Supplemental Materials 1: Used ICD 10 diagnoses

G43. Migraine

G43.0 Migraine without aura [common migraine]
G43.1 Migraine with aura [classical migraine]

Migraine:

- aura without headache
- basilar
- equivalents
- familial hemiplegic
- with:
  - acute-onset aura
  - prolonged aura
  - typical aura

G43.2 Status migrainosus
G43.3 Complicated migraine
G43.8 Other migraine

  Ophthalmoplegic migraine
  Retinal migraine

G43.9 Migraine, unspecified

G44 Other headache syndromes

G44.0 Cluster headache syndrome

  Chronic paroxysmal hemicrania
  Cluster headache:

  - chronic
  - episodic

G44.1 Vascular headache, not elsewhere classified

  Vascular headache NOS

G44.2 Tension-type headache
Chronic tension-type headache
Episodic tension headache
Tension headache NOS

G44.3 Chronic post-traumatic headache

G44.4 Drug-induced headache, not elsewhere classified

Use additional external cause code (Chapter XX), if desired, to identify drug.

G44.8 Other specified headache syndromes

R51 Headache

Incl.: Facial pain NOS
Excl.: atypical facial pain (G50.1)
       migraine and other headache syndromes (G43-G44)
       trigeminal neuralgia (G50.0)

F30 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

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 obsessionial 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:
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.
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 over-activity (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), 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 which 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)

  lailing (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, which are not mediated through the autonomic nervous system, which are limited to specific systems or parts of the body, and which 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 fatiguability 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 cramp
Psychasthenia
Psychasthenic neurosis
Psychogenic syncope

F48.9 Neurotic disorder, unspecified

Neurosis NOS

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.

Psychogenic vomiting

Use additional code (O21.-), if desired, to identify excess vomiting in pregnancy.

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 which 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 anorgasmic

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 aetiology of physical disorders which 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

**M54 Dorsalgia**

Excl.:

psychogenic dorsalgia (F45.4)

M54.0 Panniculitis affecting regions of neck and back

Excl.:

panniculitis:

- NOS (M79.3)
- lupus (L93.2)
- relapsing [Weber-Christian] (M35.6)

M54.1 Radiculopathy

Neuritis or radiculitis:

- brachial NOS
- lumbar NOS
- lumbosacral NOS
- thoracic NOS

Radiculitis NOS
Excl.:

neuralgia and neuritis NOS (M79.2)

radiculopathy with:
- cervical disc disorder (M50.1)
- lumbar and other intervertebral disc disorder (M51.1)
- spondylosis (M47.2)

M54.2 Cervicalgia
Excl.:

cervicalgia due to intervertebral cervical disc disorder (M50.-)

M54.3 Sciatica
Excl.:

lesion of sciatic nerve (G57.0)

sciatica:
- due to intervertebral disc disorder (M51.1)
- with lumbago (M54.4)

M54.4 Lumbago with sciatica
Excl.:

that due to intervertebral disc disorder (M51.1)

M54.5 Low back pain

Loin pain

Low back strain
Lumbago NOS

Excl.:

lumbago:

- due to intervertebral disc displacement (M51.2)
- with sciatica (M54.4)

M54.6 Pain in thoracic spine

Excl.:

pain due to intervertebral disc disorder (M51.-)

M54.8 Other dorsalgia

M54.9 Dorsalgia, unspecified

Backache NOS

K58 Irritable bowel syndrome

Incl.:

irritable colon

K58.1 Irritable bowel syndrome with predominant diarrhoea [IBS-D]
K58.2 Irritable bowel syndrome with predominant constipation [IBS-C]
K58.3 Irritable bowel syndrome with mixed bowel habits [IBS-M]
K58.8 Other and unspecified irritable bowel syndrome

Irritable bowel syndrome NOS