

Section 3

THE DEFINITIONS OF TERMS

I: MENTAL RETARDATION¹ (310—315)

Mental retardation refers to subnormal general intellectual functioning which originates during the developmental period and is associated with impairment of either learning and social adjustment or maturation, or both. (These disorders were classified under "Chronic brain syndrome with mental deficiency" and "Mental deficiency" in DSM-I.) The diagnostic classification of mental retardation relates to IQ as follows²:

310 Borderline mental retardation—IQ 68—83

311 Mild mental retardation—IQ 52—67

312 Moderate mental retardation—IQ 36—51

313 Severe mental retardation—IQ 20—35

314 Profound mental retardation—IQ under 20

Classifications 310-314 are based on the statistical distribution of levels of intellectual functioning for the population as a whole. The range of intelligence subsumed under each classification corresponds to one standard deviation, making the heuristic assumption that intelligence is normally distributed. It is recognized that the intelligence quotient should not be the only criterion used in making a diagnosis of mental retardation or in evaluating its severity. It should serve only to help in making a clinical judgment of the patient's adaptive behavioral capacity. This judgment should also be based on an evaluation of the patient's developmental history and present functioning, including academic and vocational achievement, motor skills, and social and emotional maturity.

315 Unspecified mental retardation
This classification is reserved for patients whose intellectual functioning

has not or cannot be evaluated precisely but which is recognized as clearly subnormal.

Clinical Subcategories of Mental Retardation

These will be coded as fourth digit subdivisions following each of the categories 310-315. When the associated condition is known more specifically, particularly when it affects the entire organism or an organ system other than the central nervous system, it should be coded additionally in the specific field affected.

.0 Following infection and intoxication

This group is to classify cases in which mental retardation is the result of residual cerebral damage from intracranial infections, serums, drugs, or toxic agents. Examples are:

Cytomegalic inclusion body disease, congenital. A maternal viral disease, usually mild or subclinical, which may infect the fetus and is recognized by the presence of inclusion bodies in the cellular elements in the urine, cerebrospinal fluid, and tissues.

Rubella, congenital. Affecting the fetus in the first trimester and usually accompanied by a variety of congenital anomalies of the ear, eye and heart.

Syphilis, congenital. Two types are described, an early meningo-vascular disease and a diffuse encephalitis leading to juvenile paresis.

Toxoplasmosis, congenital. Due to infection by a protozoan-like organism, Toxoplasma, contracted in utero. May be detected by serological tests in both mother and infant.

Encephalopathy associated with other prenatal infections. Occasionally fetal damage from maternal epidemic cerebrospinal meningitis, equine encephalomyelitis, influenza, etc. has been reported. The relationships have not as yet been definitely established.

Encephalopathy due to postnatal cerebral infection. Both focal and generalized types of cerebral infection are included and are to be given further anatomic and etiologic specification.

Encephalopathy, congenital, associated with maternal toxemia of pregnancy. Severe and prolonged toxemia of pregnancy, particularly eclampsia, may be associated with mental retardation.

Encephalopathy, congenital, associated with other maternal intoxications. Examples are carbon monoxide, lead, arsenic, quinine, ergot,

¹ For a fuller definition of terms see the "Manual on Terminology and Classification in Mental Retardation," (Supplement to *American Journal of Mental Deficiency*, Second Edition, 1961) from which most of this section has been adapted.

² The IQs specified are for the Revised Stanford-Binet Tests of Intelligence, Forms L and M. Equivalent values for other tests are listed in the manual cited in the footnote above.

Bilirubin encephalopathy (Kernicterus). Frequently due to Rh, A, B, O blood group incompatibility between fetus and mother but may also follow prematurity, severe neonatal sepsis or any condition producing high levels of serum bilirubin. Choreoathetosis is frequently associated with this form of mental retardation.

Post-immunization encephalopathy. This may follow inoculation with serum, particularly anti-tetanus serum, or vaccines such as smallpox, rabies, and typhoid.

Encephalopathy, other, due to intoxication. May result from such toxic agents as lead, carbon monoxide, tetanus and botulism exotoxin.

.1 Following trauma or physical agent

Further specification within this category follows:

Encephalopathy due to prenatal injury. This includes prenatal irradiation and asphyxia, the latter following maternal anoxia, anemia, and hypotension.

Encephalopathy due to mechanical injury at birth. These are attributed to difficulties of labor due to malposition, malpresentation, disproportion, or other complications leading to dystocia which may increase the probability of damage to the infant's brain at birth, resulting in tears of the meninges, blood vessels, and brain substance. Other reasons include venous-sinus thrombosis, arterial embolism and thrombosis. These may result in sequelae which are indistinguishable from those of other injuries, damage or organic impairment of the brain.

Encephalopathy due to asphyxia at birth. Attributable to the anoxemia following interference with placental circulation due to premature separation, placenta praevia, cord difficulties, and other interferences with oxygenation of the placental circulation.

Encephalopathy due to postnatal injury. The diagnosis calls for evidence of severe trauma such as a fractured skull, prolonged unconsciousness, etc., followed by a marked change in development. Postnatal asphyxia, infarction, thrombosis, laceration, and contusion of the brain would be included and the nature of the injury specified.

.2 With disorders of metabolism, growth or nutrition

All conditions associated with mental retardation directly due to metabolic, nutritional, or growth dysfunction should be classified here, including

ing disorders of lipid, carbohydrate and protein metabolism, and deficiencies of nutrition.

Cerebral lipiodosis, infantile (Tay-Sach's disease). This is caused by a single recessive autosomal gene and has infantile and juvenile forms. In the former there is gradual deterioration, blindness after the pathognomonic "cherry-red spot," with death occurring usually before age three.

Cerebral lipiodosis, late juvenile (Bielschowsky's disease). This differs from the preceding by presenting retinal optic atrophy instead of the "cherry-red spot."

Cerebral lipiodosis, juvenile (Spielmeyer-Vogt disease). This usually appears between the ages of five and ten with involvement of the motor systems, frequent seizures, and pigmentary degeneration of the retina. Death follows in five to ten years.

Cerebral lipoidosis, late juvenile (Kufs' disease). This is categorized under mental retardation only when it occurs at an early age.

Lipid histiocytosis of kerasin type (Gaucher's disease). As a rule this condition causes retardation only when it affects infants. It is characterized by Gaucher's cells in lymph nodes, spleen or marrow.

Lipid histiocytosis of phosphatidic type (Niemann-Pick's disease). Distinguished from Tay-Sach's disease by enlargement of liver and spleen. Biopsy of spleen, lymph or marrow show characteristic "foam cells."

Phenylketonuria. A metabolic disorder, genetically transmitted as a simple autosomal recessive gene, preventing the conversion of phenylalanine into tyrosine with an accumulation of phenylalanine, which in turn is converted to phenylpyruvic acid detectable in the urine.

Hepatolenticular degeneration (Wilson's disease). Genetically transmitted as a simple autosomal recessive. It is due to inability of ceruloplasmin to bind copper, which in turn damages the brain. Rare in children.

Porphyria. Genetically transmitted as a dominant and characterized by excretion of porphyrins in the urine. It is rare in children, in whom it may cause irreversible deterioration.

Galactosemia. A condition in which galactose is not metabolized, causing its accumulation in the blood. If milk is not removed from the diet, generalized organ deficiencies, mental deterioration and death may result.

Glucogenosis (Von Gierke's disease). Due to a deficiency in glycogen-metabolizing enzymes with deposition of glycogen in various organs, including the brain.

Hypoglycemia. Caused by various conditions producing hypoglycemia which, in the infant, may result in epilepsy and mental defect. Diagnosis may be confirmed by glucose tolerance tests.

3 Associated with gross brain disease (postnatal)

This group includes all diseases and conditions associated with neoplasms, but not growths that are secondary to trauma or infection. The category also includes a number of postnatal diseases and conditions in which the structural reaction is evident but the etiology is unknown or uncertain, though frequently presumed to be of hereditary or familial nature. Structural reactions may be degenerative, infiltrative, inflammatory, proliferative, sclerotic, or reparative.

Neurofibromatosis (Neurofibroblastomatosis, von Recklinghausen's disease). A disease transmitted by a dominant autosomal gene but with reduced penetrance and variable expressivity. It is characterized by cutaneous pigmentation ("café au lait" patches) and neurofibromas of nerve, skin and central nervous system with intellectual capacity varying from normal to severely retarded.

Trigeminal cerebral angioma (Sturge-Weber-Dimitri's disease). A condition characterized by a "port wine stain" or cutaneous angioma, usually in the distribution of the trigeminal nerve, accompanied by vascular malformation over the meninges of the parietal and occipital lobes with underlying cerebral maldevelopment.

Tuberous sclerosis (Epileia, Bourneville's disease). Transmitted by a dominant autosomal gene, characterized by multiple gliotic nodules in the central nervous system, and associated with adenoma sebaceum of the face and tumors in other organs. Retarded development and seizures may appear early and increase in severity along with tumor growth.

Intracranial neoplasm, other. Other relatively rare neoplastic diseases leading to mental retardation should be included in this category and specified when possible.

Encephalopathy associated with diffuse sclerosis of the brain. This category includes a number of similar conditions differing to some extent in their pathological and clinical features but characterized

by diffuse demyelination of the white matter with resulting diffuse glial sclerosis and accompanied by intellectual deterioration. These diseases are often familial in character and when possible should be specified under the following:

Acute infantile diffuse sclerosis (Krabbe's disease).

Aplasia axialis extracorticalis congenita.

Infantile metachromatic leukodystrophy (Greenfield's disease).

Juvenile metachromatic leukodystrophy (Scholz' disease).

Progressive subcortical encephalopathy (Encephalitis periaxialis diffusa, Schiöder's disease).

Spinal sclerosis (Friedreich's ataxia). Characterized by cerebellar degeneration, early onset followed by dementia.

Encephalopathy, other, due to unknown or uncertain cause with the structural reactions manifest. This category includes cases of mental retardation associated with progressive neuronal degeneration or other structural defects which cannot be classified in a more specific, diagnostic category.

4 Associated with diseases and conditions due to unknown prenatal influence

This category is for classifying conditions known to have existed at the time of or prior to birth but for which no definite etiology can be established. These include the primary cranial anomalies and congenital defects of undetermined origin as follows:

Anencephaly (including hemianencephaly).

Malformations of the gyri. This includes agyria, macrogyria (pachygyria) and microgyria.

Porencephaly, congenital. Characterized by large funnel-shaped cavities occurring anywhere in the cerebral hemispheres. Specify, if possible, whether the porencephaly is a result of asphyxia at birth or postnatal trauma.

Multiple-congenital anomalies of the brain.

Other cerebral defects, congenital.

Craniostenosis. The most common conditions included in this category are acrocephaly (oxycephaly) and scaphocephaly. These may or may not be associated with mental retardation.

Hydrocephalus, congenital. Under this heading is included only that type of hydrocephalus present at birth or occurring soon after delivery. All other types of hydrocephalus, secondary to other conditions, should be classified under the specific etiology when known.

Hypertelorism (Greig's disease). Characterized by abnormal development of the sphenoid bone increasing the distance between the eyes.

Macrocephaly (Megalencephaly). Characterized by an increased size and weight of the brain due partially to proliferation of glia.

Microcephaly, primary. True microcephaly is probably transmitted as a single autosomal recessive. When it is caused by other conditions it should be classified according to the primary condition, with secondary microcephaly as a supplementary term.

Laurence-Moon-Biedl syndrome. Characterized by mental retardation associated with retinitis pigmentosa, adiposo-genital dys trophy, and polydactyly.

.5 With chromosomal abnormality

This group includes cases of mental retardation associated with chromosomal abnormalities. These may be divided into two sub-groups, those associated with an abnormal number of chromosomes and those with abnormal chromosomal morphology.

Autosomal trisomy of group G. (Trisomy 21, Langdon-Down disease, Mongolism). This is the only common form of mental retardation due to chromosomal abnormality. (The others are relatively rare.) It ranges in degree from moderate to severe with infrequent cases of mild retardation. Other congenital defects are frequently present, and the intellectual development decelerates with time.

Autosomal trisomy of group E.

Autosomal trisomy of group D.

Sex chromosome anomalies. The only condition under the category which has any significant frequency is Klinefelter's syndrome.

Abnormal number of chromosomes, other. In this category would be included monosomy G, and possibly others as well as other forms of mosaicism.

Short arm deletion of chromosome 5—group B (Cri du chat). A quite rare condition characterized by congenital abnormalities and a cat-like cry during infancy which disappears with time.

Short arm deletion of chromosome 18—group E.

Abnormal morphology of chromosomes, other. This category includes a variety of translocations, ring chromosomes, fragments, and iso-chromosomes associated with mental retardation.

.6 Associated with prematurity

This category includes retarded patients who had a birth weight of less than 2500 grams (5.5 pounds) and/or a gestational age of less than 38 weeks at birth, and who do not fall into any of the preceding categories. This diagnosis should be used only if the patient's mental retardation cannot be classified more precisely under categories .0 to .5 above.

.7 Following major psychiatric disorder

This category is for mental retardation following psychosis or other major psychiatric disorder in early childhood when there is no evidence of cerebral pathology. To make this diagnosis there must be good evidence that the psychiatric disturbance was extremely severe. For example, retarded young adults with residual schizophrenia should not be classified here.

.8 With psycho-social (environmental) deprivation

This category is for the many cases of mental retardation with no clinical or historical evidence of organic disease or pathology but for which there is some history of psycho-social deprivation. Cases in this group are classified in terms of psycho-social factors which appear to bear some etiological relationship to the condition as follows:

Cultural-familial mental retardation. Classification here requires that evidence of retardation be found in at least one of the parents and in one or more siblings, presumably, because some degree of cultural deprivation results from familial retardation. The degree of retardation is usually mild.

Associated with environmental deprivation. An individual deprived of normal environmental stimulation in infancy and early childhood may prove unable to acquire the knowledge and skills required to function normally. This kind of deprivation tends to be more severe than that associated with familial mental retardation (q.v.). This type of deprivation may result from severe sensory impairment, even in an environment otherwise rich in stimulation. More rarely

it may result from severe environmental limitations or atypical cultural milieus. The degree of retardation is always marginal or mild.

.9 With other [and unspecified] condition.

II. ORGANIC BRAIN SYNDROMES

(Disorders caused by or associated with impairment of brain tissue function)

These disorders are manifested by the following symptoms:

- (a) Impairment of orientation
- (b) Impairment of memory
- (c) Impairment of all intellectual functions such as comprehension, calculation, knowledge, learning, etc.
- (d) Impairment of judgment
- (e) Lability and shallowness of affect

The organic brain syndrome is a basic mental condition characteristically resulting from diffuse impairment of brain tissue function from whatever cause. Most of the basic symptoms are generally present to some degree regardless of whether the syndrome is mild, moderate or severe.

The syndrome may be the only disturbance present. It may also be associated with psychotic symptoms and behavioral disturbances. The severity of the associated symptoms is affected by and related to not only the precipitating organic disorder but also the patient's inherent personality patterns, present emotional conflicts, his environmental situation, and interpersonal relations.

These brain syndromes are grouped into psychotic and non-psychotic disorders according to the severity of functional impairment. The psychotic level of impairment is described on page 23 and the non-psychotic on pages 31-32.

It is important to distinguish "acute" from "chronic" brain disorders because of marked differences in the course of illness, prognosis and treatment. The terms indicate primarily whether the brain pathology and its accompanying organic brain syndrome is reversible. Since the same etiology may produce either temporary or permanent brain damage, a brain disorder which appears reversible (acute) at the beginning may prove later to have left permanent damage and a persistent organic brain syndrome which will then be diagnosed "chronic". Some

brain syndromes occur in either form. Some occur only in acute forms (e.g. *Delirium tremens*). Some occur only in chronic form (e.g. *Alcoholic deterioration*). The acute and chronic forms may be indicated for those disorders coded in four digits by the addition of a fifth qualifying digit: .x1 *acute* and .x2 *chronic*.

THE PSYCHOSES

Psychoses are described in two places in this Manual, here with the organic brain syndromes and later with the functional psychoses. The general discussion of psychosis appears here because organic brain syndromes are listed first in DSM-II.

Patients are described as psychotic when their mental functioning is sufficiently impaired to interfere grossly with their capacity to meet the ordinary demands of life. The impairment may result from a serious distortion in their capacity to recognize reality. Hallucinations and delusions, for example, may distort their perceptions. Alterations of mood may be so profound that the patient's capacity to respond appropriately is grossly impaired. Deficits in perception, language and memory may be so severe that the patient's capacity for mental grasp of his situation is effectively lost.

Some confusion results from the different meanings which have become attached to the word "psychosis." Some non-organic disorders, (295-298), in the well-developed form in which they were first recognized, typically rendered patients psychotic. For historical reasons these disorders are still classified as psychoses, even though it now generally is recognized that many patients for whom these diagnoses are clinically justified are not in fact psychotic. This is true particularly in theincipient or convalescent stages of the illness. To reduce confusion, when one of these disorders listed as a "psychosis" is diagnosed in a patient who is not psychotic, the qualifying phrase *not psychotic* or *not presently psychotic* should be noted and coded .x6 with a fifth digit.

Example: 295.06 *Schizophrenia, simple type, not psychotic*.

It should be noted that this Manual permits an organic condition to be classified as a psychosis only if the patient is psychotic during the episode being diagnosed.

If the specific physical condition underlying one of these disorders is known, indicate it with a separate, additional diagnosis.

II. A. PSYCHOSES ASSOCIATED WITH ORGANIC BRAIN SYNDROMES (290—294)

290 Senile and Pre-senile dementia

290.0 Senile dementia

This syndrome occurs with senile brain disease, whose causes are largely unknown. The category does not include the pre-senile psychoses nor other degenerative diseases of the central nervous system. While senile brain disease derives its name from the age group in which it is most commonly seen, its diagnosis should be based on the brain disorder present and not on the patient's age at times of onset. Even mild cases will manifest some evidence of organic brain syndrome: self-centeredness, difficulty in assimilating new experiences, and childish emotionality. Deterioration may be minimal or progress to vegetative existence. (This condition was called "Chronic Brain Syndrome associated with senile brain disease" in DSM-I.)

290.1 Presenile dementia

This category includes a group of cortical brain diseases presenting clinical pictures similar to those of senile dementia but appearing characteristically in younger age groups. Alzheimer's and Pick's diseases are the two best known forms, each of which has a specific brain pathology. (In DSM-I Alzheimer's disease was classified as "Chronic Brain Syndrome with other disturbance of metabolism." Pick's disease was "Chronic Brain Syndrome associated with disease of unknown cause.") When the impairment is not of psychotic proportion the patient should be classified under *Non-psychotic OBS with senile or pre-senile brain disease*.

291 Alcoholic psychoses

Alcoholic psychoses are psychoses caused by poisoning with alcohol (see page 23). When a pre-existing psychotic, psychoneurotic or other disorder is aggravated by modest alcohol intake, the underlying condition, not the alcoholic psychosis, is diagnosed.

Simple drunkenness, when not specified as psychotic, is classified under *Non-psychotic OBS with alcohol*.

In accordance with ICD-8, this Manual subdivides the alcoholic psychoses into *Delirium tremens*, *Korsakoff's psychosis*, *Other alcoholic hallucinosis* and *Alcoholic paranoia*. DSM-II also adds three further

subdivisions: *Acute alcohol intoxication*, *Alcoholic deterioration* and *Pathological intoxication*. (In DSM-I "Acute Brain Syndrome, alcohol intoxication" included what is now *Delirium tremens*, *Other alcoholic hallucinosis*, *Acute alcohol intoxication* and *Pathological intoxication*.)

291.0 Delirium tremens

This is a variety of acute brain syndrome characterized by delirium, coarse tremors, and frightening visual hallucinations usually becoming more intense in the dark. Because it was first identified in alcoholics and until recently was thought always to be due to alcohol ingestion, the term is restricted to the syndrome associated with alcohol. It is distinguished from *Other alcoholic hallucinosis* by the tremors and the disordered sensorium. When this clinical picture is due to a nutritional deficiency rather than to alcohol poisoning, it is classified under *Psychosis associated with metabolic or nutritional disorder*.

291.1 Korsakoff's psychosis (alcoholic)

Also "Korsakoff",

This is a variety of chronic brain syndrome associated with longstanding alcohol use and characterized by memory impairment, disorientation, peripheral neuropathy and particularly by confabulation. Like delirium tremens, Korsakoff's psychosis is identified with alcohol because of an initial error in identifying its cause, and therefore the term is confined to the syndrome associated with alcohol. The similar syndrome due to nutritional deficiency unassociated with alcohol is classified *Psychosis associated with metabolic or nutritional disorder*.

291.2 Other alcoholic hallucinosis

Hallucinoses caused by alcohol which cannot be diagnosed as delirium tremens, Korsakoff's psychosis, or alcoholic deterioration fall in this category. A common variety manifests accusatory or threatening auditory hallucinations in a state of relatively clear consciousness. This condition must be distinguished from schizophrenia in combination with alcohol intoxication, which would require two diagnoses.

291.3 Alcohol paranoid state ((Alcoholic paranoia))

This term describes a paranoid state which develops in chronic alcoholics, generally male, and is characterized by excessive jealousy and delusions of infidelity by the spouse. Patients diagnosed under pri-

mary paranoid states or schizophrenia should not be included here even if they drink to excess.

291.4* Acute alcohol intoxication*

All varieties of acute brain syndromes of psychotic proportion caused by alcohol are included here if they do not manifest features of delirium tremens, alcoholic hallucinosis, or pathological intoxication. This diagnosis is used alone when there is no other psychiatric disorder or as an additional diagnosis with other psychiatric conditions including alcoholism. The condition should not be confused with simple drunkenness, which does not involve psychosis. (All patients with this disorder would have been diagnosed "Acute Brain Syndrome, alcohol intoxication" in DSM-I.)

291.5* Alcoholic deterioration*

All varieties of chronic brain syndromes of psychotic proportion caused by alcohol and not having the characteristic features of Korsakoff's psychosis are included here. (This condition and Korsakoff's psychosis were both included under "Chronic Brain Syndrome, alcohol intoxication with psychotic reaction" in DSM-I.)

291.6* Pathological intoxication*

This is an acute brain syndrome manifested by psychosis after minimal alcohol intake. (In DSM-I this diagnosis fell under "Acute Brain Syndrome, alcohol intoxication.")

291.9 Other [and unspecified] alcoholic psychosis

This term refers to all varieties of alcoholic psychosis not classified above.

292 Psychosis associated with intracranial infection

292.0 General paralysis

This condition is characterized by physical signs and symptoms of parenchymatosus syphilis of the nervous system, and usually by positive serology, including the paretic gold curve in the spinal fluid. The condition may simulate any of the other psychoses and brain syndromes. If the impairment is not of psychotic proportion it is classified *Non-psychotic OBS with intracranial infection*. If the specific underlying physical condition is known, indicate it with a separate, additional diagnosis. (This category was included under "Chronic Brain Syndrome associated with central nervous system syphilis (meningoencephalitic)" in DSM-I.)

292.1 Psychosis with other syphilis of central nervous system
This includes all other varieties of psychosis attributed to intracranial infection by *Spirochaeta pallida*. The syndrome sometimes has features of organic brain syndrome. The acute infection is usually produced by meningo-vascular inflammation and responds to systemic antisyphilitic treatment. The chronic condition is generally due to gummata. If not of psychotic proportion, the disorder is classified *Non-psychotic OBS with intracranial infection*. (In DSM-I "Chronic Brain Syndrome associated with other central nervous system syphilis" and "Acute Brain Syndrome associated with intracranial infection" covered this category.)

292.2 Psychosis with epidemic encephalitis (*von Economo's encephalitis*)

This term is confined to the disorder attributed to the viral epidemic encephalitis that followed World War I. Virtually no cases have been reported since 1926. The condition, however, is differentiated from other encephalitis. It may present itself as acute delirium and sometimes its outstanding feature is apparent indifference to persons and events ordinarily of emotional significance, such as the death of a family member. It may appear as a chronic brain syndrome and is sometimes dominated by involuntary, compulsive behavior. If not of psychotic proportions, the disorder is classified under *Non-psychotic OBS with intracranial infection*. (This category was classified under "Chronic Brain Syndrome associated with intracranial infection other than syphilis" in DSM-I.)

292.3 Psychosis with other and unspecified encephalitis

This category includes disorders attributed to encephalitic infections other than epidemic encephalitis and also to encephalitis not otherwise specified.¹ When possible the type of infection should be indicated. If not of psychotic proportion, the disorder is classified under *Non-psychotic OBS with intracranial infection*.

292.9 Psychosis with other [and unspecified] intracranial infection

This category includes all acute and chronic conditions due to non-syphilitic and non-encephalitic infections, such as meningitis and

¹ A list of important encephalitides may be found in "A Guide to the Control of Mental Disorders," American Public Health Association Inc., New York 1962, pp. 40 ff.

brain abscess. Many of these disorders will have been diagnosed as the acute form early in the course of the illness. If not of psychotic proportion, the disorder should be classified under *Non-psychotic OBS with intracranial infection*. (In DSM-I the acute variety was classified as "Acute Brain Syndrome associated with intracranial infection" and the chronic variety as "Chronic Brain Syndrome associated with intracranial infection other than syphilis.")

293 Psychosis associated with other cerebral condition

This major category, as its name indicates, is for all psychoses associated with cerebral conditions *other* than those previously defined. For example, the degenerative diseases following do *not* include the previous senile dementia. If the specific underlying physical condition is known, indicate it with a separate, additional diagnosis.

293.0 Psychosis with cerebral arteriosclerosis

This is a chronic disorder attributed to cerebral arteriosclerosis. It may be impossible to differentiate it from senile dementia and predominate the patient's age, history, and symptoms may help determine the predominant pathology. Commonly, the organic brain syndrome is the only mental disturbance present, but other reactions, such as depression or anxiety, may be superimposed. If not of psychotic proportion, the condition is classified under *Non-psychotic OBS with circulatory disturbance*. (In DSM-I this was called "Chronic Brain Syndrome associated with cerebral arteriosclerosis.")

293.1 Psychosis with other cerebrovascular disturbance

This category includes such circulatory disturbances as cerebral thrombosis, cerebral embolism, arterial hypertension, cardio-renal disease and cardiac disease, particularly in decompensation. It excludes conditions attributed to arteriosclerosis. The diagnosis is determined by the underlying organ pathology, which should be specified with an additional diagnosis. (In DSM-I this category was divided between "Acute Brain Syndrome associated with circulatory disturbance" and "Chronic Brain Syndrome associated with circulatory disturbance other than cerebral arteriosclerosis.")

293.2 Psychosis with epilepsy

This category is to be used only for the condition associated with "idiopathic" epilepsy. Most of the etiological agents underlying chronic brain syndromes can and do cause convulsions, particularly

syphilis, intoxication, trauma, cerebral arteriosclerosis, and intracranial neoplasms. When the convulsions are symptomatic of such diseases, the brain syndrome is classified under those disturbances rather than here. The disturbance most commonly encountered here is the clouding of consciousness before or after a convulsive attack. Instead of a convulsion, the patient may show only a dazed reaction with deep confusion, bewilderment and anxiety. The epileptic attack may also take the form of an episode of excitement with hallucinations, fears, and violent outbreaks. (In DSM-I this was included in "Acute Brain Syndrome associated with convulsive disorder" and "Chronic Brain Syndrome associated with convulsive disorder.")

293.3 Psychosis with intracranial neoplasm

Both primary and metastatic neoplasms are classified here. Reactions to neoplasms other than in the cranium should not receive this diagnosis. (In DSM-I this category included "Acute Brain Syndrome associated with intracranial neoplasm" and "Chronic Brain Syndrome associated with intracranial neoplasm.")

293.4 Psychosis with degenerative disease of the central nervous system

This category includes degenerative brain diseases not listed previously. (In DSM-I this was part of "Acute Brain Syndrome with disease of unknown or uncertain cause" and "Chronic Brain Syndrome associated with diseases of unknown or uncertain cause.")

293.5 Psychosis with brain trauma

This category includes those disorders which develop immediately after severe head injury or brain surgery and the post-traumatic chronic brain disorders. It does not include permanent brain damage which produces only focal neurological changes without significant changes in sensorium and affect. Generally, trauma producing a chronic brain syndrome is diffuse and causes permanent brain damage. If not of psychotic proportions, a post-traumatic personality disorder associated with an organic brain syndrome is classified as a *Non-psychotic OBS with brain trauma*. If the brain injury occurs in early life and produces a developmental defect of intelligence, the condition is also diagnosed *mental retardation*. A head injury may precipitate or accelerate the course of a chronic brain disease, especially cerebral arteriosclerosis. The differential diagnosis may be extremely difficult. If, before the injury, the patient had symptoms of circulatory disturbance, particularly arteriosclerosis,

and now shows signs of psychosis, he should be classified *Psychosis with cerebral arteriosclerosis*. (In DSM-I this category was divided between "Acute Brain Syndrome associated with trauma" and "Chronic Brain Syndrome associated with brain trauma.")

293.9 Psychosis with other [and unspecified] cerebral condition

This category is for cerebral conditions other than those listed above, and conditions for which it is impossible to make a more precise diagnosis. [Medical record librarians will include here *Psychoses with cerebral condition, not otherwise specified*.]

294 Psychosis associated with other physical condition

The following psychoses are caused by general systemic disorders and are distinguished from the *cerebral* conditions previously described. If the specific underlying physical condition is known, indicate it with a separate, additional diagnosis.

294.0 Psychosis with endocrine disorder

This category includes disorders caused by the complications of diabetes other than cerebral arteriosclerosis and disorders of the thyroid, pituitary, adrenals, and other endocrine glands. (In DSM-I "Chronic Brain Syndrome associated with other disturbances of metabolism, growth or nutrition" included the chronic variety of these disorders. DSM-I defined these conditions as "disorders of metabolism" but they here are considered endocrine disorders.)

294.1 Psychosis with metabolic or nutritional disorder

This category includes disorders caused by pellagra, avitaminosis and metabolic disorders. (In DSM-I this was part of "Acute Brain Syndrome associated with metabolic disturbance" and "Chronic Brain Syndrome associated with other disturbance of metabolism, growth or nutrition.")

294.2 Psychosis with systemic infection

This category includes disorders caused by severe general systemic infections, such as pneumonia, typhoid fever, malaria and acute rheumatic fever. Care must be taken to distinguish these reactions from other disorders, particularly manic depressive illness and schizophrenia, which may be precipitated by even a mild attack of infectious disease. (In DSM-I this was confined to "Acute Brain Syndrome associated with systemic infection.")

294.3 Psychosis with drug or poison intoxication (other than alcohol)

This category includes disorders caused by some drugs (including psychedelic drugs), hormones, heavy metals, gasses, and other in toxicants except alcohol. (In DSM-I these conditions were divided between "Acute Brain Syndrome, drug or poison intoxication" and "Chronic Brain Syndrome, associated with intoxication." The former excluded alcoholic acute brain syndromes, while the latter included alcoholic chronic brain syndromes.)

294.4 Psychosis with childbirth

Almost any type of psychosis may occur during pregnancy and the post-partum period and should be specifically diagnosed. This category is not a substitute for a differential diagnosis and excludes other psychoses arising during the puerperium. Therefore, this diagnosis should not be used unless all other possible diagnoses have been excluded.

294.8 Psychosis with other and undiagnosed physical condition

This is a residual category for psychoses caused by physical conditions other than those listed earlier. It also includes brain syndromes caused by physical conditions which have not been diagnosed. (In DSM-I this condition was divided between "Acute Brain Syndrome of unknown cause" and "Chronic Brain Syndrome of unknown cause." However, these categories also included the category now called *Psychosis with other [and unspecified] cerebral condition*.)

[294.9 Psychosis with unspecified physical condition]

This is not a diagnosis but is included for use by medical record librarians only.

II. B. NON-PSYCHOTIC ORGANIC BRAIN SYNDROMES (309)

309 Non-psychotic organic brain syndromes ((Mental disorders not specified as psychotic associated with physical conditions))

This category is for patients who have an organic brain syndrome but are not psychotic. If psychoses are present they should be diagnosed as previously indicated. Refer to pages 22-23 for description of organic brain syndromes in adults.

In children mild brain damage often manifests itself by hyperactivity, short attention span, easy distractability, and impulsiveness. Some-

times the child is withdrawn, listless, perseverative, and unresponsive. In exceptional cases there may be great difficulty in initiating action.

These characteristics often contribute to a negative interaction between parent and child. If the organic handicap is the major etiological factor and the child is not psychotic, the case should be classified here.

If the interactional factors are of major secondary importance, supply a second diagnosis under *Behavior disorders of childhood and adolescence*; if these interactional factors predominate give only a diagnosis from this latter category.

309.0 Non-psychotic OBS with intracranial infection

309.1 Non-psychotic OBS with drug, poison, or systemic intoxication

309.13* Non-psychotic OBS with alcohol* (simple drunkenness)

309.14* Non-psychotic OBS with other drug, poison, or systemic intoxication*

309.2 Non-psychotic OBS with brain trauma

309.3 Non-psychotic OBS with circulatory disturbance

309.4 Non-psychotic OBS with epilepsy

309.5 Non-psychotic OBS with disturbance of metabolism, growth or nutrition

309.6 Non-psychotic OBS with senile or pre-senile brain disease

309.7 Non-psychotic OBS with intracranial neoplasm

309.8 Non-psychotic OBS with degenerative disease of central nervous system

309.9 Non-psychotic OBS with other [and unspecified] physical condition

[.91* Acute brain syndrome, not otherwise specified*]

[.92* Chronic brain syndrome, not otherwise specified*]

III. PSYCHOSES NOT ATTRIBUTED TO PHYSICAL CONDITIONS LISTED PREVIOUSLY (295—298)

This major category is for patients whose psychosis is not caused by physical conditions listed previously. Nevertheless, some of these patients may show additional signs of an organic condition. If these or-

ganic signs are prominent the patient should receive the appropriate additional diagnosis.

295 Schizophrenia

This large category includes a group of disorders manifested by characteristic disturbances of thinking, mood and behavior. Disturbances in thinking are marked by alterations of concept formation which may lead to misinterpretation of reality and sometimes to delusions and hallucinations, which frequently appear psychologically self-protective. Corollary mood changes include ambivalent, constricted and inappropriate emotional responsiveness and loss of empathy with others. Behavior may be withdrawn, regressive and bizarre. The schizophrenias, in which the mental status is attributable primarily to a *thought* disorder, are to be distinguished from the *Major affective illnesses* (q.v.) which are dominated by a *mood* disorder. The *Paranoid states* (q.v.) are distinguished from schizophrenia by the narrowness of their distortions of reality and by the absence of other psychotic symptoms.

295.0 Schizophrenia, simple type

This psychosis is characterized chiefly by a slow and insidious reduction of external attachments and interests and by apathy and indifference leading to impoverishment of interpersonal relations, mental deterioration, and adjustment on a lower level of functioning. In general, the condition is less dramatically psychotic than are the hebephrenic, catatonic, and paranoid types of schizophrenia. Also, it contrasts with schizoid personality, in which there is little or no progression of the disorder.

295.1 Schizophrenia, hebephrenic type

This psychosis is characterized by disorganized thinking, shallow and inappropriate affect, unpredictable giggling, silly and regressive behavior and mannerisms, and frequent hypochondriacal complaints. Delusions and hallucinations, if present, are transient and not well organized.

295.2 Schizophrenia, catatonic type

295.23* Schizophrenia, catatonic type, excited*

295.24* Schizophrenia, catatonic type, withdrawn*

It is frequently possible and useful to distinguish two subtypes of catatonic schizophrenia. One is marked by excessive and sometimes violent motor activity and excitement and the other by generalized

inhibition manifested by stupor, mutism, negativism, or waxy flexibility. In time, some cases deteriorate to a vegetative state.

295.3 Schizophrenia, paranoid type

This type of schizophrenia is characterized primarily by the presence of persecutory or grandiose delusions, often associated with hallucinations. Excessive religiosity is sometimes seen. The patient's attitude is frequently hostile and aggressive, and his behavior tends to be consistent with his delusions. In general the disorder does not manifest the gross personality disorganization of the hebephrenic and catatonic types, perhaps because the patient uses the mechanism of projection, which ascribes to others characteristics he cannot accept in himself. Three subtypes of the disorder may sometimes be differentiated, depending on the predominant symptoms: hostile, grandiose, and hallucinatory.

295.4 Acute schizophrenic episode

This diagnosis does not apply to acute episodes of schizophrenic disorders described elsewhere. This condition is distinguished by the acute onset of schizophrenic symptoms, often associated with confusion, perplexity, ideas of reference, emotional turmoil, dreamlike dissociation, and excitement, depression, or fear. The acute onset distinguishes this condition from simple schizophrenia. In time these patients may take on the characteristics of catatonic, hebephrenic or paranoid schizophrenia, in which case their diagnosis should be changed accordingly. In many cases the patient recovers within weeks, but sometimes his disorganization becomes progressive. More frequently remission is followed by recurrence. (In DSM-I this condition was listed as "Schizophrenia, acute undifferentiated type.")

295.5 Schizophrenia, latent type

This category is for patients having clear symptoms of schizophrenia but no history of a psychotic schizophrenic episode. Disorders sometimes designated as incipient, pre-psychotic, pseudoneurotic, pseudopsychopathic, or borderline schizophrenia are categorized here. (This category includes some patients who were diagnosed in DSM-I under "Schizophrenic reaction, chronic undifferentiated type." Others formerly included in that DSM-I category are now classified under *Schizophrenia, other [and unspecified] types* (q.v.).)

295.6 Schizophrenia, residual type

This category is for patients showing signs of schizophrenia but

who, following a psychotic schizophrenic episode, are no longer psychotic.

295.7 Schizophrenia, schizo-affective type

This category is for patients showing a mixture of schizophrenic symptoms and pronounced elation or depression. Within this category it may be useful to distinguish excited from depressed types as follows:

295.73* Schizophrenia, schizo-affective type, excited*

295.74* Schizophrenia, schizo-affective type, depressed*

295.8* Schizophrenia, childhood type*

This category is for cases in which schizophrenic symptoms appear before puberty. The condition may be manifested by autistic, atypical, and withdrawn behavior; failure to develop identity separate from the mother's; and general unevenness, gross immaturity and inadequacy in development. These developmental defects may result in mental retardation, which should also be diagnosed. (This category is for use in the United States and does not appear in ICD-8. It is equivalent to "Schizophrenic reaction, childhood type" in DSM-I.)

295.90* Schizophrenia, chronic undifferentiated type*

This category is for patients who show mixed schizophrenic symptoms and who present definite schizophrenic thought, affect and behavior not classifiable under the other types of schizophrenia. It is distinguished from *Schizoid personality* (q.v.). (This category is equivalent to "Schizophrenic reaction, chronic undifferentiated type" in DSM-I except that it does not include cases now diagnosed as *Schizophrenia, latent type* and *Schizophrenia, other [and unspecified] types*.)

295.99* Schizophrenia, other [and unspecified] types*

This category is for any type of schizophrenia not previously described. (In DSM-I "Schizophrenic reaction, chronic undifferentiated type" included this category and also what is now called *Schizophrenia, latent type* and *Schizophrenia, chronic undifferentiated type*.)

296 Major affective disorders ((Affective psychoses))

This group of psychoses is characterized by a single disorder of mood, either extreme depression or elation, that dominates the mental life of the patient and is responsible for whatever loss of contact he has with his environment. The onset of the mood does not seem to be

related directly to a precipitating life experience and therefore is distinguishable from *Psychotic depressive reaction* and *Depressive neurosis*. (This category is not equivalent to the DSM-I heading "Affective reactions," which included "Psychotic depressive reaction.")

296.0 Involutional melancholia

This is a disorder occurring in the involutional period and characterized by worry, anxiety, agitation, and severe insomnia. Feelings of guilt and somatic preoccupations are frequently present and may be of delusional proportions. This disorder is distinguishable from *Manic-depressive illness* (q.v.) by the absence of previous episodes; it is distinguished from *Schizophrenia* (q.v.) in that impaired reality testing is due to a disorder of mood; and it is distinguished from *Psychotic depressive reaction* (q.v.) in that the depression is not due to some life experience. Opinion is divided as to whether this psychosis can be distinguished from the other affective disorders. It is, therefore, recommended that involutional patients not be given this diagnosis unless all other affective disorders have been ruled out. (In DSM-I this disorder was considered one of two subtypes of "Involutional Psychotic Reaction.")

Manic-depressive illnesses (Manic-depressive psychoses)

These disorders are marked by severe mood swings and a tendency to remission and recurrence. Patients may be given this diagnosis in the absence of a previous history of affective psychosis if there is no obvious precipitating event. This disorder is divided into three major subtypes: manic type, depressed type, and circular type.

296.1 Manic-depressive illness, manic type ((Manic-depressive psychosis, manic type))

This disorder consists exclusively of manic episodes. These episodes are characterized by excessive elation, irritability, talkativeness, flight of ideas, and accelerated speech and motor activity. Brief periods of depression sometimes occur, but they are never true depressive episodes.

296.2 Manic-depressive illness, depressed type ((Manic-depressive psychosis, depressed type))

This disorder consists exclusively of depressive episodes. These episodes are characterized by severely depressed mood and by mental and motor retardation progressing occasionally to stupor. Uneasiness, apprehension, perplexity and agitation may also be present.

When illusions, hallucinations, and delusions (usually of guilt or of hypochondriacal or paranoid ideas) occur, they are attributable to the dominant mood disorder. Because it is a primary mood disorder, this psychosis differs from the *Psychotic depressive reaction*, which is more easily attributable to precipitating stress. Cases incompletely labelled as "psychotic depression" should be classified here rather than under *Psychotic depressive reaction*.

296.3 Manic-depressive illness, circular type ((Manic-depressive psychosis, circular type))

This disorder is distinguished by at least one attack of both a depressive episode and a manic episode. This phenomenon makes clear why manic and depressed types are combined into a single category. (In DSM-I these cases were diagnosed under "Manic depressive reaction, other.") The current episode should be specified and coded as one of the following:

296.33* Manic-depressive illness, circular type, manic*

296.34* Manic-depressive illness, circular type, depressed*

296.8 Other major affective disorder ((Affective psychosis, other))

Major affective disorders for which a more specific diagnosis has not been made are included here. It is also for "mixed" manic-depressive illness, in which manic and depressive symptoms appear almost simultaneously. It does not include *Psychotic depressive reaction* (q.v.) or *Depressive neurosis* (q.v.). (In DSM-I this category was included under "Manic depressive reaction, other.")

[296.9 Unspecified major affective disorder]

[Affective disorder not otherwise specified] [Manic-depressive illness not otherwise specified]

297 Paranoid states

These are psychotic disorders in which a delusion, generally persecutory or grandiose, is the essential abnormality. Disturbances in mood, behavior and thinking (including hallucinations) are derived from this delusion. This distinguishes paranoid states from the affective psychoses and schizophrenias, in which mood and thought disorders, respectively, are the central abnormalities. Most authorities, however, question whether disorders in this group are distinct clinical entities and not merely variants of schizophrenia or paranoid personality.

297.0 Paranoia

This extremely rare condition is characterized by gradual development of an intricate, complex, and elaborate paranoid system based on and often proceeding logically from misinterpretation of an actual event. Frequently the patient considers himself endowed with unique and superior ability. In spite of a chronic course the condition does not seem to interfere with the rest of the patient's thinking and personality.

297.1 Involutional paranoid state ((Involutional paraphrenia))

This paranoid psychosis is characterized by delusion formation with onset in the involutional period. Formerly it was classified as a paranoid variety of involutional psychotic reaction. The absence of conspicuous thought disorders typical of schizophrenia distinguishes it from that group.

297.9 Other paranoid state

This is a residual category for paranoid psychotic reactions not classified earlier.

298 Other psychoses**298.0 Psychotic depressive reaction ((Reactive depressive psychosis))**

This psychosis is distinguished by a depressive mood attributable to some experience. Ordinarily the individual has no history of repeated depressions or cyclothymic mood swings. The differentiation between this condition and *Depressive neurosis* (q.v.) depends on whether the reaction impairs reality testing or functional adequacy enough to be considered a psychosis. (In DSM-I this condition was included with the affective psychoses.)

[298.1 Reactive excitation]**[298.2 Reactive confusion]****[Acute or subacute confusional state]****[298.3 Acute paranoid reaction]****[298.9 Reactive psychosis, unspecified]****[299 Unspecified psychosis]****[Dementia, insanity or psychosis not otherwise specified]**

This is not a diagnosis but is listed here for librarians and statisticians to use in coding incomplete diagnoses. Clinicians are

expected to complete a differential diagnosis for patients who manifest features of several psychoses.

IV. NEUROSES (300)**300 Neuroses**

Anxiety is the chief characteristic of the neuroses. It may be felt and expressed directly, or it may be controlled unconsciously and automatically by conversion, displacement and various other psychological mechanisms. Generally, these mechanisms produce symptoms experienced as subjective distress from which the patient desires relief.

The neuroses, as contrasted to the psychoses, manifest neither gross distortion or misinterpretation of external reality, nor gross personality disorganization. A possible exception to this is hysterical neurosis, which some believe may occasionally be accompanied by hallucinations and other symptoms encountered in psychoses.

Traditionally, neurotic patients, however severely handicapped by their symptoms, are not classified as psychotic because they are aware that their mental functioning is disturbed.

300.0 Anxiety neurosis

This neurosis is characterized by anxious over-concern extending to panic and frequently associated with somatic symptoms. Unlike *Phobic neurosis* (q.v.), anxiety may occur under any circumstances and is not restricted to specific situations or objects. This disorder must be distinguished from normal apprehension or fear, which occurs in realistically dangerous situations.

300.1 Hysterical neurosis

This neurosis is characterized by an involuntary psychogenic loss or disorder of function. Symptoms characteristically begin and end suddenly in emotionally charged situations and are symbolic of the underlying conflicts. Often they can be modified by suggestion alone. This is a new diagnosis that encompasses the former diagnoses "Conversion reaction" and "Dissociative reaction" in DSM-I. This distinction between conversion and dissociative reactions should be preserved by using one of the following diagnoses whenever possible.

300.13* Hysterical neurosis, conversion type*

In the conversion type, the special senses or voluntary nervous system are affected, causing such symptoms as blindness, deafness,

anosmia, anaesthesia, paraesthesia, paralyses, ataxias, akinesias, and dyskinesias. Often the patient shows an inappropriate lack of concern or *belle indifférence* about these symptoms, which may actually provide secondary gains by winning him sympathy or relieving him of unpleasant responsibilities. This type of hysterical neurosis must be distinguished from psychophysiological disorders, which are mediated by the autonomic nervous system; from malinger, which is done consciously; and from neurological lesions, which cause anatomically circumscribed symptoms.

300.14* Hysterical neurosis, dissociative type*

In the dissociative type, alterations may occur in the patient's state of consciousness or in his identity, to produce such symptoms as amnesia, somnambulism, fugue, and multiple personality.

300.2 Phobic neurosis

This condition is characterized by intense fear of an object or situation which the patient consciously recognizes as no real danger to him. His apprehension may be experienced as faintness, fatigue, palpitations, perspiration, nausea, tremor, and even panic. Phobias are generally attributed to fears displaced to the phobic object or situation from some other object of which the patient is unaware. A wide range of phobias has been described.

300.3 Obsessive compulsive neurosis

This disorder is characterized by the persistent intrusion of unwanted thoughts, urges, or actions that the patient is unable to stop. The thoughts may consist of single words or ideas, ruminations, or trains of thought often perceived by the patient as nonsensical. The actions vary from simple movements to complex rituals such as repeated handwashing. Anxiety and distress are often present either if the patient is prevented from completing his compulsive ritual or if he is concerned about being unable to control it himself.

300.4 Depressive neurosis

This disorder is manifested by an excessive reaction of depression due to an internal conflict or to an identifiable event such as the loss of a love object or cherished possession. It is to be distinguished from *Involitional melancholia* (q.v.) and *Manic-depressive illness* (q.v.). *Reactive depressions* or *Depressive reactions* are to be classified here.

300.5 Neuroasthenic neurosis ((Neurasthenia))

This condition is characterized by complaints of chronic weakness,

easy fatigability, and sometimes exhaustion. Unlike hysterical neurosis the patient's complaints are genuinely distressing to him and there is no evidence of secondary gain. It differs from *Anxiety neurosis* (q.v.) and from the *Psychophysiological disorders* (q.v.) in the nature of the predominant complaint. It differs from *Depressive neurosis* (q.v.) in the moderateness of the depression and in the chronicity of its course. (In DSM-I this condition was called "Psychophysiological nervous system reaction.")

300.6 Depersonalization neurosis ((Depersonalization syndrome))

This syndrome is dominated by a feeling of unreality and of estrangement from the self, body, or surroundings. This diagnosis should not be used if the condition is part of some other mental disorder, such as an acute situational reaction. A brief experience of depersonalization is not necessarily a symptom of illness.

300.7 Hypochondriacal neurosis

This condition is dominated by preoccupation with the body and with fear of presumed diseases of various organs. Though the fears are not of delusional quality as in psychotic depressions, they persist despite reassurance. The condition differs from hysterical neurosis in that there are no actual losses or distortions of function.

300.8 Other neurosis

This classification includes specific psychoneurotic disorders not classified elsewhere such as "writer's cramp" and other occupational neuroses. Clinicians should not use this category for patients with "mixed" neuroses, which should be diagnosed according to the predominant symptom.

[300.9 Unspecified neurosis]

This category is not a diagnosis. It is for the use of record librarians and statisticians to code incomplete diagnoses.

V. PERSONALITY DISORDERS AND CERTAIN OTHER NON-PSYCHOTIC MENTAL DISORDERS (301—304)

301 Personality disorders

This group of disorders is characterized by deeply ingrained maladaptive patterns of behavior that are perceptibly different in quality from psychotic and neurotic symptoms. Generally, these are life-long patterns, often recognizable by the time of adolescence or earlier. Sometimes the

pattern is determined primarily by malfunctioning of the brain, but such cases should be classified under one of the non-psychotic organic brain syndromes rather than here. (In DSM-I "Personality Disorders" also included disorders now classified under *Sexual deviation*, *Alcoholism*, and *Drug dependence*.)

301.0 Paranoid personality

This behavioral pattern is characterized by hypersensitivity, rigidity, unwarranted suspicion, jealousy, envy, excessive self-importance, and a tendency to blame others and ascribe evil motives to them. These characteristics often interfere with the patient's ability to maintain satisfactory interpersonal relations. Of course, the presence of suspicion of itself does not justify this diagnosis, since the suspicion may be warranted in some instances.

301.1 Cyclothymic personality ((Affective personality))

This behavior pattern is manifested by recurring and alternating periods of depression and elation. Periods of elation may be marked by ambition, warmth, enthusiasm, optimism, and high energy. Periods of depression may be marked by worry, pessimism, low energy, and a sense of futility. These mood variations are not readily attributable to external circumstances. If possible, the diagnosis should specify whether the mood is characteristically depressed, hypomanic, or alternating.

301.2 Schizoid personality

This behavior pattern manifests shyness, over-sensitivity, seclusiveness, avoidance of close or competitive relationships, and often eccentricity. Autistic thinking without loss of capacity to recognize reality is common, as is daydreaming and the inability to express hostility and ordinary aggressive feelings. These patients react to disturbing experiences and conflicts with apparent detachment.

301.3 Explosive personality (Epileptoid personality disorder)

This behavior pattern is characterized by gross outbursts of rage or of verbal or physical aggressiveness. These outbursts are strikingly different from the patient's usual behavior, and he may be regretful and repentant for them. These patients are generally considered excitable, aggressive and over-responsive to environmental pressures. It is the intensity of the outbursts and the individual's inability to control them which distinguishes this group. Cases diagnosed as "aggressive personality" are classified here. If the patient is amnesic

for the outbursts, the diagnosis of *Hysterical neurosis*, *Non-psychotic OBS with epilepsy* or *Psychosis with epilepsy* should be considered.

301.4 Obsessive compulsive personality ((Anankastic personality))

This behavior pattern is characterized by excessive concern with conformity and adherence to standards of conscience. Consequently, individuals in this group may be rigid, over-inhibited, over-conscientious, over-dutyful, and unable to relax easily. This disorder may lead to an *Obsessive compulsive neurosis* (q.v.), from which it must be distinguished.

301.5 Hysterical personality (Histrionic personality disorder)

These behavior patterns are characterized by excitability, emotional instability, over-reactivity, and self-dramatization. This self-dramatization is always attention-seeking and often seductive, whether or not the patient is aware of its purpose. These personalities are also immature, self-centered, often vain, and usually dependent on others. This disorder must be differentiated from *Hysterical neurosis* (q.v.).

301.6 Asthenic personality

This behavior pattern is characterized by easy fatigability, low energy level, lack of enthusiasm, marked incapacity for enjoyment, and oversensitivity to physical and emotional stress. This disorder must be differentiated from *Neuroasthenic neurosis* (q.v.).

301.7 Antisocial personality

This term is reserved for individuals who are basically unsocialized and whose behavior pattern brings them repeatedly into conflict with society. They are incapable of significant loyalty to individuals, groups, or social values. They are grossly selfish, callous, irresponsible, impulsive, and unable to feel guilt or to learn from experience and punishment. Frustration tolerance is low. They tend to blame others or offer plausible rationalizations for their behavior. A mere history of repeated legal or social offenses is not sufficient to justify this diagnosis. *Group delinquent reaction of childhood (or adolescence)* (q.v.), and *Social maladjustment without manifest psychiatric disorder* (q.v.) should be ruled out before making this diagnosis.

301.81* Passive-aggressive personality*

This behavior pattern is characterized by both passivity and aggressiveness. The aggressiveness may be expressed passively, for example by obstructionism, pouting, procrastination, intentional in-

efficiency, or stubbornness. This behavior commonly reflects hostility which the individual feels he dare not express openly. Often the behavior is one expression of the patient's resentment at failing to find gratification in a relationship with an individual or institution upon which he is over-dependent.

301.82* Inadequate personality*

This behavior pattern is characterized by ineffectual responses to emotional, social, intellectual and physical demands. While the patient seems neither physically nor mentally deficient, he does manifest inadaptability, ineptness, poor judgment, social instability, and lack of physical and emotional stamina.

301.89* Other personality disorders of specified types (Immature personality, Passive-dependent personality, etc.)*

301.9 [Unspecified personality disorder]

302 Sexual deviations

This category is for individuals whose sexual interests are directed primarily toward objects other than people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstances as in necrophilia, pedophilia, sexual sadism, and fetishism. Even though many find their practices distasteful, they remain unable to substitute normal sexual behavior for them. This diagnosis is not appropriate for individuals who perform deviant sexual acts because normal sexual objects are not available to them.

302.0 Homosexuality

302.1 Fetishism

302.2 Pedophilia

302.3 Transvestitism

302.4 Exhibitionism

302.5* Voyeurism*

302.6* Sadism*

302.7* Masochism*

302.8 Other sexual deviation

[302.9 Unspecified sexual deviation]

303 Alcoholism

This category is for patients whose alcohol intake is great enough to damage their physical health, or their personal or social functioning, or when it has become a prerequisite to normal functioning. If the alcoholism is due to another mental disorder, both diagnoses should be made. The following types of alcoholism are recognized:

303.0 Episodic excessive drinking

If alcoholism is present and the individual becomes intoxicated as frequently as four times a year, the condition should be classified here. Intoxication is defined as a state in which the individual's coordination or speech is definitely impaired or his behavior is clearly altered.

303.1 Habitual excessive drinking

This diagnosis is given to persons who are alcoholic and who either become intoxicated more than 12 times a year or are recognizably under the influence of alcohol more than once a week, even though not intoxicated.

303.2 Alcohol addiction

This condition should be diagnosed when there is direct or strong presumptive evidence that the patient is dependent on alcohol. If available, the best direct evidence of such dependence is the appearance of withdrawal symptoms. The inability of the patient to go one day without drinking is presumptive evidence. When heavy drinking continues for three months or more it is reasonable to presume addiction to alcohol has been established.

303.9 Other [and unspecified] alcoholism

304 Drug dependence

This category is for patients who are addicted to or dependent on drugs other than alcohol, tobacco, and ordinary caffeine-containing beverages. Dependence on medically prescribed drugs is also excluded so long as the drug is medically indicated and the intake is proportionate to the medical need. The diagnosis requires evidence of habitual use or a clear sense of need for the drug. Withdrawal symptoms are the only evidence of dependence; while always present when opium derivatives are withdrawn, they may be entirely absent when cocaine or marihuana are withdrawn. The diagnosis may stand alone or be coupled with any other diagnosis.

304.0 Drug dependence, opium, opium alkaloids and their derivatives

304.1 Drug dependence, synthetic analgesics with morphine-like effects

304.2 Drug dependence, barbiturates

304.3 Drug dependence, other hypnotics and sedatives or "tranquilizers"

304.4 Drug dependence, cocaine

304.5 Drug dependence, Cannabis sativa (hashish, marihuana)

304.6 Drug dependence, other psycho-stimulants (amphetamines, etc.)

304.7 Drug dependence, hallucinogens

304.8 Other drug dependence

[304.9 Unspecified drug dependence]

VI. PSYCHOPHYSIOLOGIC DISORDERS (305)

305 Psychophysiological disorders ((Physical disorders of presumably psychogenic origin))

This group of disorders is characterized by physical symptoms that are caused by emotional factors and involve a single organ system, usually under autonomic nervous system innervation. The physiological changes involved are those that normally accompany certain emotional states, but in these disorders the changes are more intense and sustained. The individual may not be consciously aware of his emotional state. If there is an additional psychiatric disorder, it should be diagnosed separately, whether or not it is presumed to contribute to the physical disorder. The specific physical disorder should be named and classified in one of the following categories.

305.0 Psychophysiological skin disorder

This diagnosis applies to skin reactions such as neurodermatosis, pruritis, atopic dermatitis, and hyperhydrosis in which emotional factors play a causative role.

305.1 Psychophysiological musculoskeletal disorder

This diagnosis applies to musculoskeletal disorders such as backache,

muscle cramps, and myalgias, and tension headaches in which emotional factors play a causative role. Differentiation from hysterical neurosis is of prime importance and at times extremely difficult.

305.2 Psychophysiological respiratory disorder

This diagnosis applies to respiratory disorders such as bronchial asthma, hyperventilation syndromes, sighing, and hiccoughs in which emotional factors play a causative role.

305.3 Psychophysiological cardiovascular disorder

This diagnosis applies to cardiovascular disorders such as paroxysmal tachycardia, hypertension, vascular spasms, and migraine in which emotional factors play a causative role.

305.4 Psychophysiological hemic and lymphatic disorder

Here may be included any disturbances in the hemic and lymphatic system in which emotional factors are found to play a causative role. ICD-8 has included this category so that all organ systems will be covered.

305.5 Psychophysiological gastro-intestinal disorder

This diagnosis applies to specific types of gastrointestinal disorders such as peptic ulcer, chronic gastritis, ulcerative or mucous colitis, constipation, hyperacidity, pylorospasm, "heartburn," and "irritable colon" in which emotional factors play a causative role.

305.6 Psychophysiological genito-urinary disorder

This diagnosis applies to genito-urinary disorders such as disturbances in menstruation and micturition, dyspareunia, and impotence in which emotional factors play a causative role.

305.7 Psychophysiological endocrine disorder

This diagnosis applies to endocrine disorders in which emotional factors play a causative role. The disturbance should be specified.

305.8 Psychophysiological disorder of organ of special sense

This diagnosis applies to any disturbance in the organs of special sense in which emotional factors play a causative role. Conversion reactions are excluded.

305.9 Psychophysiological disorder of other type

This diagnosis applies to skin reactions such as neurodermatosis, pruritis, atopic dermatitis, and hyperhydrosis in which emotional factors play a causative role.

VII. SPECIAL SYMPTOMS (306)

306 Special symptoms not elsewhere classified

This category is for the occasional patient whose psychopathology is

manifested by a single specific symptom. An example might be anorexia nervosa under *Feeding disturbance* as listed below. It does not apply, however, if the symptom is the result of an organic illness or defect or other mental disorder. For example, anorexia nervosa due to schizophrenia would not be included here.

306.0 Speech disturbance

306.1 Specific learning disturbance

306.2 Tic

306.3 Other psychomotor disorder

306.4 Disorder of sleep

306.5 Feeding disturbance

306.6 Enuresis

306.7 Encopresis

306.8 Cephalgia

306.9 Other special symptom

VIII. TRANSIENT SITUATIONAL DISTURBANCES (307)

307* Transient situational disturbances¹

This major category is reserved for more or less transient disorders of any severity (including those of psychotic proportions) that occur in individuals without any apparent underlying mental disorders and that represent an acute reaction to overwhelming environmental stress. A diagnosis in this category should specify the cause and manifestations of the disturbance so far as possible. If the patient has good adaptive capacity his symptoms usually recede as the stress diminishes. If, however, the symptoms persist after the stress is removed, the diagnosis of another mental disorder is indicated. Disorders in this category are classified according to the patient's developmental stage as follows:

IX. BEHAVIOR DISORDERS OF CHILDHOOD AND ADOLESCENCE (308)

308* Behavior disorders of childhood and adolescence ((Behavior disorders of childhood))²

This major category is reserved for disorders occurring in childhood and adolescence that are more stable, internalized, and resistant to

307.0* Adjustment reaction of infancy*

Example: A grief reaction associated with separation from patient's mother, manifested by crying spells, loss of appetite and severe social withdrawal.

307.1* Adjustment reaction of childhood*

Example: Jealousy associated with birth of patient's younger brother and manifested by nocturnal enuresis, attention-getting behavior, and fear of being abandoned.

307.2* Adjustment reaction of adolescence*

Example: Irritability and depression associated with school failure and manifested by temper outbursts, brooding and discouragement.

307.3* Adjustment reaction of adult life*

Example: Resentment with depressive tone associated with an unwanted pregnancy and manifested by hostile complaints and suicidal gestures.

Example: Fear associated with military combat and manifested by trembling, running and hiding.

Example: A Ganser syndrome associated with death sentence and manifested by incorrect but approximate answers to questions.

307.4* Adjustment reaction of late life*

Example: Feelings of rejection associated with forced retirement and manifested by social withdrawal.

¹ The terms included under DSM-II Category 307*, "Transient situational disturbances," differ from those in Category 307 of the ICD. DSM-II Category 307*, "Transient situational disturbances," contains adjustment reactions of infancy and childhood (307.0*), adolescence (307.1*), adolescence (307.2*), adult life (307.3*), and late life (307.4*). ICD Category 307, "Transient situational disturbances," includes only the adjustment reactions of adolescence, adult life and late life. ICD 308, "Behavioral disorders of children," contains the reactions of infancy and childhood. These differences must be taken into account in preparing statistical tabulations to conform to ICD categories.

² The terms included under DSM-II Category 308*, "Behavioral disorders of childhood and adolescence," differ from those in Category 308 of the ICD. DSM-II Category 308* includes "Behavioral disorders of childhood and adolescence," whereas ICD Category 308 includes only "Behavioral disorders of childhood." DSM-II Category 308* does not include "Adjustment reactions of infancy and childhood," whereas ICD Category 308 does. In the DSM-II classification, "Adjustment reactions of infancy and childhood" are allocated to 307* (Transitional situational disturbances). These differences should be taken into account in preparing statistical tabulations to conform to the ICD categories.

treatment than *Transient situational disturbances* (q.v.) but less so than *Psychoses*, *Neuroses*, and *Personality disorders* (q.v.). This intermediate stability is attributed to the greater fluidity of all behavior at this age. Characteristic manifestations include such symptoms as overactivity, inattentiveness, shyness, feeling of rejection, over-aggressiveness, timidity, and delinquency.

308.0* Hyperkinetic reaction of childhood (or adolescence)*

This disorder is characterized by overactivity, restlessness, distractibility, and short attention span, especially in young children; the behavior usually diminishes in adolescence.

If this behavior is caused by organic brain damage, it should be diagnosed under the appropriate non-psychotic *organic brain syndrome* (q.v.).

308.1* Withdrawing reaction of childhood (or adolescence)*

This disorder is characterized by seclusiveness, detachment, sensitivity, shyness, timidity, and general inability to form close interpersonal relationships. This diagnosis should be reserved for those who cannot be classified as having *Schizophrenia* (q.v.) and whose tendencies toward withdrawal have not yet stabilized enough to justify the diagnosis of *Schizoid personality* (q.v.).

308.2* Overanxious reaction of childhood (or adolescence)*

This disorder is characterized by chronic anxiety, excessive and unrealistic fears, sleeplessness, nightmares, and exaggerated autonomic responses. The patient tends to be immature, self-conscious, grossly lacking in self-confidence, conforming, inhibited, dutiful, approval-seeking, and apprehensive in new situations and unfamiliar surroundings. It is to be distinguished from *Neuroses* (q.v.).

X. CONDITIONS WITHOUT MANIFEST PSYCHIATRIC DISORDER AND NON-SPECIFIC CONDITIONS (316*-318*)

316* Social maladjustments without manifest psychiatric disorder

This category is for recording the conditions of individuals who are psychiatrically normal but who nevertheless have severe enough problems to warrant examination by a psychiatrist. These conditions may either become or precipitate a diagnosable mental disorder.

316.0* Marital maladjustment*

This category is for individuals who are psychiatrically normal but who have significant conflicts or maladjustments in marriage.

308.4* Unsocialized aggressive reaction of childhood (or adolescence)*

This disorder is characterized by overt or covert hostile disobedience, quarrelsome ness, physical and verbal aggressiveness, vengefulness, and destructiveness. Temper tantrums, solitary stealing, lying, and

hostile teasing of other children are common. These patients usually have no consistent parental acceptance and discipline. This diagnosis should be distinguished from *Anisocial personality* (q.v.), *Runaway reaction of childhood (or adolescence)* (q.v.), and *Group delinquent reaction of childhood (or adolescence)* (q.v.).

308.5* Group delinquent reaction of childhood (or adolescence)*

Individuals with this disorder have acquired the values, behavior, and skills of a delinquent peer group or gang to whom they are loyal and with whom they characteristically steal, skip school, and stay out late at night. The condition is more common in boys than girls. When group delinquency occurs with girls it usually involves sexual delinquency, although shoplifting is also common.

308.9* Other reaction of childhood (or adolescence)*

Here are to be classified children and adolescents having disorders not described in this group but which are nevertheless more serious than transient situational disturbances and less serious than psychoses, neuroses, and personality disorders. The particular disorder should be specified.

316.1* Social maladjustment*

This category is for individuals thrown into an unfamiliar culture (culture shock) or into a conflict arising from divided loyalties to two cultures.

316.2* Occupational maladjustment*

This category is for psychiatrically normal individuals who are grossly maladjusted in their work.

316.3* Dysocial behavior*

This category is for individuals who are not classifiable as anti-social personalities, but who are predatory and follow more or less criminal pursuits, such as racketeers, dishonest gamblers, prostitutes, and dope peddlers. (DSM-I classified this condition as "Sociopathic personality disorder, dyssocial type.")

316.9* Other social maladjustment***317* Non-specific conditions***

This category is for conditions that cannot be classified under any of the previous categories, even after all facts bearing on the case have been investigated. This category is not for "Diagnosis deferred" (q.v.).

318* No mental disorder*

This term is used when, following psychiatric examination, none of the previous disorders is found. It is not to be used for patients whose disorders are in remission.

XI. NON-DIAGNOSTIC TERMS FOR ADMINISTRATIVE USE**(319*)****319* Non-diagnostic terms for administrative use*****319.0* Diagnosis deferred*****319.1* Boarder*****319.2* Experiment only*****319.9* Other***