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CHAPTER V

Mental and behavioural disorders (F00–F99)

Incl.: disorders of psychological development

Excl.: symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00–R99)

This chapter contains the following blocks:

F00–F09	Organic, including symptomatic, mental disorders
F10–F19	Mental and behavioural disorders due to psychoactive substance use
F20–F29	Schizophrenia, schizotypal and delusional disorders
F30–F39	Mood [affective] disorders
F40–F48	Neurotic, stress-related and somatoform disorders
F50–F59	Behavioural syndromes associated with physiological disturbances and physical factors
F60–F69	Disorders of adult personality and behaviour
F70–F79	Mental retardation
F80–F89	Disorders of psychological development
F90–F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
F99	Unspecified mental disorder

Asterisk categories for this chapter are provided as follows:

F00*	Dementia in Alzheimer disease
F02*	Dementia in other diseases classified elsewhere

Organic, including symptomatic, mental disorders (F00–F09)

This block comprises a range of mental disorders grouped together on the basis of their having in common a demonstrable etiology in cerebral disease, brain injury, or other insult leading to cerebral dysfunction. The dysfunction may be primary, as in diseases, injuries, and insults that affect the brain directly and selectively; or secondary, as in systemic diseases and disorders that attack the brain only as one of the multiple organs or systems of the body that are involved.

Dementia (F00–F03) is a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement. Consciousness is not clouded. The impairments of cognitive function are commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behaviour or motivation. This syndrome occurs in Alzheimer disease, in cerebrovascular disease, and in other conditions primarily or secondarily affecting the brain.

Use additional code, if desired, to identify the underlying disease.

F00* Dementia in Alzheimer disease (G30.-†)

Alzheimer disease is a primary degenerative cerebral disease of unknown etiology with characteristic neuropathological and neurochemical features. The disorder is usually insidious in onset and develops slowly but steadily over a period of several years.

F00.0* Dementia in Alzheimer disease with early onset (G30.0†)

Dementia in Alzheimer disease with onset before the age of 65 years, with a relatively rapid deteriorating course and with marked multiple disorders of the higher cortical functions.

Alzheimer disease, type 2
Presenile dementia, Alzheimer type
Primary degenerative dementia of the Alzheimer type, presenile onset

F00.1* Dementia in Alzheimer disease with late onset (G30.1†)

Dementia in Alzheimer disease with onset after the age of 65 years, usually in the late 70s or thereafter, with a slow progression, and with memory impairment as the principal feature.

Alzheimer disease, type 1
Primary degenerative dementia of the Alzheimer type, senile onset
Senile dementia, Alzheimer type

F00.2* Dementia in Alzheimer disease, atypical or mixed type (G30.8†)

Atypical dementia, Alzheimer type

F00.9* Dementia in Alzheimer disease, unspecified (G30.9†)

F01 Vascular dementia

Vascular dementia is the result of infarction of the brain due to vascular disease, including hypertensive cerebrovascular disease. The infarcts are usually small but cumulative in their effect. Onset is usually in later life.

Incl.: arteriosclerotic dementia

F01.0 Vascular dementia of acute onset

Usually develops rapidly after a succession of strokes from cerebrovascular thrombosis, embolism or haemorrhage. In rare cases, a single large infarction may be the cause.

F01.1 Multi-infarct dementia

Gradual in onset, following a number of transient ischaemic episodes that produce an accumulation of infarcts in the cerebral parenchyma.

Predominantly cortical dementia

F01.2 Subcortical vascular dementia

Includes cases with a history of hypertension and foci of ischaemic destruction in the deep white matter of the cerebral hemispheres. The cerebral cortex is usually preserved and this contrasts with the clinical picture, which may closely resemble that of dementia in Alzheimer disease.

F01.3 Mixed cortical and subcortical vascular dementia

F01.8 Other vascular dementia

F01.9 Vascular dementia, unspecified

F02* Dementia in other diseases classified elsewhere

Cases of dementia due, or presumed to be due, to causes other than Alzheimer disease or cerebrovascular disease. Onset may be at any time in life, though rarely in old age.

F02.0* Dementia in Pick disease (G31.0†)

A progressive dementia, commencing in middle age, characterized by early, slowly progressing changes of character and social deterioration, followed by impairment of intellect, memory and language functions, with apathy, euphoria and, occasionally, extrapyramidal phenomena.

F02.1* Dementia in Creutzfeldt–Jakob disease (A81.0†)

A progressive dementia with extensive neurological signs, due to specific neuropathological changes that are presumed to be caused by a transmissible agent. Onset is usually in middle or later life, but may be at any adult age. The course is subacute, leading to death within one to two years.

F02.2* Dementia in Huntington disease (G10†)

A dementia occurring as part of a widespread degeneration of the brain. The disorder is transmitted by a single autosomal dominant gene. Symptoms typically emerge in the third and fourth decade. Progression is slow, leading to death, usually within 10 to 15 years.

Dementia in Huntington chorea

F02.3* Dementia in Parkinson disease (G20†)

A dementia developing in the course of established Parkinson disease. No particular distinguishing clinical features have yet been demonstrated.

Dementia in:
- paralysis agitans
- parkinsonism

F02.4* Dementia in human immunodeficiency virus [HIV] disease (B22.0†)

Dementia developing in the course of HIV disease, in the absence of a concurrent illness or condition other than HIV infection that could explain the clinical features.

F02.8* Dementia in other specified diseases classified elsewhere

Dementia (in):
- cerebral lipidosis (E75.-†)
- epilepsy (G40.-†)
- hepatolenticular degeneration (E83.0†)
- hypercalcaemia (E83.5†)
- hypothyroidism, acquired (E01.-† , E03.-†)
- intoxications (T36-T65†)
- Lewy body (ies) (disease) (G31.8†)
- multiple sclerosis (G35†)
- neurosyphilis (A52.1†)
- niacin deficiency [pellagra] (E52†)
- polyarteritis nodosa (M30.0†)
- systemic lupus erythematosus (M32.-†)
- trypanosomiasis (B56.-† , B57.-†)
- uraemia (N18.5†)
- vitamin B_{12} deficiency (E53.8†)

F03 Unspecified dementia

Incl.: presenile:
- dementia NOS
- psychosis NOS

primary degenerative dementia NOS
senile:
- dementia:
  - NOS
  - depressed or paranoid type
- psychosis NOS

Excl.: senile dementia with delirium or acute confusional state (F05.1)
senility NOS (R54)

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

A syndrome of prominent impairment of recent and remote memory while immediate recall is preserved, with reduced ability to learn new material and disorientation in time. Confabulation may be a marked feature, but perception and other cognitive functions, including the intellect, are usually intact. The prognosis depends on the course of the underlying lesion.

Incl.: Korsakov psychosis or syndrome, nonalcoholic

Excl.: amnesia:
- NOS (R41.3)
- anterograde (R41.1)
- dissociative (F44.0)
- retrograde (R41.2)

Korsakov syndrome:
- alcohol-induced or unspecified (F10.6)
- induced by other psychoactive substances (F11–F19 with common fourth character .6)

F05 Delirium, not induced by alcohol and other psychoactive substances

An etiologically nonspecific organic cerebral syndrome characterized by concurrent disturbances of consciousness and attention, perception, thinking, memory, psychomotor behaviour, emotion and the sleep–wake schedule. The duration is variable and the degree of severity ranges from mild to very severe.

Incl.: acute or subacute:
- brain syndrome
- confusional state (nonalcoholic)
- infective psychosis
- organic reaction
- psycho-organic syndrome

Excl.: delirium tremens, alcohol-induced or unspecified (F10.4)

F05.0 Delirium not superimposed on dementia, so described

F05.1 Delirium superimposed on dementia

Conditions meeting the above criteria but developing in the course of a dementia (F00–F03).

F05.8 Other delirium

Delirium of mixed origin
Postoperative delirium

F05.9 Delirium, unspecified

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

Includes miscellaneous conditions causally related to brain disorder due to primary cerebral disease, to systemic disease affecting the brain secondarily, to exogenous toxic substances or hormones, to endocrine disorders or to other somatic illnesses.

Excl.: associated with:
- delirium (F05.-)
- dementia as classified in F00–F03

resulting from use of alcohol and other psychoactive substances (F10–F19)

F06.0 Organic hallucinosis

A disorder of persistent or recurrent hallucinations, usually visual or auditory, that occur in clear consciousness and may or may not be recognized by the subject as such. Delusional elaboration of the hallucinations may occur, but delusions do not dominate the clinical picture; insight may be preserved.

Organic hallucinatory state (nonalcoholic)

Excl.: alcoholic hallucinosis (F10.5)
schizophrenia (F20.-)

F06.1 Organic catatonic disorder

A disorder of diminished (stupor) or increased (excitement) psychomotor activity associated with catatonic symptoms. The extremes of psychomotor disturbance may alternate.

Excl.: catatonic schizophrenia (F20.2)
stupor:
- NOS (R40.1)
- dissociative (F44.2)

F06.2 Organic delusional [schizophrenia-like] disorder

A disorder in which persistent or recurrent delusions dominate the clinical picture. The delusions may be accompanied by hallucinations. Some features suggestive of schizophrenia, such as bizarre hallucinations or thought disorder, may be present.

Paranoid and paranoid-hallucinatory organic states
Schizophrenia-like psychosis in epilepsy

Excl.: disorder:
- acute and transient psychotic (F23.-)
- persistent delusional (F22.-)
- psychotic drug-induced (F11–F19 with common fourth character .5)

schizophrenia (F20.-)

F06.3 Organic mood [affective] disorders

Disorders characterized by a change in mood or affect, usually accompanied by a change in the overall level of activity, depressive, hypomanic, manic or bipolar (see F30–F38), but arising as a consequence of an organic disorder.

Excl.: mood disorders, nonorganic or unspecified (F30–F39)

F06.4 Organic anxiety disorder

A disorder characterized by the essential descriptive features of a generalized anxiety disorder (F41.1), a panic disorder (F41.0) or a combination of both, but arising as a consequence of an organic disorder.

Excl.: anxiety disorders, nonorganic or unspecified (F41.-)

F06.5 Organic dissociative disorder

A disorder characterized by a partial or complete loss of the normal integration between memories of the past, awareness of identity and immediate sensations, and control of bodily movements (see F44.-), but arising as a consequence of an organic disorder.

Excl.: dissociative [conversion] disorders, nonorganic or unspecified (F44.-)

F06.6 Organic emotionally labile [asthenic] disorder

A disorder characterized by emotional incontinence or lability, fatigability and a variety of unpleasant physical sensations (e.g. dizziness) and pains, but arising as a consequence of an organic disorder.

Excl.: somatoform disorders, nonorganic or unspecified (F45.-)

F06.7 Mild cognitive disorder

A disorder characterized by impairment of memory, learning difficulties and reduced ability to concentrate on a task for more than brief periods. There is often a marked feeling of mental fatigue when mental tasks are attempted, and new learning is found to be subjectively difficult, even when objectively successful. None of these symptoms is so severe that a diagnosis of either dementia (F00–F03) or delirium (F05.-) can be made. This diagnosis should be made only in association with a specified physical disorder, and should not be made in the presence of any of the mental or behavioural disorders classified to F10–F99. The disorder may precede, accompany or follow a wide variety of infections and physical disorders, both cerebral and systemic, but direct evidence of cerebral involvement is not necessarily present. It can be differentiated from postencephalitic syndrome (F07.1) and postconcussional syndrome (F07.2) by its different etiology, more restricted range of generally milder symptoms and usually shorter duration.

F06.8 Other specified mental disorders due to brain damage and dysfunction and to physical disease

Epileptic psychosis NOS

F06.9 Unspecified mental disorder due to brain damage and dysfunction and to physical disease

Organic:
- brain syndrome NOS
- mental disorder NOS

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

Alteration of personality and behaviour can be a residual or concomitant disorder of brain disease, damage or dysfunction.

F07.0 Organic personality disorder

A disorder characterized by a significant alteration of the habitual patterns of behaviour displayed by the subject premorbidly, involving the expression of emotions, needs and impulses. Impairment of cognitive and thought functions and altered sexuality may also be part of the clinical picture.

Organic:
- pseudopsychopathic personality
- pseudoretarded personality

Syndrome:
- frontal lobe
- limbic epilepsy personality
- lobotomy
- postleucotomy

Excl.: enduring personality change after:
- catastrophic experience (F62.0)
- psychiatric illness (F62.1)

postconcussional syndrome (F07.2)
postencephalitic syndrome (F07.1)
specific personality disorder (F60.-)

F07.1 Postencephalitic syndrome

Residual nonspecific and variable behavioural change following recovery from either viral or bacterial encephalitis. The principal difference between this disorder and the organic personality disorders is that it is reversible.

Excl.: organic personality disorder (F07.0)

F07.2 Postconcussional syndrome

A syndrome that occurs following head trauma (usually sufficiently severe to result in loss of consciousness) and includes a number of disparate symptoms such as headache, dizziness, fatigue, irritability, difficulty in concentration and performing mental tasks, impairment of memory, insomnia and reduced tolerance to stress, emotional excitement or alcohol.

Postcontusional syndrome (encephalopathy)
Post-traumatic brain syndrome, nonpsychotic

Excl.: current concussion, brain (S06.0)

F07.8 Other organic personality and behavioural disorders due to brain disease, damage and dysfunction

Right hemispheric organic affective disorder

F07.9 Unspecified organic personality and behavioural disorder due to brain disease, damage and dysfunction

Organic psychosyndrome

F09 Unspecified organic or symptomatic mental disorder

Incl.: psychosis:
- organic NOS
- symptomatic NOS

Excl.: psychosis NOS (F29)

Mental and behavioural disorders due to psychoactive substance use (F10–F19)

This block contains a wide variety of disorders that differ in severity and clinical form but that are all attributable to the use of one or more psychoactive substances, which may or may not have been medically prescribed. The third character of the code identifies the substance involved and the fourth character specifies the clinical state. The codes should be used, as required, for each substance specified, but it should be noted that not all fourth-character codes are applicable to all substances.

Identification of the psychoactive substance should be based on as many sources of information as possible. These include self-report data, analysis of blood and other body fluids, characteristic physical and psychological symptoms, clinical signs and behaviour, and other evidence such as a drug being in the patient's possession or reports from informed third parties. Many drug users take more than one type of psychoactive substance. The main diagnosis should be classified, whenever possible, according to the substance or class of substances that has caused or contributed most to the presenting clinical syndrome. Other diagnoses should be coded when other psychoactive substances have been taken in intoxicating amounts (common fourth character .0) or to the extent of causing harm (common fourth character .1), dependence (common fourth character .2) or other disorders (common fourth character .3–.9).

Only in cases in which patterns of psychoactive substance-taking are chaotic and indiscriminate, or in which the contributions of different psychoactive substances are inextricably mixed, should the diagnosis of disorders resulting from multiple drug use (F19.-) be used.

Excl.: abuse of non-dependence-producing substances (F55)

The following fourth-character subdivisions are for use with categories F10–F19:

.0 Acute intoxication

A condition that follows the administration of a psychoactive substance resulting in disturbances in level of consciousness, cognition, perception, affect or behaviour, or other psycho-physiological functions and responses. The disturbances are directly related to the acute pharmacological effects of the substance and resolve with time, with complete recovery, except where tissue damage or other complications have arisen. Complications may include trauma, inhalation of vomitus, delirium, coma, convulsions, and other medical complications. The nature of these complications depends on the pharmacological class of substance and mode of administration.

Acute drunkenness (in alcoholism)
'Bad trips' (drugs)
Drunkenness NOS
Pathological intoxication
Trance and possession disorders in psychoactive substance intoxication

Excl.: intoxication meaning poisoning (T36–T50)

.1 Harmful use

A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of injected psychoactive substances) or mental (e.g. episodes of depressive disorder secondary to heavy consumption of alcohol).

Psychoactive substance abuse

.2 Dependence syndrome

A cluster of behavioural, cognitive and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.

The dependence syndrome may be present for a specific psychoactive substance (e.g. tobacco, alcohol or diazepam), for a class of substances (e.g. opioid drugs) or for a wider range of pharmacologically different psychoactive substances.

Chronic alcoholism
Dipsomania
Drug addiction

.3 Withdrawal state

A group of symptoms of variable clustering and severity, occurring on absolute or relative withdrawal of a psychoactive substance after persistent use of that substance. The onset and course of the withdrawal state are time-limited and are related to the type of psychoactive substance and dose being used immediately before cessation or reduction of use. The withdrawal state may be complicated by convulsions.

.4 Withdrawal state with delirium

A condition where the withdrawal state as defined in the common fourth character .3 is complicated by delirium as defined in F05.-. Convulsions may also occur. When organic factors are also considered to play a role in the etiology, the condition should be classified to F05.8.

Delirium tremens (alcohol-induced)

.5 Psychotic disorder

A cluster of psychotic phenomena that occur during or following psychoactive substance use but that are not explained on the basis of acute intoxication alone and do not form part of a withdrawal state. The disorder is characterized by hallucinations (typically auditory, but often in more than one sensory modality), perceptual distortions, delusions (often of a paranoid or persecutory nature), psychomotor disturbances (excitement or stupor) and an abnormal affect, which may range from intense fear to ecstasy. The sensorium is usually clear but some degree of clouding of consciousness, though not severe confusion, may be present.

Alcoholic:
- hallucinosis
- jealousy
- paranoia
- psychosis NOS

Excl.: alcohol- or other psychoactive-substance-induced residual and late-onset psychotic disorder (F10–F19 with common fourth character .7)

.6 Amnesic syndrome

A syndrome associated with chronic prominent impairment of recent and remote memory. Immediate recall is usually preserved and recent memory is characteristically more disturbed than remote memory. Disturbances of time sense and ordering of events are usually evident, as are difficulties in learning new material. Confabulation may be marked but is not invariably present. Other cognitive functions are usually relatively well preserved and amnesic defects are out of proportion to other disturbances.

Amnestic disorder, alcohol- or drug-induced
Korsakov psychosis or syndrome, alcohol- or other psychoactive substance-induced or unspecified
Use additional code, (E51.2†, G32.8*), if desired, when associated with Wernicke disease or syndrome.

Excl.: nonalcoholic Korsakov psychosis or syndrome (F04)

.7 Residual and late-onset psychotic disorder

A disorder in which alcohol- or psychoactive-substance-induced changes of cognition, affect, personality, or behaviour persist beyond the period during which a direct psychoactive-substance-related effect might reasonably be assumed to be operating. Onset of the disorder should be directly related to the use of the psychoactive substance. Cases in which initial onset of the state occurs later than episode(s) of such substance use should be coded here only where clear and strong evidence is available to attribute the state to the residual effect of the psychoactive substance. Flashbacks may be distinguished from psychotic state partly by their episodic nature, frequently of very short duration, and by their duplication of previous alcohol- or other psychoactive-substance-related experiences.

Alcoholic dementia NOS
Chronic alcoholic brain syndrome
Dementia and other milder forms of persisting impairment of cognitive functions
Flashbacks
Late-onset psychoactive substance-induced psychotic disorder
Posthallucinogen perception disorder
Residual:
- affective disorder
- disorder of personality and behaviour

Excl.: alcohol- or psychoactive-substance-induced:
- Korsakov syndrome (F10–F19 with common fourth character .6)
- psychotic state (F10–F19 with common fourth character .5)

.8 Other mental and behavioural disorders

.9 Unspecified mental and behavioural disorder

F10 **Mental and behavioural disorders due to use of alcohol**
[See before F10 for subdivisions]

F11 **Mental and behavioural disorders due to use of opioids**
[See before F10 for subdivisions]

F12 **Mental and behavioural disorders due to use of cannabinoids**
[See before F10 for subdivisions]

F13 **Mental and behavioural disorders due to use of sedatives or hypnotics**
[See before F10 for subdivisions]

F14 **Mental and behavioural disorders due to use of cocaine**
[See before F10 for subdivisions]

F15 **Mental and behavioural disorders due to use of other stimulants, including caffeine**
[See before F10 for subdivisions]

F16 **Mental and behavioural disorders due to use of hallucinogens**
[See before F10 for subdivisions]

F17 **Mental and behavioural disorders due to use of tobacco**
[See before F10 for subdivisions]

F18 **Mental and behavioural disorders due to use of volatile solvents**
[See before F10 for subdivisions]

F19 **Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances**
[See before F10 for subdivisions]

This category should be used when two or more psychoactive substances are known to be involved, but it is impossible to assess which substance is contributing most to the disorders. It should also be used when the exact identity of some or even all the psychoactive substances being used is uncertain or unknown, since many multiple drug users themselves often do not know the details of what they are taking.

Incl.: misuse of drugs NOS

Schizophrenia, schizotypal and delusional disorders (F20–F29)

This block brings together schizophrenia, as the most important member of the group, schizotypal disorder, persistent delusional disorders, and a larger group of acute and transient psychotic disorders. Schizoaffective disorders have been retained here in spite of their controversial nature.

F20 Schizophrenia

The schizophrenic disorders are characterized in general by fundamental and characteristic distortions of thinking and perception, and affects that are inappropriate or blunted. Clear consciousness and intellectual capacity are usually maintained, although certain cognitive deficits may evolve in the course of time. The most important psychopathological phenomena include thought echo; thought insertion or withdrawal; thought broadcasting; delusional perception and delusions of control; influence or passivity; hallucinatory voices commenting or discussing the patient in the third person; thought disorders; and negative symptoms.

The course of schizophrenic disorders can be either continuous, or episodic with progressive or stable deficit, or there can be one or more episodes with complete or incomplete remission. The diagnosis of schizophrenia should not be made in the presence of extensive depressive or manic symptoms unless it is clear that schizophrenic symptoms antedate the affective disturbance. Nor should schizophrenia be diagnosed in the presence of overt brain disease or during states of drug intoxication or withdrawal. Similar disorders developing in the presence of epilepsy or other brain disease should be classified under F06.2, and those induced by psychoactive substances under F10–F19 with common fourth character .5.

Excl.: schizophrenia:
- acute (undifferentiated) (F23.2)
- cyclic (F25.2)

schizophrenic reaction (F23.2)
schizotypal disorder (F21)

F20.0 Paranoid schizophrenia

Paranoid schizophrenia is dominated by relatively stable, often paranoid delusions, usually accompanied by hallucinations, particularly of the auditory variety, and perceptual disturbances. Disturbances of affect, volition and speech, and catatonic symptoms, are either absent or relatively inconspicuous.

Paraphrenic schizophrenia

Excl.: involutional paranoid state (F22.8)
paranoia (F22.0)

F20.1 Hebephrenic schizophrenia

A form of schizophrenia in which affective changes are prominent, delusions and hallucinations fleeting and fragmentary, behaviour irresponsible and unpredictable, and mannerisms common. The mood is shallow and inappropriate, thought is disorganized, and speech is incoherent. There is a tendency to social isolation. Usually the prognosis is poor because of the rapid development of 'negative' symptoms, particularly flattening of affect and loss of volition. Hebephrenia should normally be diagnosed only in adolescents or young adults.

Disorganized schizophrenia
Hebephrenia

F20.2 Catatonic schizophrenia

Catatonic schizophrenia is dominated by prominent psychomotor disturbances that may alternate between extremes such as hyperkinesis and stupor, or automatic obedience and negativism. Constrained attitudes and postures may be maintained for long periods. Episodes of violent excitement may be a striking feature of the condition. The catatonic phenomena may be combined with a dream-like (oneiroid) state with vivid scenic hallucinations.

Catatonic stupor
Schizophrenic:
- catalepsy
- catatonia
- flexibilitas cerea

F20.3 Undifferentiated schizophrenia

Psychotic conditions meeting the general diagnostic criteria for schizophrenia but not conforming to any of the subtypes in F20.0–F20.2, or exhibiting the features of more than one of them without a clear predominance of a particular set of diagnostic characteristics.

Atypical schizophrenia

Excl.: acute schizophrenia-like psychotic disorder (F23.2)
chronic undifferentiated schizophrenia (F20.5)
post-schizophrenic depression (F20.4)

F20.4 Post-schizophrenic depression

A depressive episode, which may be prolonged, arising in the aftermath of a schizophrenic illness. Some schizophrenic symptoms, either 'positive' or 'negative', must still be present but they no longer dominate the clinical picture. These depressive states are associated with an increased risk of suicide. If the patient no longer has any schizophrenic symptoms, a depressive episode should be diagnosed (F32.-). If schizophrenic symptoms are still florid and prominent, the diagnosis should remain that of the appropriate schizophrenic subtype (F20.0–F20.3).

F20.5 Residual schizophrenia

A chronic stage in the development of a schizophrenic illness in which there has been a clear progression from an early stage to a later stage characterized by long-term, though not necessarily irreversible, 'negative' symptoms, e.g. psychomotor slowing; underactivity; blunting of affect; passivity and lack of initiative; poverty of quantity or content of speech; poor nonverbal communication by facial expression, eye contact, voice modulation and posture; poor self-care and social performance.

Chronic undifferentiated schizophrenia
Restzustand (schizophrenic)
Schizophrenic residual state

F20.6 Simple schizophrenia

A disorder in which there is an insidious but progressive development of oddities of conduct, inability to meet the demands of society, and decline in total performance. The characteristic negative features of residual schizophrenia (e.g. blunting of affect and loss of volition) develop without being preceded by any overt psychotic symptoms.

F20.8 Other schizophrenia

Cenesthopathic schizophrenia
Schizophreniform:
- disorder NOS
- psychosis NOS

Excl.: brief schizophreniform disorders (F23.2)

F20.9 Schizophrenia, unspecified

F21 Schizotypal disorder

A disorder characterized by eccentric behaviour and anomalies of thinking and affect that resemble those seen in schizophrenia, though no definite and characteristic schizophrenic anomalies occur at any stage. The symptoms may include a cold or inappropriate affect; anhedonia; odd or eccentric behaviour; a tendency to social withdrawal; paranoid or bizarre ideas not amounting to true delusions; obsessive ruminations; thought disorder and perceptual disturbances; occasional transient quasi-psychotic episodes with intense illusions, auditory or other hallucinations and delusion-like ideas, usually occurring without external provocation. There is no definite onset and evolution and course are usually those of a personality disorder.

Incl.: latent schizophrenic reaction
schizophrenia:
- borderline
- latent
- prepsychotic
- prodromal
- pseudoneurotic
- pseudopsychopathic

schizotypal personality disorder

Excl.: Asperger syndrome (F84.5)
schizoid personality disorder (F60.1)

F22 Persistent delusional disorders

Includes a variety of disorders in which long-standing delusions constitute the only, or the most conspicuous, clinical characteristic and that cannot be classified as organic, schizophrenic or affective. Delusional disorders that have lasted for less than a few months should be classified, at least temporarily, under F23.-.

F22.0 Delusional disorder

A disorder characterized by the development either of a single delusion or of a set of related delusions that are usually persistent and sometimes lifelong. The content of the delusion or delusions is very variable. Clear and persistent auditory hallucinations (voices), schizophrenic symptoms such as delusions of control and marked blunting of affect, and definite evidence of brain disease are all incompatible with this diagnosis. However, the presence of occasional or transitory auditory hallucinations, particularly in elderly patients, does not rule out this diagnosis, provided that they are not typically schizophrenic and form only a small part of the overall clinical picture.

Paranoia
Paranoid:
- psychosis
- state

Paraphrenia (late)
Sensitiver beziehungswahn

Excl.: paranoid:
- personality disorder (F60.0)
- psychosis, psychogenic (F23.3)
- reaction (F23.3)
- schizophrenia (F20.0)

F22.8 Other persistent delusional disorders

Disorders in which the delusion or delusions are accompanied by persistent hallucinatory voices or by schizophrenic symptoms that do not justify a diagnosis of schizophrenia (F20.-).

Delusional dysmorphophobia
Involutional paranoid state
Paranoia querulans

F22.9 Persistent delusional disorder, unspecified

F23 Acute and transient psychotic disorders

A heterogeneous group of disorders characterized by the acute onset of psychotic symptoms such as delusions, hallucinations and perceptual disturbances, and by the severe disruption of ordinary behaviour. Acute onset is defined as a crescendo development of a clearly abnormal clinical picture in about two weeks or less. For these disorders, there is no evidence of organic causation. Perplexity and puzzlement are often present but disorientation for time, place and person is not persistent or severe enough to justify a diagnosis of organically caused delirium (F05.-). Complete recovery usually occurs within a few months, often within a few weeks or even days. If the disorder persists, a change in classification will be necessary. The disorder may or may not be associated with acute stress, defined as usually stressful events preceding the onset by one to two weeks.

F23.0 Acute polymorphic psychotic disorder without symptoms of schizophrenia

An acute psychotic disorder in which hallucinations, delusions or perceptual disturbances are obvious but markedly variable, changing from day to day or even from hour to hour. Emotional turmoil with intense transient feelings of happiness or ecstasy, or anxiety and irritability, is also frequently present. The polymorphism and instability are characteristic for the overall clinical picture and the psychotic features do not justify a diagnosis of schizophrenia (F20.-). These disorders often have an abrupt onset, developing rapidly within a few days, and they frequently show a rapid resolution of symptoms with no recurrence. If the symptoms persist, the diagnosis should be changed to persistent delusional disorder (F22.-).

Bouffée délirante without symptoms of schizophrenia or unspecified
Cycloid psychosis without symptoms of schizophrenia or unspecified

F23.1 Acute polymorphic psychotic disorder with symptoms of schizophrenia

An acute psychotic disorder in which the polymorphic and unstable clinical picture is present, as described in F23.0; despite this instability, however, some symptoms typical of schizophrenia are also in evidence for the majority of the time. If the schizophrenic symptoms persist, the diagnosis should be changed to schizophrenia (F20.-).

Bouffée délirante with symptoms of schizophrenia
Cycloid psychosis with symptoms of schizophrenia

F23.2 Acute schizophrenia-like psychotic disorder

An acute psychotic disorder in which the psychotic symptoms are comparatively stable and justify a diagnosis of schizophrenia, but have lasted for less than about one month; the polymorphic unstable features, as described in F23.0, are absent. If the schizophrenic symptoms persist, the diagnosis should be changed to schizophrenia (F20.-).

Acute (undifferentiated) schizophrenia
Brief schizophreniform:
- disorder
- psychosis

Oneirophrenia
Schizophrenic reaction

Excl.: organic delusional [schizophrenia-like] disorder (F06.2)
schizophreniform disorders NOS (F20.8)

F23.3 Other acute predominantly delusional psychotic disorders

Acute psychotic disorders in which comparatively stable delusions or hallucinations are the main clinical features, but do not justify a diagnosis of schizophrenia (F20.-). If the delusions persist, the diagnosis should be changed to persistent delusional disorder (F22.-).

Paranoid reaction
Psychogenic paranoid psychosis

F23.8 Other acute and transient psychotic disorders

Any other specified acute psychotic disorders for which there is no evidence of organic causation and that do not justify classification to F23.0–F23.3.

F23.9 Acute and transient psychotic disorder, unspecified

Brief reactive psychosis NOS
Reactive psychosis

F24 Induced delusional disorder

A delusional disorder shared by two or more people with close emotional links. Only one of the people suffers from a genuine psychotic disorder; the delusions are induced in the other(s) and usually disappear when the people are separated.

Incl.: folie à deux
induced:
- paranoid disorder
- psychotic disorder

F25 Schizoaffective disorders

Episodic disorders in which both affective and schizophrenic symptoms are prominent but that do not justify a diagnosis of either schizophrenia or depressive or manic episodes. Other conditions in which affective symptoms are superimposed on a pre-existing schizophrenic illness, or coexist or alternate with persistent delusional disorders of other kinds, are classified under F20–F29. Mood-incongruent psychotic symptoms in affective disorders do not justify a diagnosis of schizoaffective disorder.

F25.0 Schizoaffective disorder, manic type

A disorder in which both schizophrenic and manic symptoms are prominent, so that the episode of illness does not justify a diagnosis of either schizophrenia or a manic episode. This category should be used for both a single episode and a recurrent disorder in which the majority of episodes are schizoaffective, manic type.

Schizoaffective psychosis, manic type
Schizophreniform psychosis, manic type

F25.1 Schizoaffective disorder, depressive type

A disorder in which both schizophrenic and depressive symptoms are prominent, so that the episode of illness does not justify a diagnosis of either schizophrenia or a depressive episode. This category should be used for both a single episode and a recurrent disorder in which the majority of episodes are schizoaffective, depressive type.

Schizoaffective psychosis, depressive type
Schizophreniform psychosis, depressive type

F25.2 Schizoaffective disorder, mixed type

Cyclic schizophrenia
Mixed schizophrenic and affective psychosis

F25.8 Other schizoaffective disorders

F25.9 Schizoaffective disorder, unspecified
Schizoaffective psychosis NOS

F28 Other nonorganic psychotic disorders

Delusional or hallucinatory disorders that do not justify a diagnosis of schizophrenia (F20.-), persistent delusional disorders (F22.-), acute and transient psychotic disorders (F23.-), psychotic types of manic episode (F30.2) or severe depressive episode (F32.3).

Incl.: chronic hallucinatory psychosis

F29 Unspecified nonorganic psychosis

Incl.: psychosis NOS

Excl.: mental disorder NOS (F99)
organic or symptomatic psychosis NOS (F09)

Mood [affective] disorders (F30–F39)

This block contains disorders in which the fundamental disturbance is a change in affect or mood, to depression (with or without associated anxiety) or to elation. The mood change is usually accompanied by a change in the overall level of activity; most of the other symptoms are either secondary to, or easily understood in the context of, the change in mood and activity. Most of these disorders tend to be recurrent and the onset of individual episodes can often be related to stressful events or situations.

F30 Manic episode

All the subdivisions of this category should be used only for a single episode. Hypomanic or manic episodes in individuals who have had one or more previous affective episodes (depressive, hypomanic, manic or mixed) should be coded as bipolar affective disorder (F31.-).

Incl.: bipolar disorder, single manic episode

F30.0 Hypomania

A disorder characterized by a persistent mild elevation of mood, increased energy and activity, and usually marked feelings of well-being and both physical and mental efficiency. Increased sociability, talkativeness, over-familiarity, increased sexual energy and a decreased need for sleep are often present but not to the extent that they lead to severe disruption of work or result in social rejection. Irritability, conceit and boorish behaviour may take the place of the more usual euphoric sociability. The disturbances of mood and behaviour are not accompanied by hallucinations or delusions.

F30.1 Mania without psychotic symptoms

Mood is elevated out of keeping with the patient's circumstances and may vary from carefree joviality to almost uncontrollable excitement. Elation is accompanied by increased energy, resulting in overactivity, pressure of speech and a decreased need for sleep. Attention cannot be sustained, and there is often marked distractibility. Self-esteem is often inflated, with grandiose ideas and overconfidence. Loss of normal social inhibitions may result in behaviour that is reckless, foolhardy or inappropriate to the circumstances, and out of character.

F30.2 Mania with psychotic symptoms

In addition to the clinical picture described in F30.1, delusions (usually grandiose) or hallucinations (usually of voices speaking directly to the patient) are present, or the excitement, excessive motor activity and flight of ideas are so extreme that the subject is incomprehensible or inaccessible to ordinary communication.

Mania with:
- mood-congruent psychotic symptoms
- mood-incongruent psychotic symptoms

Manic stupor

~~**F30.8 Other manic episodes**~~

~~**F30.9 Manic episode, unspecified**~~
~~Mania NOS~~

F31 Bipolar affective disorder

A disorder characterized by two or more episodes in which the patient's mood and activity levels are significantly disturbed this disturbance consisting on some occasions of an elevation of mood and increased energy and activity (hypomania or mania) and on others of a lowering of mood and decreased energy and activity (depression). Repeated episodes of hypomania or mania only are classified as bipolar.

Incl.: manic depression
manic-depressive:
- illness
- psychosis
- reaction

Excl.: bipolar disorder, single manic episode (F30.-)
cyclothymia (F34.0)

F31.0 Bipolar affective disorder, current episode hypomanic

The patient is currently hypomanic and has had at least one other affective episode (hypomanic, manic, depressive or mixed) in the past.

F31.1 Bipolar affective disorder, current episode manic without psychotic symptoms

The patient is currently manic, without psychotic symptoms (as in F30.1) and has had at least one other affective episode (hypomanic, manic, depressive or mixed) in the past.

F31.2 Bipolar affective disorder, current episode manic with psychotic symptoms

The patient is currently manic, with psychotic symptoms (as in F30.2), and has had at least one other affective episode (hypomanic, manic, depressive or mixed) in the past.

F31.3 Bipolar affective disorder, current episode mild or moderate depression

The patient is currently depressed, as in a depressive episode of either mild or moderate severity (F32.0 or F32.1), and has had at least one authenticated hypomanic, manic or mixed affective episode in the past.

F31.4 Bipolar affective disorder, current episode severe depression without psychotic symptoms

The patient is currently depressed, as in severe depressive episode without psychotic symptoms (F32.2), and has had at least one authenticated hypomanic, manic or mixed affective episode in the past.

F31.5 Bipolar affective disorder, current episode severe depression with psychotic symptoms

The patient is currently depressed, as in severe depressive episode with psychotic symptoms (F32.3), and has had at least one authenticated hypomanic, manic or mixed affective episode in the past.

F31.6 Bipolar affective disorder, current episode mixed

The patient has had at least one authenticated hypomanic, manic, depressive or mixed affective episode in the past, and currently exhibits either a mixture or a rapid alteration of manic and depressive symptoms.

Excl.: single mixed affective episode (F38.0)

F31.7 Bipolar affective disorder, currently in remission

The patient has had at least one authenticated hypomanic, manic or mixed affective episode in the past, and at least one other affective episode (hypomanic, manic, depressive or mixed) in addition, but is not currently suffering from any significant mood disturbance, and has not done so for several months. Periods of remission during prophylactic treatment should be coded here.

~~F31.8 Other bipolar affective disorders~~

~~Bipolar II disorder~~
~~Recurrent manic episodes NOS~~

~~F31.9 Bipolar affective disorder, unspecified~~

~~Manic depression NOS~~

F32 Depressive episode

In typical mild, moderate or severe depressive episodes, the patient suffers from lowering of mood, reduction of energy and decrease in activity. Capacity for enjoyment, interest and concentration is reduced, and marked tiredness after even minimum effort is common. Sleep is usually disturbed and appetite diminished. Self-esteem and self-confidence are almost always reduced and, even in the mild form, some ideas of guilt or worthlessness are often present. The lowered mood varies little from day to day, is unresponsive to circumstances and may be accompanied by so-called 'somatic' symptoms, such as loss of interest and pleasurable feelings, waking in the morning several hours before the usual time, depression worst in the morning, marked psychomotor retardation, agitation, loss of appetite, weight loss, and loss of libido. Depending upon the number and severity of the symptoms, a depressive episode may be specified as mild, moderate or severe.

Incl.: single episodes of:
- depressive reaction
- psychogenic depression
- reactive depression

Excl.: adjustment disorder (F43.2)
recurrent depressive disorder (F33.-)
when associated with conduct disorders in F91.- (F92.0)

F32.0 Mild depressive episode

Two or three of the above symptoms are usually present. The patient is usually distressed by these but will probably be able to continue with most activities.

F32.1 Moderate depressive episode

Four or more of the above symptoms are usually present and the patient is likely to have great difficulty in continuing with ordinary activities.

F32.2 Severe depressive episode without psychotic symptoms

An episode of depression in which several of the above symptoms are marked and distressing, typically loss of self-esteem and ideas of worthlessness or guilt. Suicidal thoughts and acts are common and a number of 'somatic' symptoms are usually present.

Agitated depression Major depression Vital depression	single episode without psychotic symptoms

F32.3 Severe depressive episode with psychotic symptoms

An episode of depression as described in F32.2, but with the presence of hallucinations, delusions, psychomotor retardation or stupor so severe that ordinary social activities are impossible; there may be danger to life from suicide, dehydration or starvation. The hallucinations and delusions may or may not be mood-congruent.

Single episodes of:
- major depression with psychotic symptoms
- psychogenic depressive psychosis
- psychotic depression
- reactive depressive psychosis

~~F32.8~~ ~~Other depressive episodes~~
~~Atypical depression~~
~~Single episodes of 'masked' depression NOS~~

~~F32.9~~ ~~Depressive episode, unspecified~~
~~Depression NOS~~
~~Depressive disorder NOS~~

F33 Recurrent depressive disorder

A disorder characterized by repeated episodes of depression as described for depressive episode (F32.-), without any history of independent episodes of mood elevation and increased energy (mania). There may, however, be brief episodes of mild mood elevation and overactivity (hypomania) immediately after a depressive episode, sometimes precipitated by antidepressant treatment. The more severe forms of recurrent depressive disorder (F33.2 and F33.3) have much in common with earlier concepts such as manic-depressive depression, melancholia, vital depression and endogenous depression. The first episode may occur at any age from childhood to old age, the onset may be either acute or insidious, and the duration varies from a few weeks to many months. The risk that a patient with recurrent depressive disorder will have an episode of mania never disappears completely, however many depressive episodes have been experienced. If such an episode does occur, the diagnosis should be changed to bipolar affective disorder (F31.-).

Incl.: recurrent episodes of:
- depressive reaction
- psychogenic depression
- reactive depression

seasonal depressive disorder

Excl.: recurrent brief depressive episodes (F38.1)

F33.0 Recurrent depressive disorder, current episode mild

A disorder characterized by repeated episodes of depression, the current episode being mild, as in F32.0, and without any history of mania.

F33.1 Recurrent depressive disorder, current episode moderate

A disorder characterized by repeated episodes of depression, the current episode being of moderate severity, as in F32.1, and without any history of mania.

F33.2 Recurrent depressive disorder, current episode severe without psychotic symptoms

A disorder characterized by repeated episodes of depression, the current episode being severe without psychotic symptoms, as in F32.2, and without any history of mania.

Endogenous depression without psychotic symptoms
Major depression, recurrent without psychotic symptoms
Manic-depressive psychosis, depressed type without psychotic symptoms
Vital depression, recurrent without psychotic symptoms

F33.3 Recurrent depressive disorder, current episode severe with psychotic symptoms

A disorder characterized by repeated episodes of depression, the current episode being severe with psychotic symptoms, as in F32.3, and with no previous episodes of mania.

Endogenous depression with psychotic symptoms
Manic-depressive psychosis, depressed type with psychotic symptoms
Recurrent severe episodes of:
- major depression with psychotic symptoms
- psychogenic depressive psychosis
- psychotic depression
- reactive depressive psychosis

F33.4 Recurrent depressive disorder, currently in remission

The patient has had two or more depressive episodes as described in F33.0–F33.3, in the past, but has been free from depressive symptoms for several months.

~~F33.8 Other recurrent depressive disorders~~

~~F33.9 Recurrent depressive disorder, unspecified~~

~~Monopolar depression NOS~~

F34 Persistent mood [affective] disorders

Persistent and usually fluctuating disorders of mood in which the majority of the individual episodes are not sufficiently severe to warrant being described as hypomanic or mild depressive episodes. Because they last for many years, and sometimes for the greater part of the patient's adult life, they involve considerable distress and disability. In some instances, recurrent or single manic or depressive episodes may become superimposed on a persistent affective disorder.

F34.0 Cyclothymia

A persistent instability of mood involving numerous periods of depression and mild elation, none of which is sufficiently severe or prolonged to justify a diagnosis of bipolar affective disorder (F31.-) or recurrent depressive disorder (F33.-). This disorder is frequently found in the relatives of patients with bipolar affective disorder. Some patients with cyclothymia eventually develop bipolar affective disorder.

Affective personality disorder
Cycloid personality
Cyclothymic personality

F34.1 Dysthymia

A chronic depression of mood, lasting at least several years, which is not sufficiently severe, or in which individual episodes are not sufficiently prolonged, to justify a diagnosis of severe, moderate or mild recurrent depressive disorder (F33.-).

Depressive:
- neurosis
- personality disorder

Neurotic depression
Persistent anxiety depression

Excl.: anxiety depression (mild or not persistent) (F41.2)

~~F34.8 Other persistent mood [affective] disorders~~

~~F34.9 Persistent mood [affective] disorder, unspecified~~

F38 Other mood [affective] disorders

Any other mood disorders that do not justify classification to F30–F34, because they are not of sufficient severity or duration.

F38.0 Other single mood [affective] disorders

Mixed affective episode

~~F38.1 Other recurrent mood [affective] disorders~~

~~Recurrent brief depressive episodes~~

~~F38.8 Other specified mood [affective] disorders~~

F39 ~~Unspecified mood [affective] disorder~~

Incl.: ~~affective psychosis NOS~~

Neurotic, stress-related and somatoform disorders (F40–F48)

Excl.: when associated with conduct disorder in F91.- (F92.8)

F40 Phobic anxiety disorders

A group of disorders in which anxiety is evoked only, or predominantly, in certain well-defined situations that are not currently dangerous. As a result, these situations are characteristically avoided or endured with dread. The patient's concern may be focused on individual symptoms like palpitations or feeling faint and is often associated with secondary fears of dying, losing control, or going mad. Contemplating entry to the phobic situation usually generates anticipatory anxiety. Phobic anxiety and depression often coexist. Whether two diagnoses, phobic anxiety and depressive episode, are needed, or only one, is determined by the time course of the two conditions and by therapeutic considerations at the time of consultation.

F40.0 Agoraphobia

A fairly well-defined cluster of phobias embracing fears of leaving home, entering shops, crowds and public places, or travelling alone in trains, buses or planes. Panic disorder is a frequent feature of both present and past episodes. Depressive and obsessional symptoms and social phobias are also commonly present as subsidiary features. Avoidance of the phobic situation is often prominent, and some agoraphobics experience little anxiety because they are able to avoid their phobic situations.

Agoraphobia without history of panic disorder
Panic disorder with agoraphobia

F40.1 Social phobias

Fear of scrutiny by other people, leading to avoidance of social situations. More pervasive social phobias are usually associated with low self-esteem and fear of criticism. They may present as a complaint of blushing, hand tremor, nausea or urgency of micturition, the patient sometimes being convinced that one of these secondary manifestations of their anxiety is the primary problem. Symptoms may progress to panic attacks.

Anthropophobia
Social neurosis

F40.2 Specific (isolated) phobias

Phobias restricted to highly specific situations such as proximity to particular animals, heights, thunder, darkness, flying, closed spaces, urinating or defecating in public toilets, eating certain foods, dentistry or the sight of blood or injury. Though the triggering situation is discrete, contact with it can evoke panic as in agoraphobia or social phobia.

Acrophobia
Animal phobias
Claustrophobia
Simple phobia

Excl.: dysmorphophobia (nondelusional) (F45.2)
nosophobia (F45.2)

~~F40.8 Other phobic anxiety disorders~~

~~F40.9~~ Phobic anxiety disorder, unspecified

~~Phobia NOS~~
~~Phobic state NOS~~

F41 Other anxiety disorders

Disorders in which manifestation of anxiety is the major symptom and is not restricted to any particular environmental situation. Depressive and obsessional symptoms, and even some elements of phobic anxiety, may also be present, provided that they are clearly secondary or less severe.

F41.0 Panic disorder [episodic paroxysmal anxiety]

The essential feature is recurrent attacks of severe anxiety (panic), which are not restricted to any particular situation or set of circumstances and are therefore unpredictable. As with other anxiety disorders, the dominant symptoms include sudden onset of palpitations, chest pain, choking sensations, dizziness and feelings of unreality (depersonalization or derealization). There is often also a secondary fear of dying, losing control or going mad. Panic disorder should not be given as the main diagnosis if the patient has a depressive disorder at the time the attacks start; in these circumstances, the panic attacks are probably secondary to depression.

Panic:
- attack
- state

Excl.: panic disorder with agoraphobia (F40.0)

F41.1 Generalized anxiety disorder

Anxiety that is generalized and persistent but not restricted to, or even strongly predominating in, any particular environmental circumstances (i.e. it is 'free-floating'). The dominant symptoms are variable but include complaints of persistent nervousness, trembling, muscular tensions, sweating, lightheadedness, palpitations, dizziness and epigastric discomfort. Fears that the patient or a relative will shortly become ill or have an accident are often expressed.

Anxiety:
- neurosis
- reaction
- state

Excl.: neurasthenia (F48.0)

F41.2 Mixed anxiety and depressive disorder

This category should be used when symptoms of anxiety and depression are both present, but neither is clearly predominant, and neither type of symptom is present to the extent that justifies a diagnosis if considered separately. When both anxiety and depressive symptoms are present and severe enough to justify individual diagnoses, both diagnoses should be recorded and this category should not be used.

Anxiety depression (mild or not persistent)

F41.3 Other mixed anxiety disorders

Symptoms of anxiety mixed with features of other disorders in F42–F48. Neither type of symptom is severe enough to justify a diagnosis if considered separately.

~~F41.8 Other specified anxiety disorders~~

~~Anxiety hysteria~~

~~F41.9 Anxiety disorder, unspecified~~

~~Anxiety NOS~~

F42 Obsessive-compulsive disorder

The essential feature is recurrent obsessional thoughts or compulsive acts. Obsessional thoughts are ideas, images or impulses that enter the patient's mind again and again in a stereotyped form. They are almost invariably distressing and the patient often tries, unsuccessfully, to resist them. They are, however, recognized as his or her own thoughts, even though they are involuntary and often repugnant. Compulsive acts or rituals are stereotyped behaviours that are repeated again and again. They are not inherently enjoyable, nor do they result in the completion of inherently useful tasks. Their function is to prevent some objectively unlikely event, often involving harm to, or caused by, the patient, which he or she fears might otherwise occur. Usually, this behaviour is recognized by the patient as pointless or ineffectual and repeated attempts are made to resist. Anxiety is almost invariably present. If compulsive acts are resisted, the anxiety gets worse.

Incl.: anankastic neurosis
obsessive-compulsive neurosis

Excl.: obsessive-compulsive personality (disorder) (F60.5)

F42.0 Predominantly obsessional thoughts or ruminations

These may take the form of ideas, mental images or impulses to act, which are nearly always distressing to the subject. Sometimes the ideas are an indecisive, endless consideration of alternatives, associated with an inability to make trivial but necessary decisions in day-to-day living. The relationship between obsessional ruminations and depression is particularly close and a diagnosis of obsessive-compulsive disorder should be preferred only if ruminations arise or persist in the absence of a depressive episode.

F42.1 Predominantly compulsive acts [obsessional rituals]

The majority of compulsive acts are concerned with cleaning (particularly handwashing), repeated checking to ensure that a potentially dangerous situation has not been allowed to develop, or orderliness and tidiness. Underlying the overt behaviour is a fear, usually of danger either to or caused by the patient, and the ritual is an ineffectual or symbolic attempt to avert that danger.

F42.2 Mixed obsessional thoughts and acts

~~F42.8 Other obsessive-compulsive disorders~~

~~F42.9 Obsessive-compulsive disorder, unspecified~~

F43 Reaction to severe stress, and adjustment disorders

This category differs from others, in that it includes disorders identifiable on the basis of not only symptoms and course but also the existence of one or other of two causative influences: an exceptionally stressful life event producing an acute stress reaction, or a significant life change leading to continued unpleasant circumstances that result in an adjustment disorder. Although less severe psychosocial stress ('life events') may precipitate the onset or contribute to the presentation of a very wide range of disorders classified elsewhere in this chapter, its etiological importance is not always clear and in each case will be found to depend on individual, often idiosyncratic, vulnerability, i.e. the life events are neither necessary nor sufficient to explain the occurrence and form of the disorder. In contrast, the disorders brought together here are thought to arise always as a direct consequence of acute severe stress or continued trauma. The stressful events or the continuing unpleasant circumstances are the primary and overriding causal factor and the disorder would not have occurred without their impact. The disorders in this section can thus be regarded as maladaptive responses to severe or continued stress, in that they interfere with successful coping mechanisms and therefore lead to problems of social functioning.

F43.0 Acute stress reaction

A transient disorder that develops in an individual without any other apparent mental disorder, in response to exceptional physical and mental stress and that usually subsides within hours or days. Individual vulnerability and coping capacity play a role in the occurrence and severity of acute stress reactions. The symptoms show a typically mixed and changing picture and include an initial state of 'daze', with some constriction of the field of consciousness and narrowing of attention, inability to comprehend stimuli, and disorientation. This state may be followed either by further withdrawal from the surrounding situation (to the extent of a dissociative stupor – F44.2), or by agitation and overactivity (flight reaction or fugue). Autonomic signs of panic anxiety (tachycardia, sweating, flushing) are commonly present. The symptoms usually appear within minutes of the impact of

the stressful stimulus or event, and disappear within two to three days (often within hours). Partial or complete amnesia (F44.0) for the episode may be present. If the symptoms persist, a change in diagnosis should be considered.

Acute:
- crisis reaction
- reaction to stress

Combat fatigue
Crisis state
Psychic shock

F43.1 Post-traumatic stress disorder

Arises as a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. Predisposing factors, such as personality traits (e.g. compulsive, asthenic) or previous history of neurotic illness, may lower the threshold for the development of the syndrome or aggravate its course, but they are neither necessary nor sufficient to explain its occurrence. Typical features include episodes of repeated reliving of the trauma in intrusive memories ('flashbacks'), dreams or nightmares, occurring against the persisting background of a sense of 'numbness' and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. The onset follows the trauma with a latency period that may range from a few weeks to months. The course is fluctuating but recovery can be expected in the majority of cases. In a small proportion of cases, the condition may follow a chronic course over many years, with eventual transition to an enduring personality change (F62.0).

Traumatic neurosis

F43.2 Adjustment disorders

States of subjective distress and emotional disturbance, usually interfering with social functioning and performance, arising in the period of adaptation to a significant life change or a stressful life event. The stressor may have affected the integrity of an individual's social network (bereavement, separation experiences) or the wider system of social supports and values (migration, refugee status), or represented a major developmental transition or crisis (going to school, becoming a parent, failure to attain a cherished personal goal, retirement). Individual predisposition or vulnerability plays an important role in the risk of occurrence and the shaping of the manifestations of adjustment disorders, but it is nevertheless assumed that the condition would not have arisen without the stressor. The manifestations vary and include depressed mood, anxiety or worry (or mixture of these) and a feeling of inability to cope, plan ahead or continue in the present situation, as well as some degree of disability in the performance of daily routine. Conduct disorders may be an associated feature, particularly in adolescents. The predominant feature may be a brief or prolonged depressive reaction, or a disturbance of other emotions and conduct.

Culture shock
Grief reaction
Hospitalism in children

Excl.: separation anxiety disorder of childhood (F93.0)

~~F43.8 Other reactions to severe stress~~

~~F43.9 Reaction to severe stress, unspecified~~

F44 Dissociative [conversion] disorders

The common themes that are shared by dissociative or conversion disorders are a partial or complete loss of the normal integration between memories of the past, awareness of identity and immediate sensations, and control of bodily movements. All types of dissociative disorders tend to remit after a few weeks or months, particularly if their onset is associated with a traumatic life event. More chronic disorders, particularly paralyses and anaesthesias, may develop if the onset is associated with insoluble problems or interpersonal difficulties. These disorders have previously been classified as various types of 'conversion hysteria'. They are presumed to be psychogenic in origin, being associated closely in time with traumatic events, insoluble and intolerable problems, or disturbed relationships. The symptoms often represent the patient's concept of how a physical illness would be manifest. Medical examination and investigation do not reveal the presence of any known physical or neurological disorder. In addition, there is evidence that the loss of function is an expression of emotional conflicts or needs. The symptoms may develop in close relationship to psychological stress, and often appear suddenly. Only disorders of physical functions normally under voluntary control, and loss of sensations, are included here. Disorders involving pain and other complex physical sensations, mediated by the autonomic nervous system are classified under somatization disorder (F45.0). The possibility of the later appearance of serious physical or psychiatric disorders should always be kept in mind.

Incl.: conversion:
- hysteria
- reaction

hysteria
hysterical psychosis

Excl.: malingering [conscious simulation] (Z76.5)

F44.0 Dissociative amnesia

The main feature is loss of memory, usually of important recent events, that is not due to organic mental disorder, and is too great to be explained by ordinary forgetfulness or fatigue. The amnesia is usually centred on traumatic events, such as accidents or unexpected bereavements, and is usually partial and selective. Complete and generalized amnesia is rare, and is usually part of a fugue (F44.1). If this is the case, the disorder should be classified as such. The diagnosis should not be made in the presence of organic brain disorders, intoxication or excessive fatigue.

Excl.: alcohol- or other psychoactive-substance-induced amnesic disorder (F10–F19 with common fourth character .6)
amnesia:
- NOS (R41.3)
- anterograde (R41.1)
- retrograde (R41.2)

nonalcoholic organic amnesic syndrome (F04)
postictal amnesia in epilepsy (G40.-)

F44.1 Dissociative fugue

Dissociative fugue has all the features of dissociative amnesia, plus purposeful travel beyond the usual everyday range. Although there is amnesia for the period of the fugue, the patient's behaviour during this time may appear completely normal to independent observers.

Excl.: postictal fugue in epilepsy (G40.-)

F44.2 Dissociative stupor

Dissociative stupor is diagnosed on the basis of a profound diminution or absence of voluntary movement and normal responsiveness to external stimuli such as light, noise and touch, but examination and investigation reveal no evidence of a physical cause. In addition, there is positive evidence of psychogenic causation in the form of recent stressful events or problems.

Excl.: organic catatonic disorder (F06.1)
stupor:
- NOS (R40.1)
- catatonic (F20.2)
- depressive (F31–F33)
- manic (F30.2)

F44.3 Trance and possession disorders

Disorders in which there is a temporary loss of the sense of personal identity and full awareness of the surroundings. Include here only trance states that are involuntary or unwanted, occurring outside religious or culturally accepted situations.

Excl.: states associated with:
- acute and transient psychotic disorders (F23.-)
- organic personality disorder (F07.0)
- postconcussional syndrome (F07.2)
- psychoactive-substance intoxication (F10–F19 with common fourth character .0)
- schizophrenia (F20.-)

F44.4 Dissociative motor disorders

In the commonest varieties, there is loss of ability to move the whole or a part of a limb or limbs. There may be close resemblance to almost any variety of ataxia, apraxia, akinesia, aphonia, dysarthria, dyskinesia, seizures or paralysis.

Psychogenic:
- aphonia
- dysphonia

F44.5 Dissociative convulsions

Dissociative convulsions may mimic epileptic seizures very closely in terms of movements, but tongue-biting, bruising due to falling, and incontinence of urine are rare, and consciousness is maintained or replaced by a state of stupor or trance.

F44.6 Dissociative anaesthesia and sensory loss

Anaesthetic areas of skin often have boundaries that make it clear that they are associated with the patient's ideas about bodily functions, rather than medical knowledge. There may be differential loss between the sensory modalities that cannot be due to a neurological lesion. Sensory loss may be accompanied by complaints of paraesthesia. Loss of vision and hearing are rarely total in dissociative disorders.

Psychogenic deafness

F44.7 Mixed dissociative [conversion] disorders

Combination of disorders specified in F44.0–F44.6

~~F44.8 Other dissociative [conversion] disorders~~

~~Ganser syndrome~~
~~Multiple~~ personality
~~Psychogenic:~~
~~• confusion~~
~~• twilight state~~

~~F44.9 Dissociative [conversion] disorder, unspecified~~

F45 Somatoform disorders

The main feature is repeated presentation of physical symptoms, together with persistent requests for medical investigations, in spite of repeated negative findings and reassurances by doctors that the symptoms have no physical basis. If any physical disorders are present, they do not explain the nature and extent of the symptoms or the distress and preoccupation of the patient.

Excl.: dissociative disorders (F44.-)
hair-plucking (F98.4)
lalling (F80.0)
lisping (F80.8)
nail-biting (F98.8)
psychological or behavioural factors associated with disorders or diseases classified elsewhere (F54)
sexual dysfunction, not caused by organic disorder or disease (F52.-)
thumb-sucking (F98.8)
tic disorders (in childhood and adolescence) (F95.-)
Tourette syndrome (F95.2)
trichotillomania (F63.3)

F45.0 Somatization disorder

The main features are multiple, recurrent and frequently changing physical symptoms of at least two years' duration. Most patients have a long and complicated history of contact with both primary and specialist medical care services, during which many negative investigations or fruitless exploratory operations may have been carried out. Symptoms may be referred to any part or system of the body. The course of the disorder is chronic and fluctuating, and is often associated with

disruption of social, interpersonal and family behaviour. Short-lived (less than two years) and less striking symptom patterns should be classified under undifferentiated somatoform disorder (F45.1).

Briquet disorder
Multiple psychosomatic disorder

Excl.: malingering [conscious simulation] (Z76.5)

F45.1 Undifferentiated somatoform disorder

When somatoform complaints are multiple, varying and persistent, but the complete and typical clinical picture of somatization disorder is not fulfilled, the diagnosis of undifferentiated somatoform disorder should be considered.

Undifferentiated psychosomatic disorder

F45.2 Hypochondriacal disorder

The essential feature is a persistent preoccupation with the possibility of having one or more serious and progressive physical disorders. Patients manifest persistent somatic complaints or a persistent preoccupation with their physical appearance. Normal or commonplace sensations and appearances are often interpreted by patients as abnormal and distressing, and attention is usually focused upon only one or two organs or systems of the body. Marked depression and anxiety are often present, and may justify additional diagnoses.

Body dysmorphic disorder
Dysmorphophobia (nondelusional)
Hypochondriacal neurosis
Hypochondriasis
Nosophobia

Excl.: delusional dysmorphophobia (F22.8)
fixed delusions about bodily functions or shape (F22.-)

F45.3 Somatoform autonomic dysfunction

Symptoms are presented by the patient as if they were due to a physical disorder of a system or organ that is largely or completely under autonomic innervation and control, i.e. the cardiovascular, gastrointestinal, respiratory and urogenital systems. The symptoms are usually of two types, neither of which indicates a physical disorder of the organ or system concerned. First, there are complaints based upon objective signs of autonomic arousal, such as palpitations, sweating, flushing, tremor and expression of fear and distress about the possibility of a physical disorder. Second, there are subjective complaints of a nonspecific or changing nature, such as fleeting aches and pains, sensations of burning, heaviness, tightness and feelings of being bloated or distended, which are referred by the patient to a specific organ or system.

Cardiac neurosis
Da Costa syndrome
Gastric neurosis
Neurocirculatory asthenia
Psychogenic forms of:
- aerophagy
- cough

- diarrhoea
- dyspepsia
- dysuria
- flatulence
- hiccough
- hyperventilation
- increased frequency of micturition
- irritable bowel syndrome
- pylorospasm

Excl.: psychological and behavioural factors associated with disorders or diseases classified elsewhere (F54)

F45.4 Persistent somatoform pain disorder

The predominant complaint is of persistent, severe and distressing pain, which cannot be explained fully by a physiological process or a physical disorder, and which occurs in association with emotional conflict or psychosocial problems that are sufficient to allow the conclusion that they are the main causative influences. The result is usually a marked increase in support and attention, either personal or medical. Pain presumed to be of psychogenic origin occurring during the course of depressive disorders or schizophrenia should not be included here.

Psychalgia
Psychogenic:
- backache
- headache

Somatoform pain disorder

Excl.: backache NOS (M54.9)
pain:
- NOS (R52.9)
- acute (R52.0)
- chronic (R52.2)
- intractable (R52.1)

tension headache (G44.2)

~~F45.8 Other somatoform disorders~~

~~Any other disorders of sensation, function and behaviour, not due to physical disorders, that are not mediated through the autonomic nervous system, that are limited to specific systems or parts of the body and that are closely associated in time with stressful events or problems.~~

~~Psychogenic:~~
- ~~dysmenorrhoea~~
- ~~dysphagia, including 'globus hystericus'~~
- ~~pruritus~~
- ~~torticollis~~

~~Teeth-grinding~~

~~F45.9 Somatoform disorder, unspecified~~

~~Psychosomatic disorder NOS~~

F48 Other neurotic disorders

F48.0 Neurasthenia

Considerable cultural variations occur in the presentation of this disorder, and two main types occur, with substantial overlap. In one type, the main feature is a complaint of increased fatigue after mental effort, often associated with some decrease in occupational performance or coping efficiency in daily tasks. The mental fatigability is typically described as an unpleasant intrusion of distracting associations or recollections, difficulty in concentrating, and generally inefficient thinking. In the other type, the emphasis is on feelings of bodily or physical weakness and exhaustion after only minimal effort, accompanied by a feeling of muscular aches and pains and inability to relax. In both types, a variety of other unpleasant physical feelings is common, such as dizziness, tension headaches and feelings of general instability. Worry about decreasing mental and bodily well-being, irritability, anhedonia and varying minor degrees of both depression and anxiety are all common. Sleep is often disturbed in its initial and middle phases but hypersomnia may also be prominent.

Fatigue syndrome
Use additional code, if desired, to identify previous physical illness.

Excl.: asthenia NOS (R53)
burn-out (Z73.0)
malaise and fatigue (R53)
postviral fatigue syndrome (G93.3)
psychasthenia (F48.8)

F48.1 Depersonalization-derealization syndrome

A rare disorder in which the patient complains spontaneously that his or her mental activity, body and surroundings are changed in their quality, so as to be unreal, remote or automatized. Among the varied phenomena of the syndrome, patients complain most frequently of loss of emotions and feelings of estrangement or detachment from their thinking, their body or the real world. In spite of the dramatic nature of the experience, the patient is aware of the unreality of the change. The sensorium is normal and the capacity for emotional expression intact. Depersonalization-derealization symptoms may occur as part of a diagnosable schizophrenic, depressive, phobic or obsessive-compulsive disorder. In such cases, the diagnosis should be that of the main disorder.

~~F48.8 Other specified neurotic disorders~~

~~Dhat syndrome~~
~~Occupational neurosis, including writer's cramp~~
~~Psychasthenia~~
~~Psychasthenic neurosis~~
~~Psychogenic syncope~~

~~F48.9 Neurotic disorder, unspecified~~

~~Neurosis NOS~~

Behavioural syndromes associated with physiological disturbances and physical factors (F50–F59)

F50 Eating disorders

Excl.: anorexia NOS (R63.0)
feeding:
- difficulties and mismanagement (R63.3)
- disorder of infancy or childhood (F98.2)

polyphagia (R63.2)

F50.0 Anorexia nervosa

A disorder characterized by deliberate weight loss, induced and sustained by the patient. It occurs most commonly in adolescent girls and young women, but adolescent boys and young men may also be affected, as may children approaching puberty and older women up to the menopause. The disorder is associated with a specific psychopathology whereby a dread of fatness and flabbiness of body contour persists as an intrusive overvalued idea, and the patients impose a low weight threshold on themselves. There is usually undernutrition of varying severity, with secondary endocrine and metabolic changes and disturbances of bodily function. The symptoms include restricted dietary choice, excessive exercise, induced vomiting and purgation, and use of appetite suppressants and diuretics.

Excl.: loss of appetite (R63.0)
loss of appetite
- psychogenic (F50.8)

F50.1 Atypical anorexia nervosa

Disorders that fulfil some of the features of anorexia nervosa but in which the overall clinical picture does not justify that diagnosis. For instance, one of the key symptoms, such as amenorrhoea or marked dread of being fat, may be absent, in the presence of marked weight loss and weight-reducing behaviour. This diagnosis should not be made in the presence of known physical disorders associated with weight loss.

F50.2 Bulimia nervosa

A syndrome characterized by repeated bouts of overeating and an excessive preoccupation with the control of body weight, leading to a pattern of overeating followed by vomiting or use of purgatives. This disorder shares many psychological features with anorexia nervosa, including an overconcern with body shape and weight. Repeated vomiting is likely to give rise to disturbances of body electrolytes and physical complications. There is often, but not always, a history of an earlier episode of anorexia nervosa, the interval ranging from a few months to several years.

Bulimia NOS
Hyperorexia nervosa

F50.3 Atypical bulimia nervosa

Disorders that fulfil some of the features of bulimia nervosa, but in which the overall clinical picture does not justify that diagnosis. For instance, there may be recurrent bouts of overeating and overuse of purgatives without significant weight change, or the typical overconcern about body shape and weight may be absent.

F50.4 Overeating associated with other psychological disturbances

Overeating due to stressful events, such as bereavement, accident, childbirth, etc.

Psychogenic overeating

Excl.: obesity (E66.-)

F50.5 Vomiting associated with other psychological disturbances

Repeated vomiting that occurs in dissociative disorders (F44.-) and hypochondriacal disorder (F45.2), and that is not solely due to conditions classified outside this chapter. This subcategory may also be used in addition to O21.- (excessive vomiting in pregnancy) when emotional factors are predominant in the causation of recurrent nausea and vomiting in pregnancy.

Psychogenic vomiting

Excl.: nausea (R11)
vomiting NOS (R11)

~~**F50.8 Other eating disorders**~~
~~Pica in adults~~
~~Psychogenic loss of appetite~~
~~***Excl.:*** pica of infancy and childhood (F98.3)~~

~~**F50.9 Eating disorder, unspecified**~~

F51 Nonorganic sleep disorders

In many cases, a disturbance of sleep is one of the symptoms of another disorder, either mental or physical. Whether a sleep disorder in a given patient is an independent condition or simply one of the features of another disorder classified elsewhere, either in this chapter or in others, should be determined on the basis of its clinical presentation and course, as well as on the therapeutic considerations and priorities at the time of the consultation. Generally, if the sleep disorder is one of the major complaints and is perceived as a condition in itself, the present code should be used, along with other pertinent diagnoses describing the psychopathology and pathophysiology involved in a given case. This category includes only those sleep disorders in which emotional causes are considered to be a primary factor, and that are not due to identifiable physical disorders classified elsewhere.

Excl.: sleep disorders (organic) (G47.-)

F51.0 Nonorganic insomnia

A condition of unsatisfactory quantity and/or quality of sleep, which persists for a considerable period of time, including difficulty falling asleep, difficulty staying asleep, or early final wakening. Insomnia is a common symptom of many mental and physical disorders, and should be classified here in addition to the basic disorder only if it dominates the clinical picture.

Excl.: insomnia (organic) (G47.0)

F51.1 Nonorganic hypersomnia

Hypersomnia is defined as a condition of either excessive daytime sleepiness and sleep attacks (not accounted for by an inadequate amount of sleep) or prolonged transition to the fully aroused state upon awakening. In the absence of an organic factor for the occurrence of hypersomnia, this condition is usually associated with mental disorders.

Excl.: hypersomnia (organic) (G47.1)
narcolepsy (G47.4)

F51.2 Nonorganic disorder of the sleep–wake schedule

A lack of synchrony between the sleep-wake schedule and the desired sleep–wake schedule for the individual's environment, resulting in a complaint of either insomnia or hypersomnia.

Psychogenic inversion of:
- circadian
- nyctohemeral
- sleep

rhythm

Excl.: disorders of the sleep–wake schedule (organic) (G47.2)

F51.3 Sleepwalking [somnambulism]

A state of altered consciousness in which phenomena of sleep and wakefulness are combined. During a sleepwalking episode, the individual arises from bed, usually during the first third of nocturnal sleep, and walks about, exhibiting low levels of awareness, reactivity and motor skill. Upon awakening, there is usually no recall of the event.

F51.4 Sleep terrors [night terrors]

Nocturnal episodes of extreme terror and panic associated with intense vocalization, motility and high levels of autonomic discharge. The individual sits up or gets up, usually during the first third of nocturnal sleep, with a panicky scream. Quite often, he or she rushes to the door as if trying to escape, although very seldom leaves the room. Recall of the event, if any, is very limited (usually to one or two fragmentary mental images).

F51.5 Nightmares

Dream experiences loaded with anxiety or fear. There is very detailed recall of the dream content. The dream experience is very vivid and usually includes themes involving threats to survival, security or self-esteem. Quite often, there is a recurrence of the same or similar frightening nightmare themes. During a typical episode, there is a degree of autonomic discharge but no appreciable vocalization or body motility. Upon awakening, the individual rapidly becomes alert and oriented.

Dream anxiety disorder

~~**F51.8 Other nonorganic sleep disorders**~~

~~**F51.9 Nonorganic sleep disorder, unspecified**~~
~~Emotional sleep disorder NOS~~

F52 Sexual dysfunction, not caused by organic disorder or disease

Sexual dysfunction covers the various ways in which an individual is unable to participate in a sexual relationship as he or she would wish. Sexual response is a psychosomatic process and both psychological and somatic processes are usually involved in the causation of sexual dysfunction.

Excl.: Dhat syndrome (F48.8)

F52.0 Lack or loss of sexual desire

Loss of sexual desire is the principal problem and is not secondary to other sexual difficulties, such as erectile failure or dyspareunia.

Frigidity
Hypoactive sexual desire disorder

F52.1 Sexual aversion and lack of sexual enjoyment

Either the prospect of sexual interaction produces sufficient fear or anxiety that sexual activity is avoided (sexual aversion) or sexual responses occur normally and orgasm is experienced but there is a lack of appropriate pleasure (lack of sexual enjoyment).

Anhedonia (sexual)

F52.2 Failure of genital response

The principal problem in men is erectile dysfunction (difficulty in developing or maintaining an erection suitable for satisfactory intercourse). In women, the principal problem is vaginal dryness or failure of lubrication.

Female sexual arousal disorder
Male erectile disorder
Psychogenic impotence

Excl.: impotence of organic origin (N48.4)

F52.3 Orgasmic dysfunction

Orgasm either does not occur or is markedly delayed.

Inhibited orgasm (male)(female)
Psychogenic anorgasmy

F52.4 Premature ejaculation

The inability to control ejaculation sufficiently for both partners to enjoy sexual interaction.

F52.5 Nonorganic vaginismus

Spasm of the pelvic floor muscles that surround the vagina, causing occlusion of the vaginal opening. Penile entry is either impossible or painful.

Psychogenic vaginismus

Excl.: vaginismus (organic) (N94.2)

F52.6 Nonorganic dyspareunia

Dyspareunia (or pain during sexual intercourse) occurs in both women and men. It can often be attributed to local pathology and should then properly be categorized under the pathological condition. This category is to be used only if there is no primary nonorganic sexual dysfunction (e.g. vaginismus or vaginal dryness).

Psychogenic dyspareunia

Excl.: dyspareunia (organic) (N94.1)

F52.7 Excessive sexual drive

Nymphomania
Satyriasis

~~F52.8 Other sexual dysfunction, not caused by organic disorder or disease~~

~~F52.9 Unspecified sexual dysfunction, not caused by organic disorder or disease~~

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

This category includes only mental disorders associated with the puerperium (commencing within six weeks of delivery) that do not meet the criteria for disorders classified elsewhere in this chapter, either because insufficient information is available, or because it is considered that special additional clinical features are present that make their classification elsewhere inappropriate.

F53.0 Mild mental and behavioural disorders associated with the puerperium, not elsewhere classified

Depression:
- postnatal NOS
- postpartum NOS

F53.1 Severe mental and behavioural disorders associated with the puerperium, not elsewhere classified

Puerperal psychosis NOS

~~F53.8 Other mental and behavioural disorders associated with the puerperium, not elsewhere classified~~

~~F53.9 Puerperal mental disorder, unspecified~~

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

This category should be used to record the presence of psychological or behavioural influences thought to have played a major part in the etiology of physical disorders that can be classified to other chapters. Any resulting mental disturbances are usually mild, and often prolonged (such as worry, emotional conflict, apprehension), and do not of themselves justify the use of any of the categories in this chapter.

Incl.: psychological factors affecting physical conditions
examples of the use of this category are:

- asthma F54 and J45.-
- dermatitis F54 and L23–L25
- gastric ulcer F54 and K25.-
- irritable bowel syndrome F54 and K58.-
- ulcerative colitis F54 and K51.-
- urticaria F54 and L50.-

Use additional code, if desired, to identify the associated physical disorder.

Excl.: tension-type headache (G44.2)

F55 Abuse of non-dependence-producing substances

A wide variety of medicaments and folk remedies may be involved, but the particularly important groups are: (a) psychotropic drugs that do not produce dependence, such as antidepressants, (b) laxatives, and (c) analgesics that may be purchased without medical prescription, such as aspirin and paracetamol.

Persistent use of these substances often involves unnecessary contacts with medical professionals or supporting staff, and is sometimes accompanied by harmful physical effects of the substances. Attempts to dissuade or forbid the use of the substance are often met with resistance; for laxatives and analgesics, this may be in spite of warnings about (or even the development of) physical harm such as renal dysfunction or electrolyte disturbances. Although it is usually clear that the patient has a strong motivation to take the substance, dependence or withdrawal symptoms do not develop as in the case of the psychoactive substances specified in F10–F19.

Incl.: abuse of:

- antacids
- herbal or folk remedies
- steroids or hormones
- vitamins

laxative habit

Excl.: abuse of psychoactive substances (F10-F19)

F59 ~~Unspecified behavioural syndromes associated with~~ physiological disturbances and physical factors

~~***Incl.:*** psychogenic physiological dysfunction NOS~~

Disorders of adult personality and behaviour (F60–F69)

This block includes a variety of conditions and behaviour patterns of clinical significance that tend to be persistent and appear to be the expression of the individual's characteristic lifestyle and mode of relating to himself or herself and others. Some of these conditions and patterns of behaviour emerge early in the course of individual development, as a result of both constitutional factors and social experience, while others are acquired later in life. Specific personality disorders (F60.-), mixed and other personality disorders (F61.-) and enduring personality changes (F62.-) are deeply ingrained and enduring behaviour patterns, manifesting as inflexible responses to a broad range of personal and social situations. They represent extreme or significant deviations from the way in which the average individual in a given culture perceives, thinks, feels and, particularly, relates to others. Such behaviour patterns tend to be stable and to encompass multiple domains of behaviour and psychological functioning. They are frequently, but not always, associated with various degrees of subjective distress and problems of social performance.

F60 Specific personality disorders

These are severe disturbances in the personality and behavioural tendencies of the individual; not directly resulting from disease, damage or other insult to the brain, or from another psychiatric disorder; usually involving several areas of the personality; nearly always associated with considerable personal distress and social disruption; and usually manifest since childhood or adolescence and continuing throughout adulthood.

F60.0 Paranoid personality disorder

Personality disorder characterized by excessive sensitivity to setbacks; unforgiveness of insults; suspiciousness and a tendency to distort experience by misconstruing the neutral or friendly actions of others as hostile or contemptuous; recurrent suspicions, without justification, regarding the sexual fidelity of the spouse or sexual partner; and a combative and tenacious sense of personal rights. There may be excessive self-importance and there is often excessive self-reference.

Personality (disorder):
- expansive paranoid
- fanatic
- querulant
- paranoid
- sensitive paranoid

Excl.: paranoia (F22.0)
paranoia querulans (F22.8)
paranoid:
- psychosis (F22.0)
- schizophrenia (F20.0)
- state (F22.0)

F60.1 Schizoid personality disorder

Personality disorder characterized by withdrawal from affectional, social and other contacts, with preference for fantasy, solitary activities and introspection. There is a limited capacity to express feelings and to experience pleasure.

Excl.: Asperger syndrome (F84.5)
delusional disorder (F22.0)
schizoid disorder of childhood (F84.5)
schizophrenia (F20.-)
schizotypal disorder (F21)

F60.2 Dissocial personality disorder

Personality disorder characterized by disregard for social obligations, and callous unconcern for the feelings of others. There is gross disparity between behaviour and the prevailing social norms. Behaviour is not readily modifiable by adverse experience, including punishment. There is a low tolerance to frustration and a low threshold for discharge of aggression, including violence; there is a tendency to blame others, or to offer plausible rationalizations for the behaviour, bringing the patient into conflict with society.

Personality (disorder):
- amoral
- antisocial
- asocial
- psychopathic
- sociopathic

Excl.: conduct disorders (F91.-)
emotionally unstable personality disorder (F60.3)

F60.3 Emotionally unstable personality disorder

Personality disorder characterized by a definite tendency to act impulsively and without consideration of the consequences; the mood is unpredictable and capricious. There is a liability to outbursts of emotion and an incapacity to control the behavioural explosions. There is a tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or censored. Two types may be distinguished: the impulsive type, characterized predominantly by emotional instability and lack of impulse control, and the borderline type, characterized in addition by disturbances in self-image, aims and internal preferences, by chronic feelings of emptiness, by intense and unstable interpersonal relationships, and by a tendency to self-destructive behaviour, including suicide gestures and attempts.

Personality (disorder):
- aggressive
- borderline
- explosive

Excl.: dissocial personality disorder (F60.2)

F60.4 Histrionic personality disorder

Personality disorder characterized by shallow and labile affectivity, self-dramatization, theatricality, exaggerated expression of emotions, suggestibility, egocentricity, self-indulgence, lack of consideration for others, easily hurt feelings, and continuous seeking for appreciation, excitement and attention.

Personality (disorder):
- hysterical
- psychoinfantile

F60.5 Anankastic personality disorder

Personality disorder characterized by feelings of doubt, perfectionism, excessive conscientiousness, checking and preoccupation with details, stubbornness, caution, and rigidity. There may be insistent and unwelcome thoughts or impulses that do not attain the severity of an obsessive-compulsive disorder.

Personality (disorder):
- compulsive
- obsessional
- obsessive-compulsive

Excl.: obsessive-compulsive disorder (F42.-)

F60.6 Anxious [avoidant] personality disorder

Personality disorder characterized by feelings of tension and apprehension, insecurity and inferiority. There is a continuous yearning to be liked and accepted, a hypersensitivity to rejection and criticism, with restricted personal attachments, and a tendency to avoid certain activities by habitual exaggeration of the potential dangers or risks in everyday situations.

F60.7 Dependent personality disorder

Personality disorder characterized by pervasive passive reliance on other people to make one's major and minor life decisions, great fear of abandonment, feelings of helplessness and incompetence, passive compliance with the wishes of elders and others, and a weak response to the demands of daily life. Lack of vigour may show itself in the intellectual or emotional spheres; there is often a tendency to transfer responsibility to others.

Personality (disorder):
- asthenic
- inadequate
- passive
- self-defeating

~~F60.8 Other specific personality disorders~~

~~Personality (disorder):~~
- ~~eccentric~~
- ~~'haltlose' type~~
- ~~immature~~
- ~~narcissistic~~
- ~~passive-aggressive~~
- ~~psychoneurotic~~

~~F60.9~~ ~~Personality disorder, unspecified~~
~~Character neurosis NOS~~
~~Pathological personality NOS~~

F61 Mixed and other personality disorders

This category is intended for personality disorders that are often troublesome but do not demonstrate the specific pattern of symptoms that characterize the disorders described in F60.-. As a result, they are often more difficult to diagnose than the disorders in F60.-.

Examples include:

- mixed personality disorders with features of several of the disorders in F60.- but without a predominant set of symptoms that would allow a more specific diagnosis;
- troublesome personality changes, not classifiable to F60.- or F62.-, and regarded as secondary to a main diagnosis of a coexisting affective or anxiety disorder.

Excl.: accentuated personality traits (Z73.1)

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

Disorders of adult personality and behaviour that have developed in persons with no previous personality disorder, following exposure to catastrophic or excessive prolonged stress, or following a severe psychiatric illness. These diagnoses should be made only when there is evidence of a definite and enduring change in a person's pattern of perceiving, relating to or thinking about the environment and himself or herself. The personality change should be significant and be associated with inflexible and maladaptive behaviour not present before the pathogenic experience. The change should not be a direct manifestation of another mental disorder or a residual symptom of any antecedent mental disorder.

Excl.: personality and behavioural disorder due to brain disease, damage and dysfunction (F07.-)

F62.0 Enduring personality change after catastrophic experience

Enduring personality change, present for at least two years, following exposure to catastrophic stress. The stress must be so extreme that it is not necessary to consider personal vulnerability in order to explain its profound effect on the personality. The disorder is characterized by a hostile or distrustful attitude toward the world, social withdrawal, feelings of emptiness or hopelessness, a chronic feeling of 'being on edge' as if constantly threatened, and estrangement. Post-traumatic stress disorder (F43.1) may precede this type of personality change.

Personality change after:
- concentration camp experiences
- disasters
- prolonged:
  - captivity with an imminent possibility of being killed
  - exposure to life-threatening situations such as being a victim of terrorism
- torture

Excl.: post-traumatic stress disorder (F43.1)

F62.1 Enduring personality change after psychiatric illness

Personality change, persisting for at least two years, attributable to the traumatic experience of suffering from a severe psychiatric illness. The change cannot be explained by a previous personality disorder and should be differentiated from residual schizophrenia and other states of incomplete recovery from an antecedent mental disorder. This disorder is characterized by an excessive dependence on and a demanding attitude towards others; conviction of being changed or stigmatized by the illness, leading to an inability to form and maintain close and confiding personal relationships and to social isolation; passivity, reduced interests, and diminished involvement in leisure activities; persistent complaints of being ill, which may be associated with hypochondriacal claims and illness behaviour; dysphoric or labile mood, not due to the presence of a current mental disorder or antecedent mental disorder with residual affective symptoms; and longstanding problems in social and occupational functioning.

~~F62.8 Other enduring personality changes~~

~~Chronic pain personality syndrome~~

~~F62.9 Enduring personality change, unspecified~~

F63 Habit and impulse disorders

This category includes certain disorders of behaviour that are not classifiable under other categories. They are characterized by repeated acts that have no clear rational motivation, cannot be controlled, and generally harm the patient's own interests and those of other people. The patient reports that the behaviour is associated with impulses to action. The cause of these disorders is not understood and they are grouped together because of broad descriptive similarities, not because they are known to share any other important features.

Excl.: habitual excessive use of alcohol or psychoactive substances (F10–F19)
impulse and habit disorders involving sexual behaviour (F65.-)

F63.0 Pathological gambling

The disorder consists of frequent, repeated episodes of gambling that dominate the patient's life to the detriment of social, occupational, material and family values and commitments.

Compulsive gambling

Excl.: excessive gambling by manic patients (F30.-)
gambling and betting NOS (Z72.6)
gambling in dissocial personality disorder (F60.2)

F63.1 Pathological fire-setting [pyromania]

Disorder characterized by multiple acts of, or attempts at, setting fire to property or other objects, without apparent motive, and by a persistent preoccupation with subjects related to fire and burning. This behaviour is often associated with feelings of increasing tension before the act, and intense excitement immediately afterwards.

Excl.: fire-setting (by)(in):

- adult with dissocial personality disorder (F60.2)
- alcohol or psychoactive substance intoxication (F10–F19, with common fourth character .0)

- as the reason for observation for suspected mental disorder (Z03.2)
- conduct disorders (F91.-)
- organic mental disorders (F00–F09)
- schizophrenia (F20.-)

F63.2 Pathological stealing [kleptomania]

Disorder characterized by repeated failure to resist impulses to steal objects that are not acquired for personal use or monetary gain. The objects may instead be discarded, given away or hoarded. This behaviour is usually accompanied by an increasing sense of tension before, and a sense of gratification during and immediately after, the act.

Excl.: depressive disorder with stealing (F31–F33)
organic mental disorders (F00–F09)
shoplifting as the reason for observation for suspected mental disorder (Z03.2)

F63.3 Trichotillomania

A disorder characterized by noticeable hairloss due to a recurrent failure to resist impulses to pull out hairs. The hair-pulling is usually preceded by mounting tension and is followed by a sense of relief or gratification. This diagnosis should not be made if there is a pre-existing inflammation of the skin, or if the hair-pulling is in response to a delusion or a hallucination.

Excl.: stereotyped movement disorder with hair-plucking (F98.4)

~~F63.8 Other habit and impulse disorders~~

Other kinds of persistently repeated maladaptive behaviour that are not secondary to a recognized psychiatric syndrome, and in which it appears that the patient is repeatedly failing to resist impulses to carry out the behaviour. There is a prodromal period of tension with a feeling of release at the time of the act.

Intermittent explosive disorder

~~F63.9 Habit and impulse disorder, unspecified~~

F64 Gender identity disorders

F64.0 Transsexualism

A desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex, and a wish to have surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex.

F64.1 Dual-role transvestism

The wearing of clothes of the opposite sex for part of the individual's existence, in order to enjoy the temporary experience of membership of the opposite sex, but without any desire for a more permanent sex change or associated surgical reassignment, and without sexual excitement accompanying the cross-dressing.

Gender identity disorder of adolescence or adulthood, nontranssexual type

Excl.: fetishistic transvestism (F65.1)

F64.2 Gender identity disorder of childhood

A disorder, usually first manifest during early childhood (and always well before puberty), characterized by a persistent and intense distress about assigned sex, together with a desire to be (or insistence that one is) of the other sex. There is a persistent preoccupation with the dress and activities of the opposite sex and repudiation of the individual's own sex. The diagnosis requires a profound disturbance of the normal gender identity; mere tomboyishness in girls or girlish behaviour in boys is not sufficient. Gender identity disorders in individuals who have reached or are entering puberty should not be classified here but in F66.-.

Excl.: egodystonic sexual orientation (F66.1)
sexual maturation disorder (F66.0)

~~F64.8 Other gender identity disorders~~

~~F64.9 Gender identity disorder, unspecified~~

~~Gender role disorder NOS~~

F65 Disorders of sexual preference

Incl.: paraphilias

F65.0 Fetishism

Reliance on some non-living object as a stimulus for sexual arousal and sexual gratification. Many fetishes are extensions of the human body, such as articles of clothing or footwear. Other common examples are characterized by some particular texture such as rubber, plastic or leather. Fetish objects vary in their importance to the individual. In some cases they simply serve to enhance sexual excitement achieved in ordinary ways (e.g. having the partner wear a particular garment).

F65.1 Fetishistic transvestism

The wearing of clothes of the opposite sex principally to obtain sexual excitement and to create the appearance of a person of the opposite sex. Fetishistic transvestism is distinguished from transsexual transvestism by its clear association with sexual arousal and the strong desire to remove the clothing once orgasm occurs and sexual arousal declines. It can occur as an earlier phase in the development of transsexualism.

Transvestic fetishism

F65.2 Exhibitionism

A recurrent or persistent tendency to expose the genitalia to strangers (usually of the opposite sex) or to people in public places, without inviting or intending closer contact. There is usually, but not invariably, sexual excitement at the time of the exposure and the act is commonly followed by masturbation.

F65.3 Voyeurism

A recurrent or persistent tendency to look at people engaging in sexual or intimate behaviour such as undressing. This is carried out without the observed people being aware, and usually leads to sexual excitement and masturbation.

F65.4 Paedophilia

A sexual preference for children, boys or girls or both, usually of prepubertal or early pubertal age.

F65.5 Sadomasochism

A preference for sexual activity that involves the infliction of pain or humiliation, or bondage. If the subject prefers to be the recipient of such stimulation, this is called masochism; if the provider, sadism. Often an individual obtains sexual excitement from both sadistic and masochistic activities.

Masochism
Sadism

F65.6 Multiple disorders of sexual preference

Sometimes more than one abnormal sexual preference occurs in one person and there is none of first rank. The most common combination is fetishism, transvestism and sadomasochism.

~~F65.8 Other disorders of sexual preference~~

A variety of other patterns of sexual preference and activity, including making obscene telephone calls, rubbing up against people for sexual stimulation in crowded public places, sexual activity with animals, and use of strangulation or anoxia for intensifying sexual excitement.

Frotteurism
Necrophilia

~~F65.9 Disorder of sexual preference, unspecified~~

~~Sexual deviation NOS~~

F66 Psychological and behavioural disorders associated with sexual development and orientation

Note: Sexual orientation by itself is not to be regarded as a disorder.

F66.0 Sexual maturation disorder

The patient suffers from uncertainty about his or her gender identity or sexual orientation, which causes anxiety or depression. Most commonly this occurs in adolescents who are not certain whether they are homosexual, heterosexual or bisexual in orientation, or in individuals who, after a period of apparently stable sexual orientation (often within a longstanding relationship), find that their sexual orientation is changing.

F66.1 Egodystonic sexual orientation

The gender identity or sexual preference (heterosexual, homosexual, bisexual or prepubertal) is not in doubt, but the individual wishes it were different because of associated psychological and behavioural disorders, and may seek treatment in order to change it.

F66.2 Sexual relationship disorder

The gender identity or sexual orientation (heterosexual, homosexual or bisexual) is responsible for difficulties in forming or maintaining a relationship with a sexual partner.

~~F66.8 Other psychosexual development disorders~~

~~F66.9 Psychosexual development disorder, unspecified~~

F68 Other disorders of adult personality and behaviour

F68.0 Elaboration of physical symptoms for psychological reasons

Physical symptoms compatible with and originally due to a confirmed physical disorder, disease or disability become exaggerated or prolonged, due to the psychological state of the patient. The patient is commonly distressed by this pain or disability, and is often preoccupied with worries, which may be justified, of the possibility of prolonged or progressive disability or pain.

Compensation neurosis

F68.1 Intentional production or feigning of symptoms or disabilities, either physical or psychological [factitious disorder]

The patient feigns symptoms repeatedly for no obvious reason and may even inflict self-harm in order to produce symptoms or signs. The motivation is obscure and presumably internal with the aim of adopting the sick role. The disorder is often combined with marked disorders of personality and relationships.

Hospital hopper syndrome
Münchausen syndrome
Peregrinating patient

Excl.: factitial dermatitis (L98.1)
person feigning illness (with obvious motivation) (Z76.5)

F68.8 ~~Other specified disorders of adult personality and behaviour~~

~~Character disorder NOS~~
~~Relationship disorder NOS~~

F69 Unspecified disorder of adult personality and behaviour

~~Mental retardation (F70–F79)~~

A condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, skills which contribute to the overall level of intelligence, i.e. cognitive, language, motor and social abilities. Retardation can occur with or without any other mental or physical condition.

Degrees of mental retardation are conventionally estimated by standardized intelligence tests. These can be supplemented by scales assessing social adaptation in a given environment. These measures provide an approximate indication of the degree of mental retardation. The diagnosis will also depend on the overall assessment of intellectual functioning by a skilled diagnostician.

Intellectual abilities and social adaptation may change over time, and, however poor, may improve as a result of training and rehabilitation. Diagnosis should be based on the current levels of functioning.

Use additional code, if desired, to identify associated conditions such as autism, other developmental disorders, epilepsy, conduct disorders or severe physical handicap.

The following fourth-character subdivisions are for use with categories F70–F79 to identify the extent of impairment of behaviour:

.0 With the statement of no, or minimal, impairment of behaviour

.1 Significant impairment of behaviour requiring attention or treatment

.8 Other impairments of behaviour

.9 Without mention of impairment of behaviour

F70 Mild mental retardation

[See before F70 for subdivisions]

Approximate IQ range of 50 to 69 (in adults, mental age from 9 to under 12 years). Likely to result in some learning difficulties in school. Many adults will be able to work and maintain good social relationships and contribute to society.

Incl.: feeble-mindedness
mild mental subnormality

F71 Moderate mental retardation

[See before F70 for subdivisions]

Approximate IQ range of 35 to 49 (in adults, mental age from 6 to under 9 years). Likely to result in marked developmental delays in childhood but most can learn to develop some degree of independence in self-care and acquire adequate communication and academic skills. Adults will need varying degrees of support to live and work in the community.

Incl.: moderate mental subnormality

F72 Severe mental retardation

[See before F70 for subdivisions]

Approximate IQ range of 20 to 34 (in adults, mental age from 3 to under 6 years). Likely to result in continuous need of support.

Incl.: severe mental subnormality

F73 Profound mental retardation

[See before F70 for subdivisions]

IQ under 20 (in adults, mental age below 3 years). Results in severe limitation in self-care, continence, communication and mobility.

Incl.: profound mental subnormality

F78 Other mental retardation

[See before F70 for subdivisions]

F79 Unspecified mental retardation

[See before F70 for subdivisions]

Incl.: mental:
- deficiency NOS
- subnormality NOS

Disorders of psychological development (F80–F89)

The disorders included in this block have in common: (a) onset invariably during infancy or childhood; (b) impairment or delay in development of functions that are strongly related to biological maturation of the central nervous system; and (c) a steady course without remissions and relapses. In most cases, the functions affected include language, visuo-spatial skills and motor coordination. Usually, the delay or impairment has been present from as early as it could be detected reliably and will diminish progressively as the child grows older, although milder deficits often remain in adult life.

F80 Specific developmental disorders of speech and language

Disorders in which normal patterns of language acquisition are disturbed from the early stages of development. The conditions are not directly attributable to neurological or speech-mechanism abnormalities, sensory impairments, mental retardation or environmental factors. Specific developmental disorders of speech and language are often followed by associated problems, such as difficulties in reading and spelling, abnormalities in interpersonal relationships, and emotional and behavioural disorders.

F80.0 Specific speech articulation disorder

A specific developmental disorder in which the child's use of speech sounds is below the appropriate level for its mental age, but in which there is a normal level of language skills.

Developmental:
- phonological disorder
- speech articulation disorder

Dyslalia
Functional speech articulation disorder
Lalling

Excl.: speech articulation impairment (due to):
- aphasia NOS (R47.0)
- apraxia (R48.2)
- hearing loss (H90–H91)
- mental retardation (F70–F79)
- with language developmental disorder:
  - expressive (F80.1)
  - receptive (F80.2)

F80.1 Expressive language disorder

A specific developmental disorder in which the child's ability to use expressive spoken language is markedly below the appropriate level for its mental age, but in which language comprehension is within normal limits. There may or may not be abnormalities in articulation.

Developmental dysphasia or aphasia, expressive type

Excl.: acquired aphasia with epilepsy [Landau–Kleffner] (F80.3)
dysphasia and aphasia:
- NOS (R47.0)
- developmental, receptive type (F80.2)

elective mutism (F94.0)
mental retardation (F70–F79)
pervasive developmental disorders (F84.-)

F80.2 Receptive language disorder

A specific developmental disorder in which the child's understanding of language is below the appropriate level for its mental age. In virtually all cases expressive language will also be markedly affected and abnormalities in word-sound production are common.

Congenital auditory imperception
Developmental:
- dysphasia or aphasia, receptive type
- Wernicke aphasia

Word deafness

Excl.: acquired aphasia with epilepsy [Landau–Kleffner] (F80.3)
autism (F84.0–F84.1)
dysphasia and aphasia:
- NOS (R47.0)
- developmental, expressive type (F80.1)

elective mutism (F94.0)
language delay due to deafness (H90–H91)
mental retardation (F70–F79)

F80.3 Acquired aphasia with epilepsy [Landau–Kleffner]

A disorder in which the child, having previously made normal progress in language development, loses both receptive and expressive language skills but retains general intelligence; the onset of the disorder is accompanied by paroxysmal abnormalities on the EEG, and, in the majority of cases, also by epileptic seizures. Usually the onset is between the ages of three and seven years, with skills being lost over days or weeks. The temporal association between the onset of seizures and loss of language is variable, with one preceding the other (either way round) by a few months to two years. An inflammatory encephalitic process has been suggested as a possible cause of this disorder. About two thirds of patients are left with a more or less severe receptive language deficit.

Excl.: aphasia (due to):
- NOS (R47.0)
- autism (F84.0–F84.1)
- disintegrative disorders of childhood (F84.2–F84.3)

F80.8 Other developmental disorders of speech and language

Lisping

F80.9 Developmental disorder of speech and language, unspecified

Language disorder NOS

F81 Specific developmental disorders of scholastic skills

Disorders in which the normal patterns of skill acquisition are disturbed from the early stages of development. This is not simply a consequence of a lack of opportunity to learn, it is not solely a result of mental retardation, and it is not due to any form of acquired brain trauma or disease.

F81.0 Specific reading disorder

The main feature is a specific and significant impairment in the development of reading skills that is not solely accounted for by mental age, visual acuity problems or inadequate schooling. Reading comprehension skill, reading word recognition, oral reading skill and performance of tasks requiring reading may all be affected. Spelling difficulties are frequently associated with specific reading disorder and often remain into adolescence, even after some progress in reading has been made. Specific developmental disorders of reading are commonly preceded by a history of disorders in speech or language development. Associated emotional and behavioural disturbances are common during the school age period.

'Backward reading'
Developmental dyslexia
Specific reading retardation

Excl.: alexia NOS (R48.0)
dyslexia NOS (R48.0)
reading difficulties secondary to emotional disorders (F93.-)

F81.1 Specific spelling disorder

The main feature is a specific and significant impairment in the development of spelling skills, in the absence of a history of specific reading disorder, which is not solely accounted for by low mental age, visual acuity problems or inadequate schooling. The abilities to spell orally and to write out words correctly are both affected.

Specific spelling retardation (without reading disorder)

Excl.: agraphia NOS (R48.8)
spelling difficulties:
- associated with a reading disorder (F81.0)
- due to inadequate teaching (Z55.8)

F81.2 Specific disorder of arithmetical skills

Involves a specific impairment in arithmetical skills that is not solely explicable on the basis of general mental retardation or of inadequate schooling. The deficit concerns mastery of basic computational skills of addition, subtraction, multiplication and division, rather than of the more abstract mathematical skills involved in algebra, trigonometry, geometry or calculus.

Developmental:
- acalculia
- arithmetical disorder
- Gerstmann's syndrome

Excl.: acalculia NOS (R48.8)
arithmetical difficulties:
- associated with a reading or spelling disorder (F81.3)
- due to inadequate teaching (Z55.8)

F81.3 Mixed disorder of scholastic skills

An ill-defined residual category of disorders in which both arithmetical and reading or spelling skills are significantly impaired, but in which the disorder is not solely explicable in terms of general mental retardation or of inadequate schooling. It should be used for disorders meeting the criteria for both F81.2 and either F81.0 or F81.1.

Excl.: specific:
- disorder of arithmetical skills (F81.2)
- reading disorder (F81.0)
- spelling disorder (F81.1)

F81.8 Other developmental disorders of scholastic skills

Developmental expressive writing disorder

F81.9 Developmental disorder of scholastic skills, unspecified

Knowledge acquisition disability NOS
Learning:
- disability NOS
- disorder NOS

F82 Specific developmental disorder of motor function

A disorder in which the main feature is a serious impairment in the development of motor coordination that is not solely explicable in terms of general intellectual retardation or of any specific congenital or acquired neurological disorder. Nevertheless, in most cases, a careful clinical examination shows marked neurodevelopmental immaturities such as choreiform movements of unsupported limbs or mirror movements and other associated motor features, as well as signs of impaired fine and gross motor coordination.

Incl.: clumsy child syndrome
developmental:
- coordination disorder
- dyspraxia

Excl.: abnormalities of gait and mobility (R26.-)
lack of coordination (R27.-)
lack of coordination
- secondary to mental retardation (F70–F79)

F83 Mixed specific developmental disorders

A residual category for disorders in which there is some admixture of specific developmental disorders of speech and language, of scholastic skills, and of motor function, but in which none predominates sufficiently to constitute the prime diagnosis. This mixed category should be used only when there is a major overlap between each of these specific developmental disorders. The disorders are usually, but not always, associated with some degree of general impairment of cognitive functions. Thus, the category should be used when there are dysfunctions meeting the criteria for two or more of F80.-, F81.- and F82.

F84 Pervasive developmental disorders

A group of disorders characterized by qualitative abnormalities in reciprocal social interactions and in patterns of communication, and by a restricted, stereotyped, repetitive repertoire of interests and activities. These qualitative abnormalities are a pervasive feature of the individual's functioning in all situations.

Use additional code, if desired, to identify any associated medical condition and mental retardation.

F84.0 Childhood autism

A type of pervasive developmental disorder that is defined by: (a) the presence of abnormal or impaired development that is manifest before the age of three years, and (b) the characteristic type of abnormal functioning in all the three areas of psychopathology: reciprocal social interaction, communication and restricted, stereotyped, repetitive behaviour. In addition to these specific diagnostic features, a range of other nonspecific problems are common, such as phobias, sleeping and eating disturbances, temper tantrums and (self-directed) aggression.

Autistic disorder
Infantile:
- autism
- psychosis

Kanner syndrome

Excl.: autistic psychopathy (F84.5)

F84.1 Atypical autism

A type of pervasive developmental disorder that differs from childhood autism, either in age of onset or in failing to fulfil all three sets of diagnostic criteria. This subcategory should be used when there is abnormal and impaired development that is present only after age three years, and a lack of sufficient demonstrable abnormalities in one or two of the three areas of psychopathology required for the diagnosis of autism (namely, reciprocal social interactions, communication and restricted, stereotyped, repetitive behaviour) in spite of characteristic abnormalities in the other area(s). Atypical autism arises most often in profoundly retarded individuals and in individuals with a severe specific developmental disorder of receptive language.

Atypical childhood psychosis
Mental retardation with autistic features
Use additional code (F70–F79), if desired, to identify mental retardation.

F84.2 Rett syndrome

A condition, so far found only in girls, in which apparently normal early development is followed by partial or complete loss of speech and of skills in locomotion and use of hands, together with deceleration in head growth, usually with an onset between seven and 24 months of age. Loss of purposive hand movements, hand-wringing stereotypies, and hyperventilation are characteristic. Social and play development are arrested but social interest tends to be maintained. Trunk ataxia and apraxia start to develop by age four years and choreoathetoid movements frequently follow. Severe mental retardation almost invariably results.

F84.3 Other childhood disintegrative disorder

A type of pervasive developmental disorder that is defined by a period of entirely normal development before the onset of the disorder, followed by a definite loss of previously acquired skills in several areas of development over the course of a few months. Typically, this is accompanied by a general loss of interest in the environment, by stereotyped, repetitive motor mannerisms, and by autistic-like abnormalities in social interaction and communication. In some cases the disorder can be shown to be due to some associated encephalopathy but the diagnosis should be made on the behavioural features.

Dementia infantilis
Disintegrative psychosis
Heller syndrome
Symbiotic psychosis
Use additional code, if desired, to identify any associated neurological condition.

Excl.: Rett syndrome (F84.2)

F84.4 Overactive disorder associated with mental retardation and stereotyped movements

An ill-defined disorder of uncertain nosological validity. The category is designed to include a group of children with severe mental retardation (IQ below 35) who show major problems in hyperactivity and in attention, as well as stereotyped behaviours. They tend not to benefit from stimulant drugs (unlike those with an IQ in the normal range) and may exhibit a severe dysphoric reaction (sometimes with psychomotor retardation) when given stimulants. In adolescence, the overactivity tends to be replaced by underactivity (a pattern that is not usual in hyperkinetic children with normal intelligence). This syndrome is also often associated with a variety of developmental delays, either specific or global. The extent to which the behavioural pattern is a function of low IQ or of organic brain damage is not known.

F84.5 Asperger syndrome

A disorder of uncertain nosological validity, characterized by the same type of qualitative abnormalities of reciprocal social interaction that typify autism, together with a restricted, stereotyped, repetitive repertoire of interests and activities. It differs from autism primarily in the fact that there is no general delay or retardation in language or in cognitive development. This disorder is often associated with marked clumsiness. There is a strong tendency for the abnormalities to persist into adolescence and adult life. Psychotic episodes occasionally occur in early adult life.

Autistic psychopathy
Schizoid disorder of childhood

F84.8 Other pervasive developmental disorders

F84.9 Pervasive developmental disorder, unspecified

F88 Other disorders of psychological development

Incl.: developmental agnosia

F89 Unspecified disorder of psychological development

Incl.: developmental disorder NOS

~~Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90–F98)~~

F90 Hyperkinetic disorders

A group of disorders characterized by an early onset (usually in the first five years of life), lack of persistence in activities that require cognitive involvement, and a tendency to move from one activity to another without completing any one, together with disorganized, ill-regulated, and excessive activity. Several other abnormalities may be associated. Hyperkinetic children are often reckless, impulsive and prone to accidents, and find themselves in disciplinary trouble because of unthinking breaches of rules rather than deliberate defiance. Their relationships with adults are often socially disinhibited, with a lack of normal caution and reserve. They are unpopular with other children and may become isolated. Impairment of cognitive functions is common, and specific delays in motor and language development are disproportionately frequent. Secondary complications include dissocial behaviour and low self-esteem.

Excl.: anxiety disorders (F41.-)
mood [affective] disorders (F30–F39)
pervasive developmental disorders (F84.-)
schizophrenia (F20.-)

F90.0 Disturbance of activity and attention

Attention deficit:
- disorder with hyperactivity
- hyperactivity disorder
- syndrome with hyperactivity

Excl.: hyperkinetic disorder associated with conduct disorder (F90.1)

F90.1 Hyperkinetic conduct disorder

Hyperkinetic disorder associated with conduct disorder

F90.8 Other hyperkinetic disorders

F90.9 Hyperkinetic disorder, unspecified

Hyperkinetic reaction of childhood or adolescence NOS
Hyperkinetic syndrome NOS

F91 Conduct disorders

Disorders characterized by a repetitive and persistent pattern of dissocial, aggressive or defiant conduct. Such behaviour should amount to major violations of age-appropriate social expectations; it should therefore be more severe than ordinary childish mischief or adolescent rebelliousness and should imply an enduring pattern of behaviour (six months or longer). Features of conduct disorder can also be symptomatic of other psychiatric conditions, in which case the underlying diagnosis should be preferred.

Examples of the behaviours on which the diagnosis is based include excessive levels of fighting or bullying, cruelty to other people or animals, severe destructiveness to property, fire-setting, stealing, repeated lying, truancy from school and running away from home, unusually frequent and severe temper tantrums, and disobedience. Any one of these behaviours, if marked, is sufficient for the diagnosis, but isolated dissocial acts are not.

Excl.: mood [affective] (F30–F39)
pervasive developmental disorders (F84.-)
schizophrenia (F20.-)
when associated with:
- emotional disorders (F92.-)
- hyperkinetic disorders (F90.1)

F91.0 Conduct disorder confined to the family context

Conduct disorder involving dissocial or aggressive behaviour (and not merely oppositional, defiant, disruptive behaviour), in which the abnormal behaviour is entirely, or almost entirely, confined to the home and to interactions with members of the nuclear family or immediate household. The disorder requires that the overall criteria for F91.- be met; even severely disturbed parent–child relationships are not of themselves sufficient for diagnosis.

F91.1 Unsocialized conduct disorder

Disorder characterized by the combination of persistent dissocial or aggressive behaviour (meeting the overall criteria for F91.- and not merely comprising oppositional, defiant, disruptive behaviour) with significant pervasive abnormalities in the individual's relationships with other children.

Conduct disorder, solitary aggressive type
Unsocialized aggressive disorder

F91.2 Socialized conduct disorder

Disorder involving persistent dissocial or aggressive behaviour (meeting the overall criteria for F91.- and not merely comprising oppositional, defiant, disruptive behaviour) occurring in individuals who are generally well integrated into their peer group.

Conduct disorder, group type
Group delinquency
Offences in the context of gang membership
Stealing in company with others
Truancy from school

F91.3 Oppositional defiant disorder

Conduct disorder, usually occurring in younger children, primarily characterized by markedly defiant, disobedient, disruptive behaviour that does not include delinquent acts or the more extreme forms of aggressive or dissocial behaviour. The disorder requires that the overall criteria for F91.- be met; even severely mischievous or naughty behaviour is not in itself sufficient for diagnosis. Caution should be employed before using this category, especially with older children, because clinically significant conduct disorder will usually be accompanied by dissocial or aggressive behaviour that goes beyond mere defiance, disobedience or disruptiveness.

F91.8 Other conduct disorders

F91.9 Conduct disorder, unspecified

Childhood:
- behavioural disorder NOS
- conduct disorder NOS

F92 Mixed disorders of conduct and emotions

A group of disorders characterized by the combination of persistently aggressive, dissocial or defiant behaviour with overt and marked symptoms of depression, anxiety or other emotional upsets. The criteria for both conduct disorders of childhood (F9l.-) and emotional disorders of childhood (F93.-) or an adult-type neurotic diagnosis (F40–F48) or a mood disorder (F30–F39) must be met.

F92.0 Depressive conduct disorder

This category requires the combination of conduct disorder (F91.-) with persistent and marked depression of mood (F32.-), as demonstrated by symptoms such as excessive misery, loss of interest and pleasure in usual activities, self-blame and hopelessness; disturbances of sleep or appetite may also be present.

Conduct disorder in F91.- associated with depressive disorder in F32.-

F92.8 Other mixed disorders of conduct and emotions

This category requires the combination of conduct disorder (F91.-) with persistent and marked emotional symptoms such as anxiety, obsessions or compulsions, depersonalization or derealization, phobias or hypochondriasis.

Conduct disorder in F91.- associated with:
- emotional disorder in F93.-
- neurotic disorder in F40–F48

F92.9 Mixed disorder of conduct and emotions, unspecified

F93 Emotional disorders with onset specific to childhood

Mainly exaggerations of normal developmental trends rather than phenomena that are qualitatively abnormal in themselves. Developmental appropriateness is used as the key diagnostic feature in defining the difference between these emotional disorders, with onset specific to childhood, and the neurotic disorders (F40–F48).

Excl.: when associated with conduct disorder (F92.-)

F93.0 Separation anxiety disorder of childhood

Should be diagnosed when fear of separation constitutes the focus of the anxiety and when such anxiety first arose during the early years of childhood. It is differentiated from normal separation anxiety when it is of a degree (severity) that is statistically unusual (including an abnormal persistence beyond the usual age period), and when it is associated with significant problems in social functioning.

Excl.: mood [affective] disorders (F30–F39)
neurotic disorders (F40–F48)
phobic anxiety disorder of childhood (F93.1)
social anxiety disorder of childhood (F93.2)

F93.1 Phobic anxiety disorder of childhood

Fears in childhood that show a marked developmental-phase specificity and arise (to some extent) in a majority of children, but that are abnormal in degree. Other fears that arise in childhood but that are not a normal part of psychosocial development (for example agoraphobia) should be coded under the appropriate category in section F40–F48.

Excl.: generalized anxiety disorder (F41.1)

F93.2 Social anxiety disorder of childhood

In this disorder there is a wariness of strangers and social apprehension or anxiety when encountering new, strange or socially threatening situations. This category should be used only where such fears arise during the early years, and are both unusual in degree and accompanied by problems in social functioning.

Avoidant disorder of childhood or adolescence

F93.3 Sibling rivalry disorder

Some degree of emotional disturbance usually following the birth of an immediately younger sibling is shown by a majority of young children. A sibling rivalry disorder should be diagnosed only if the degree or persistence of the disturbance is both statistically unusual and associated with abnormalities of social interaction.

Sibling jealousy

F93.8 Other childhood emotional disorders

Identity disorder
Overanxious disorder

Excl.: gender identity disorder of childhood (F64.2)

F93.9 Childhood emotional disorder, unspecified

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

A somewhat heterogeneous group of disorders that have in common abnormalities in social functioning that begin during the developmental period, but that (unlike the pervasive developmental disorders) are not primarily characterized by an apparently constitutional social incapacity or deficit that pervades all areas of functioning. In many instances, serious environmental distortions or privations probably play a crucial role in etiology.

F94.0 Elective mutism

Characterized by a marked, emotionally determined selectivity in speaking, such that the child demonstrates a language competence in some situations but fails to speak in other (definable) situations. The disorder is usually associated with marked personality features involving social anxiety, withdrawal, sensitivity or resistance.

Selective mutism

Excl.: pervasive developmental disorders (F84.-)
schizophrenia (F20.-)
specific developmental disorders of speech and language (F80.-)
transient mutism as part of separation anxiety in young children (F93.0)

F94.1 Reactive attachment disorder of childhood

Starts in the first five years of life and is characterized by persistent abnormalities in the child's pattern of social relationships that are associated with emotional disturbance and are reactive to changes in environmental circumstances (e.g. fearfulness and hypervigilance, poor social interaction with peers, aggression towards self and others, misery, and growth failure in some cases). The syndrome probably occurs as a direct result of severe parental neglect, abuse or serious mishandling.

Use additional code, if desired, to identify any associated failure to thrive or growth retardation.

Excl.: Asperger syndrome (F84.5)
disinhibited attachment disorder of childhood (F94.2)
maltreatment syndromes (T74.-)
normal variation in pattern of selective attachment
sexual or physical abuse in childhood, resulting in psychosocial problems (Z61.4–Z61.6)

F94.2 Disinhibited attachment disorder of childhood

A particular pattern of abnormal social functioning that arises during the first five years of life and that tends to persist despite marked changes in environmental circumstances, e.g. diffuse, nonselectively focused attachment behaviour, attention-seeking and indiscriminately friendly behaviour, poorly modulated peer interactions; depending on circumstances, there may also be associated emotional or behavioural disturbance.

Affectionless psychopathy
Institutional syndrome

Excl.: Asperger syndrome (F84.5)
hospitalism in children (F43.2)
hyperkinetic disorders (F90.-)
reactive attachment disorder of childhood (F94.1)

F94.8 Other childhood disorders of social functioning

F94.9 Childhood disorder of social functioning, unspecified

F95 Tic disorders

Syndromes in which the predominant manifestation is some form of tic. A tic is an involuntary, rapid, recurrent, nonrhythmic motor movement (usually involving circumscribed muscle groups) or vocal production that is of sudden onset and that serves no apparent purpose. Tics tend to be experienced as irresistible but usually they can be suppressed for varying periods of time, are exacerbated by stress, and disappear during sleep. Common simple motor tics include only eye-blinking, neck-jerking, shoulder-shrugging and facial grimacing. Common simple vocal tics include throat-clearing, barking, sniffing and hissing. Common complex tics include hitting oneself, jumping and hopping. Common complex vocal tics include the repetition of particular words, and sometimes the use of socially unacceptable (often obscene) words (coprolalia) and the repetition of one's own sounds or words (palilalia).

F95.0 Transient tic disorder

Meets the general criteria for a tic disorder but the tics do not persist longer than 12 months. The tics usually take the form of eye-blinking, facial grimacing or head-jerking.

F95.1 Chronic motor or vocal tic disorder

Meets the general criteria for a tic disorder, in which there are motor or vocal tics (but not both), that may be either single or multiple (but usually multiple) and last for more than a year.

F95.2 Combined vocal and multiple motor tic disorder [Tourette]

A form of tic disorder in which there are, or have been, multiple motor tics and one or more vocal tics, although these need not have occurred concurrently. The disorder usually worsens during adolescence and tends to persist into adult life. The vocal tics are often multiple, with explosive repetitive vocalizations, throat-clearing and grunting, and there may be the use of obscene words or phrases. Sometimes there is associated gestural echopraxia, which may also be of an obscene nature (copropraxia).

F95.8 Other tic disorders

F95.9 Tic disorder, unspecified

Tic NOS

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

A heterogeneous group of disorders that share the characteristic of an onset in childhood but otherwise differ in many respects. Some of the conditions represent well-defined syndromes but others are no more than symptom complexes that need inclusion because of their frequency and association with psychosocial problems, and because they cannot be incorporated into other syndromes.

Excl.: breath-holding spells (R06.8)
gender identity disorder of childhood (F64.2)
Kleine–Levin syndrome (G47.8)
obsessive-compulsive disorder (F42.-)
sleep disorders due to emotional causes (F51.-)

F98.0 Nonorganic enuresis

A disorder characterized by involuntary voiding of urine, by day and by night, that is abnormal in relation to the individual's mental age, and that is not a consequence of a lack of bladder control due to any neurological disorder, to epileptic attacks, or to any structural abnormality of the urinary tract. The enuresis may have been present from birth or it may have arisen following a period of acquired bladder control. The enuresis may or may not be associated with a more widespread emotional or behavioural disorder.

Enuresis (primary)(secondary) of nonorganic origin
Functional enuresis
Psychogenic enuresis
Urinary incontinence of nonorganic origin

Excl.: enuresis NOS (R32)

F98.1 Nonorganic encopresis

Repeated, voluntary or involuntary passage of faeces, usually of normal or near-normal consistency, in places not appropriate for that purpose in the individual's own sociocultural setting. The condition may represent an abnormal continuation of normal infantile incontinence, it may involve a loss of continence following the acquisition of bowel control, or it may involve the deliberate deposition of faeces in inappropriate places in spite of normal physiological bowel control. The condition may occur as a monosymptomatic disorder, or it may form part of a wider disorder, especially an emotional disorder (F93.-) or a conduct disorder (F91.-).

Functional encopresis
Incontinence of faeces of nonorganic origin
Psychogenic encopresis
Use additional code, if desired, to identify the cause of any coexisting constipation.

Excl.: encopresis NOS (R15)

F98.2 Feeding disorder of infancy and childhood

A feeding disorder of varying manifestations, usually specific to infancy and early childhood. It generally involves food refusal and extreme faddiness in the presence of an adequate food supply, a reasonably competent caregiver, and the absence of organic disease. There may or may not be associated rumination (repeated regurgitation without nausea or gastrointestinal illness).

Rumination disorder of infancy

Excl.: anorexia nervosa and other eating disorders (F50.-)
feeding:
- difficulties and mismanagement (R63.3)
- problems of newborn (P92.-)

pica of infancy or childhood (F98.3)

F98.3 Pica of infancy and childhood

Persistent eating of non-nutritive substances (such as soil, paint chippings, etc.). It may occur as one of many symptoms that are part of a more widespread psychiatric disorder (such as autism), or as a relatively isolated psychopathological behaviour; only the latter is classified here. The phenomenon is most common in mentally retarded children and, if mental retardation is also present, F70–F79 should be selected as the main diagnosis.

F98.4 Stereotyped movement disorders

Voluntary, repetitive, stereotyped, nonfunctional (and often rhythmic) movements that do not form part of any recognized psychiatric or neurological condition. When such movements occur as symptoms of some other disorder, only the overall disorder should be recorded. The movements that are of a non-self-injurious variety include: body-rocking, head-rocking, hair-plucking, hair-twisting, finger-flicking mannerisms, and hand-flapping. Stereotyped self-injurious behaviour includes repetitive head-banging, face-slapping, eye-poking and biting of hands, lips or other body parts. All the stereotyped movement disorders occur most frequently in association with mental retardation (when this is the case, both should be recorded). If eye-poking occurs in a child with visual impairment, both should be coded: eye-poking under this category and the visual condition under the appropriate somatic disorder code.

Stereotype/habit disorder

Excl.: abnormal involuntary movements (R25.-)
movement disorders of organic origin (G20–G25)
nail-biting (F98.8)
nose-picking (F98.8)
stereotypies that are part of a broader psychiatric condition (F00–F95)
thumb-sucking (F98.8)
tic disorders (F95.-)
trichotillomania (F63.3)

F98.5 Stuttering [stammering]

Speech that is characterized by frequent repetition or prolongation of sounds or syllables or words, or by frequent hesitations or pauses that disrupt the rhythmic flow of speech. It should be classified as a disorder only if its severity is such as to markedly disturb the fluency of speech.

Excl.: cluttering (F98.6)
tic disorders (F95.-)

F98.6 Cluttering

A rapid rate of speech with breakdown in fluency, but no repetitions or hesitations, of a severity to give rise to diminished speech intelligibility. Speech is erratic and dysrhythmic, with rapid jerky spurts that usually involve faulty phrasing patterns.

Excl.: stuttering (F98.5)
tic disorders (F95.-)

F98.8 Other specified behavioural and emotional disorders with onset usually occurring in childhood and adolescence

Attention deficit disorder without hyperactivity
Excessive masturbation
Nail-biting
Nose-picking
Thumb-sucking

F98.9 Unspecified behavioural and emotional disorders with onset usually occurring in childhood and adolescence

Unspecified mental disorder (F99)

F99 ~~**Mental disorder, not otherwise specified**~~

Incl.: ~~mental illness NOS~~

Excl.: ~~organic mental disorder NOS (F06.9)~~