-related classifications
1.12 Other health-related classifications
1.13 International nomenclature of diseases
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1.14 Administrative version of ICD-10 Chapter V
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B. Text for sheets for transparencies

**WHY IS IT NECESSARY TO CLASSIFY MENTAL DISORDERS?**

* to facilitate reporting about mental disorders and thus allow rational decisions about health care
* to provide a framework for research on the nature of mental disorder
* to simplify and improve communication among health workers and between them and others involved in health care provision and evaluation

**CLASSIFICATION: DEFINITIONS OF KEY CONCEPTS**

* classification: the activity of placing phenomena or objects into categories according to their characteristics
* classificatory system: a set of categories into which objects or phenomena can be placed
* disorder: is used in ICD-10 to imply the existence of a recognizable set of symptoms and behavioural signs associated in most cases with distress and with interference with personal functions and social roles
* diagnosis: a short statement about a disorder, indicating its origin, cause, probable reaction to treatment, course and outcome
* taxonomy: the study of various strategies of classification
* nosology: the study of disorders according to theories that support the classification of symptoms, signs, syndromes, and disorders
* nosography: the act of assigning names to disorders
* nomenclature: a listing of names of symptoms, disorders and disease

**REQUIREMENTS OF AN INTERNATIONAL CLASSIFICATION**

It should be:

* comprehensive
* well-defined
* acceptable
* attractive
* reliable
* conservative
* compatible with
	+ previous classifications
	+ classification of other sectors (e.g. social insurance)
	+ monitoring procedures (e.g. epidemiological reports)

**INTERNATIONAL CLASSIFICATION OF DISEASES**

1853 First International Statistical Conference

1893 Adoption of the International Statistical Classification of Causes of Death

1900, 1910, 1920, 1929

Revisions 1 - 4 of International List of Causes of Death

1938 Revision 5 of List of Causes of Death (ICD-5):
Cat. 84. Mental diseases and deficiency

a. Mental deficiency

b. Schizophrenia

c. Manic depressive psychosis

d. Other mental diseases

1946 WHO is entrusted with task to prepare 6th revision and to establish an International List of Causes of Morbidity

**INTERNATIONAL CLASSIFICATION OF DISEASES**

1948 First World Health Assembly:

Adoption of Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death (ICD-6)

1955 ICD-7

Section V: Mental, psychoneurotic and personality disorders contains 26 three-digit categories

1965 ICD-8

Chapter V Mental Disorders (wit glossary definitions)

1974 Publication of Glossary accompanying ICD-8

1975 ICD-9

Chapter 5 cotains 30 three-digit categories

1989 Adoption of International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10)

Chapter V Mental and Behavioural Disorders contains 78 three-character categories

1994 Introduction of the ICD-10 into health services as a reporting system by WHO member states

**INTERNATIONAL STATISTICAL CLASSIFICATION OF DISEASE AND RELATED HEALTH PROBLEMS TENTH REVISION**

Geneva, World Health Organization

Vol. 1: Tabular list (1992)

Vol. 2: Instruction manual (1993)

History

Rules and guidance for coding

Vol. 3: Index (1994)

Alphabetical

With synonyms and inclusion terms

**ICD-10 COMPOSITION OF CHAPTERS (1)**

Chapter number and designation Range of codes

*I Certain infectious and parasitic diseases A00-B99*

*II Neoplasms C00-D48*

*III Disease of the blood and bloodforming organs and certain disorders involving the immune mechanism D50-D89*

*IV Endocrine, nutritional and metabolic diseases E00-E90*

*V Mental and behavioural disorders F00-F99*

*VI Diseases of the nervous system G00-G99*

*VII Diseases of the eye and adnexa H00-H59*

*VIII Diseases of the ear and mastoid process H60-H95*

*IX Diseases of the circulatory system I00-I99*

*X Diseases of the respiratory system J00-J99*

*XI Diseases of the digestive system K00-K93*

*XII Disease of the skin and subcutaneous tissue L00-L99*

*XIII Diseases of the musculo-skeletal M00-M99 system and connective tissue*

**ICD-10 COMPOSITION OF CHAPTERS (2)**

Chapter number and designation Range of codes

*XIV Disease of the genito-urinary system N00-N99*

*XV Pregnancy, childbirth and the puerperium O00-O99*

*XVI Certain conditions originating in the perinatal period P00-P95*

*XVII Congenital malformations, deformations, and chromosomal abnormalities Q00-Q99*

*XVIII Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified R00-R99*

*XIX Injury, poisoning and certain other consequences of external causes S00-T98*

*XX External causes of morbidity and mortality V01-Y98*

*XXI Factors influencing health status and contact with health services Z00-Z98*

**EXAMPLES (1)**

Chapter XX External causes of morbidity and mortality

Intentional self-harm (X60-X84)

X61 Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified (Includes: barbiturates, tranquillizers, etc.)

X70 Intentional self-harm by hanging, strangulation and suffocation

X80 Intentional self-harm by jumping from a high place

**EXAMPLES (2)**

Chapter XXI Factors influencing health status and contact with health services

Persons encountering health services for examination and investigation (Z00-Z13)

Z03.2 Observation for suspected mental and behavioural disorders

Z04.6 General psychiatric examination, requested by authority

Persons with potential health hazards related to socioeconomic circumstances (Z55-Z65)

Z55 Problems related to education and literacy

Z55.3 Underachievement in school

Z56 Problems related to employment and unemployment

Z56.2 Threat of job loss

Z60 Problems related to social environment

Z60.3 Acculturation difficulty

Z65 Problems related to other psychosocial circumstances

Z65.4 Victim of crime and terrorism (Includes victim of torture)

**FAMILY OF DISEASE AND HEALTH-RELATED CLASSIFICATIONS**

INTERNATIONAL STATISTICAL CLASSIFICATION OF DISEASES AND RELATED HEALTH PROBLEMS

ICD-10

ICD 3-character core

Short tabulation lists

ICD

4-character classification

OTHER HEALTH RELATED CLASSIFICATIONS

Classification of Impairments, Disabilities and Handicaps

Procedures

Reasons for encounter (complaints)

INTERNATIONAL NOMENCLATURE OF DISEASES (IND)

Objectives:

* to provide, for each morbid entity, a single recommended name
* to provide for each disease a definition, as unambiguous and brief as possible
* to provide synonyms for each disorder after each definition

Available:

* Diseases of the lower respiratory tract (WHO, 1979)
* Cardiac and vascular diseases (WHO, 1989)
* Diseases of the digestive system (WHO, 1990)
* Metabolic, nutritional and endocrine disorders (WHO, 1991)
* Diseases of the kidney, the lower urinary tract, and the male genital system (WHO, 1992)
* Diseases of the female genital system (WHO, 1992)
* Infectious diseases (WHO, 1992)

STRUCTURE OF AN ICD-10 CODE

* mental and behavioural disorders
* section on schizophrenia and related disorders
* schizophrenia
* hebephrenic type
* continous course

An extra number may be used as a subdivision for special purposes

**ADMINISTRATIVE VERSION OF ICD-10 CHAPTER V**

Aims: to provide administrators in psychiatric hospitals and psychiatrists, concerned with coding, with a convenient tool

Contents: ICD-10 chapter V, including glossary definitions

Other conditions, frequently seen in mental health care facilities

Conversion tables between ICD-8, -9, -10 and ICD-9-CM (Clinical Modification)

Index

**APPLICATION OF ICD-10 TO NEUROLOGY**

(ICD-NA, SECOND EDITION)

Aims:

* To provide a code for each recognized neurological disorder
* To encourage making detailed diagnoses and the recording of all disorders present
* To provide standard recording system for neurological disorders, available in several languages
* To facilitate national and international epidemiological research for support of programmes of prevention and control of neurological disorders

**APPLICATION OF ICD-10 TO NEUROLOGY**

(ICD-10 NA)

Contents:
Instructions and recommendations for the use of ICD-10 NA
Tabular list of neurological and related disorders
Morphology of neoplasms, numerical list
Acknowledgements
Index, including list of drugs and chemicals

EXAMPLE OF A CATEGORY IN THE ICD-10 NA

G43 Migraine

Use additional external cause code (Ch.XX) if desired to identify drug, if drug-induced

Excludes : headache NOS (R51)

atypical facial pain (G50)

G43.0 Migraine without aura

[common migraine]

G43.1 Migraine with aura [classical migraine]

G43.10 With typical aura

G43.11 With prolonged aura

G43.12 With acute onset aura

Use sixth character, if desired, to identify neurological symptoms:

G43.1x0 Hemianoptic and other visual migraine

G43.1x1 Hemisensory migraine

G43.1x2 Migraine with aphasia

G43.1x3 Basilar migraine

G43.1x4 Migraine aura (all types) without headache

G43.1x5 Familial hemiplegic migraine

G43.1x7 Multiple types of aura

G43.1x8 Other specified migraine with aura

**ICD-10 GUIDES IN DEVELOPMENT**

* Headaches
* Mental retardation
* Cerebrovascular disorders
* Epilepsy
* Movement disorders

**ICD-10 CHAPTER V: MAIN INNOVATIONS**

* EXPANSION OF THE PROVISION FOR CATEGORIES IMPORTANT FOR GENERAL HEALTH CARE
* BRINGING TOGETHER RELATED CATEGORIES
* CONCEPTUAL CHANGES FOR PUBLIC HEALTH REASONS

**MAIN INNOVATIONS (1)**

EXPANSION OF THE PROVISION FOR CATEGORIES IMPORTANT FOR GENERAL HEALTH CARE

* Acute and transient psychotic disorders
* Somatoform disorders
* Stress-related disorders
* ICD-9 rubric "Sexual deviations and disorders" split into three categories: Disorders of sexual preference, gender identity disorders and sexual dysfunctions
* Childhood and developmental disorders

MAIN INNOVATIONS (2):

BRINGING TOGETHER RELATED CATEGORIES

* Organic disorders
* Alcohol and drug-related disorders
* Affective disorders
* Disorders with onset specific to childhood and adolescence

MAIN INNOVATIONS (3):

CONCEPTUAL CHANGES FOR PUBLIC HEALTH REASONS

* Substance abuse section: 3-character code for the substance involved
* "Culture-bound" syndromes to be classified according to predominant psychopathology

ICD-10: CHAPTER V: CALENDAR OF EVENTS

* 1964-1976 "Programme A"
* 1980-1981 Reviews of Literature and Scientific Group Meetings
* 1981 Copenhagen "Strategic" Conference
* 1983-1996 Drafting of texts; technical meetings; circulation of texts & revisions
* 1987 Prefinal draft
* 1987-1990 Field tests of Clinical Guidelines & Research Criteria
* 1992 Publication of Clinical Guidelines
* 1993 Publication of Research Criteria
* 1991-1995 Completion of tests of PHC version, multiaxial version and instruments
* 1996 Publication of PHC version,
* 1997 multiaxial version and instruments (CIDI, SCAN, IPDE)
* 1965-1996: DEVELOPMENT OF A COMMON LANGUAGE IN PSYCHIATRY (1)
* 1965-1974 WHO Programme A

Aims:

* standardization of psychiatric diagnosis, classification and statistics
* development of transculturally applicable and acceptable instruments for reliable assessment of the mentally ill

Resulting inter alia in:

* ICD-8 (1967) with GLOSSARY;
* the Present State Examination (PSE) and other crossculturally applicable instruments
* and a collaborative, global network

1965-1974 Collaborative international research with important implications for diagnosis and classification:

* UK-US Diagnostic study on psychiatric diagnosis
* WHO International pilot study of schizophrenia (IPSS)

1965-1996: DEVELOPMENT OF A COMMON LANGUAGE IN PSYCHIATRY (2)

1972-1975 Diagnostic Criteria for Research (Feighner and Spitzer)

1978-1986 International study on longterm course and outcome of schizophrenia;

International studies on depression and disability

1980 DSM-III

1983-1993 Development of ICD-10 Chapter V: International Classification of Mental and Behavioural Disorders:

**AIMS OF ICD-10 CHAPTER V**

to facilitate medical practice and public health action by providing a common language to all concerned.

The acceptance of the diagnostic and classification system proposed in the ICD-10 will enable mental health workers, public health decision makers, statisticians and professionals in disciplines relevant to psychiatry:

* to understand one another
* to share results of research
* to improve and unify training strategies

**FEATURES OF ICD-10 CHAPTER V (1)**

* based on cnsensus
* based on field trials
developed in collaboration between a Governmental Organization (WHO) and non-Governmental Organizations (WPA, WFN, AD, etc.)
* developed simultaneously in many languages
* rendered compatible with national classifications
* developed in collaboration with a network of centres around the world participating in relevant research, undertaking translation and providing training and support to users

**FEATURES OF ICD-10 CHAPTER V (2)**

* composed of a family of documents:
* different versions of the classification:
	+ short definitions
	+ guidelines for diagnosis
	+ criteria for research
	+ primary health care version
	+ multiaxial presentation
* tools:
* conversion tables between ICD-10 and previous revisions
	+ lexicon of psychiatric and mental health terms
	+ lexicon of alcohol and drug terms
	+ lexicon of culture-specific terms in mental health
	casebook
	+ training materials - linked to assessment instruments

**FEATURES OF ICD-10 CHAPTER V (3)**

BASED ON CONSENSUS (1)

STEPS:

1. Review of evidence by individual experts,
2. A series of workshops each devoted to a disease group,
3. A summary strategic conference
4. Establishment of a special advisory group to help in setting up the framework for the classification
5. Selection and invitation of experts to draft definitions, guidelines and criteria for research
6. Production of draft texts by some 50 experts from different parts of the world and from different schools of psychiatry
7. Circulation of texts to experts organized in panels for the different groups of disorders

**FEATURES OF ICD-10 CHAPTER V (4)**

BASED ON CONSENSUS (2)

STEPS (continued):

1. Circulation of amended drafts to nongovernmental organizations representing psychiatry and other disciplines.
2. Circulation of drafts to member societies of the NGO's and meetings with groups preparing national classifications (e.g. DSM IV, French classification of disorders in childhood)
3. Presentation of drafts to heads of ICD-10/MH centres for comments and approval from the point of view of translatability
4. Finalization of drafts and field trials
5. Finalization of texts, taking into account results of field trials

**FEATURES OF ICD-10 CHAPTER V (5)**

**BASED ON FIELD TRIALS (1)**

Overview of field trials of different versions

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Version** | **Countries** | **Centers** | **Clinicians** | **Patients** |
| Clinical | 39 | 112 | 711 | 15,302 |
| Research | 32 | 150 | 150 | 13,793 |
| Multiaxial | 35 | 75 | 200 | 4,330 |
| Primary care | 45 | 20 | 564 | 3,123 |

**FEATURES OF ICD-10 CHAPTER V (6)**

BASED ON FIELD TRIALS (2)

Objectives of field trials of the classification and of the clinical descriptions and diagnostic guidelines (1987 draft):

*I. Assessment of ease to understand and to use thenew classification*

*II. Assessment of goodness of fit in routine clinical practice*

*III. Assessment of inter-rater reliability of users in different countries and internationally*

**FEATURES OF ICD-10 CHAPTER V (7)**

BASED ON FIELD TRIALS (3)

Results from the Clinical Descriptions and Diagnostic Guidelines version field trials (1)

Clinicians' assessment:

* easy to use 85%
* good fit 82%
* feeling confident in making diagnosis 91%
* reliability: weighted kappas .60 - .100

**FEATURES OF ICD-10 CHAPTER V (8)**

BASED ON FIELD TRIALS (4)

Results from the Clinical Descriptions and Diagnostic Guidelines version field trials (2)

Interrater reliability for major groups of disorders (kappa coefficients)

F0: 0,78 F5: 0,91

F1: 0,80 F6: 0,51

F2: 0,82 F7: 0,77

F3: 0,77 F8: not enough cases

F4: 0,74 F9: 0,74

overall agreement: at 2 character level: 0,81

at 3 character level: 0,71 at 4 character level: 0,59

**FEATURES OF ICD-10 CHAPTER V (9)**

DEVELOPED SIMULTANEOUSLY IN MANY LANGUAGES

* ARABIC
* CHINESE
* ENGLISH
* FRENCH
* GERMAN
* JAPANESE
* PORTUGUESE
* RUSSIAN
* SPANISH

OTHER LANGUAGES INTO WHICH ICD-10 CHAPTER V HAS BEEN TRANSLATED
(until march 1996)

* BULGARIAN
* CROATIAN
* CZECH
* DANISH
* DUTCH
* ESTONIAN
* FARSI (IRAN)
* GREEK
* HEBREW
* HUNGARIAN
* INDONESIAN
* ITALIAN
* KOREAN
* LATVIAN
* LITHUANIAN
* NORWEGIAN
* POLISH
* RUMANIAN
* SERBIAN
* SWEDISH
* THAI
* TURKISH
* UKRAINIAN
* VIETNAMESE

**FEATURES OF ICD-10 CHAPTER V (10)**

RENDERED COMPATIBLE WITH NATIONAL CLASSIFICATIONS AND CLASSIFICATIONS OF SPECIALTIES

DSM-III, DSM-IIIR, DSM-IV

* French INSERM classification
* French classification of childhood mental disorders
* Indonesian official classification of mental disorders
* Nordic countries' classification
* Russian classification
* classification of Alzheimer International Association
* classification of epilepsy
* classification of headaches
* classification of sleep disorders
* and others

**DIFFERENCES BETWEEN ICD-10 AND A**

NATIONAL OR SPECIALIST CLASSIFICATION (1)

|  |  |
| --- | --- |
| **ICD-10** | **National or specialists classifications** |
| WHO Member States use ICD-10 for official reporting about disease and death | The use of a national classification does not obviate the need to also report data in ICD-terms, for all official purposes |
| Continuity between revisions of the classification is considered essential | Continuity is desirable;innovations are welcome |
| The general structure of ICD-10 imposes limitations on structure and contents of Chapter V | No limitations concerning structure |
| Chapter V is part of a comprehensive classification of all diseases and disorders, and includes other reasons for contact of health services | It is not part of an overall classification |
| Adopted by national governments and used for reporting by intergovernmental agencies (i.e. WHO) | Approved by national or international professional organizations |

**DIFFERENCES BETWEEN ICD-10 AND A**

**NATIONAL OR SPECIALIST CLASSIFICATION (2)**

|  |  |
| --- | --- |
| **ICD-10** | **National or specialist classifications** |
| Translation into oter languages is an integral part of development | May be translated after it as been developed |
| ICD-10 reflects current usage in psychiatry | Is directive concerning utilization in practice |
| ICD-10 is a uniaxial classification which can be presented in a multiaxial way | Different axes are independent |
| Developed in different versions for different users | Ussually exists in only one version |
| Social criteria are as far as possible avoided | Social criteria are used |
| ICD-10 is a member of a family of classifications | Ussually independent, sometimes with various presentations |

**RELATIONSHIPS BETWEEN ICD-10 CHAPTER V AND DSM-IV**

COLLABORATION IN DEVELOPMENT

* Experts were involved who worked both on ICD-10 and DSM developments
* Activities undertaken in the framework of the Joint Project of WHO and ADAMHA (USA), from 1982-1995 contributed to the scientific basis of both classifications
* The National Institute of Mental Health (USA) has sponsored special meetings (during 1988-1991) to facilitate harmonious development of ICD-10 and DSM-IV
* Field trials of ICD-10 and DSM-IV were carried out in the US and elsewhere (often in the same centres)

**FEATURES OF ICD-10 CHAPTER V (11)**

ESTABLISHMENT OF A NETWORK OF SUPPORT CENTRES AROUND THE WORLD:

WHO Training and Reference Centres on Classification, Diagnosis and Assessment of Mental and Behavioural Disorders (ICD-10/MH CENTRES)

coordinating field studies of clinical and research criteria

* AARHUS
* BANGALORE
* BEIJING
* CAIRO
* LUBECK
* LUXEMBOURG
* MADRID
* MOSCOW
* NAGASAKI
* OXFORD
* ROCKVILLE

**FAMILY OF DOCUMENTS RELATED TO ICD-10 CHAPTER V**

MENTAL AND BEHAVIOURAL DISORDERS

* composed of a family of documents:
* different versions of the classification:
* short definitions
* guidelines for diagnosis
* criteria for research
* primary health care version
* multiaxial presentation

tools:

* conversion tables between ICD-10 and previous revisions
* lexica and glossaries
* casebook
* training materials

linked to assessment instruments

* Composite International Diagnostic Interview (CIDI)
* Schedules for Clinical Assessment in Neuropsychiatry (SCAN)
* International Personality Disorder Examination (IPDE)

**GLOSSARY DEFINITIONS IN ICD-10: EXAMPLE**

F23.2 Acute schizophrenia-like psychotic disorder

An acute psychotic disorder in which the psychotic symptoms are comparitively stable and justify a diagnosis of schizophrenia, but have lasted for less than about one month. If the schizophrenic symptoms persist the diagnosis should be changed to schizophrenia (F20.-)

Acute (undifferentiated) schizophrenia

Brief schizophreniform disorder or psychosis

Oneirophrenia

Schizophrenic reaction

Excludes: organic delusional [schizophrenia-like disorder (F06.2)

schizophreniform disorder NOS (F20.8)

**CLINICAL DESCRIPTIONS AND DIAGNOSTIC GUIDELINES**

Characteristics:

* For general clinical and educational use
* Users: psychiatrists and other mental health workers
* Narrative style of description of the main clinical features of each disorder
* Diagnostic guidelines, indicating the number of symptoms usually required for a confident diagnosis
* Allows for a provisional diagnosis, even if not all criteria are fullfilled

**CLINICAL DESCRIPTIONS AND DIAGNOSTIC GUIDELINES**

Example:

F32.0 Mild depressive episode Diagnostic guidelines

Depressed mood, loss of interest and enjoyment, and increased fatiguability are usually regarded as the most typical symptoms of depression, and at least two of these, plus at least two of a list of other common symptoms (e.g. decreased self-esteem, disturbed sleep) should usually be present for a definite diagnosis. None of the symptoms should be present to an intense degree. Minimum duration of the whole episode is about 2 weeks.

An individual with a mild depressive episode is usually distressed by the symptoms and has some difficulty in continuing with ordinary work and social activities, but will probably not cease to function completely.

**DIAGNOSTIC CRITERIA FOR RESEACH**

Characteristics

* For use in psychiatric research
* Contains precise criteria for diagnoses
* Does not contain descriptions of clinical concepts and must therefore be used in conjunction with the "Clinical Descriptions and Diagnostic Guidelines"
* Criteria are restrictive so as to maximize homogeneity of groups of patients in research

**DIAGNOSTIC CRITERIA FOR RESEARCH**

Example:

F32 Depressive episode
G1 The depressive episode should last for at least 2 weeks.
G2 There have been no hypomanic or manic symptoms sufficient to meet the criteria for hypomanic or manic episode (F30.-) at any time in the individual's life.
G3 Most commonly used exclusion clause: The episode is not attributable to psychoactive substance use (F10-F19) or to any organic mental disorder (in the sense of F00-F09).

F32.1 Moderate depressive episode

A. The general criteria for depressive episode (F32) must be met.
B. At least two of the three symptoms listed for F32.0, criterion B (i.e. depressed mood, loss of interest or pleasure, decreased energy or increased fatiguability), must be present.
C. Additional symptoms from a list of 7 (e.g. sleep disturbance, change in appetite)(described in F32.0, criterion C), must be present, to give a total of at least six.

A fifth character .x0 or .x1 may be used to specify the presence or absence of the "somatic syndrome" (also called "vital" or "melancholic" in other classifications). To qualify for this syndrome 4 from a list of 7 symptoms must be present (e.g. depression worse in the morning).

PRIMARY HEALTH CARE VERSION (ICD-10 PHC)

Basic features:

- reduced number of categories:

* version with 24 categories
* version with 6 categories

- brief definitions
- uses familiar diagnostic terms
- offers guidelines for recognition
- offers guidelines for management

PRIMARY HEALTH CARE VERSION (ICD-10 PHC)

ICD-10 categories which were selected for ICD-10 PHC

- groups of disorders of public health importance

- high prevalence

- associated with significant disablement, morbidity or mortality

- associated with significant burden on family

- health care resources needed to help people with the condition

- for which it is posible to provide effective and acceptable management in PHC setting

List of categories

* F00\* Dementia
* F05 Delirium
* F10 Alcohol use disorder
* F11\* Drug use disorders
* F17.1 Tobacco use
* F20 Chronic psychotic disorders
* F23\* Acute psychotic disorders
* F31 Bipolar disorder
* F32\* Depression
* F40\* Phobic disorders
* F41.0 Panic disorder
* F41.1 Generalized anxiety disorder
* F41.2 Mixed anxiety and depression
* F43\* Adjustment disorders
* (Z63\* Bereavement)
* F44\* Dissociative disorder
* F45 Unexplained somatic complaints
* F48.0 Neurasthenia
* F50\* Eating disorders
* F51\* Sleep problems
* F52 Sexual disorders
* F70 Mental retardation
* F90 Hyperkinetic disorder
* F91 Conduct disorder
* F98.0 Enuresis

\* An asterisk indicates that more than one ICD-10 code is included (e.g. F00\* includes disorders coded in F00-F04)

Components of ICD-10 PHC

listing of categories

* diagnostic and management guidelines for each category
* flow-charts
* symptom index
* supporting material:
* patient leaflets
* medication cards

For each disorder

Diagnostic guidelines

* presenting complaints
* diagnostic features
* differential diagnosis

Management guidelines

* essential information for patient and family
* specific counselling for patient and family
* medication
* need for specialist consultation

**Example: DEMENTIA F00 (1)**

Presenting complaint

Patients may complain of forgetfulness or feeling depressed, but may be unaware of memory loss. Patients and family may sometimes deny severity of memory loss.

Families ask for help initially because of failing memory, change in personality or behaviour in later stages because of confusion, wandering, or incontinence.

Poor personal hygiene in an older patient may indicate memory loss

Example: DEMENTIA F00 (2)

Diagnostic features

Decline in recent memory, thinking and judgement, orientation, language

Patients often appear apathetic or disinterested, but may appear alert and appropriate despite poor memory.

Decline in everyday functioning (dressing, washing, cooking).

Loss of emotional control - patients may be easily upset, tearful or irritable.

Common in older patients, very rare in youth or middle age.

Tests of memory and thinking include:

* ability to recall names of three common objects immediately and again after three minutes,
* ability to name days of week in reverse order.

Example: DEMENTIA F00 (3)

Differential diagnosis

Examine for other illnesses causing memory loss.

Examples include:

* depression (F32\*) anaemia
* urinary infection vitamin B12 or folate
* HIV infection deficiency
* siphilis normal pressure
* subdural haematoma hydrocephalus
* other infectious illnesses
* Prescribed drugs or alcohol may affect memory and concentration.

Sudden increases in confusion may indicate a physical illness (i.e. acute infectious illness) or toxicity from medication. If confusion, wandering attention or agitation are present, see Delirium F05.

Depression may cause memory and concentration problems similar to those of dementia, especially in older patients. If low or sad mood is prominent, see Depression F32\*.

Example: DEMENTIA F00 (4)

Management guidelines:

Essential information for patient and family

Dementia is frequent in old age

Memory loss and confusion may cause behaviour problems (e.g. agitation, suspiciousness, emotional outbursts).

Memory loss usually proceeds slowly, but course is quite variable.

Physical illness or mental stress can increase confusion

Provide available information and describe community resources

Example: DEMENTIA F00 (5)

Management guidelines:

Specific counselling to patient and family

Monitor the patient's ability to perform daily tasks

Consider use of memory aids or reminders if memory loss is mild

Avoid placing patient in unfamiliar places or situations

Consider ways to reduse stress on those caring for the patient (e.g. self-help groups). Support from other families caring for relatives with dementia may be helpful

Discuss planning of legal and financial affairs

As appropriate, discuss arrangements for support in the home, community or day care programmes, or residential placement

Uncontrollable agitation may require admission to a hospital or nursing home

Example: DEMENTIA F00 (6)

Management guidelines:

Medication

Use sedative or hypnotic medications (e.g. benzodiazepines) cautiously; they may increase confusion.

Antipsychotic medication in low doses (e. g. haloperidol 0.5 to 1.0 mg once or twice a day) may sometimes be needed to control agitation, psychotic symptoms or aggression. Beware of drug side-effects (Parkinsonian symptoms, anticholinergic effects) and drug interactions.

Example: DEMENTIA F00 (7)

Management guidelines:

Specialist consultation

Consider consultation for

* uncontrollable agitation
* sudden onset or worsening of memory loss
* physical causes of dementia requiring specialist treatment (e.g. syphilis, subdural haematoma)

Consider placement in a hospital or nursing home if intensive care is needed

**MULTIAXIAL PRESENTATION OF ICD-10**

Why do we need axes1?

To provide a comprehensive description of the patient's condition, which is likely to facilitate:

* appropriate decisions about therapy
* an accurate prognosis

To facilitate the interpretation of statistics from health facilities

To facilitate coordination of interventions by different health professionals (e.g. psychiatrist and social workers)

To allocate health care resources in a efficient way

Axis I Clinical diagnoses

* mental disorders
* physical disorders
* personality disorders

Chapters I to XX of ICD-10

Axis II Disability (following the principles of ICIDH)rating of 4 specific areas of functioning

Axis III Contextual factors (selected ICD-10 Z-codes: Chapter XXI)environmental and life style factors relevant to pathogenesis and course of patient's illness

Axis II Disability1

* personal care
* occupation
* family and household
* functioning in broader social context rating of specific areas of functioning on a scale of 6 points, which are defined in operational terms

Axis III Contextual factors (selected ICD-10 Z-codes: Ch. XXI)

* problems related to negative events in childhood
* problems related to education and literacy
* problems related to primary support group, including family circumstances
* problems related to social environment
* problems related to housing or economic circumstances
* problems related to (un)employment
* problems related to physical environment
* problems related to certain psychosocial circumstances
* problems related to legal circumstances
* problems related to family history of diseases or disabilities
* problems related to life-style and life-management difficulties

Example of a multiaxial diagnostic formulation

**Axis I: CLINICAL DIAGNOSES**

Somatization disorder F45.0

Axis II: DISABILITIES

ratings (0-5)

A. Personal care . . . 0

B. Occupation . . . 1

C. Family and household . . 1

D. Broader social context . 2

Axis III: CONTEXTUAL FACTORS

Acculturation difficulty Z60.3

CONVERSION TABLES BETWEEN ICD-8, -9, -10 AND ICD-9-CM (CLINICAL MODIFICATION)

example

|  |  |  |
| --- | --- | --- |
| **ICD-10** | **ICD-9** | **ICD-8** |
| F50 Eating disorders |   | 306.5 Feeding disturbances |
| F50.0 Anorexia nervosa | 307.1 Anorexia nervosa |   |
| F50.1 Atypical anorexiaF50.2 Bulimia nervosaF50.3 Atypical bulimiaF50.4 Overeating and F50.5 Vomiting associated with other psychological disturbanceF50.8 Other eating disorderF50.9 Eating disorder, unspecified | 307.5 Other unspecified disorders of eating |   |

ICD-10 CASEBOOK

The Many Faces of Mental Disorders-

Adult Case Histories

According to ICD-10

Provides case histories illustrating disorders classified in F0-F6 of Chapter V of ICD-10, accompanied by discussions of the diagnosis

Example of a case history (shortened): Mr X, a 35-year old factory worker, married, with 3 children, was admitted to a general hospital, after having broken his leg by falling of the stairs.

On the third day of his stay, he grew increasingly nervous and started to tremble. During the night he could not sleep, talked incoherently and was obviously very anxious.

According to his wife, Mr X had drunk large quantities of beer each night after he came home until he would fall asleep, for over three years. At the night of admissal, he had slipped on the stairs when he came home, breaking his leg, before having his first beer. During the past year he had missed work several times and had been threatened with dismissal. He had a car accident when drunk two years before, but without any major injury. His father had been a chronic alcoholic and died from liver cirrhosis, when Mr X was 24 years old.

On examination Mr X spoke incoherently. He was disoriented in time, place, and at times also in person. On several occasions he picked at bugs that he could see on his blanket. He trembled and sweated profusely. He tried constantly to get out of bed and seemed unaware that his right leg was in plaster.

Example of discussion of the diagnosis (shortened): Mr X

Mr X had a long history of heavy alcohol use and developed severe withdrawal symptoms when he could not get alcohol. He presented with the characteristic symptoms of a delirium: clouding of consciousness, global disturbance of cognition, psychomotor agitation, disturbance of the sleep-wake cycle, rapid onset and fluctuation of the symptoms. Since there were no convulsions, the diagnosis according to ICD-10 is

F10.40 Alcohol withdrawal state with delirium, without convulsions.

The information provided by his wife gives evidence pointing to an additional diagnosis of alcohol dependence syndrome: continuous heavy use during the last 3 years, difficulties in controlling the drinking and the presence of a withdrawal state. Although this is not enough for a definite diagnosis according to ICD-10, a provisional additional diagnosis may be made:

F10.24 Alcohol dependence syndrome, currently using the substance.

LEXICA OF TERMS

Lexicon of psychiatric and mental health terms, WHO, Geneva, 1989

Provides definitions of over 300 terms that appear in the text of ICD-9 Chapter V.

Lexicon of psychiatric and mental health terms. 2nd edition. WHO, Geneva, 1994

Provides definitions of some 700 terms that appear in the text of ICD-10, Chapter V.

Lexicon of alcohol and drug terms. WHO, Geneva (1994)

Provides definitions of terms related to use, abuse and dependence of psychoactive substances. For each general class of psychoactive drugs the definitions include information on effects, symptomatology, sequelae, and therapeutic indiations. Social as well as health aspects of drug use and problems related to use are covered.

Lexicon of culture-specific terms in mental health. WHO, Geneva (1997)

Facilitates the use of the ICD-10 Classification of Mental and Behavioural Disorders in various cultural settings. It contains definitions of terms, concepts, symptoms and syndromes, that are important for the understanding of human experience in a socio-cultural setting.

APPLICATION OF THE INTERNATIONAL CLASSIFICATION OF MENTAL AND BEHAVIOURAL DISORDERS

1. Basic coding rules

2. General conventions on use of terminology

BASIC CODING RULES (1)

* Use as many diagnoses as are necessary to describe the condition of the patient
* Record main diagnosis first
* Write down both your own diagnosis in words and the ICD-10 category to which it is assigned

BASIC CODING RULES (2)

Main diagnosis precedence should be given to that diagnosis most relevant to the purpose for which the diagnoses are being collected in clinical work the main diagnosis is usually the reason for consultation or contact with health services in case of doubt about what the main diagnosis is, follow the numeric order of ICD-10

BASIC CODING RULES (3)

Levels of diagnostic confidence

Confidence in diagnostic categorization may be expressed as follows:

definite: Criteria are fulfilled for a specific category of ICD-10

provisional: Criteria are not completely fulfilled

More information will probably become available, after which the criteria will most likely be fulfilled probable: Criteria are not fulfilled. More information cannot be obtained, current diagnosis is the most likely under the circumstances

**BASIC CODING RULES (4)**

Example of the different elements of a diagnosis according to ICD-10

Main diagnosis: F32.2 Severe depressive episode without psychotic symptoms

Other diagnoses: X70 Intentional self-harm by hanging, strangulation and suffocation

F10.2 Alcohol dependence syndrome

F60.7 Dependent personality disorder

K29.2 Alcoholic gastritis

Z56.2 Threat of job loss

**GENERAL CONVENTIONS ON USE OF TERMINOLOGY (1)**

DISORDER

The term "disorder" is used throughout the classification. Although it is recognized that "disorder" is not an exact term, its use avoids even greater problems inherent in the use of terms such as "disease" and "illness".

The term "disorder" implies the existence of a clinically recognizable set of symptoms or behaviour, associated in most cases with distress and with interference with personal functions.

Social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder as defined here.

**GENERAL CONVENTIONS ON USE OF TERMINOLOGY (2)**

ORGANIC and SYMPTOMATIC

The term "organic" is used for those syndromes that can be attributed to an independently diagnosable cerebral or systemic disease or disorder

Use of the term "organic" does not imply that conditions elsewhere in the classification are "nonorganic" in the sense of having no cerebral substrate

The term "symptomatic" is used for those organic mental disorders in which cerebral involvement is secondary to a systemic extracerebral disease of disorder

**GENERAL CONVENTIONS ON USE OF TERMINOLOGY (3)**

PSYCHOTIC

The term "psychotic" has been retained as a convenient descriptive term, particularly in F23, Acute and transient psychotic disorders

Its use does not involve assumptions about psychodynamic mechanisms

The term "psychotic" is used only to indicate the presence of hallucinations, delusions, or a limited number of severe abnormalities of behaviour (such as abnormal excitement and overactivity, marked psychomotor retardation, and catatonic behaviour)

**GENERAL CONVENTIONS ON USE OF TERMINOLOGY (4)**

NEUROTIC

The traditional division between neurosis and psychosis, that was evident in ICD-9 is not longer used in ICD-10

However, the term "neurotic" is still retained for occasional use and occurs, for instance, in the heading of section F4 "Neurotic, stress-related and somatoform disorders"

Most of the disorders regarded as neuroses by those who still use the concept (except depressive neurosis) are to be found in block F40 - F48

**GENERAL CONVENTIONS ON USE OF TERMINOLOGY (5)**

PSYCHOGENIC

The term "psychogenic" has not been used in the titles of categories, in view of its different meanings in different languages and psychiatric traditions

It still occurs occasionally in the text, and should be taken to indicate that the diagnostician regards obvious life events or difficulties as playing an important role in the genesis of the disorder

**GENERAL CONVENTIONS ON USE OF TERMINOLOGY (6)**

PSYCHOSOMATIC

The term "psychosomatic" has not been used in the titles of categories, in view of its different meanings in different languages and psychiatric traditions, and because use of this term might be taken to imply that psychological factors play no role in the occurrence, course and outcome of other diseases that are not so described

Disorders described as psychosomatic in other classifications can be found in ICD-10 in F45 (Somatoform disorders), F50 (Eating disorders), F52 (Sexual dysfunction), and F54 (Psychological or behavioural factors associated with disorders or diseases classified elsewhere)

**GENERAL CONVENTIONS ON USE OF TERMINOLOGY (7)**

IMPAIRMENT, DISABILITY, HANDICAP

The terms "impairment, "disability" and "handicap" are used according to the recommendation of WHO (International classification of impairments, disabilities and handicaps, Geneva, WHO, 1980)1\*

"Impairment" is defined as: "loss or abnormality . . of structure or function". Many types of psychological impairment have always been recognized as psychiatric symptoms

"Disability" is defined as: "a restriction or lack . . of ability to perform an activity in the manner or within the range considered normal for a human being". Disability at the personal level includes ordinary activities of daily living (such as washing, dressing, eating and excretion), is influenced little, if at all, by culture, and may be used as a criterion for certain psychiatric diagnoses (such as dementia)

"Handicap" is defined as: "the disadvantage for an individual . . that prevents or limits the performance of a role that is normal . . for that individual", and represents the effects of impairments or disabilities in a wide social context that may be heavily influenced by culture. Handicap should not be used as a central component of a diagnosis

**STRUCTURE OF ICD-10 CHAPTER V**

F0 Organic and symptomatic mental disorders

F1 Mental and behavioural disorders due to psychoactive and other substance use

F2 Schizophrenia, schizotypal and delusional disorders

F3 Mood [affective] disorders

F4 Neurotic, stress-related and somatoform disorders

F5 Behavioural syndromes and mental disorders associated with physiological dysfunction

F6 Disorders of adult personality and behaviour

F7 Mental retardation

F8 Disorders of psychological development

F9 Behavioural and emotional disorders with onset usually occurring in childhood or adolescence

F99 Unspecified mental disorder

**F00-F09 ORGANIC, INCLUDING SYMPTOMATIC, MENTAL DISORDERS**

F00 Dementia in Alzheimer's disease

F01 Vascular dementia

F02 Dementia in other diseases classified elsewhere

F03 Unspecified dementia

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

F05 Delirium, not induced by alcohol and other psychoactive substances

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

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

F09 Unspecified organic or symptomatic mental disorder

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

F10 Alcohol

F11 Opioids

F12 Cannabinoids

F13 Sedatives and hypnotics

F14 Cocaine

F15 Other stimulants (incl. caffeine)

F16 Hallucinogens

F17 Tobacco

F18 Volatile solvents

F19 Multiple, other and unidentified substances

**F20-F29 SCHIZOPHRENIA, SCHIZOTYPAL AND DELUSIONAL DISORDERS**

F20 Schizophrenia

F21 Schizotypal disorder

F22 Persistent delusional disorders

F23 Acute and transient psychotic disorders

F24 Induced delusional disorder

F25 Schizoaffective disorders

F28 Other nonorganic psychotic disorders

F29 Unspecified nonorganic psychosis

**F30-F39 MOOD [AFFECTIVE] DISORDERS**

F30 Manic episode

F31 Bipolar affective disorder

F32 Depressive episode

F33 Recurrent depressive disorder

F34 Persistent mood [affective] disorders

F38 Other mood [affective] disorders

F39 Unspecified mood [affective] disorder

**F40-F48 NEUROTIC, STRESS-RELATED AND SOMATOFORM DISORDERS**

F40 Phobic anxiety disorders

F41 Other anxiety disorders

F42 Obsessive-compulsive disorder

F43 Reaction to severe stress, and adjustment disorder

F44 Dissociative [conversion] disorder

F45 Somatoform disorders

F48 Other neurotic disorders

**F50-F59 BEHAVIOURAL SYNDROMES ASSOCIATED WITH PHYSIOLOGICAL DISTURBANCES AND PHYSICAL FACTORS**

F50 Eating disorders

F51 Nonorganic sleep disorders

F52 Sexual dysfunction, not caused by organic disorder or disease

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

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

F55 Abuse of non-dependence-producing substances

F59 Unspecified behavioural syndromes associated with physiological disturbances and physical factors

**F60-F69 DISORDERS OF ADULT PERSONALITY AND BEHAVIOUR**

F60 Specific personality disorders

F61 Mixed and other personality disorders

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

F63 Habit and impulse disorders

F64 Gender identity disorders

F65 Disorders of sexual preference

F66 Psychological and behavioural disorders associated with sexual development and orientation

F68 Other disorders of adult personality and behaviour

F69 Unspecified disorder of adult personality and behaviour

**F70-F79 MENTAL RETARDATION**

F70 Mild mental retardation

F71 Moderate mental retardation

F72 Profound mental retardation

F78 Other mental retardation

F79 Unspecified mental retardation

**F80-F89 DISORDERS OF PSYCHOLOGICAL DEVELOPMENT**

F80 Specific developmental disorders of speech and language

F81 Specific developmental disorders of scholastic skills

F82 Specific developmental disorder of motor function

F83 Mixed specific developmental disorders

F84 Pervasive developmental disorders

F88 Other disorders of psychological development

F89 Unspecified disorder of psychological development

**F90-F98 DISORDERS OF PSYCHOLOGICAL DEVELOPMENT**

F90 Hyperkinetic disorders

F91 Conduct disorders

F92 Mixed disorders of conduct and emotions

F93 Emotional disorders with onset specific to childhood

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

F95 Tic disorders

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

**F99 NON SPECIFIED MENTAL DISORDER**

F99 Mental disorder, not otherwise specified

**ASSESSMENT INSTRUMENTS LINKED TO ICD-10 CHAPTER V**

Purposes:

* to improve precision of assessment in psychiatry
* to increase reliability of psychiatric assessment and diagnosis
* to standardise data collection so as to
* increase replicability and comparability across
* to facilitate collaboration and communication among resarchers

|  |  |  |  |
| --- | --- | --- | --- |
| Checklists | ICD-10 Checklists | Summary of assessment | Clinicians |
| Composite International | Diagnostic Interview | Epidemiological surveys | Lay interviewers |
| SCAN | Schedules for Clinical Assessment in Neuropsychiatry | Clinical research and practice | Clinicians |
| IPDE | International Personality Disorder Examination | Clinical research | Clinicians |
| DAS | Disability Assessment Schedule | Clinical research and practice | Clinicians and other mental health workers |
|   | MODULES & MODIFICATIONS |   |   |

**ICD-10 CHECKLISTS**

I. ICD-10 symptom checklist for mental disorders, accompanied by ICD-10 symptom glossary

II. International Diagnostic Checklists for ICD-10, accompanied by manual

ICD-10 SYMPTOM CHECKLIST FOR MENTAL DISORDERS

A semi-structured instrument intended for clinician's assessment of the psychiatric symptoms and syndromes in F0 - F6; accompanied by ICD-10 symptom glossary for mental disorders

Example: F0/F1 Module: Organic mental and psychoactive substance use syndromes

Organic mental disorders

A. Which of the following are present?

1. decline in memory [\_\_]

2. decline in other intellectual abilities [\_\_]

3. deterioration in emotional control, social behaviour or motivation [\_\_]

4. impairment of consciousness and attention [\_\_]

5. disturbances of perception or disorientation [\_\_]

6. psychomotor disturbances [\_\_]

7. disturbance of the sleep-wake cycle [\_\_]

8. rapid onset and diurnal fluctuations of symptoms [\_\_]

**ICD-10 SYMPTOM GLOSSARY FOR MENTAL DISORDERS**

Provides brief descriptions of the symptoms and terms used in the criteria in the F0 - F6 categories and has been developed as a companion to the checklist

Example:

Decline in memory

A decline in the registration, storage and retrieval of new information. Previously learned and familiar material may also be lost, particularly in the later stages of dementia.

**COMPOSITE INTERNATIONAL DIAGNOSTIC INTERVIEW (CIDI)**

Purpose Assessment of current and/or life time symptoms of mental disorders for case identification and assessment (e.g. in epidemiological research)

Type of instrument Fully structured diagnostic interview schedule: symptom questions are spelled out positive answers are further explored

computerized data entry and diagnostic programmes

available in different life time and 12 monhs versions

can be supplemented by different modules

User Interviewers without clinical experience as well as clinicians

Training Essential (5 days)

Administration time 75 minutes

How to ask CIDI questions:

* all questions should be read as written
* no interpretation of questions and answers by the interviewer (if the respondent does not understand the question or interrupts the interviewer, the question should be read again without additional clarification)
* a rating will be made only when the respondent understands the intent of the question and has responded appropriately
* interviewers should probe and not assume answers

**SCHEDULES FOR CLINICAL ASSESSMENT IN NEUROPSYCHIATRY (SCAN)**

Purpose Assessment of present state and clinical history for clinical diagnosis

Type of instrument Semi-structured clinical interview schedule with semi-standardized questions

User Psychiatrists or psychologists

Training Essential

Administration time 60 - 90 minutes

Components:

1. Glossary of definitions

2. Assessment manual

* Present State Examination (PSE-10)
* Item Group Checklist (IGC)
* Clinical History Schedule (CHS)

3. Rating record schedules

4. Computer program

Catego-5: - descriptive profiles - ICD-10, DSM-IV diagnoses

5. Version 2.1 (1998) revised with CAPSE for ICD-10 and DSM-IV

Principles of SCAN Interview

* - Based on definitions of items in SCAN glossary
* - Aims at comprehensive assessment of symptoms and signs
* - Clinically semi-structured interview with additional probes, if judged necessary by clinician
* - Ratings based on judgement of clinician
* - Flexible order of administration according to state of patient and judgement of clinician

A sample item from SCAN (Version 2.0, p. 117) (1)

10.005 Overtalkativeness

Have people said that you talked too fast [\_\_][\_\_]

and too much so that they couldn't understand

you? Or do you feel pressure to keep talking?

Use SCALE 1

If > 2 years, consider cyclothymia

Glossary definition

Overtalkativeness: Respondents may sense a pressure to keep talking but, more often, it is the others who notice an abnormality. Speech is fluent, rapid and loud. There may be overcircum-stantiality and shifts of topic, bur conversation can be conducted with wit. It may be possible to rate this item from self-description, but respondents may also report the comments of others at the time which corroborate their account.

A sample item from SCAN (Version 2.0, p. 189)(2)

22.014 Distractibility

Changes behaviour or speech inappropriately [\_\_][\_\_]

though attending to irrelevant noises or events or objects

Use RATING SCALE III

Glossary definition

Distractibility: The respondent's attention is taken up by trivial events occurring while the interview proceeds which usually would not be noticed, let alone interfere with the interview. The respondent is unable to sustain attention for a period required by the task at hand. The subject may remark on the wallpaper instead of replying to a question, or break off to comment on the furniture or the sound of someone walking by. If this is occurring continuously, rate (2). If it occurs quite markedly but not continuously, rate (1).

Write down an example.

COMPARISON BETWEEN CIDI AND SCAN

|  |  |
| --- | --- |
| CIDI | SCAN |
| Fully structured | Semi-structured |
| Applied by lay-iterviewer | Applied by clinician |
| Probe-flow chart | "Cross-examination" |
| Based on answers of subject (no interviewer’s interpretation) | Ratings reflect interviewer’s interpretation |
| Selection of items based on diagnostic criteria | Aims at comprehensive assessment |

* Computer scoring programme
* Specific training needed
* Coverage of ICD-10 and DSM IV diagnoses
* Available in many languages
* Network of training centers available

**INTERNATIONAL PERSONALITY DISORDER EXAMINATION (IPDE)**

Purpose to assess the phenomenology and life experiences relevant to the diagnosis of personality disorders in the ICD-10 and DSM-IV classification systems.

Type of instrument Structured clinical interview schedule with semi-standardized probes

* module for ICD-10 diagnoses
* module for DSM-IV diagnoses
* screening questionnaire

User Psychiatrists or psychologists

Training Essential (3 days)

Administration time 1,5 - 3 hours

Description:

152 items arranged under 6 headings:

work

self

interpersonal relationships

affects

reality testing

impulse control

items are introduced by open-ended queries that offer the individual opportunity to discuss topic before answering

answers need to be supplemented by examples

additional questions to determine whether the individual has met frequency, duration and age of onset requirements (duration should be at least 5 years; at least one criterion to be met before age 25)

second scoring column for data from informants

last 6 items to be scored by interviewer based on observation during interview

Sample item from IPDE (1): questions

Preoccupation with details, lists, order, organization, or schedules to the extent that the major point of activity is lost

DSM-III-R Obsessive Compulsive: 2

Preoccupation with details, rules, lists, order, organization or schedule

ICD-10 Anankastic (obsessive compulsive): 2

Are you fussy about little details?

If yes: Do you spend much more time on them than you really have to?

If yes: Does that prevent you from getting much work done as you're expected to do?

If yes: Tell me about it.

Do you spend so much time scheduling and organizing things that you don't have any time left to do the job you're really supposed to do?

If yes: Tell me about it.

Sample item from IPDE (2): commentary

The subject is so concerned with the method or details of accomplishing a task or objective, that they almost become an end in themselves, consuming much more time and effort than is necessary, and thereby preventing the task from being accomplished or markedly prolonging the time required to achieve the objective. The subject need not display all of the features enumerated in the criterion.

2 Convincing evidence supported by examples that the behaviour frequently interferes with reasonable expectations of productivity.

1 Convincing evidence supported by examples that the behaviour occasionally interferes with reasonable expectations of productivity.

0 Denied, rare, or the consequences are insignificant.

**WHO DISABILITY ASSESSMENT SCHEDULE (DAS)**

Purpose: Evaluation of social functioning, and some of the factors influencing it.

Type of instrument: Semi-structured clinical assessment schedule

User: Psychiatrists, psychologists, sociologists or social workers

Training: Essential (2 days)

Administration time: 30 minutes

Description

97 items, divided in 5 parts:

Part 1: Overall behaviour (including self-care, under-activity, slowness, social withdrawal)

Part 2: Social role performance

Part 3: Functioning in hospital

Part 4: Modifying factors, such as specific assets and specific liabilities, home atmosphere, outside support

Part 5: Global evaluation

Part 6: Summary of ratings and scoring

Sample item

2. Social role performance

2.1 Participation in household activities during past month

Inquire about:

(i) patient's participation in common activities Card of the household, such as having meals together, Column doing domestic chores, going out or visiting together, playing games, watching television, etc.;

(ii) patient's participation in decision-making concerning the household, e.g. decisions about the children, money, etc. For housewives, consider the household jobs that a housewife usually has to do.

Make a rating without regard to whether the patient is asked to participate, left on his/her own or rejected [\_\_] 38 in some way.

RATING SCHEDULE

Rate 8 if information not available and 9 if item not applicable

No dysfunction: patient participates in household 0 -- activities as much as is expected for his/her age, sex, position in the household, and sociocultural context.

Minimum dysfunction: patient participates less than 1 -- would be expected and has little interest in (ii), although such participation would normally be expected for someone in similar circumstances.

Obvious dysfunction: ....... 2 --

Serious dysfunction: ........ 3 --

Very serious dysfunction: ......... 4 --

Maximum dysfunction: patient totally excludes him 5 --

self/herself, or is excluded, from participation in any common household activities; disrupts the functioning of the household as a unit.

Chapter number and designation Range of codes

I Certain infectious and parasitic diseases A00-B99

II Neoplasms C00-D48

III Disease of the blood and bloodforming organs and certain disorders involving the immune mechanism D50-D89

IV Endocrine, nutritional and metabolic diseases E00-E90

V Mental and behavioural disorders F00-F99

VI Diseases of the nervous system G00-G99

VII Diseases of the eye and adnexa H00-H59

VIII Diseases of the ear and mastoid process H60-H95

IX Diseases of the circulatory system I00-I99

X Diseases of the respiratory system J00-J99

XI Diseases of the digestive system K00-K93

XII Disease of the skin and subcutaneous tissue L00-L99

XIII Diseases of the musculo-skeletal M00-M99 system and connective tissue

ICD-10 COMPOSITION OF CHAPTERS (2)

Chapter number and designation Range of codes

XIV Disease of the genito-urinary system N00-N99

XV Pregnancy, childbirth and the puerperium O00-O99

XVI Certain conditions originating in the perinatal period P00-P95

XVII Congenital malformations, deformations, and chromosomal abnormalities Q00-Q99

XVIII Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified R00-R99

XIX Injury, poisoning and certain other consequences of external causes S00-T98

XX External causes of morbidity and mortality V01-Y98

XXI Factors influencing health status and contact with health services Z00-Z98

EXAMPLES (1)

Chapter XX External causes of morbidity and mortality

Intentional self-harm (X60-X84)

X61 Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified (Includes: barbiturates, tranquillizers, etc.)

X70 Intentional self-harm by hanging, strangulation and suffocation

X80 Intentional self-harm by jumping from a high place

EXAMPLES (2)

Chapter XXI Factors influencing health status and contact with health services

Persons encountering health services for examination and investigation (Z00-Z13)

Z03.2 Observation for suspected mental and behavioural disorders

Z04.6 General psychiatric examination, requested by authority

Persons with potential health hazards related to socioeconomic circumstances (Z55-Z65)

Z55 Problems related to education and literacy

Z55.3 Underachievement in school

Z56 Problems related to employment and unemployment

Z56.2 Threat of job loss

Z60 Problems related to social environment

Z60.3 Acculturation difficulty

Z65 Problems related to other psychosocial circumstances

Z65.4 Victim of crime and terrorism (Includes victim of torture)

FAMILY OF DISEASE AND HEALTH-RELATED CLASSIFICATIONS

INTERNATIONAL STATISTICAL CLASSIFICATION OF DISEASES AND RELATED HEALTH PROBLEMS

ICD-10

ICD 3-character core

Short tabulation lists

ICD

4-character classification

OTHER HEALTH RELATED CLASSIFICATIONS

Classification of Impairments, Disabilities and Handicaps

Procedures

Reasons for encounter (complaints)

INTERNATIONAL NOMENCLATURE OF DISEASES (IND)

Objectives:

to provide, for each morbid entity, a single recommended name
to provide for each disease a definition, as unambiguous and brief as possible
to provide synonyms for each disorder after each definition
Available:

Diseases of the lower respiratory tract (WHO, 1979)
Cardiac and vascular diseases (WHO, 1989)
Diseases of the digestive system (WHO, 1990)
Metabolic, nutritional and endocrine disorders (WHO, 1991)
Diseases of the kidney, the lower urinary tract, and the male genital system (WHO, 1992)
Diseases of the female genital system (WHO, 1992)
Infectious diseases (WHO, 1992)

STRUCTURE OF AN ICD-10 CODE

mental and behavioural disorders
section on schizophrenia and related disorders
schizophrenia
hebephrenic type
continous course

An extra number may be used as a subdivision for special purposes

ADMINISTRATIVE VERSION OF ICD-10 CHAPTER V

Aims: to provide administrators in psychiatric hospitals and psychiatrists, concerned with coding, with a convenient tool

Contents: ICD-10 chapter V, including glossary definitions

Other conditions, frequently seen in mental health care facilities

Conversion tables between ICD-8, -9, -10 and ICD-9-CM (Clinical Modification)

Index

APPLICATION OF ICD-10 TO NEUROLOGY

(ICD-NA, SECOND EDITION)

Aims:
To provide a code for each recognized neurological disorder
To encourage making detailed diagnoses and the recording of all disorders present
To provide standard recording system for neurological disorders, available in several languages
To facilitate national and international epidemiological research for support of programmes of prevention and control of neurological disorders

APPLICATION OF ICD-10 TO NEUROLOGY

(ICD-10 NA)

Contents:
Instructions and recommendations for the use of ICD-10 NA
Tabular list of neurological and related disorders
Morphology of neoplasms, numerical list
Acknowledgements
Index, including list of drugs and chemicals

EXAMPLE OF A CATEGORY IN THE ICD-10 NA

G43 Migraine

Use additional external cause code (Ch.XX) if desired to identify drug, if drug-induced

Excludes : headache NOS (R51)

atypical facial pain (G50)

G43.0 Migraine without aura

[common migraine]

G43.1 Migraine with aura [classical migraine]

G43.10 With typical aura

G43.11 With prolonged aura

G43.12 With acute onset aura

Use sixth character, if desired, to identify neurological symptoms:

G43.1x0 Hemianoptic and other visual migraine

G43.1x1 Hemisensory migraine

G43.1x2 Migraine with aphasia

G43.1x3 Basilar migraine

G43.1x4 Migraine aura (all types) without headache

G43.1x5 Familial hemiplegic migraine

G43.1x7 Multiple types of aura

G43.1x8 Other specified migraine with aura

ICD-10 GUIDES IN DEVELOPMENT

Headaches

Mental retardation

Cerebrovascular disorders

Epilepsy

Movement disorders

ICD-10 CHAPTER V: MAIN INNOVATIONS

EXPANSION OF THE PROVISION FOR CATEGORIES IMPORTANT FOR GENERAL HEALTH CARE
BRINGING TOGETHER RELATED CATEGORIES
CONCEPTUAL CHANGES FOR PUBLIC HEALTH REASONS

MAIN INNOVATIONS (1)

EXPANSION OF THE PROVISION FOR CATEGORIES IMPORTANT FOR GENERAL HEALTH CARE

Acute and transient psychotic disorders
Somatoform disorders
Stress-related disorders
ICD-9 rubric "Sexual deviations and disorders" split into three categories: Disorders of sexual preference, gender identity disorders and sexual dysfunctions
Childhood and developmental disorders

MAIN INNOVATIONS (2):

BRINGING TOGETHER RELATED CATEGORIES

Organic disorders
Alcohol and drug-related disorders
Affective disorders
Disorders with onset specific to childhood and adolescence

MAIN INNOVATIONS (3):

CONCEPTUAL CHANGES FOR PUBLIC HEALTH REASONS

Substance abuse section: 3-character code for the substance involved
"Culture-bound" syndromes to be classified according to predominant psychopathology

ICD-10: CHAPTER V: CALENDAR OF EVENTS

1964-1976 "Programme A"
1980-1981 Reviews of Literature and Scientific Group Meetings
1981 Copenhagen "Strategic" Conference
1983-1996 Drafting of texts; technical meetings; circulation of texts & revisions
1987 Prefinal draft
1987-1990 Field tests of Clinical Guidelines & Research Criteria
1992 Publication of Clinical Guidelines
1993 Publication of Research Criteria
1991-1995 Completion of tests of PHC version, multiaxial version and instruments
1996 Publication of PHC version,
1997 multiaxial version and instruments (CIDI, SCAN, IPDE)
1965-1996: DEVELOPMENT OF A COMMON LANGUAGE IN PSYCHIATRY (1)
1965-1974 WHO Programme A

Aims:

standardization of psychiatric diagnosis, classification and statistics
development of transculturally applicable and acceptable instruments for reliable assessment of the mentally ill

Resulting inter alia in:

ICD-8 (1967) with GLOSSARY;
the Present State Examination (PSE) and other crossculturally applicable instruments
and a collaborative, global network

1965-1974 Collaborative international research with important implications for diagnosis and classification:

UK-US Diagnostic study on psychiatric diagnosis
WHO International pilot study of schizophrenia (IPSS)

1965-1996: DEVELOPMENT OF A COMMON LANGUAGE IN PSYCHIATRY (2)

1972-1975 Diagnostic Criteria for Research (Feighner and Spitzer)

1978-1986 International study on longterm course and outcome of schizophrenia;

International studies on depression and disability

1980 DSM-III

1983-1993 Development of ICD-10 Chapter V: International Classification of Mental and Behavioural Disorders:

AIMS OF ICD-10 CHAPTER V

to facilitate medical practice and public health action by providing a common language to all concerned.

The acceptance of the diagnostic and classification system proposed in the ICD-10 will enable mental health workers, public health decision makers, statisticians and professionals in disciplines relevant to psychiatry:

to understand one another
to share results of research
to improve and unify training strategies

FEATURES OF ICD-10 CHAPTER V (1)

based on consensus
based on field trials
developed in collaboration between a Governmental Organization (WHO) and non-Governmental Organizations (WPA, WFN, AD, etc.)
developed simultaneously in many languages
rendered compatible with national classifications
developed in collaboration with a network of centres around the world participating in relevant research, undertaking translation and providing training and support to users

FEATURES OF ICD-10 CHAPTER V (2)

composed of a family of documents:
different versions of the classification:
short definitions
guidelines for diagnosis
criteria for research
primary health care version
multiaxial presentation
tools:
conversion tables between ICD-10 and previous revisions
lexicon of psychiatric and mental health terms
lexicon of alcohol and drug terms
lexicon of culture-specific terms in mental health
casebook
training materials - linked to assessment instruments

FEATURES OF ICD-10 CHAPTER V (3)

BASED ON CONSENSUS (1)

STEPS:

Review of evidence by individual experts,
A series of workshops each devoted to a disease group,
A summary strategic conference
Establishment of a special advisory group to help in setting up the framework for the classification
Selection and invitation of experts to draft definitions, guidelines and criteria for research
Production of draft texts by some 50 experts from different parts of the world and from different schools of psychiatry
Circulation of texts to experts organized in panels for the different groups of disorders

FEATURES OF ICD-10 CHAPTER V (4)

BASED ON CONSENSUS (2)

STEPS (continued):

Circulation of amended drafts to nongovernmental organizations representing psychiatry and other disciplines.
Circulation of drafts to member societies of the NGO's and meetings with groups preparing national classifications (e.g. DSM IV, French classification of disorders in childhood)
Presentation of drafts to heads of ICD-10/MH centres for comments and approval from the point of view of translatability
Finalization of drafts and field trials
Finalization of texts, taking into account results of field trials

FEATURES OF ICD-10 CHAPTER V (5)

BASED ON FIELD TRIALS (1)

Overview of field trials of different versions Version Countries Centers Clinicians Patients
Clinical 39 112 711 15,302
Research 32 150 150 13,793
Multiaxial 35 75 200 4,330
Primary care 45 20 564 3,123

FEATURES OF ICD-10 CHAPTER V (6)

BASED ON FIELD TRIALS (2)

Objectives of field trials of the classification and of the clinical descriptions and diagnostic guidelines (1987 draft):

I. Assessment of ease to understand and to use thenew classification

II. Assessment of goodness of fit in routine clinical practice

III. Assessment of inter-rater reliability of users in different countries and internationally

FEATURES OF ICD-10 CHAPTER V (7)

BASED ON FIELD TRIALS (3)

Results from the Clinical Descriptions and Diagnostic Guidelines version field trials (1)

Clinicians' assessment:

easy to use 85%
good fit 82%
feeling confident in making diagnosis 91%
reliability: weighted kappas .60 - .100

FEATURES OF ICD-10 CHAPTER V (8)

BASED ON FIELD TRIALS (4)

Results from the Clinical Descriptions and Diagnostic Guidelines version field trials (2)

Interrater reliability for major groups of disorders (kappa coefficients)

F0: 0,78 F5: 0,91

F1: 0,80 F6: 0,51

F2: 0,82 F7: 0,77

F3: 0,77 F8: not enough cases

F4: 0,74 F9: 0,74

overall agreement: at 2 character level: 0,81

at 3 character level: 0,71 at 4 character level: 0,59

FEATURES OF ICD-10 CHAPTER V (9)

DEVELOPED SIMULTANEOUSLY IN MANY LANGUAGES

ARABIC
CHINESE
ENGLISH
FRENCH
GERMAN
JAPANESE
PORTUGUESE
RUSSIAN
SPANISH

OTHER LANGUAGES INTO WHICH ICD-10 CHAPTER V HAS BEEN TRANSLATED
(until march 1996)

BULGARIAN
CROATIAN
CZECH
DANISH
DUTCH
ESTONIAN
FARSI (IRAN)
GREEK
HEBREW
HUNGARIAN
INDONESIAN
ITALIAN
KOREAN
LATVIAN
LITHUANIAN
NORWEGIAN
POLISH
RUMANIAN
SERBIAN
SWEDISH
THAI
TURKISH
UKRAINIAN
VIETNAMESE

FEATURES OF ICD-10 CHAPTER V (10)

RENDERED COMPATIBLE WITH NATIONAL CLASSIFICATIONS AND CLASSIFICATIONS OF SPECIALTIES

DSM-III, DSM-IIIR, DSM-IV
French INSERM classification
French classification of childhood mental disorders
Indonesian official classification of mental disorders
Nordic countries' classification
Russian classification
classification of Alzheimer International Association
classification of epilepsy
classification of headaches
classification of sleep disorders
and others

DIFFERENCES BETWEEN ICD-10 AND A

NATIONAL OR SPECIALIST CLASSIFICATION (1)

ICD-10 National or specialists classifications
WHO Member States use ICD-10 for official reporting about disease and death The use of a national classification does not obviate the need to also report data in ICD-terms, for all official purposes
Continuity between revisions of the classification is considered essential Continuity is desirable;innovations are welcome
The general structure of ICD-10 imposes limitations on structure and contents of Chapter V No limitations concerning structure
Chapter V is part of a comprehensive classification of all diseases and disorders, and includes other reasons for contact of health services It is not part of an overall classification
Adopted by national governments and used for reporting by intergovernmental agencies (i.e. WHO) Approved by national or international professional organizations

DIFFERENCES BETWEEN ICD-10 AND A

NATIONAL OR SPECIALIST CLASSIFICATION (2)

ICD-10 National or specialist classifications
Translation into oter languages is an integral part of development May be translated after it as been developed
ICD-10 reflects current usage in psychiatry Is directive concerning utilization in practice
ICD-10 is a uniaxial classification which can be presented in a multiaxial way Different axes are independent
Developed in different versions for different users Ussually exists in only one version
Social criteria are as far as possible avoided Social criteria are used
ICD-10 is a member of a family of classifications Ussually independent, sometimes with various presentations

RELATIONSHIPS BETWEEN ICD-10 CHAPTER V AND DSM-IV

COLLABORATION IN DEVELOPMENT

Experts were involved who worked both on ICD-10 and DSM developments
Activities undertaken in the framework of the Joint Project of WHO and ADAMHA (USA), from 1982-1995 contributed to the scientific basis of both classifications
The National Institute of Mental Health (USA) has sponsored special meetings (during 1988-1991) to facilitate harmonious development of ICD-10 and DSM-IV
Field trials of ICD-10 and DSM-IV were carried out in the US and elsewhere (often in the same centres)

FEATURES OF ICD-10 CHAPTER V (11)

ESTABLISHMENT OF A NETWORK OF SUPPORT CENTRES AROUND THE WORLD:

WHO Training and Reference Centres on Classification, Diagnosis and Assessment of Mental and Behavioural Disorders (ICD-10/MH CENTRES)

coordinating field studies of clinical and research criteria

AARHUS
BANGALORE
BEIJING
CAIRO
LUBECK
LUXEMBOURG
MADRID
MOSCOW
NAGASAKI
OXFORD
ROCKVILLE

FAMILY OF DOCUMENTS RELATED TO ICD-10 CHAPTER V

MENTAL AND BEHAVIOURAL DISORDERS

composed of a family of documents:
different versions of the classification:
short definitions
guidelines for diagnosis
criteria for research
primary health care version
multiaxial presentation

tools:
conversion tables between ICD-10 and previous revisions
lexica and glossaries
casebook
training materials

linked to assessment instruments
Composite International Diagnostic Interview (CIDI)
Schedules for Clinical Assessment in Neuropsychiatry (SCAN)
International Personality Disorder Examination (IPDE)

GLOSSARY DEFINITIONS IN ICD-10: EXAMPLE

F23.2 Acute schizophrenia-like psychotic disorder

An acute psychotic disorder in which the psychotic symptoms are comparitively stable and justify a diagnosis of schizophrenia, but have lasted for less than about one month. If the schizophrenic symptoms persist the diagnosis should be changed to schizophrenia (F20.-)

Acute (undifferentiated) schizophrenia

Brief schizophreniform disorder or psychosis

Oneirophrenia

Schizophrenic reaction

Excludes: organic delusional [schizophrenia-like disorder (F06.2)

schizophreniform disorder NOS (F20.8)

CLINICAL DESCRIPTIONS AND DIAGNOSTIC GUIDELINES

Characteristics:

For general clinical and educational use
Users: psychiatrists and other mental health workers
Narrative style of description of the main clinical features of each disorder
Diagnostic guidelines, indicating the number of symptoms usually required for a confident diagnosis
Allows for a provisional diagnosis, even if not all criteria are fullfilled

CLINICAL DESCRIPTIONS AND DIAGNOSTIC GUIDELINES

Example:

F32.0 Mild depressive episode Diagnostic guidelines

Depressed mood, loss of interest and enjoyment, and increased fatiguability are usually regarded as the most typical symptoms of depression, and at least two of these, plus at least two of a list of other common symptoms (e.g. decreased self-esteem, disturbed sleep) should usually be present for a definite diagnosis. None of the symptoms should be present to an intense degree. Minimum duration of the whole episode is about 2 weeks.

An individual with a mild depressive episode is usually distressed by the symptoms and has some difficulty in continuing with ordinary work and social activities, but will probably not cease to function completely.

DIAGNOSTIC CRITERIA FOR RESEACH

Characteristics

For use in psychiatric research
Contains precise criteria for diagnoses
Does not contain descriptions of clinical concepts and must therefore be used in conjunction with the "Clinical Descriptions and Diagnostic Guidelines"
Criteria are restrictive so as to maximize homogeneity of groups of patients in research

DIAGNOSTIC CRITERIA FOR RESEARCH

Example:

F32 Depressive episode
G1 The depressive episode should last for at least 2 weeks.
G2 There have been no hypomanic or manic symptoms sufficient to meet the criteria for hypomanic or manic episode (F30.-) at any time in the individual's life.
G3 Most commonly used exclusion clause: The episode is not attributable to psychoactive substance use (F10-F19) or to any organic mental disorder (in the sense of F00-F09).

F32.1 Moderate depressive episode

A. The general criteria for depressive episode (F32) must be met.
B. At least two of the three symptoms listed for F32.0, criterion B (i.e. depressed mood, loss of interest or pleasure, decreased energy or increased fatiguability), must be present.
C. Additional symptoms from a list of 7 (e.g. sleep disturbance, change in appetite)(described in F32.0, criterion C), must be present, to give a total of at least six.

A fifth character .x0 or .x1 may be used to specify the presence or absence of the "somatic syndrome" (also called "vital" or "melancholic" in other classifications). To qualify for this syndrome 4 from a list of 7 symptoms must be present (e.g. depression worse in the morning).

PRIMARY HEALTH CARE VERSION (ICD-10 PHC)

Basic features:

- reduced number of categories:

version with 24 categories
version with 6 categories

- brief definitions
- uses familiar diagnostic terms
- offers guidelines for recognition
- offers guidelines for management

PRIMARY HEALTH CARE VERSION (ICD-10 PHC)

ICD-10 categories which were selected for ICD-10 PHC

- groups of disorders of public health importance

- high prevalence

- associated with significant disablement, morbidity or mortality

- associated with significant burden on family

- health care resources needed to help people with the condition

- for which it is posible to provide effective and acceptable management in PHC setting

List of categories

F00\* Dementia
F05 Delirium
F10 Alcohol use disorder
F11\* Drug use disorders
F17.1 Tobacco use
F20 Chronic psychotic disorders
F23\* Acute psychotic disorders
F31 Bipolar disorder
F32\* Depression
F40\* Phobic disorders
F41.0 Panic disorder
F41.1 Generalized anxiety disorder
F41.2 Mixed anxiety and depression
F43\* Adjustment disorders
(Z63\* Bereavement)
F44\* Dissociative disorder
F45 Unexplained somatic complaints
F48.0 Neurasthenia
F50\* Eating disorders
F51\* Sleep problems
F52 Sexual disorders
F70 Mental retardation
F90 Hyperkinetic disorder
F91 Conduct disorder
F98.0 Enuresis

\* An asterisk indicates that more than one ICD-10 code is included (e.g. F00\* includes disorders coded in F00-F04)

Components of ICD-10 PHC

listing of categories
diagnostic and management guidelines for each category
flow-charts
symptom index
supporting material:
patient leaflets
medication cards

For each disorder

Diagnostic guidelines

presenting complaints
diagnostic features
differential diagnosis

Management guidelines

essential information for patient and family
specific counselling for patient and family
medication
need for specialist consultation

Example: DEMENTIA F00 (1)

Presenting complaint

Patients may complain of forgetfulness or feeling depressed, but may be unaware of memory loss. Patients and family may sometimes deny severity of memory loss.

Families ask for help initially because of failing memory, change in personality or behaviour in later stages because of confusion, wandering, or incontinence.

Poor personal hygiene in an older patient may indicate memory loss

Example: DEMENTIA F00 (2)

Diagnostic features

Decline in recent memory, thinking and judgement, orientation, language

Patients often appear apathetic or disinterested, but may appear alert and appropriate despite poor memory.

Decline in everyday functioning (dressing, washing, cooking).

Loss of emotional control - patients may be easily upset, tearful or irritable.

Common in older patients, very rare in youth or middle age.

Tests of memory and thinking include:

* ability to recall names of three common objects immediately and again after three minutes,
* ability to name days of week in reverse order.

Example: DEMENTIA F00 (3)

Differential diagnosis

Examine for other illnesses causing memory loss.

Examples include:

depression (F32\*) anaemia

urinary infection vitamin B12 or folate

HIV infection deficiency

siphilis normal pressure

subdural haematoma hydrocephalus

other infectious illnesses

Prescribed drugs or alcohol may affect memory and concentration.

Sudden increases in confusion may indicate a physical illness (i.e. acute infectious illness) or toxicity from medication. If confusion, wandering attention or agitation are present, see Delirium F05.

Depression may cause memory and concentration problems similar to those of dementia, especially in older patients. If low or sad mood is prominent, see Depression F32\*.

Example: DEMENTIA F00 (4)

Management guidelines:

Essential information for patient and family

Dementia is frequent in old age

Memory loss and confusion may cause behaviour problems (e.g. agitation, suspiciousness, emotional outbursts).

Memory loss usually proceeds slowly, but course is quite variable.

Physical illness or mental stress can increase confusion

Provide available information and describe community resources

Example: DEMENTIA F00 (5)

Management guidelines:

Specific counselling to patient and family

Monitor the patient's ability to perform daily tasks

Consider use of memory aids or reminders if memory loss is mild

Avoid placing patient in unfamiliar places or situations

Consider ways to reduse stress on those caring for the patient (e.g. self-help groups). Support from other families caring for relatives with dementia may be helpful

Discuss planning of legal and financial affairs

As appropriate, discuss arrangements for support in the home, community or day care programmes, or residential placement

Uncontrollable agitation may require admission to a hospital or nursing home

Example: DEMENTIA F00 (6)

Management guidelines:

Medication

Use sedative or hypnotic medications (e.g. benzodiazepines) cautiously; they may increase confusion.

Antipsychotic medication in low doses (e. g. haloperidol 0.5 to 1.0 mg once or twice a day) may sometimes be needed to control agitation, psychotic symptoms or aggression. Beware of drug side-effects (Parkinsonian symptoms, anticholinergic effects) and drug interactions.

Example: DEMENTIA F00 (7)

Management guidelines:

Specialist consultation

Consider consultation for

uncontrollable agitation
sudden onset or worsening of memory loss
physical causes of dementia requiring specialist treatment (e.g. syphilis, subdural haematoma)

Consider placement in a hospital or nursing home if intensive care is needed

MULTIAXIAL PRESENTATION OF ICD-10

Why do we need axes1?

To provide a comprehensive description of the patient's condition, which is likely to facilitate:

appropriate decisions about therapy
an accurate prognosis

To facilitate the interpretation of statistics from health facilities

To facilitate coordination of interventions by different health professionals (e.g. psychiatrist and social workers)

To allocate health care resources in a efficient way

Axis I Clinical diagnoses

mental disorders

physical disorders

personality disorders

Chapters I to XX of ICD-10

Axis II Disability (following the principles of ICIDH)rating of 4 specific areas of functioning

Axis III Contextual factors (selected ICD-10 Z-codes: Chapter XXI)environmental and life style factors relevant to pathogenesis and course of patient's illness

Axis II Disability1

personal care
occupation
family and household
functioning in broader social context rating of specific areas of functioning on a scale of 6 points, which are defined in operational terms

Axis III Contextual factors (selected ICD-10 Z-codes: Ch. XXI)

problems related to negative events in childhood
problems related to education and literacy
problems related to primary support group, including family circumstances
problems related to social environment
problems related to housing or economic circumstances
problems related to (un)employment
problems related to physical environment
problems related to certain psychosocial circumstances
problems related to legal circumstances
problems related to family history of diseases or disabilities
problems related to life-style and life-management difficulties

Example of a multiaxial diagnostic formulation

Axis I: CLINICAL DIAGNOSES

Somatization disorder F45.0

Axis II: DISABILITIES

ratings (0-5)

A. Personal care . . . 0

B. Occupation . . . 1

C. Family and household . . 1

D. Broader social context . 2

Axis III: CONTEXTUAL FACTORS

Acculturation difficulty Z60.3

CONVERSION TABLES BETWEEN ICD-8, -9, -10 AND ICD-9-CM (CLINICAL MODIFICATION)

example

ICD-10 ICD-9 ICD-8
F50 Eating disorders 306.5 Feeding disturbances
F50.0 Anorexia nervosa 307.1 Anorexia nervosa
F50.1 Atypical anorexia
F50.2 Bulimia nervosa
F50.3 Atypical bulimia
F50.4 Overeating and F50.5 Vomiting associated with other psychological disturbance
F50.8 Other eating disorder
F50.9 Eating disorder, unspecified 307.5 Other unspecified disorders of eating

ICD-10 CASEBOOK

The Many Faces of Mental Disorders-

Adult Case Histories

According to ICD-10

Provides case histories illustrating disorders classified in F0-F6 of Chapter V of ICD-10, accompanied by discussions of the diagnosis

Example of a case history (shortened): Mr X, a 35-year old factory worker, married, with 3 children, was admitted to a general hospital, after having broken his leg by falling of the stairs.

On the third day of his stay, he grew increasingly nervous and started to tremble. During the night he could not sleep, talked incoherently and was obviously very anxious.

According to his wife, Mr X had drunk large quantities of beer each night after he came home until he would fall asleep, for over three years. At the night of admissal, he had slipped on the stairs when he came home, breaking his leg, before having his first beer. During the past year he had missed work several times and had been threatened with dismissal. He had a car accident when drunk two years before, but without any major injury. His father had been a chronic alcoholic and died from liver cirrhosis, when Mr X was 24 years old.

On examination Mr X spoke incoherently. He was disoriented in time, place, and at times also in person. On several occasions he picked at bugs that he could see on his blanket. He trembled and sweated profusely. He tried constantly to get out of bed and seemed unaware that his right leg was in plaster.

Example of discussion of the diagnosis (shortened): Mr X

Mr X had a long history of heavy alcohol use and developed severe withdrawal symptoms when he could not get alcohol. He presented with the characteristic symptoms of a delirium: clouding of consciousness, global disturbance of cognition, psychomotor agitation, disturbance of the sleep-wake cycle, rapid onset and fluctuation of the symptoms. Since there were no convulsions, the diagnosis according to ICD-10 is

F10.40 Alcohol withdrawal state with delirium, without convulsions.

The information provided by his wife gives evidence pointing to an additional diagnosis of alcohol dependence syndrome: continuous heavy use during the last 3 years, difficulties in controlling the drinking and the presence of a withdrawal state. Although this is not enough for a definite diagnosis according to ICD-10, a provisional additional diagnosis may be made:

F10.24 Alcohol dependence syndrome, currently using the substance.

LEXICA OF TERMS

Lexicon of psychiatric and mental health terms, WHO, Geneva, 1989

Provides definitions of over 300 terms that appear in the text of ICD-9 Chapter V.

Lexicon of psychiatric and mental health terms. 2nd edition. WHO, Geneva, 1994

Provides definitions of some 700 terms that appear in the text of ICD-10, Chapter V.

Lexicon of alcohol and drug terms. WHO, Geneva (1994)

Provides definitions of terms related to use, abuse and dependence of psychoactive substances. For each general class of psychoactive drugs the definitions include information on effects, symptomatology, sequelae, and therapeutic indiations. Social as well as health aspects of drug use and problems related to use are covered.

Lexicon of culture-specific terms in mental health. WHO, Geneva (1997)

Facilitates the use of the ICD-10 Classification of Mental and Behavioural Disorders in various cultural settings. It contains definitions of terms, concepts, symptoms and syndromes, that are important for the understanding of human experience in a socio-cultural setting.

APPLICATION OF THE INTERNATIONAL CLASSIFICATION OF MENTAL AND BEHAVIOURAL DISORDERS

1. Basic coding rules
2. General conventions on use of terminology

BASIC CODING RULES (1)

Use as many diagnoses as are necessary to describe the condition of the patient
Record main diagnosis first
Write down both your own diagnosis in words and the ICD-10 category to which it is assigned

BASIC CODING RULES (2)

Main diagnosis precedence should be given to that diagnosis most relevant to the purpose for which the diagnoses are being collected in clinical work the main diagnosis is usually the reason for consultation or contact with health services in case of doubt about what the main diagnosis is, follow the numeric order of ICD-10

BASIC CODING RULES (3)

Levels of diagnostic confidence

Confidence in diagnostic categorization may be expressed as follows:

definite: Criteria are fulfilled for a specific category of ICD-10

provisional: Criteria are not completely fulfilled

More information will probably become available, after which the criteria will most likely be fulfilled probable: Criteria are not fulfilled. More information cannot be obtained, current diagnosis is the most likely under the circumstances

BASIC CODING RULES (4)

Example of the different elements of a diagnosis according to ICD-10

Main diagnosis: F32.2 Severe depressive episode without psychotic symptoms

Other diagnoses: X70 Intentional self-harm by hanging, strangulation and suffocation

F10.2 Alcohol dependence syndrome

F60.7 Dependent personality disorder

K29.2 Alcoholic gastritis

Z56.2 Threat of job loss

GENERAL CONVENTIONS ON USE OF TERMINOLOGY (1)

DISORDER

The term "disorder" is used throughout the classification. Although it is recognized that "disorder" is not an exact term, its use avoids even greater problems inherent in the use of terms such as "disease" and "illness".

The term "disorder" implies the existence of a clinically recognizable set of symptoms or behaviour, associated in most cases with distress and with interference with personal functions.

Social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder as defined here.

GENERAL CONVENTIONS ON USE OF TERMINOLOGY (2)

ORGANIC and SYMPTOMATIC

The term "organic" is used for those syndromes that can be attributed to an independently diagnosable cerebral or systemic disease or disorder

Use of the term "organic" does not imply that conditions elsewhere in the classification are "nonorganic" in the sense of having no cerebral substrate

The term "symptomatic" is used for those organic mental disorders in which cerebral involvement is secondary to a systemic extracerebral disease of disorder

GENERAL CONVENTIONS ON USE OF TERMINOLOGY (3)

PSYCHOTIC

The term "psychotic" has been retained as a convenient descriptive term, particularly in F23, Acute and transient psychotic disorders

Its use does not involve assumptions about psychodynamic mechanisms

The term "psychotic" is used only to indicate the presence of hallucinations, delusions, or a limited number of severe abnormalities of behaviour (such as abnormal excitement and overactivity, marked psychomotor retardation, and catatonic behaviour)

GENERAL CONVENTIONS ON USE OF TERMINOLOGY (4)

NEUROTIC

The traditional division between neurosis and psychosis, that was evident in ICD-9 is not longer used in ICD-10

However, the term "neurotic" is still retained for occasional use and occurs, for instance, in the heading of section F4 "Neurotic, stress-related and somatoform disorders"

Most of the disorders regarded as neuroses by those who still use the concept (except depressive neurosis) are to be found in block F40 - F48

GENERAL CONVENTIONS ON USE OF TERMINOLOGY (5)

PSYCHOGENIC

The term "psychogenic" has not been used in the titles of categories, in view of its different meanings in different languages and psychiatric traditions

It still occurs occasionally in the text, and should be taken to indicate that the diagnostician regards obvious life events or difficulties as playing an important role in the genesis of the disorder

GENERAL CONVENTIONS ON USE OF TERMINOLOGY (6)

PSYCHOSOMATIC

The term "psychosomatic" has not been used in the titles of categories, in view of its different meanings in different languages and psychiatric traditions, and because use of this term might be taken to imply that psychological factors play no role in the occurrence, course and outcome of other diseases that are not so described

Disorders described as psychosomatic in other classifications can be found in ICD-10 in F45 (Somatoform disorders), F50 (Eating disorders), F52 (Sexual dysfunction), and F54 (Psychological or behavioural factors associated with disorders or diseases classified elsewhere)

GENERAL CONVENTIONS ON USE OF TERMINOLOGY (7)

IMPAIRMENT, DISABILITY, HANDICAP

The terms "impairment, "disability" and "handicap" are used according to the recommendation of WHO (International classification of impairments, disabilities and handicaps, Geneva, WHO, 1980)1\*

"Impairment" is defined as: "loss or abnormality . . of structure or function". Many types of psychological impairment have always been recognized as psychiatric symptoms

"Disability" is defined as: "a restriction or lack . . of ability to perform an activity in the manner or within the range considered normal for a human being". Disability at the personal level includes ordinary activities of daily living (such as washing, dressing, eating and excretion), is influenced little, if at all, by culture, and may be used as a criterion for certain psychiatric diagnoses (such as dementia)

"Handicap" is defined as: "the disadvantage for an individual . . that prevents or limits the performance of a role that is normal . . for that individual", and represents the effects of impairments or disabilities in a wide social context that may be heavily influenced by culture. Handicap should not be used as a central component of a diagnosis

STRUCTURE OF ICD-10 CHAPTER V

F0 Organic and symptomatic mental disorders

F1 Mental and behavioural disorders due to psychoactive and other substance use

F2 Schizophrenia, schizotypal and delusional disorders

F3 Mood [affective] disorders

F4 Neurotic, stress-related and somatoform disorders

F5 Behavioural syndromes and mental disorders associated with physiological dysfunction

F6 Disorders of adult personality and behaviour

F7 Mental retardation

F8 Disorders of psychological development

F9 Behavioural and emotional disorders with onset usually occurring in childhood or adolescence

F99 Unspecified mental disorder

F00-F09 ORGANIC, INCLUDING SYMPTOMATIC, MENTAL DISORDERS

F00 Dementia in Alzheimer's disease

F01 Vascular dementia

F02 Dementia in other diseases classified elsewhere

F03 Unspecified dementia

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

F05 Delirium, not induced by alcohol and other psychoactive substances

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

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

F09 Unspecified organic or symptomatic mental disorder

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

F10 Alcohol

F11 Opioids

F12 Cannabinoids

F13 Sedatives and hypnotics

F14 Cocaine

F15 Other stimulants (incl. caffeine)

F16 Hallucinogens

F17 Tobacco

F18 Volatile solvents

F19 Multiple, other and unidentified substances

F20-F29 SCHIZOPHRENIA, SCHIZOTYPAL AND DELUSIONAL DISORDERS

F20 Schizophrenia

F21 Schizotypal disorder

F22 Persistent delusional disorders

F23 Acute and transient psychotic disorders

F24 Induced delusional disorder

F25 Schizoaffective disorders

F28 Other nonorganic psychotic disorders

F29 Unspecified nonorganic psychosis

F30-F39 MOOD [AFFECTIVE] DISORDERS

F30 Manic episode

F31 Bipolar affective disorder

F32 Depressive episode

F33 Recurrent depressive disorder

F34 Persistent mood [affective] disorders

F38 Other mood [affective] disorders

F39 Unspecified mood [affective] disorder

F40-F48 NEUROTIC, STRESS-RELATED AND SOMATOFORM DISORDERS

F40 Phobic anxiety disorders

F41 Other anxiety disorders

F42 Obsessive-compulsive disorder

F43 Reaction to severe stress, and adjustment disorder

F44 Dissociative [conversion] disorder

F45 Somatoform disorders

F48 Other neurotic disorders

F50-F59 BEHAVIOURAL SYNDROMES ASSOCIATED WITH PHYSIOLOGICAL DISTURBANCES AND PHYSICAL FACTORS

F50 Eating disorders

F51 Nonorganic sleep disorders

F52 Sexual dysfunction, not caused by organic disorder or disease

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

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

F55 Abuse of non-dependence-producing substances

F59 Unspecified behavioural syndromes associated with physiological disturbances and physical factors

F60-F69 DISORDERS OF ADULT PERSONALITY AND BEHAVIOUR

F60 Specific personality disorders

F61 Mixed and other personality disorders

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

F63 Habit and impulse disorders

F64 Gender identity disorders

F65 Disorders of sexual preference

F66 Psychological and behavioural disorders associated with sexual development and orientation

F68 Other disorders of adult personality and behaviour

F69 Unspecified disorder of adult personality and behaviour

F70-F79 MENTAL RETARDATION

F70 Mild mental retardation

F71 Moderate mental retardation

F72 Profound mental retardation

F78 Other mental retardation

F79 Unspecified mental retardation

F80-F89 DISORDERS OF PSYCHOLOGICAL DEVELOPMENT

F80 Specific developmental disorders of speech and language

F81 Specific developmental disorders of scholastic skills

F82 Specific developmental disorder of motor function

F83 Mixed specific developmental disorders

F84 Pervasive developmental disorders

F88 Other disorders of psychological development

F89 Unspecified disorder of psychological development

F90-F98 DISORDERS OF PSYCHOLOGICAL DEVELOPMENT

F90 Hyperkinetic disorders

F91 Conduct disorders

F92 Mixed disorders of conduct and emotions

F93 Emotional disorders with onset specific to childhood

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

F95 Tic disorders

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

F99 NON SPECIFIED MENTAL DISORDER

F99 Mental disorder, not otherwise specified

ASSESSMENT INSTRUMENTS LINKED TO ICD-10 CHAPTER V

Purposes:

to improve precision of assessment in psychiatry
to increase reliability of psychiatric assessment and diagnosis
to standardise data collection so as to
increase replicability and comparability across
to facilitate collaboration and communication among resarchers

Checklists ICD-10 Checklists Summary of assessment Clinicians
Composite International Diagnostic Interview Epidemiological surveys Lay interviewers
SCAN Schedules for Clinical Assessment in Neuropsychiatry Clinical research and practice Clinicians
IPDE International Personality Disorder Examination Clinical research Clinicians
DAS Disability Assessment Schedule Clinical research and practice Clinicians and other mental health workers
MODULES & MODIFICATIONS

ICD-10 CHECKLISTS

I. ICD-10 symptom checklist for mental disorders, accompanied by ICD-10 symptom glossary

II. International Diagnostic Checklists for ICD-10, accompanied by manual

ICD-10 SYMPTOM CHECKLIST FOR MENTAL DISORDERS

A semi-structured instrument intended for clinician's assessment of the psychiatric symptoms and syndromes in F0 - F6; accompanied by ICD-10 symptom glossary for mental disorders

Example: F0/F1 Module: Organic mental and psychoactive substance use syndromes

Organic mental disorders

A. Which of the following are present?

1. decline in memory [\_\_]

2. decline in other intellectual abilities [\_\_]

3. deterioration in emotional control, social behaviour or motivation [\_\_]

4. impairment of consciousness and attention [\_\_]

5. disturbances of perception or disorientation [\_\_]

6. psychomotor disturbances [\_\_]

7. disturbance of the sleep-wake cycle [\_\_]

8. rapid onset and diurnal fluctuations of symptoms [\_\_]

ICD-10 SYMPTOM GLOSSARY FOR MENTAL DISORDERS

Provides brief descriptions of the symptoms and terms used in the criteria in the F0 - F6 categories and has been developed as a companion to the checklist

Example:

Decline in memory

A decline in the registration, storage and retrieval of new information. Previously learned and familiar material may also be lost, particularly in the later stages of dementia.

COMPOSITE INTERNATIONAL DIAGNOSTIC INTERVIEW (CIDI)

Purpose Assessment of current and/or life time symptoms of mental disorders for case identification and assessment (e.g. in epidemiological research)

Type of instrument Fully structured diagnostic interview schedule: symptom questions are spelled out positive answers are further explored

computerized data entry and diagnostic programmes

available in different life time and 12 monhs versions

can be supplemented by different modules

User Interviewers without clinical experience as well as clinicians

Training Essential (5 days)

Administration time 75 minutes

More information is available on the Internet:

<http://www.unsw.edu.au/clients/crvfad/home.ktm>

How to ask CIDI questions:

all questions should be read as written
no interpretation of questions and answers by the interviewer (if the respondent does not understand the question or interrupts the interviewer, the question should be read again without additional clarification)
a rating will be made only when the respondent understands the intent of the question and has responded appropriately
interviewers should probe and not assume answers

SCHEDULES FOR CLINICAL ASSESSMENT IN NEUROPSYCHIATRY (SCAN)

Purpose Assessment of present state and clinical history for clinical diagnosis

Type of instrument Semi-structured clinical interview schedule with semi-standardized questions

User Psychiatrists or psychologists

Training Essential

Administration time 60 - 90 minutes

Components:

1. Glossary of definitions

2. Assessment manual

Present State Examination (PSE-10)
Item Group Checklist (IGC)
Clinical History Schedule (CHS)

3. Rating record schedules

4. Computer program

Catego-5: - descriptive profiles - ICD-10, DSM-IV diagnoses

5. Version 2.1 (1998) revised with CAPSE for ICD-10 and DSM-IV

Principles of SCAN Interview

- Based on definitions of items in SCAN glossary
- Aims at comprehensive assessment of symptoms and signs
- Clinically semi-structured interview with additional probes, if judged necessary by clinician
- Ratings based on judgement of clinician
- Flexible order of administration according to state of patient and judgement of clinician

A sample item from SCAN (Version 2.0, p. 117) (1)

10.005 Overtalkativeness

Have people said that you talked too fast [\_\_][\_\_]

and too much so that they couldn't understand

you? Or do you feel pressure to keep talking?

Use SCALE 1

If > 2 years, consider cyclothymia

Glossary definition

Overtalkativeness: Respondents may sense a pressure to keep talking but, more often, it is the others who notice an abnormality. Speech is fluent, rapid and loud. There may be overcircum-stantiality and shifts of topic, bur conversation can be conducted with wit. It may be possible to rate this item from self-description, but respondents may also report the comments of others at the time which corroborate their account.

A sample item from SCAN (Version 2.0, p. 189)(2)

22.014 Distractibility

Changes behaviour or speech inappropriately [\_\_][\_\_]

though attending to irrelevant noises or events or objects

Use RATING SCALE III

Glossary definition

Distractibility: The respondent's attention is taken up by trivial events occurring while the interview proceeds which usually would not be noticed, let alone interfere with the interview. The respondent is unable to sustain attention for a period required by the task at hand. The subject may remark on the wallpaper instead of replying to a question, or break off to comment on the furniture or the sound of someone walking by. If this is occurring continuously, rate (2). If it occurs quite markedly but not continuously, rate (1).

Write down an example.

COMPARISON BETWEEN CIDI AND SCAN

CIDI SCAN
Fully structured Semi-structured
Applied by lay-iterviewer Applied by clinician
Probe-flow chart "Cross-examination"
Based on answers of subject (no interviewer’s interpretation) Ratings reflect interviewer’s interpretation
Selection of items based on diagnostic criteria Aims at comprehensive assessment

Computer scoring programme
Specific training needed
Coverage of ICD-10 and DSM IV diagnoses
Available in many languages
Network of training centers available

INTERNATIONAL PERSONALITY DISORDER EXAMINATION (IPDE)

Purpose to assess the phenomenology and life experiences relevant to the diagnosis of personality disorders in the ICD-10 and DSM-IV classification systems.

Type of instrument Structured clinical interview schedule with semi-standardized probes

module for ICD-10 diagnoses
module for DSM-IV diagnoses
screening questionnaire

User Psychiatrists or psychologists

Training Essential (3 days)

Administration time 1,5 - 3 hours

Description:

152 items arranged under 6 headings:

work

self

interpersonal relationships

affects

reality testing

impulse control

items are introduced by open-ended queries that offer the individual opportunity to discuss topic before answering

answers need to be supplemented by examples

additional questions to determine whether the individual has met frequency, duration and age of onset requirements (duration should be at least 5 years; at least one criterion to be met before age 25)

second scoring column for data from informants

last 6 items to be scored by interviewer based on observation during interview

Sample item from IPDE (1): questions

Preoccupation with details, lists, order, organization, or schedules to the extent that the major point of activity is lost

DSM-III-R Obsessive Compulsive: 2

Preoccupation with details, rules, lists, order, organization or schedule

ICD-10 Anankastic (obsessive compulsive): 2

Are you fussy about little details?

If yes: Do you spend much more time on them than you really have to?

If yes: Does that prevent you from getting much work done as you're expected to do?

If yes: Tell me about it.

Do you spend so much time scheduling and organizing things that you don't have any time left to do the job you're really supposed to do?

If yes: Tell me about it.

Sample item from IPDE (2): commentary

The subject is so concerned with the method or details of accomplishing a task or objective, that they almost become an end in themselves, consuming much more time and effort than is necessary, and thereby preventing the task from being accomplished or markedly prolonging the time required to achieve the objective. The subject need not display all of the features enumerated in the criterion.

2 Convincing evidence supported by examples that the behaviour frequently interferes with reasonable expectations of productivity.

1 Convincing evidence supported by examples that the behaviour occasionally interferes with reasonable expectations of productivity.

0 Denied, rare, or the consequences are insignificant.

WHO DISABILITY ASSESSMENT SCHEDULE (DAS)

Purpose: Evaluation of social functioning, and some of the factors influencing it.

Type of instrument: Semi-structured clinical assessment schedule

User: Psychiatrists, psychologists, sociologists or social workers

Training: Essential (2 days)

Administration time: 30 minutes

Description

97 items, divided in 5 parts:

Part 1: Overall behaviour (including self-care, under-activity, slowness, social withdrawal)

Part 2: Social role performance

Part 3: Functioning in hospital

Part 4: Modifying factors, such as specific assets and specific liabilities, home atmosphere, outside support

Part 5: Global evaluation

Part 6: Summary of ratings and scoring

Sample item

2. Social role performance

2.1 Participation in household activities during past month

Inquire about:

(i) patient's participation in common activities Card of the household, such as having meals together, Column doing domestic chores, going out or visiting together, playing games, watching television, etc.;

(ii) patient's participation in decision-making concerning the household, e.g. decisions about the children, money, etc. For housewives, consider the household jobs that a housewife usually has to do.

Make a rating without regard to whether the patient is asked to participate, left on his/her own or rejected [\_\_] 38 in some way.

RATING SCHEDULE

Rate 8 if information not available and 9 if item not applicable

No dysfunction: patient participates in household 0 -- activities as much as is expected for his/her age, sex, position in the household, and sociocultural context.

Minimum dysfunction: patient participates less than 1 -- would be expected and has little interest in (ii), although such participation would normally be expected for someone in similar circumstances.

Obvious dysfunction: ....... 2 --

Serious dysfunction: ........ 3 --

Very serious dysfunction: ......... 4 --

Maximum dysfunction: patient totally excludes him 5 --

self/herself, or is excluded, from participation in any common household activities; disrupts the functioning of the household as a unit.