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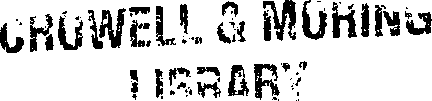
**FOURTH EDITION**

**D SM - I V ™**

**AM ERICAN P SY CHI ATRIC AsSO CIATION**

**DSM-IV™**

**RECEIVED**







**DSM-IV™**

PUBLISHED BY THE

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*To Melvin Sabshin, a man for all seasons*



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**[Acknowledgments](#_bookmark0)**

SM-IV is a team effort. More than 1,000 people (and numerous professional organizations) have helped us in the preparation of this document. Members of

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the Task Force on DSM-IV and DSM-IV Staff are listed on p. ix, members of the DSM-IV Work Groups are listed on pp. x-xii, and a list of other participants is included in Appendix].

The major responsibility for the content of DSM-IV rests with the Task Force on DSM-IV and members of the DSM-IV Work Groups. They have worked (often much harder than they bargained for) with a dedication and good cheer that has been inspirational to us. Bob Spitzer has our special thanks for his untiring efforts and unique perspective. Norman Sartorius, Darrel Regier, Lewis Judd, Fred Goodwin, and Chuck Kaelber were instrumental in facilitating a mutually productive interchange between the American Psychiatric Association and the World Health Organization that has improved both DSM-IV and ICD-10, and increased their compatibility. We are grateful to Robert Israel, Sue Meads, and Amy Blum at the National Center for Health Statistics and Andrea Albaum-Feinstein at the American Health Information Management Association for suggestions on the DSM-IV coding system. Denis Prager, Peter Nathan, and David Kupfer helped us to develop a novel data reanalysis strategy that has been supported with funding from the John D. and Catherine T. MacArthur Foundation.

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#### [Introduction](#_bookmark0)

his is the fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* or DSM-IV. The utility and credibility of

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DSM-IV require that it focus on its clinical, research, and educational purposes and be supported by an extensive empirical foundation. Our highest priority has been to provide a helpful guide to clinical practice. We hoped to make DSM-IV practical and useful for clinicians by striving for brevity of criteria sets, clarity of language, and explicit statements of the constructs embodied in the diagnostic criteria. An additional goal was to facilitate research and improve communication among clinicians and researchers. We were also mindful of the use of DSM-IV for improving the collection of clinical information and as an educational tool for teaching psychopathology.

An official nomenclature must be applicable in a wide diversity of contexts. DSM-IV is used by clinicians and researchers of many different orientations (e.g., biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems). It is used by psychiatrists, other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, counselors, and other health and mental health professionals. DSM-IV must be usable across settings-inpatient, outpatient, partial hospital, consulta­ tion-liaison, clinic, private practice, and primary care, and with community populations. It is also a necessary tool for collecting and communicating accurate public health statistics. Fortunately, all these many uses are compatible with one another.

DSM-IV was the product of 13 Work Groups (see Appendix J), each of which had primary responsibility for a section of the manual. This organization was designed to increase participation by experts in each of the respective fields. We took a number of precautions to ensure that the Work Group recommendations would reflect the breadth of available evidence and opinion and not just the views of the specific members. After extensive consultations with experts and clinicians in each *field,* we *selected* Work Group members who represented a wide range of perspectives and experiences. Work Group members were instructed that they were to participate as consensus scholars and not as advocates of previously held views. Furthermore, we established a formal evidence­ based process for the Work Groups to follow.

The Work Groups reported to the Task Force on DSM-IV (seep. ix), which consisted of 27 members, many of whom also chaired a Work Group. Each of the 13 Work Groups was composed of 5 (or more) members whose reviews were critiqued by between 50 and 100 advisers, who were also chosen to represent diverse clinical and research expertise, disciplines, backgrounds, and settings. The involvement of many international experts ensured that DSM-IV had available the widest pool of information and would be applicable across cultures. Conferences and workshops were held to provide

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conceptual and methodological guidance for the DSM-IV effort. These included a number of consultations between the developers of DSM-IV and the developers of ICD-10 conducted for the purpose of increasing compatibility between the two systems. Also held were methods conferences that focused on cultural factors in the diagnosis of mental disorder, on geriatric diagnosis, and on psychiatric diagnosis in primary care settings.

To maintain open and extensive lines of communication, the Task Force on DSM-IV established a liaison with many other components within the American Psychiatric Association and with more than 60 organizations and associations interested in the development of DSM-IV (e.g., American Health Information Management Association, American Nurses' Association, American Occupational Therapy Association, American Psychoanalytic Association, American Psychological Association, American Psychologi­ cal Society, Coalition for the Family, Group for the Advancement of Psychiatry, National Association of Social Workers, National Center for Health Statistics, World Health Organization). We attempted to air issues and empirical evidence early in the process in order to identify potential problems and differences in interpretation. Exchanges of information were also made possible through the distribution of a semiannual newsletter (the *DSM-IV Update),* the publication of a regular column on DSM-IV in *Hospital and Community Psychiatry,* frequent presentations at national and international conferences, and numerous journal articles.

Two years before the publication of DSM-IV, the Task Force published and widely distributed the *DSM-IV Options Book.* This volume presented a comprehensive summary of the alternative proposals that were being considered for inclusion in DSM-IV in order to solicit opinion and additional data for our deliberations. We received extensive correspondence from interested individuals who shared with us additional data and recommendations on the potential impact of the possible changes in DSM-IV on their clinical practice, teaching, research, and administrative work. This breadth of discussion helped us to anticipate problems and to attempt to find the best solution among the various options. One year before the publication of DSM-IV, a near-final draft of the proposed criteria sets was distributed to allow for one last critique.

In arriving at final DSM-IV decisions, the Work Groups and the Task Force reviewed all of the extensive empirical evidence and correspondence that had been gathered. It is our belief that the major innovation of DSM-IV lies not in any of its specific content changes but rather in the systematic and explicit process by which it was constructed and documented. More than any other nomenclature of mental disorders, DSM-IV is grounded in empirical evidence.

**Historical Background**

The need for a classification of mental disorders has been clear throughout the history of medicine, but there has been little agreement on which disorders should be included and the optimal method for their organization. The many nomenclatures that have been developed during the past two millennia have differed in their relative emphasis on phenomenology, etiology, and course as defining features. Some systems have included only a handful of diagnostic categories; others have included thousands. Moreover, the various systems for categorizing mental disorders have differed with respect to whether their principle objective was for use in clinical, research, or statistical settings. Because

the history of classification is too extensive to be summarized here, we focus briefly only on those aspects that have led directly to the development of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and to the "Mental Disorders" sections in the various editions of the *International Classification of Diseases* (ICD).

In the United States, the initial impetus for developing a classification of mental disorders was the need to collect statistical information. What might be considered the first official attempt to gather information about mental illness in the United States was the recording of the frequency of one category-"idiocy/insanity" in the 1840 census. By the 1880 census, seven categories of mental illness were distinguished-mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy. In 1917, the Committee on Statistics of the American Psychiatric Association (at that time called the American Medico-Psychological Association [the name was changed in 1921]), together with the National Commission on Mental Hygiene, formulated a plan that was adopted by the Bureau of the Census for gathering uniform statistics across mental hospitals. Although this system devoted more attention to clinical utility than did previous systems, it was still primarily a statistical classification. The American Psychiatric Association subsequently collaborated with the New York Academy of Medicine to develop a nationally acceptable psychiatric nomenclature that would be incorporated within the first edition of the American Medical Association's Standard Classified Nomenclature of Disease. This nomenclature was designed primarily for diagnosing inpatients with severe psychiatric and neurological disorders.

A much broader nomenclature was later developed by the U.S. Army (and modified by the Veterans Administration) in order to better incorporate the outpatient presenta­ tions of World War II servicemen and veterans (e.g., psychophysiological, personality, and acute disorders). Contemporaneously, the World Health Organization (WHO) published the sixth edition of ICD, which, for the first time, included a section for mental disorders. ICD-6 was heavily influenced by the Veterans Administration nomenclature and included 10 categories for psychoses, 9 for psychoneuroses, and 7 for disorders of character, behavior, and intelligence.

The American Psychiatric Association Committee on Nomenclature and Statistics developed a variant of the ICD-6 that was published in 1952 as the first edition of the *Diagnostic and Statistical Manual: MentalDisorders(DSM-1).* DSM-I contained a glossary of descriptions of the diagnostic categories and was the first official manual of mental disorders to focus on clinical utility. The use of the term *reaction* throughout DSM-I reflected the influence of Adolf Meyer's psychobiological view that mental disorders represented reactions of the personality to psychological, social, and biological factors. In part because of the lack of widespread acceptance of the mental disorder taxonomy contained in ICD-6 and ICD-7, WHO sponsored a comprehensive review of diagnostic issues that was conducted by the British psychiatrist Stengel. His report can be credited with having inspired many of the recent advances in diagnostic methodol­ ogy-most especially the need for explicit definitions as a means of promoting reliable clinical diagnoses. However, the next round of diagnostic revision, which led to DSM-II and ICD-8, did not follow Stengel's recommendations to any great degree. DSM-II was

similar to DSM-I but eliminated the term *reaction.*

As had been the case for DSM-I and DSM-II, the development of DSM-III was coordinated with the development of the next (ninth) version of ICD, which was published in 1975 and implemented in 1978. Work began on DSM-III in 1974, with publication in 1980. DSM-III introduced a number of important methodological innova­ tions, including explicit diagnostic criteria, a multiaxial system, and a descriptive

approach that attempted to be neutral with respect to theories of etiology. This effort was facilitated by the extensive empirical work then under way on the construction and validation of explicit diagnostic criteria and the development of semistructured inter­ views. ICD-9 did not include diagnostic criteria or a multiaxial system largely because the primary function of this international system was to delineate categories to facilitate the collection of basic health statistics. In contrast, DSM-III was developed with the additional goal of providing a medical nomenclature for clinicians and researchers. Because of dissatisfaction across all of medicine with the lack of specificity in ICD-9, a decision was made to modify it for use in the United States, resulting in ICD-9-CM (for Clinical Modification).

Experience with DSM-Ill revealed a number of inconsistencies in the system and a number of instances in which the criteria were not entirely clear. Therefore, the American Psychiatric Association appointed a Work Group to Revise DSM-III, which developed the revisions and corrections that led to the publication of DSM-III-R in 1987.

**The DSM..-IV Revision Process**

The third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) represented a major advance in the diagnosis of mental disorders and greatly facilitated empirical research. The development of DSM-IV has benefited from the substantial increase in the research on diagnosis that was generated in part by DSM-III and DSM-III-R. Most diagnoses now have an empirical literature or available data sets that are relevant to decisions regarding the revision of the diagnostic manual. The Task Force o"n DSM-IV and its Work Groups conducted a three-stage empirical process that included

1) comprehensive and systematic reviews of the published literature, 2) reanalyses of already-collected data sets, and 3) extensive issue-focused field trials.

***Literature Reviews***

Two methods conferences were sponsored to articulate for all the Work Groups a systematic procedure for finding, extracting, aggregating, and interpreting data in a comprehensive and objective fashion. The initial tasks of each of the DSM-IV Work Groups were to identify the most pertinent issues regarding each diagnosis and to determine the kinds of empirical data relevant to their resolution. A Work Group member or adviser was then assigned the responsibility of conducting a systematic and comprehensive review of the relevant literature that would inform the resolution of the issue and also document the text of DSM-IV. The domains considered in making decisions included clinical utility, reliability, descriptive validity, psychometric perfor­ mance characteristics of individual criteria, and a number of validating variables.

Each literature review specified 1) the issues or aspects of the text and criteria under consideration and the significance of the issues with respect to DSM-IV; 2) the review method (including the sources for identifying relevant studies, the number of studies considered, the criteria for inclusion and exclusion from the review, and the variables catalogued in each study); 3) the results of the review (including a descriptive summary of the studies with respect to methodology, design, and substantive correlates of the findings, the relevant findings, and the analyses conducted on these findings); and 4) the various options for resolving the issue, the advantages and disadvantages of each option,

recommendations, and suggestions for additional research that would be needed to provide a more conclusive resolution.

The goal of the DSM-IV literature reviews was to provide comprehensive and unbiased information and to ensure that DSM-IV reflects the best available clinical and research literature. For this reason, we used systematic computer searches and critical reviews done by large groups of advisers to ensure that the literature coverage was adequate and that the interpretation of the results was justified. Input was solicited especially from those persons likely to be critical of the conclusions of the review. The literature reviews were revised many times to produce as comprehensive and balanced a result as possible. It must be noted that for some issues addressed by the DSM-IV Work Groups, particularly those that were more conceptual in nature or for which there were insufficient data, a review of the empirical literature had limited utility. Despite these limitations, the reviews were helpful in documenting the rationale and empirical support for decisions made by the DSM-IV Work Groups.

***Data Reanalyses***

When a review of the literature revealed a lack of evidence (or conflicting evidence) for the resolution of an issue, we often made use of two additional resources-data reanalyses and field trials-to help in making final decisions. Analyses of relevant unpublished data sets were supported by a grant to the American Psychiatric Association from the John D. and Catherine T. MacArthur Foundation. Most of the 40 data reanalyses performed for DSM-IV involved the collaboration of several investigators at different sites. These researchers jointly subjected their data to questions posed by the Work Groups concerning the criteria included in DSM-III-R or criteria that might be included in DSM-IV. Data reanalyses also made it possible for Work Groups to generate several criteria sets that were then tested in the DSM-IV field trials. Although, for the most part, the data sets used in the reanalyses had been collected as part of epidemiological studies or treatment or other clinical studies, they were also highly relevant to the nosological questions facing the DSM-IV Work Groups.

***Field Trials***

Twelve DSM-IV field trials were sponsored by the National Institute of Mental Health (NIMH) in collaboration with the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The field trials allowed the DSM-IV Work Groups to compare alternative options and to study the possible impact of suggested changes. Field trials compared DSM-III, DSM-III-R, ICD-10, and proposed DSM-IV criteria sets in 5-10 different sites per field trial, with approximately 100 subjects at each site. Diverse sites, with representative groups of subjects from a range of sociocultural and ethnic backgrounds, were selected to ensure generalizability of field-trial results and to test some of the most difficult questions in differential diagnosis. The 12 field trials included more than 70 sites and evaluated more than 6,000 subjects. The field trials collected information on the reliability and performance characteristics of each criteria set as a whole, as well as of the specific items within each criteria set. The field trials also helped to bridge the boundary between clinical research and clinical practice by determining how well suggestions for change that are derived from clinical research findings apply in clinical practice.

***Criteria for Change***

Although it was impossible to develop absolute and infallible criteria for when changes should be made, there were some principles that guided our efforts. The threshold for making revisions in DSM-IV was set higherthan that for DSM-III and DSM-III-R. Decisions had to be substantiated by explicit statements of rationale and by the systematic review of relevant empirical data. To increase the practicality and clinical utility of DSM-IV, the criteria sets were simplified and clarified when this could be justified by empirical data. An attempt was made to strike an optimal balance in DSM-IV with respect to historical tradition (as embodied in DSM-III and DSM-III-R), compatibility with ICD-10, evidence from reviews of the literature, analyses of unpublished data sets, results of field trials, and consensus of the field. Although the amount of evidence required to support changes was set at a high threshold, it necessarily varied across disorders because the empirical support for the decisions made in DSM-III and DSM-III-R also varied across disorders. Of course, common sense was necessary, and major changes to solve minor problems required more evidence than minor changes to solve major problems.

We received suggestions to include numerous new diagnoses in DSM-IV. The proponents argued that the new diagnoses were necessary to improve the coverage of the system by including a group of individuals that were undiagnosable in DSM-III-R or diagnosable only under the Not Otherwise Specified rubric. We decided that, in general, new diagnoses should be included in the system only after research has established that they should be included rather than being included to stimulate that research. However, diagnoses already included in ICD-10 were given somewhat more consideration than those that were being proposed fresh for DSM-IV. The increased marginal utility, clarity, and coverage provided by each newly proposed diagnosis had to be balanced against the cumulative cumbersomeness imposed on the whole system, the paucity of empirical documentation, and the possible misdiagnosis or misuse that might result. No classifi­ cation of mental disorders can have a sufficient number of specific categories to encompass every conceivable clinical presentation. The Not Otherwise Specified cate­ gories are provided to cover the not infrequent presentations that are at the boundary of specific categorical definitions.

***The* DSM-IV Sourcebook**

Documentation has been the essential foundation of the DSM-IV process. The *DSM-IV Sourcebook,* published in five volumes, is intended to provide a comprehensive and convenient reference record of the clinical and research support for the various decisions reached by the Work Groups and the Task Force. The first three volumes of the *Sourcebookcontain* condensed versions of the 150 DSM-IV literature reviews. The fourth volume contains reports of the data reanalyses, and the fifth volume contains reports of the field trials and a final executive summary of the rationale for the decisions made by each Work Group. In addition, many papers were stimulated by the efforts toward empirical documentation in DSM-IV, and these have been published in peer-reviewed journals.

**Relation to 1co...1o**

The tenth revision of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10), developed by WHO, was published in 1992, but will probably

not come into official use in the United States until the late 1990s. Those preparing ICD-10 and DSM-IV have worked closely to coordinate their efforts, resulting in much mutual influence. ICD-10 consists of an official coding system and other related clinical and research documents and instruments. The codes and terms provided in DSM-IV are fully compatible with both ICD-9-CM and ICD-10 (see Appendix H). The clinical and research drafts of ICD-10 were thoroughly reviewed by the DSM-IV Work Groups and suggested important topics for DSM-IV literature reviews and data reanalyses. Draft versions of the ICD-10 Diagnostic Criteria for Research were included as alternatives to be compared with DSM-III, DSM-III-R, and suggested DSM-IV criteria sets in the DSM-IV field trials. The many consultations between the developers of DSM-IV and ICD-10 (which were facilitated by NIMH, NIDA, and NIAAA) were enormously useful in increasing the congruence and reducing meaningless differences in wording between the two systems.

**Definition of *Mental Disorder***

Although this volume is titled the *Diagnostic and Statistical Manual of Mental Disorders,* the term *mental disorder* unfortunately implies a distinction between "mental" disorders and "physical" disorders that is a reductionistic anachronism of mind/body dualism. A compelling literature documents that there is much "physical" in "mental" disorders and much "mental" in "physical" disorders. The problem raised by the term "mental" disorders has been much clearer than its solution, and, unfortunately, the term persists in the title of DSM-IV because we have not found an appropriate substitute.

Moreover, although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept of "mental disorder." The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations. All medical conditions are defined on various levels of abstraction-for example, structural pathology (e.g., ulcerative colitis), symptom presentation (e.g., migraine), deviance from a physiological norm (e.g., hypertension), and etiology (e.g., pneumo­ coccal pneumonia). Mental disorders have also been defined by a variety of concepts (e.g., distress, dyscontrol, disadvantage, disability, inflexibility, irrationality, syndromal pattern, etiology, and statistical deviation). Each is a useful indicator for a mental disorder, but none is equivalent to the concept, and different situations call for different definitions.

Despite these caveats, the definition of *mentaldisorderthat* was included in DSM-III and DSM-III-R is presented here because it is as useful as any other available definition and has helped to guide decisions regarding which conditions on the boundary between normality and pathology should be included in DSM-IV. In DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in

the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above. A common misconception is that a classification of mental disorders classifies people, when actually what are being classified are disorders that people have. For this reason, the text of DSM-IV (as did the text of DSM-III-R) avoids the use of such expressions as "a schizophrenic" or "an alcoholic" and instead uses the more accurate, but admittedly more cumbersome, "an individual with Schizophrenia" or "an individual with Alcohol

Dependence."

**Issues in the Use of DSM-IV**

***Limitations of the Categorical Approach***

DSM-IV is a categorical classification that divides mental disorders into types based on criteria sets with defining features. This naming of categories is the traditional method of organizing and transmitting information in everyday life and has been the fundamental approach used in all systems of medical diagnosis. A categorical approach to classifica­ tion works best when all members of a diagnostic class are homogeneous, when there are clear boundaries between classes, and when the different classes are mutually exclusive. Nonetheless, the limitations of the categorical classification system must be recognized.

In DSM-IV, there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder. There is also no assumption that all individuals described as having the same mental disorder are alike in all important ways. The clinician using DSM-IV should therefore consider that individuals sharing a diagnosis are likely to be heterogeneous even in regard to the defining features of the diagnosis and that boundary cases will be difficult to diagnose in any but a probabilistic fashion. This outlook allows greater flexibility in the use of the system, encourages more specific attention to boundary cases, and emphasizes the need to capture additional clinical information that goes beyond diagnosis. In recognition of the heterogeneity of clinical presentations, DSM-IV often includes polythetic criteria sets, in which the individual need only present with a subset of items from a longer list (e.g., the diagnosis of Borderline Personality Disorder requires only five out of nine items).

It was suggested that the DSM-IV Classification be organized following a dimensional model rather than the categorical model used in DSM-III-R. A dimensional system classifies clinical presentations based on quantification of attributes rather than the assignment to categories and works best in describing phenomena that are distributed continuously and that do not have clear boundaries. Although dimensional systems increase reliability and communicate more clinical information (because they report clinical attributes that might be subthreshold in a categorical system), they also have serious limitations and thus far have been less useful than categorical systems in clinical practice and in stimulating research. Numerical dimensional descriptions are much less familiar and vivid than are the categorical names for mental disorders. Moreover, there is as yet no agreement on the choice of the optimal dimensions to be used for classification purposes. Nonetheless, it is possible that the increasing research on, and familiarity with, dimensional systems may eventually result in their greater acceptance both as a method of conveying clinical information and as a research tool.

***Use of ClinicalJudgment***

DSM-IV is a classification of mental disorders that was developed for use in clinical, educational, and research settings. The diagnostic categories, criteria, and textual descriptions are meant to be employed by individuals with appropriate clinical training and experience in diagnosis. It is important that DSM-IV not be applied mechanically by untrained individuals. The specific diagnostic criteria included in DSM-IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion. For example, the exercise of clinical judgment may justify giving a certain diagnosis to an individual even though the clinical presentation falls just short of meeting the full criteria for the diagnosis as long as the symptoms that are present are persistent and severe. On the other hand, lack of familiarity with DSM-IV or excessively flexible and idiosyncratic application of DSM-IV criteria or conventions substantially reduces its utility as a common language for communication.

***Use of DSM-IV in Forensic Settings***

When the DSM-IV categories, criteria, and textual descriptions are employed for forensic purposes, there are significant risks that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a "mental disorder," "mental disability," "mental disease," or "mental defect." In determining whether an individual meets a specified legal standard (e.g., for competence, criminal responsibility, or disability), additional information is usually required beyond that contained in the DSM-IV diagnosis. This might include information about the individual's functional impairments and how these impairments affect the particular abilities in question. It is precisely because impairments, abilities, and disabilities vary widely within each diagnostic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability.

Nonclinical decision makers should also be cautioned that a diagnosis does not carry any necessary implications regarding the causes of the individual's mental disorder or its associated impairments. Inclusion of a disorder in the Classification (as in medicine generally) does not require that there be knowledge about its etiology. Moreover, the fact that an individual's presentation meets the criteria for a DSM-IV diagnosis does not carry any necessary implication regarding the individual's degree of control over the behaviors that may be associated with the disorder. Even when diminished control over one's behavior is a feature of the disorder, having the diagnosis in itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time.

It must be noted that DSM-IV reflects a consensus about the classification and diagnosis of mental disorders derived at the time of its initial publication. New knowledge generated by research or clinical experience will undoubtedly lead to an increased understanding of the disorders included in DSM-IV, to the identification of new disorders, and to the removal of some disorders in future classifications. The text and criteria sets included in DSM-IV will require reconsideration in light of evolving new information.

The use of DSM-IV in forensic settings should be informed by an awareness of the risks and limitations discussed above. When used appropriately, diagnoses and

diagnostic information can assist decision makers in their determinations. For example, when the presence of a mental disorder is the predicate for a subsequent legal determination (e.g., involuntary civil commitment), the use of an established system of diagnosis enhances the value and reliability of the determination. By providing a compendium based on a review of the pertinent clinical and research literature, DSM-IV may facilitate the legal decision makers' understanding of the relevant characteristics of mental disorders. The literature related to diagnoses also serves as a check on ungrounded speculation about mental disorders and about the functioning of a particular individual. Finally, diagnostic information regarding longitudinal course may improve decision making when the legal issue concerns an individual's mental functioning at a past or future point in time.

***Ethnic and Cultural Considerations***

Special efforts have been made in the preparation of DSM-IV to incorporate an awareness that the manual is used in culturally diverse populations in the United States and internationally. Clinicians are called on to evaluate individuals from numerous different ethnic groups and cultural backgrounds (including many who are recent immigrants). Diagnostic assessment can be especially challenging when a clinician from one ethnic or cultural group uses the DSM-IV Classification to evaluate an individual from a different ethnic or cultural group. A clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behavior, belief, or experience that are particular to the individual's culture. For example, certain religious practices or beliefs (e.g., hearing or seeing a deceased relative during bereavement) may be misdiagnosed as manifestations of a Psychotic Disorder. Applying Personality Disorder criteria across cultural settings may be especially difficult because of the wide cultural variation in concepts of self, styles of communica­ tion, and coping mechanisms.

DSM-IV includes three types of information specifically related to cultural consider­ ations: 1) a discussion in the text of cultural variations in the clinical presentations of those disorders that have been included in the DSM-IV Classification; 2) a description of culture-bound syndromes that have not been included in the DSM-IV Classification (these are included in Appendix I); and 3) an outline for cultural formulation designed to assist the clinician in systematically evaluating and reporting the impact of the individual's cultural context (also in Appendix I).

The wide international acceptance of DSM suggests that this classification is useful in describing mental disorders as they are experienced by individuals throughout the world. Nonetheless, evidence also suggests that the symptoms and course of a number of DSM-IV disorders are influenced by cultural and ethnic factors. To facilitate its application to individuals from diverse cultural and ethnic settings, DSM-IV includes a new section in the text to cover culture-related features. This section describes the ways in which varied cultural backgrounds affect the content and form of the symptom presentation (e.g., depressive disorders characterized by a preponderance of somatic symptoms rather than sadness in certain cultures), preferred idioms for• describing distress, and information on prevalence when it is available.

The second type of cultural information provided pertains to "culture-bound syndromes" that have been described in just one, or a few, of the world's societies. DSM-IV provides two ways of increasing the recognition of culture-bound syndromes:

1. some (e.g., *amok, ataque de neroios)* are included as separate examples in Not Otherwise Specified categories; and 2) an appendix of culture-bound syndromes (Appendix I) has been introduced in DSM-IV that includes the name for the condition, the cultures in which it was first described, and a brief description of the psychopa­ thology.

The provision of a culture-specific section in the DSM-IV text, the inclusion of a glossary of culture-bound syndromes, and the provision of an outline for cultural formulation are designed to enhance the cross-cultural applicability of DSM-IV. It is hoped that these new features will increase sensitivity to variations in how mental disorders may be expressed in different cultures and will reduce the possible effect of unintended bias stemming from the clinician's own cultural background.

***Use of DSM-IV in Treatment Planning***

Making a DSM-IV diagnosis is only the first step in a comprehensive evaluation. To formulate an adequate treatment plan, the clinician will invariably require considerable additional information about the person being evaluated beyond that required to make a DSM-IV diagnosis.

***Distinction Between* Mental Disorder *and***

**General Medical Condition**

The terms *mental disorder* and *general medical condition* are used throughout this manual. The term *mental disorder* is explained above. The term *general medical condition* is used merely as a convenient shorthand to refer to conditions and disorders that are listed outside the "Mental and Behavioural Disorders" chapter of ICD. It should be recognized that these are merely terms of convenience and should not be taken to imply that there is any fundamental distinction between mental disorders and general medical conditions, that mental disorders are unrelated to physical or biological factors or processes, or that general medical conditions are unrelated to behavioral or psychosocial factors or processes.

**Organization of the Manual**

The manual begins with instructions concerning the use of the manual (p. 1), followed by the DSM-IV Classification (pp. 13-24), which provides a systematic listing of the official codes and categories. Next is a description of the DSM-IV multiaxial system for diagnosis (pp. 25-35). This is followed by the diagnostic criteria for each of the DSM-IV disorders accompanied by descriptive text (pp. 37-687). Finally, DSM-IV includes 10 appendixes.

#### [Cautionary Statement](#_bookmark0)

he specified diagnostic criteria for each mental disorder are offered as guidelines for making diagnoses, because it has been demonstrated that the use of such criteria enhances agreement among clinicians and investigators. The proper use of these criteria requires specialized clinical training that provides both a body of knowledge and clinical

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skills.

These diagnostic criteria and the DSM-IV Classification of mental disorders reflect a consensus of current formulations of evolving knowledge in our field. They do not encompass, however, all the conditions for which people may be treated or that may be appropriate topics for research efforts.

The purpose of DSM-IV is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat people with various mental disorders. It is to be understood that inclusion here, for clinical and research purposes, of a diagnostic category such as Pathological Gambling or Pedophilia does not imply that the condition meets legal or other nonmedical criteria for what constitutes mental disease, mental disorder, or mental disability. The clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination, and competency.

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### [Use of the Manual](#_bookmark0)

**Coding and Reporting Procedures**

***Di.agnostic Codes***

The official coding system in use in the United States as of publication of this manual is the *International Classification of Diseases,* Ninth Revision, Clinical Modification (ICD-9-CM). Most DSM-IV disorders have a numerical ICD-9-CM code that appears several times: 1) preceding the name of the disorder in the Classification (pp. 13-24),

1. at the beginning of the text section for each disorder, and 3) accompanying the criteria set for each disorder. For some diagnoses (e.g., Mental Retardation, Substance-Induced Mood Disorder), the appropriate code depends on further specification and is listed after the text and criteria set for the disorder. The names of some disorders are followed by alternative terms enclosed in parentheses, which, in most cases, were the DSM-III-R names for the disorders.

The use of diagnostic codes is fundamental to medical record keeping. Diagnostic coding facilitates data collection and retrieval and compilation of statistical information. Codes also are often required to report diagnostic data to interested third parties, including governmental agencies, private insurers, and the World Health Organization. For example, in the United States, the use of these codes has been mandated by the Health Care Financing Administration for purposes of reimbursement under the Medicare system.

Subtypes (some of which are coded in the fifth digit) and specifiers are provided for increased specificity. *Subtypes* define mutually exclusive and jointly exhaustive phenomenological subgroupings within a diagnosis and are indicated by the instruction "specify type" in the criteria set. For example, Delusional Disorder is subtyped based on the content of the delusions, with seven subtypes provided: Erotomanic Type, Grandiose Type, Jealous Type, Persecutory Type, Somatic Type, Mixed Type, and Unspecified Type. In contrast, *specifiers* are not intended to be mutually exclusive or jointly exhaustive and are indicated by the instruction "specify if" in the criteria set (e.g., for Social Phobia, the instruction notes "Specify if: Generalized"). Specifiers provide an opportunity to define a more homogeneous subgrouping of individuals with the disorder who share certain features (e.g., Major Depressive Disorder, With Melancholic Features). Although a fifth digit is sometimes assigned to code a subtype or specifier (e.g., 290.12 Dementia of the Alzheimer's Type, With Early Onset, With Delusions) or severity (296.21 Major Depressive Disorder, Single Episode, Mild), the majority of subtypes and specifiers included in DSM-IV cannot be coded within the ICD-9-CM system and are indicated

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only by including the subtype or specifier after the name of the disorder (e.g., Social Phobia, Generalized).

***Severity and Course Specifiers***

A DSM-IV diagnosis is usually applied to the individual's current presentation and is not typically used to denote previous diagnoses from which the individual has recovered. The following specifiers indicating severity and course may be listed after the diagnosis: Mild, Moderate, Severe, In Partial Remission, In Full Remission, and Prior History.

The specifiers Mild, Moderate, and Severe should be used only when the full criteria for the disorder are currently met. In deciding whether the presentation should be described as mild, moderate, or severe, the clinician should take into account the number and intensity of the signs and symptoms of the disorder and any resulting impairment in occupational or social functioning. For the majority of disorders, the following guidelines may be used:

**Mild.** Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairment in social or occupational functioning.

**Moderate.** Symptoms or functional impairment between "mild" and "severe" are present.

**Severe.** Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.

**In Partial Remission.** The full criteria for the disorder were previously met, but currently only some of the symptoms or signs of the disorder remain.

**In Full Remission.** There are no longer any symptoms or signs of the disorder,

but it is still clinically relevant to note the disorder-for example, in an individual with previous episodes of Bipolar Disorder who has been symptom free on lithium for the past 3 years. After a period of time in full remission, the clinician may judge the individual to be recovered and, therefore, would no longer code the disorder as a current diagnosis. The differentiation of In Full Remission from recovered requires consideration of many factors, including the characteristic course of the disorder, the length of time since the last period of disturbance, the total duration of the disturbance, and the need for continued evaluation or prophylactic treatment.

**Prior History.** For some purposes, it may be useful to note a history of the criteria having been met for a disorder even when the individual is considered to be recovered from it. Such past diagnoses of mental disorder would be indicated by using the specifier Prior History (e.g., Separation Anxiety Disorder, Prior History, for an individual with a history of Separation Anxiety Disorder who has no current disorder or who currently meets criteria for Panic Disorder).

Specific criteria for defining Mild, Moderate, and Severe have been provided for the following: Mental Retardation, Conduct Disorder, Manic Episode, and Major Depressive Episode. Specific criteria for defining In Partial Remission and In Full Remission have been provided for the following: Manic Episode, Major Depressive Episode, and Substance Dependence.

***Recurrence***

Not infrequently in clinical practice, individuals after a period of time in which the full criteria for the disorder are no longer met (i.e., in partial or full remission or recovery) may develop symptoms that suggest a recurrence of their original disorder but that do not yet meet the full threshold for that disorder as specified in the criteria set. It is a matter of clinical judgment as to how best to indicate the presence of these symptoms. The following options are available:

* If the symptoms are judged to be a new episode of a recurrent condition, the disorder may be diagnosed as current (or provisional) even before the full criteria have been met (e.g., after meeting criteria for a Major Depressive Episode for only 10 days instead of the 14 days usually required).
* If the symptoms are judged to be clinically significant but it is not clear whether they constitute a recurrence of the original disorder, the appropriate Not Otherwise Specified category may be given.
* If it is judged that the symptoms are not clinically significant, no additional current or provisional diagnosis is given, but "Prior History" may be noted (see p. 2).

***Principal magnosis/Reason for Visit***

When more than one diagnosis for an individual is given in an inpatient setting, the *principal diagnosis* is the condition established after study to be chiefly responsible for occasioning the admission of the individual. When more than one diagnosis is given for an individual in an outpatient setting, the *reason for visit* is the condition that is chiefly responsible for the ambulatory care medical services received during the visit. In most cases, the principal diagnosis or the reason for visit is also the main focus of attention or treatment. It is often difficult (and somewhat arbitrary) to determine which diagnosis is the principal diagnosis or the reason for visit, especially in situations of "dual diagnosis" (a substance-related diagnosis like Amphetamine Dependence accompanied by a non-substance-related diagnosis like Schizophrenia). For example, it may be unclear which diagnosis should be considered "principal" for an individual hospitalized with both Schizophrenia and Amphetamine Intoxication, because each condition may have contributed equally to the need for admission and treatment.

Multiple diagnoses can be reported in a multiaxial fashion (seep. 33) or in a nonaxial fashion (see p. 35). When the principal diagnosis is an Axis I disorder, this is indicated by listing it first. The remaining disorders are listed in order of focus of attention and treatment. When a person has both an Axis I and an Axis II diagnosis, the principal diagnosis or the reason for visit will be assumed to be on Axis I unless the Axis II diagnosis is followed by the qualifying phrase "(Principal Diagnosis)" or "(Reason for Visit)."

***Provisional magnosis***

The specifier *provisional* can be used when there is a strong presumption that the full criteria will ultimately be met for a disorder, but not enough information is available to make a firm diagnosis. The clinician can indicate the diagnostic uncertainty by recording "(Provisional)" following the diagnosis. For example, the individual appears to have a Major Depressive Disorder, but is unable to give an adequate history to establish that

the full criteria are met. Another use of the term *provisional* is for those situations in which differential diagnosis depends exclusively on the duration of illness. For example, a diagnosis of Schizophreniform Disorder requires a duration of less than 6 months and can only be given provisionally if assigned before remission has occurred.

**Use of Not Otherwise Specified Categories**

Because of the diversity of clinical presentations, it is impossible for the diagnostic nomenclature to cover every possible situation. For this reason, each diagnostic class has at least one Not Otherwise Specified (NOS) category and some classes have several NOS categories. There are four situations in which an NOS diagnosis may be appropriate:

* The presentation conforms to the general guidelines for a mental disorder in the diagnostic class, but the symptomatic picture does not meet the criteria for any of the specific disorders. This would occur either when the symptoms are below the diagnostic threshold for one of the specific disorders or when there is an atypical or mixed presentation.
* The presentation conforms to a symptom pattern that has not been included in the DSM-IV Classification but that causes clinically significant distress or impair­ ment. Research criteria for some of these symptom patterns have been included in Appendix B ("Criteria Sets and Axes Provided for Further Study"), in which case a page reference to the suggested research criteria set in Appendix B is provided.
* There is uncertainty about etiology (i.e., whether the disorder is due to a general medical condition, is substance induced, or is primary).
* There is insufficient opportunity for complete data collection (e.g., in emergency situations) or inconsistent or contradictory information, but there is enough information to place it within a particular diagnostic class (e.g., the clinician determines that the individual has psychotic symptoms but does not have enough information to diagnose a specific Psychotic Disorder).

**Ways of Indicating Diagnostic Uncertainty**

The following table indicates the various ways in which a clinician may indicate diagnostic uncertainty:

**Term Examples of clinical situations**

V Codes (for Other Conditions That May Be a Focus of Clinical Attention)

Insufficient information to know whether or not a presenting problem is attributable to a mental disorder, e.g., Academic Problem; Adult Antisocial Behavior

|  |  |  |
| --- | --- | --- |
| 799.9 | Diagnosis or Condition Deferred on Axis I | Information inadequate to make any diagnostic judgment about an Axis I diagnosis or condition |
| 799.9 | Diagnosis Deferred on Axis II | Information inadequate to make any diagnostic judgment about an Axis II  diagnosis *(continued)* |

**Term Examples of clinical situations**

300.9

298.9

Unspecified Mental Disorder (nonpsychotic)

Psychotic Disorder Not Otherwise Specified

Enough information available to rule out a Psychotic Disorder, but further specification is not possible

Enough information available to determine the presence of a Psychotic Disorder, but further specification is not possible

[Class of disorder] Not Otherwise Specified e.g., Depressive Disorder Not Otherwise Specified

[Specific diagnosis] (Provisional)

e.g., Schizophreniform Disorder (Provisional)

Enough information available to indicate the class of disorder that is present, but further specification is not possible, either because there is not sufficient information to make a more specific diagnosis or because the clinical features of the disorder do not meet the criteria for any of the specific categories in that class

Enough information available to make a "working" diagnosis, but the clinician wishes to indicate a significant degree of diagnostic uncertainty

**Frequently Used Criteria**

***Criteria Used to Exclude Other Di.agnoses and to Suggest Di.fferential Di.agnoses***

Most of the criteria sets presented in this manual include exclusion criteria that are necessary to establish boundaries between disorders and to clarify differential diagnoses. The several different wordings of exclusion criteria in the criteria sets throughout DSM-IV reflect the different types of possible relationships among disorders:

* + **"Criteria have never been met for ... "** This exclusion criterion is used to define a lifetime hierarchy between disorders. For example, a diagnosis of Major Depressive Disorder can no longer be given once a Manic Episode has occurred and must be changed to a diagnosis of Bipolar I Disorder.
  + **"Criteria are not met for ... "** This exclusion criterion is used to establish a hierarchy between disorders (or subtypes) defined cross-sectionally. For example, the specifier With Melancholic Features takes precedence over With Atypical Features for describing the current Major Depressive Episode.
  + **"does not occur exclusively during the course of ... "** This exclusion criterion prevents a disorder from being diagnosed when its symptom presenta­ tion occurs only during the course of another disorder. For example, dementia is not diagnosed separately if it occurs only during delirium; Conversion Disorder is not diagnosed separately if it occurs only during Somatization Disorder; Bulimia Nervosa is not diagnosed separately if it occurs only during episodes of Anorexia Nervosa. This exclusion criterion is typically used in situations in which the symptoms of one disorder are associated features or a subset of the symptoms of the preempting disorder. The clinician should consider periods of partial remission as part of the "course of another disorder." It should be noted that the

excluded diagnosis can be given at times when it occurs independently (e.g., when the excluding disorder is in full remission).

* + **"not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition."** This exclusion criterion is used to indicate that a substance-induced and general medical etiology must be considered and ruled out before the disorder can be diagnosed (e.g., Major Depressive Disorder can be diagnosed only after etiologies based on substance use and a general medical condition have been ruled out).
  + **"not better accounted for by .** . ." This exclusion criterion is used to indicate that the disorders mentioned in the criterion must be considered in the differential diagnosis of the presenting psychopathology and that, in boundary cases, clinical judgment will be necessary to determine which disorder provides the most appropriate diagnosis. In such cases, the "Differential Diagnosis" section of the text for the disorders should be consulted for guidance.

The general convention in DSM-IV is to allow multiple diagnoses to be assigned for those presentations that meet criteria for more than one DSM-IV disorder. There are three situations in which the above-mentioned exclusion criteria help to establish a diagnostic hierarchy (and thus prevent multiple diagnoses) or to highlight differential diagnostic considerations (and thus discourage multiple diagnoses):

* + When a Mental Disorder Due to a General Medical Condition or a Substance­ Induced Disorder is responsible for the symptoms, it preempts the diagnosis of the corresponding primary disorder with the same symptoms (e.g., Cocaine­ Induced Mood Disorder preempts Major Depressive Disorder). In such cases, an exclusion criterion containing the phrase "not due to the direct physiological effects of ... " is included in the criteria set for the primary disorder.
  + When a more pervasive disorder (e.g., Schizophrenia) has among its defining symptoms (or associated symptoms) what are the defining symptoms of a less pervasive disorder (e.g., Dysthymic Disorder), one of the following three exclusion criteria appears in the criteria set for the less pervasive disorder, indicating that only the more pervasive disorder is diagnosed: "Criteria have never been met for ... ," "Criteria are not met for ... ," "does not occur exclusively during the course of. "
  + When there are particularly difficult differential diagnostic boundaries, the phrase "not better accounted for by ... " is included to indicate that clinical judgment is necessary to determine which diagnosis is most appropriate. For example, Panic Disorder With Agoraphobia includes the criterion "not better accounted for by Social Phobia" and Social Phobia includes the criterion "not better accounted for by Panic Disorder With Agoraphobia" in recognition of the fact that this is a particularly difficult boundary to draw. In some cases, both diagnoses might be appropriate.

***Criteria for Substance-Induced Di,sorders***

It is often difficult to determine whether presenting symptomatology is substance induced, that is, the direct physiological consequence of Substance Intoxication or Withdrawal, medication use, or toxin exposure. In an effort to provide some assistance in making this determination, the two criteria listed below have been added to each of

the Substance-Induced Disorders. These criteria are intended to provide general guidelines, but at the same time allow for clinical judgment in determining whether or not the presenting symptoms are best accounted for by the direct physiological effects of the substance. For further discussion of this issue, seep. 192.

B. There is evidence from the history, physical examination, or laboratory findings of either (1) or (2):

1. the symptoms developed during, or within a month of, Substance Intoxication or Withdrawal
2. medication use is etiologically related to the disturbance

C. The disturbance is not better accounted for by a disorder that is not substance induced. Evidence that the symptoms are better accounted for by a disorder that is not substance induced might include the following: the symptoms precede the onset of the substance use (or medication use); the symptoms persist for a substantial period of time (e.g., about a month) after the cessation of acute withdrawal or severe intoxication, or are substantially in excess of what would be expected given the type, duration, or amount of the substance used; or there is other evidence that suggests the existence of an independent non­ substance-induced disorder (e.g., a history of recurrent non-substance­ related episodes).

***Criteria for a Mental Disorder***

***Due to a General Medical Condition***

The criterion listed below is necessary to establish the etiological requirement for each of the Mental Disorders Due to a General Medical Condition (e.g., Mood Disorder Due to Hypothyroidism). For further discussion of this issue, see p. 165.

There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition.

***Criteria for Clinical Significance***

The definition of *mental disorder* in the introduction to DSM-IV requires that there be clinically significant impairment or distress. To highlight the importance of considering this issue, the criteria sets for most disorders include a clinical significance criterion (usually worded "... causes clinically significant distress or impairment in social, occupational, or other important areas of functioning"). This criterion helps establish the threshold for the diagnosis of a disorder in those situations in which the symptomatic presentation by itself (particularly in its milder forms) is not inherently pathological and may be encountered in individuals for whom a diagnosis of "mental disorder" would be inappropriate. Assessing whether this criterion is met, especially in terms of role function, is an inherently difficult clinical judgment. Reliance on information from family members and other third parties (in addition to the individual) regarding the individual's performance is often necessary.

**Types of Information in the DSM.-JV Text**

The text of DSM-IV systematically describes each disorder under the following headings: "Diagnostic Features"; "Subtypes and/or Specifiers"; "Recording Procedures"; "Associated Features and Disorders"; "Specific Culture, Age, and Gender Features"; "Prevalence"; "Course"; "Familial Pattern"; and "Differential Diagnosis." When no information is available for a section, that section is not included. In some instances, when many of the specific disorders in a group of disorders share common features, this information is included in the general introduction to the group.

**Diagnostic Features.** This section clarifies the diagnostic criteria and often provides illustrative examples.

**Subtypes and/or Specifiers.** This section provides definitions and brief discussions concerning applicable subtypes and/or specifiers.

**Recording Procedures.** This section provides guidelines for reporting the name of the disorder and for selecting and recording the appropriate ICD-9-CM diagnostic code. It also includes instructions for applying any appropriate subtypes and/or specifiers.

**Associated Features and Disorders.** This section is usually subdivided into three parts:

* + *Associated descriptive features and mental disorders.* This section includes clinical features that are frequently associated with the disorder but that are not considered essential to making the diagnosis. In some cases, these features were considered for inclusion as possible diagnostic criteria but were insufficiently sensitive or specific to be included in the final criteria set. Also noted in this section are other mental disorders associated with the disorder being discussed. It is specified (when known) if these disorders precede, co-occur with, or are consequences of the disorder in question (e.g., Alcohol-Induced Persisting Dementia is a consequence of chronic Alcohol Dependence). If available, information on predisposing factors and complications is also included in this section.
  + *Associated laboratory findings.* This section provides information on three types of laboratory findings that may be associated with the disorder: 1) those associated laboratory findings that are considered to be "diagnostic" of the disorder-for example, polysomnographic findings in certain sleep disorders; 2) those associ­ ated laboratory findings that are not considered to be diagnostic of the disorder but that have been noted to be abnormal in groups of individuals with the disorder relative to control subjects-for example, ventricle size on computed tomography as a validator of the construct of Schizophrenia; and 3) those laboratory findings that are associated with the complications of a disorder-for example, electrolyte imbalances in individuals with Anorexia Nervosa.
  + *Associated physical examination findings and general medical conditions.* This section includes information about symptoms elicited by history, or findings noted during physical examination, that may be of diagnostic significance but that are not essential to the diagnosis-for example, dental erosion in Bulimia Nervosa. Also included are those disorders that are coded outside the "Mental and

Behavioural Disorders" chapter of ICD that are associated with the disorder being discussed. As is done for associated mental disorders, the type of association (i.e., precedes, co-occurs with, is a consequence oD is specified if known-for example, that cirrhosis is a consequence of Alcohol Dependence.

**Specific Culture, Age, and Gender Features.** This section provides guidance for the clinician concerning variations in the presentation of the disorder that may be attributable to the individual's cultural setting, developmental stage (e.g., infancy, childhood, adolescence, adulthood, late life), or gender. This section also includes information on differential prevalence rates related to culture, age, and gender (e.g., sex ratio).

**Prevalence.** This section provides available data on point and lifetime prevalence, incidence, and lifetime risk. These data are provided for different settings (e.g., community, primary care, outpatient mental health clinics, and inpatient psychiatric settings) when this information is known.

**Course.** This section describes the typical lifetime patterns of presentation and evolution of the disorder. It contains information on typical *age at onset* and *mode of onset(e.g.,* abrupt or insidious) of the disorder; *episodic* versus *continuous course; single episode* versus *recurrent; duration,* characterizing the typical length of the illness and its episodes; and *progression,* describing the general trend of the disorder over time (e.g., stable, worsening, improving).

**Familial Pattern.** This section describes data on the frequency of the disorder among first-degree biological relatives of those with the disorder compared with the frequency in the general population. It also indicates other disorders that tend to occur more frequently in family members of those with the disorder.

**Differential Diagnosis.** This section discusses how to differentiate this disorder from other disorders that have some similar presenting characteristics.

**DSM-IV Organizational Plan**

The DSM-IV disorders are grouped into 16 major diagnostic classes (e.g., Substance­ Related Disorders, Mood Disorders, Anxiety Disorders) and one additional section, "Other Conditions That May Be a Focus of Clinical Attention."

The first section is devoted to "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence." This division of the Classification according to age at presentation is for convenience only and is not absolute. Although disorders in this section are usually first evident in childhood and adolescence, some individuals diagnosed with disorders located in this section (e.g., Attention-Deficit/Hyperactivity Disorder) may not present for clinical attention until adulthood. In addition, it is not uncommon for the age at onset for many disorders placed in other sections to be during childhood or adolescence (e.g., Major Depressive Disorder, Schizophrenia, Generalized Anxiety Disorder). Clinicians who work primarily with children and adolescents should therefore be familiar with the entire manual, and those who work primarily with adults should also be familiar with this section.

The next three sections-"Delirium, Dementia, and Amnestic and Other Cognitive Disorders"; "Mental Disorders Due to a General Medical Condition"; and "Substance­ Related Disorders"-were grouped together in DSM-III-R under the single heading of "Organic Mental Syndromes and Disorders." The term "organic mental disorder" is no longer used in DSM-IV because it incorrectly implies that the other mental disorders in the manual do not have a biological basis. As in DSM-IIIcR, these sections are placed before the remaining disorders in the manual because of their priority in differential diagnosis (e.g., substance-related causes of depressed mood must be ruled out before making a diagnosis of Major Depressive Disorder). To facilitate differential diagnosis, complete lists of Mental Disorders Due to a General Medical Condition and Substance­ Related Disorders appear in these sections, whereas the text and criteria for these disorders are placed in the diagnostic sections with disorders with which they share phenomenology. For example, the text and criteria for Substance-Induced Mood Disorder and Mood Disorder Due to a General Medical Condition are included in the Mood Disorders section.

The organizing principle for all the remaining sections (except for Adjustment Disorders) is to group disorders based on their shared phenomenological features in order to facilitate differential diagnosis. The "Adjustment Disorders" section is organized differently in that these disorders are grouped based on their common etiology (e.g., maladaptive reaction to a stressor). Therefore, the Adjustment Disorders include a variety of heterogeneous clinical presentations (e.g., Adjustment Disorder With Depressed Mood, Adjustment Disorder With Anxiety, Adjustment Disorder With Disturbance of Conduct).

Finally, DSM-IV includes a section for "Other Conditions That May Be a Focus of Clinical Attention."

DSM-IV includes 10 appendixes:

**Appendix A: Decision Trees for Differential Diagnosis.** This appendix contains six decision trees (for Mental Disorders Due to a General Medical Condition, Substance­ Induced Disorders, Psychotic Disorders, Mood Disorders, Anxiety Disorders, and Somatoform Disorders). Their purpose is to aid the clinician in differential diagnosis and in understanding the hierarchical structure of the DSM-IV Classification.

**Appendix B: Criteria Sets and Axes Provided for Further Study.** This appen­ dix contains a number of proposals that were suggested for possible inclusion in DSM-IV. Brief texts and research criteria sets are provided for the following: postconcussional disorder, mild neurocognitive disorder, caffeine withdrawal, postpsychotic depressive disorder of Schizophrenia, simple deteriorative disorder, premenstrual dysphoric disor­ der, minor depressive disorder, recurrent brief depressive disorder, mixed anxiety­ depressive disorder, factitious disorder by proxy, dissociative trance disorder, binge-eating disorder, depressive personality disorder, passive-aggressive personality disorder, Neuroleptic-Induced Parkinsonism, Neuroleptic Malignant Syndrome, Neuro­ leptic-Induced Acute Dystonia, Neuroleptic-Induced Acute Akathisia, Neuroleptic­ Induced Tardive Dyskinesia, and Medication-Induced Postural Tremor. In addition, alternative dimensional descriptors for Schizophrenia and an alternative Criterion B for Dysthymic Disorder are included. Finally, three proposed axes (Defensive Functioning Scale, Global Assessment of Relational Functioning [GARF] Scale, and Social and Occupational Functioning Assessment Scale [SOFAS]) are provided.

**Appendix C: Glossary of Technical Terms.** This appendix contains glossary def­ initions of selected terms to assist users of the manual in the application of the criteria sets.

**Appendix D: Annotated Listing of Changes in DSM-IV.** This appendix indicates the major changes from DSM-III-R that have been included in the DSM-IV terms and categories.

**Appendix E: Alphabetical Listing of DSM-IV Diagnoses and Codes.** This ap­ pendix lists the DSM-IV disorders and conditions (with their ICD-9-CM codes) in alphabetical order. It has been included to facilitate the selection of diagnostic codes.

**Appendix F: Numerical Listing of DSM-IV Diagnoses and Codes.** This appen­ dix lists the DSM-IV disorders and conditions (with their ICD-9-CM codes) in numerical order by code. It has been included to facilitate recording of diagnostic terms.

**Appendix G: ICD-9-CM Codes for Selected General Medical Conditions and Medication-Induced Disorders.** This appendix contains a list of ICD-9-CM codes for selected general medical conditions and has been provided to facilitate coding on Axis III. This appendix also provides ICD-9-CM E-codes for selected medications, prescribed at therapeutic dose levels, that cause Substance-Induced Disorders. The E-codes may optionally be coded on Axis I immediately following the related disorder (e.g., 292.39 Oral Contraceptive-Induced Mood Disorder, With Depressive Features; E932.2 oral contraceptives).

**Appendix H: DSM-IV Classification With ICD-10 Codes.** As of the publication of this manual (in early 1994), the official coding system in use in the United States is the *International Classification of Diseases,* Ninth Revision, Clinical Modification (ICD-9- CM). At some point within the next several years, the U.S. Department of Health and Human Services will require for reporting purposes in the United States the use of codes from the *International Statistical Classification Qf Diseases and Related Health Problems,* Tenth Revision (ICD-10). To facilitate this transition process, this appendix contains the complete DSM-IV Classification with ICD-10 diagnostic codes.

**Appendix I: Outline for Cultural Formulation and Glossary of Culture-Bound Syndromes.** This appendix is divided into two sections. The first provides an outline for cultural formulation designed to assist the clinician in systematically evaluating and reporting the impact of the individual's cultural context. The second is a glossary of culture-bound syndromes.

**AppendixJ: DSM-IV Contributors.** This appendix lists the names of the advisers and field-trial participants and other individuals and organizations that contributed to the development of DSM-IV.



**[DSM IV Classification](#_bookmark0)**

NOS= Not Otherwise Specified

An *x* appearing in a diagnostic code indi­ cates that a specific code number is re­ quired

**Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence** <rl

**MENTAL RETARDATION** (39)

An ellipsis ( ... ) is used in the names of certain disorders to indicate that the name of a specific mental disorder or general medical condition should be inserted when recording the name (e.g., 293.0 De­ lirium Due to Hypothyroidism)

***Note:***

317

318.0

318.1

318.2

319

*These are coded on Axis II*

Mild Mental Retardation (41) Moderate Mental Retardation (41) Severe Mental Retardation (41) Profound Mental Retardation (41) Mental Retardation, Severity Unspecified (42)

Numbers in parentheses are page numbers.

If criteria are currently met, one of the following severity specifiers may be noted after the diagnosis:

Mild Moderate Severe

**LEARNING DISORDERS** (46)

315.00 Rea ding Disorder (48)

* 1. Mathematics Disorder (50)
  2. Disorder of Written Expression (51)

315.9 Learning Disorder NOS (53)

**MOTOR SKILLS DISORDER**

315.4 Developmental Coordination Disorder (53)

**COMMUNICATION DISORDERS** (55)

|  |  |  |
| --- | --- | --- |
| If criteria are no longer met, one of the following specifiers may be noted | 315.31 | Expressive Language Disorder (55) |
| In Partial Remission In Full Remission Prior History | 315.31  315.39 | Mixed Receptive-Expressive Language Disorder (58)  Phonological Disorder (61) |
|  | 307.0 | Stuttering (63) |
|  | 307.9 | Communication Disorder |
|  |  | NOS (65) |

**PERVASIVE DEVELOPMENTAL DISORDERS** (65)

299.00 Autistic Disorder (66)

299.80 Rett's Disorder (71)

**13**

|  |  |
| --- | --- |
| 299.10 | Childhood Disintegrative  Disorder (73) |
| 299.80 | Asperger's Disorder (75) |
| 299.80 | Pervasive Developmental  Disorder NOS (77) |

**ATIENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS** (78)

314.xx Attention-Deficit/Hyperactivity Disorder (78)

.01 Combined Type

1. Predominantly Inattentive Type
2. Predominantly

Hyperactive-Impulsive Type

314*.9* Attention-Deficit/Hyperactivity Disorder NOS (85)

312.8 Conduct Disorder (85)

*Spec/fy type:* Childhood-Onset Type/ Adolescent-Onset Type

313.81 Oppositional Defiant Disorder (91)

312.9 Disruptive Behavior Disorder NOS (94)

**FEEDING AND EATING DISORDERS OF INFANCY OR EARLY CHILDHOOD** (94)

* 1. Pica (95)
  2. Rumination Disorder (96)

307.59 Feeding Disorder of Infancy or Early Childhood (98)

**TIC DISORDERS** (100)

307.23 Tourette's Disorder (101)

307.22 Chronic Motor or Vocal Tic Disorder (103)

307.21 Transient Tic Disorder (104)

*Specijy if* Single Episode/Recurrent

307.20 Tic Disorder NOS (105)

**ELIMINATION DISORDERS** (106)

Encopresis (106)

787.6 With Constipation and

Overflow Incontinence

307.7 Without Constipation and

Overflow Incontinence

307.6 Enuresis (Not Due to a General Medical Condition) (108) *Spec/fytype:* Nocturnal Only/Diurnal Only/Nocturnal and Diurnal

**OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE**

309.21 Separation Anxiety Disorder (110)

*Spec/fy !l* Early Onset

313.23 Selective Mutism (114)

313.89 Reactive Attachment Disorder of Infancy or Early

Childhood (116)

*SpeciJ.y type:* Inhibited Type/ Disinhibited Type

307.3 Stereotypic Movement Disorder (118)

*Spec/fy if* With Self-Injurious Behavior

313.9 Disorder of Infancy, Childhood, or Adolescence NOS (121)

**Delirium, Dementia, and Amnestic and Other Cognitive Disorders** ( 1 23)

**DELIRIUM** (124)

293.0 Delirium Due to ... *[Indicate the General Medical Condition}* (127)

Substance Intoxication Delirium

(129) *(refer to Substance­ Related Disorders for substance­ specific codes)*

Substance Withdrawal Delirium

(129) *(refer to Substance­ Related Disorders for substance­ specific codes)*

Delirium Due to Multiple Etiologies *( code each of the specific etiologies)* (132)

780.09 Delirium NOS 033)

**DEMENTIA** 033)

290.xx Dementia of the Alzheimer's Type, With Early Onset *(also code 331.0 Alzheimer's disease on Axis III)* (139)

1. Uncomplicated
2. With Delirium
3. With Delusions
4. With Depressed Mood

*Specify if* With Behavioral Disturbance

290.xx Dementia of the Alzheimer 's Substance-Induced Persisting

Type, With Late Onset *(also* Dementia *(refer to Substance- code 331.0 Alzheimer's disease Related Disorders for substance- on Axis III)* 039) *specific codes)* 052)

.0 Uncomplicated Dementia Due to Multiple

.3 With Delirium Etiologies *(code each of the*

1. With Delusions *specific etiologies)* (l 54)
2. With Depressed Mood 294.8 Dementia NOS 055)

*Specify if* With Behavioral Disturbance

290.xx Vascular Dementia (143)

1. Uncomplicated **AMNESTIC DISORDERS** (156)
2. With Delirium 294.0 Amnestic Disorder Due to ...
3. With Delusions *(Indicate the General Medical*
4. With Depressed Mood *Condition}* (158)

*Specify if* With Behavioral Disturbance *Specify if* Transient/Chronic

294 .9 Dementia Due to HIV Disease Substance-Induced Persisting *(also code 043.1 HIV infection* Amnestic Disorder *(refer to affecting central neroous system Substance-Related Disorders for on Axis III)* (148) *substance-specific codes)* 061)

294.1 Dementia Due to Head Trauma 294.8 Amnestic Disorder NOS (163)

*(also code 854.00 head injury*

*on Axis III)* 048) **OTHER COGNITIVE DISORDERS** (163)

294.1 Dementia Due to Parkinson's 294.9 Cognitive Disorder NOS (163) Disease *(also code 332.0*

*Parkinson's disease on*

*Axis II/)* 0 48) **Mental Disorders Due to a**

294.l Dementia Due to Huntington 's **General Medical Condition**

Disease *(also code 333.4* **Not Elsewhere Classified** c t6'i>

*Huntington 's disease on*

*Axis III)* (149) 293.89 Catatonic Disorder Due to ...

290.10 Dementia Due to Pick's Disease *(Indicate the General Medical (also code 331.1 Pick's disease Condition}* (169)

*on Axis III)* (149) 310.1 Personality Change Due to . . .

290.10 Dementia Due to *(Indicat e the General Medical*

Creutzfeldt-Jakob Disease *(also Condition}* (171)

*code 046.1 Creutzfeldt-Jakob Specify type:* Labile Type/Disinhibited Type/Aggress ive Type/ Apathetic Type/

*disease on Axis III)* (150)

Paranoid Type/ Other Type/Combined

294.1 Dementia Due to ... *(Indicate* Type/ Unspe cified Type

*the General Medical Condition* 293.9 Mental Disorder NOS Due to ...

*not listed above} (also code the (Indicat e the General Medical*

*general medical condition on Condition}* (174)

*Axis III)* (151)

**Substance-Related Disorders** o 75)

a *The following specifiers may be applied to Substance Dependence:*

With Physiological Dependence/Without Physiological Dependence

Early Full Remission/Early Partial Remission Sustained Full Remission/Sustained Partial

Remission

On Agonist Therapy/In a Controlled Environment

**AMPHETAMINE (OR AMPHETAMINE­ LIKE}-REIATED DISORDERS** (204)

**Amphetamine Use Disorders**

304.40 Amphetamine Dependencea (206)

305.70 Amphetamine Abuse (206)

**Amphetamine-Induced Disorders**

292.89 Amphetamine Intoxication (207)

*Specify if* With Perceptual Disturbances

292.0 Amphetamine Withdrawal (208)

292.81 Amphetamine Intoxication Delirium (129)

*The following specifiers apply to Substance-Induced Disorders as noted:*

1With Onset During Intoxication/wWith Onset During Withdrawal

**ALCOHOL-REIATED DISORDERS** (194)

292.xx

.11

.12

292.84

Amphetamine-Induced Psychotic Disorder (310)

With Delusions 1

With Hallucinations 1 Amphetamine-Induced Mood Disorder1·w (370)

**Alcohol Use Disorders**

303.90 Alcohol Dependencea 095)

305.00 Alcohol Abuse (196)

**Alcohol-Induced Disorders**

292.89 Amphetamine-Induced Anxiety Disorder1 ( 439)

292.89 Amphetamine-Induced Sexual Dysfunction1 (519)

292.89 Amphetamine-Induced Sleep Disorder 1·w (601)

|  |  |
| --- | --- |
| 303.00 | Alcohol Intoxication (196) |
| 291.8 | Alcohol Withdrawal (197)  *Spec/fy if* With Perceptual Disturbances |
| 291.0 | Alcohol Intoxication Delirium (129) |
| 291.0 | Alcohol Withdrawal Delirium (129) |

292.9 Amphetamine-Related Disorder NOS (211)

291.2

Alcohol-Induced Persisting Dementia (152)

**CAFFEINE-REIATED DISORDERS** (212)

**Caffeine-Induced Disorders**

291.1 Alcohol-Induced Persisting Amnestic Disorder (161)

291.x Alcohol-Induced Psychotic Disorder (310)

305.90 Caffeine Intoxication (212)

292.89 Caffeine-Induced Anxiety Disorder1 ( 439)

292.89 Caffeine-Induced Sleep

.5

.3

291.8

With Delusions 1·w With Hallu cinations1·w

Alcohol-Induced Mood Disorder 1·w (370)

Disorder 1 (601)

292.9 Caffeine-Related Disorder NOS (215)

291.8 Alcohol-Induced Anxiety Disorder 1·w (439)

291.8 Alcohol-Induced Sexual Dysfunction 1 (519)

* 1. Alcohol-Induced Sleep Disorder1·w (601)
  2. Alcohol-Related Disorder NOS (204)

**CANNABIS-REIATED DISORDERS** (215)

**Cannabis Use Disorders**

304.30 Cannabis Dependencea (216)

305.20 Cannabis Abuse (217)

**Cannabis-Induced Disorders**

292.89 Cannabis Intoxication (217)

*Spec/fy if* With Perceptual Disturbances

292.81 Cannabis Intoxication Delirium (129)

|  |  |  |  |
| --- | --- | --- | --- |
| 292.xx | Cannabis-Induced Psychotic | 292.81 | Hallucinogen Intoxication |
|  | Disorder (310) |  | Delirium (129) |
| .11 | With Delusio ns1 | 292.xx | Hallucinogen-Induced Psychotic |
| .12 | With Hallu cinatio ns1 |  | Disorder (310) |
| 292.89 | Cannabis-Induced Anxiety | .11 | With Delusions1 |
|  | Disorde r1 ( 439) | .12 | With Hallucinations1 |
| 292.9 | Cannabis-Related Disorder | 292.84 | Hallucinogen-Induced Mood Disorder 1 (370) |

NOS (221)

**COCAINE-REIATED DISORDERS** (221)

**Cocaine Use Disorders**

304.20 Cocaine Dependence" (222)

305.60 Cocaine Abuse (223)

**Cocaine-Induced Disorders**

292.89 Cocaine Intoxication (223)

*Specify !f* With Perceptual Disturbances

292.0 Cocaine Withdrawal (225)

292.81 Cocaine Intoxication Delirium 029)

292.89 Hallucinogen-Induced Anxiety Disorder 1 (439)

292.9 Hallucinogen-Related Disorder NOS (236)

**INHALANT-REIATED DISORDERS** (236)

**Inhalant Use Disorders**

304.60 Inhalant Dependencea (238)

305.90 Inhalant Abuse (238)

**Inhalant-Induced Disorders**

292.89 Inhalant Intoxication (239)

* 1. Inhalant Intoxication

292.xx

.11

.12

Cocaine-Induced Psychotic Disorder (310)

With Delusions1

With Hallucinations 1

Delirium (129)

* 1. Inhalant-Induced Persisting Dementia (152)

292.xx Inhalant-Induced Psychotic

1

|  |  |  |  |
| --- | --- | --- | --- |
| 292.84 | Cocaine-Induced Mood |  | Disorder (310) |
|  | Disorder 1·w (370) | .11 | With Delusions1 |
| 292.89 | Cocaine-Induced Anxiety | .12 | With Hallucinations |

|  |  |  |  |
| --- | --- | --- | --- |
| 292.89 | Disor de r1·w (439)  Cocaine-Induced Sexual Dysfunction1 (519) | 292.84  292.89 | Inhalant-Induced Mood Disorder 1 (370)  Inhalant-Induced Anxiety |
| 292.89 | Cocaine-Induced Sleep |  | Disorder 1 (439) |
|  | Disorde r1·w (601) | 292.9 | Inhalant-Related Disorder |
| 292.9 | Cocaine-Related Disorder |  | NOS (242) |

NOS (229)

**HALLUCINOGEN-REIATED DISORDERS** (229)

**Hallucinogen Use Disorders**

304.50 Hallucinogen Dependence• (230)

305.30 Hallucinogen Abuse (231)

**Hallucinogen-Induced Disorders**

292.89 Hallucinogen Intoxication (232)

292.89 Hallucinogen Persisting Perception Disorder (Flashbacks) (233)

**NICOTINE-REIATED DISORDERS** (242)

**Nicotine Use Disorder**

305.10 Nicotine Dependencea (243)

**Nicotine-Induced Disorder**

292.0 Nicotine Withdrawal (244)

292.9 Nicotine-Related Disorder NOS (247)

**OPIOID-REIATED DISORDERS** (247)

**Opioid Use Disorders**

304.00 Opioid Dependence• (248)

305.50 Opioid Abuse (249)

**Opioid-Induced Disorders**

292.89 Opioid Intoxication (249)

*Specify if* With Perceptual Disturbances

305.40 Sedative, Hypnotic, or Anxiolytic Abuse (263)

292.0

292.81

292.xx

.11

Opioid Withdrawal (250)

Opioid Intoxication Delirium (129) Opioid-Induced Psychotic Disorder (310)

With Delusions 1

**Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders**

292.89 Sedative, Hypnotic, or Anxiolytic Intoxication (263)

292.0 Sedative, Hypnotic, or Anxiolytic

.12 With Hallucinations'

|  |  |
| --- | --- |
| 292.84 | Opioid-Induced Mood |
|  | Disor der 1 (370) |
| 292.89 | Opioid-Induced Sexual  Dysfunctio n1 (519) |
| 292.89 | Opioid-Induced Sleep Disorde r1·w (601) |
| 292.9 | Opioid-Related Disorder NOS (255) |

**PHENCYCLIDINE (OR PHENCYCLIDINE-LIKE)­ RELATED DISORDERS** (255)

**Phencyclidine Use Disorders**

304.90 Phencyclidine Dependencea (256)

305.90 Phencyclidine Abuse (257)

**Phencyclidine-Induced Disorders**

292.89 Phencyclidine Intoxication (257)

*Specify if* With Perceptual Disturbances

292.81 Phencyclidine Intoxication Delirium (129)

Withdrawal (264)

*Specify !f* With Perceptual Disturbances

292.81 Sedative, Hypnotic, or Anxiolytic Intoxication Delirium (129)

* 1. Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium (129)
  2. Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Dementia (152)
  3. Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Amnestic Disorder (161)

292.xx Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder (310)

1. With Delusions 1·w
2. With Hallucinations1.w
   1. Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder 1·w (370)

292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety

292.xx

.11

**.12**

|  |  |
| --- | --- |
| 292.84 | Phencyclidine-Induced Mood |
|  | Disorder 1 (370) |
| 292.89 | Phencyclidine-Induced Anxiety Disorder 1 (439) |
| 292.9 | Phencyclidine-Related Disorder |
|  | NOS (261) |

Phencyclidine-Induced Psychotic Disorder (310)

With Delusions 1

With Hallucina tions1

Disorderw (439)

292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Sexual Dysfunction1 (519)

292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Sleep Disorder 1·w (601)

292.9 Sedative-, Hypnotic-, or Anxiolytic-Related Disorder NOS (269)

**SEDATIVE-, HYPNOTIC-, OR ANXIOLYTIC-RELATED DISORDERS** (261)

**Sedative,Hypnotic,or Anxiolytic Use Disorders**

304.10 Sedative, Hypnotic, or Anxiolytic Dependence" (262)

**POLYSUBSTANCE-RELATED DISORDER**

304.80 Polysubstance Dependence" (270)

**OTHER (OR UNKNOWN) SUBSTANCE-REIATED DISORDERS** (270)

**Other (or Unknown) Substance Use Disorders**

304.90 Other (or Unknown) Substance Dependencea O76)

305.90 Other (or Unknown) Substance Abuse (182)

**Other (or Unknown) Substance­ Induced Disorders**

292.89 Other (or Unknown) Substance Intoxication (183)

*Specify (f* With Perceptual Disturbances

292.0 Other (or Unknown) Substance Withdrawal (184)

*Specify if* With Perceptual Disturbances

* 1. Other (or Unknown) Substance­ Induced Delirium (129)
  2. Other (or Unknown) Substance-Induced Persisting Dementia (152)
  3. Other (or Unknown) Substance-Induced Persisting Amnestic Disorder (161)

292.xx Other (or Unknown) Substance-Induced Psychotic

Disorder (310)

**Schizophrenia and Other Psychotic Disorders** (273)

295.xx Schizophrenia (274)

*The following Classification of Longitudi­ nal Course applies to all subtypes of Schizo­ phrenia:*

Episodic With lnterepisode Residual Symptoms *(spec/fy if* With Prominent Negative Symptoms)/Episodic With No Interepisode Residual Symptoms/Continuous *(specify if* With Prominent Negative Symptoms)

Single Episode In Partial Remission *(specify if* With Prominent Negative Symptoms)/Single Episode In Full Remission

Other or Unspecified Pattern

.30 Paranoid Type (287)

.10 Disorganized Type (287)

.20 Catatonic Type (288)

.90 Undifferentiated Type (289)

.60 Residual Type (289)

295.40 Schizophreniform Disorder (290) *Spec/fy if* Without Good Prognostic Features/With Good Prognostic Features

295.70 Schizoaffective Disorder (292) *Specify type:* Bipolar Type/ Depressive Type

297.1 Delusional Disorder (296) *Specify type:* Erotomanic Type/Grandiose Type/Jealous

.11

.12

292.89

292.89

292.89

With Delusions1·w With Hallucinations 1·w

Other (or Unknown) Substance­ Induced Mood Diso rde r1·w (370) Other (or Unknown)

Substance-Induced Anxiety Disor de r1·w (439)

Other (or Unknown) Substance-Induced Sexual Dysfunction1 (519)

Other (or Unknown) Substance­ Induced Sleep Disorde r1·w (601)

Type/Persecutory Type/Somatic Type/Mixed Type/Unspecified Type

298.8 Brief Psychotic Disorder (302)

*spec/f'y if* With Marked Stressor(s)/Without Marked

Stressor(s)/With Postpartum Onset

297.3 Shared Psychotic Disorder (305)

293.xx Psychotic Disorder Due to ... *[Indicate the General Medical Condition}* (306)

1. With Delusions
2. With Hallucinations Substance-Induced Psychotic

292.9 Other (or Unknown) Substance­ Related Disorder NOS (272)

Disorder *( refer to Substance­ Related Disorders for substance­ pecific codes)* (310)

*Spec!fY if* With Onset During

Intoxication/With Onset During Withdrawal

298.9 Psychotic Disorder NOS (315)

**Mood Disorders** (317)

*Code current state of Major Depressive Disorder or Bipolar I Disorder in fifth digit:*

1 =Mild

2 = Moderate

3 = Severe Without Psychotic Features 4 = Severe With Psychotic Features

*Specify:* Mood-Congment Psychotic Features/Mood-Incongment Psychotic Features

5 = In Partial Remission 6 = In Full Remission

0 = Unspecified

*The following specifiers apply (for current or most recent episode) to Mood Disorders as noted:*

"Severity/Psychotic/Remission Specifiersl'Chronic/With Catatonic Features/With Melancholic Features/'With Atypical Features/With Postpartum Onset

*The following specifiers apply to Mood Disorders as noted:*

gWith or Without Full Interepisode Recovery/ hWith Seasonal PatterniWith Rapid Cycling

**DEPRESSIVE DISORDERS**

296.xx Major Depressive Disorder, (339)

.2x Single Episode,h,c,d,e,f

.3x Recurrenta,b,c,d,e,f,g,h

300.4 Dysthyrnic Disorder (345) *Specify if* Early Onset/Late Onset *Specify:* With Atypical Features

311 Depressive Disorder NOS (350)

**BIPOLAR DISORDERS**

301.13 Cyclothyrnic Disorder (363)

296.80 Bipolar Disorder NOS (366)

293.83 Mood Disorder Due to ... *[Indicate the General Medical Condition}* (366)

*Specify type:* With Depressive Features/With Major Depressive-Like Episode/With Manic Features/With Mixed Features

Substance-Induced Mood Disorder *(rf!fer to Substance­ Related Disorders for substance­ specific codes)* (370)

*Specify type:* With Depressive Features/With Manic Features/With Mixed Features

*Specify if* With Onset During Intoxication/With Onset During Withdrawal

296.90 Mood Disorder NOS (375)

**Anxiety Disorders** (393)

300.01 Panic Disorder Without Agoraphobia (397)

* 1. Panic Disorder With Agoraphobia (397)
  2. Agoraphobia Without History of Panic Disorder (403)

300.29 Specific Phobia (405)

*Specify type:* Animal Type/Natural Environment Type/ Blood-Injection­ Injury Type/Situational Type/Other Type

296.xx Bipolar I Disorder, (350) 300.23

.Ox Single Manic Episodea,c.f

*Specify if:* Mixed 300.3

.40 Most Recent Episode Hypornanicg,h,i

Social Phobia (411) *Specify if* Generalized Obsessive-Compulsive

Disorder (417)

*Spec/fy if:* With Poor Insight

.4x Most Recent Episode Manica,c,f,g,h,i

309.81

Posttraumatic Stress Disorder (424)

*Specify !f* Acute/Chronic

*Specify if:* With Delayed Onset

.6x Most Recent Episode 308.3

Mixeda,c,f,g,h,i 300.02

.5x Most Recent Episode

Depresseda,h,c,d,e,f,g,h,i 293.89

.7 Most Recent Episode

Unspecifiedg,h,i

296.89 Bipolar II Disorder"·h,c,d,e,f,g,h,i (359)

*Specify ( current or most recent episode):* Hypomanic/Depressed

Acute Stress Disorder (429) Generalized Anxiety Disorder (432)

Anxiety Disorder Due to ... *[Indicate the General Medical Condition}* (436)

*Spec/fy if:* With Generalized Anxiety/

With Panic Attacks/With Obsessive­ Compulsive Symptoms

Substance-Induced Anxiety Disorder *(refer to Substance­*

**Dissociative Disorders** (4

*Related Disorders for substance­ specific codes)* (439)

*Spec(fy if* With Generalized

Anxiety/With Panic Attacks/With Obsessive-Compulsive Symptoms/ With Phobic Symptoms

*Specify !f* With Onset During

Intoxication/With Onset During

300.12

300.13

300.14

300.6

300.15

Dissociative Amnesia (478)

Dissociative Fugue (481) Dissociative Identity Disorder (484) Depersonalization Disorder (488) Dissociative Disorder NOS (490)

Withdrawal

300.00 Anxiety Disorder NOS (444)

**Somatoform Disorders** ( 5)

300.81 Somatization Disorder (446)

300.81 Undifferentiated Somatoform Disorder (450)

300.11 Conversion Disorder (452) *Spec/fy (ype:* With Motor Symptom or Deficit/With Sensory Symptom or Deficit/With Seizures or Convulsions/With Mixed

Presentation

307.xx Pain Disorder (458)

**Sexual and Gender Identity Disorders** (493>

**SEXUAL DYSFUNCTIONS** (493)

*Tbe following specifiers apply to all primary Sexual Dyifunctions:*

Lifelong Type/Acquired Type Generalized Type/Situational Type Due to Psychological Factors/Due to Combined Factors

**Sexual Desire Disorders**

302.71 Hypoactive Sexual Desire Disorder (496)

302.79 Sexual Aversion Disorder (499)

**Sexual Arousal Disorders**

300.7 Body Dysmorphic Disorder (466)

|  |  |  |  |
| --- | --- | --- | --- |
| .80 | Associated With  Psychological Factors | 302.72 | Female Sexual Arousal Disorder (500) |
| .89 | Associated With Both | 302.72 | Male Erectile Disorder (502) |
|  | Psychological Factors and a |  |  |
| General Medical Condition **Orgasmic Disorders** | | | |
|  | *Specify !f* Acute/Chronic | 302.73 | Female Orgasmic Disorder (505) |
| 300.7 | Hypochondriasis (462) | 302.74 | Male Orgasmic Disorder (507) |
|  | *Specify if* With Poor Insight | 302.75 | Premature Ejaculation (509) |

300.81 Somatoform Disorder NOS (468)

**Factitious Disorders** (471)

300.xx Factitious Disorder (471)

.16 With Predominantly

**Sexual Pain Disorders**

302.76 Dyspareunia (Not Due to a General Medical Condition) (511)

306.51 Vaginismus (Not Due to a General Medical Condition) (513)

**Sexual Dysfunction Due to a General Medical Condition** (515)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Psychological Signs and | 625.8 | Female Hypoactive Sexual |
| Symptoms |  | Desire Disorder Due to ... |
| .19 | With Predominantly Physical |  | *(Indicate the General Medical* |
|  | Signs and Symptoms |  | *Condition}* (515) |
| .19 | With Combined Psychological | 608.89 | Male Hypoactive Sexual |
|  | and Physical Signs and |  | Desire Disorder Due to ... |
|  | Symptoms |  | *(Indicate the General Medical* |
| 300.19 | Factitious Disorder NOS (475) |  | *Condition}* (515) |

607.84 Male Erectile Disorder Due to ... *[Indicate the General Medical Condition]* (515)

625.0 Female Dyspareunia Due to ... *[Indicate the General Medical Condition]* (515)

**GENDER IDENTITY DISORDERS** (532)

302.xx Gender Identity Disorder (532)

.6 in Children

.85 in Adolescents or Adults *Spec/fy if* Sexually Attracted to Males/ Sexually Attracted to Females/Sexually Attracted to Both/Sexually Attracted to

|  |  |  |  |
| --- | --- | --- | --- |
| 608.89 | Male Dyspareunia Due to ...  *[Indicate the General Medical* | 302.6 | Neither  Gender Identity Disorder |
| 625.8 | *Condition}* (515)  Other Female Sexual Dysfunction |  | NOS (538) |
|  | Due to ... *!Indicate the General Medical Condition]* (515) | 302.9 | Sexual Disorder NOS (538) |
| 608.89 | Other Male Sexual Dysfunction |  |  |

Due to ... *[Indicate the General Medical Condition]* (515)

Substance-Induced Sexual Dysfunction *(refer to Substance­ Related Disorders for substance­ specific codes)* (519)

*Specify if* With Impaired Desire/

With Impaired Arousal/With Impaired Orgasm/With Sexual Pain

*Specify if* With Onset During Intoxication

302.70 Sexual Dysfunction NOS (522)

**PARAPHILIAS** (522)

302.4 Exhibitionism (525)

302.81 Fetishism (526)

302.89 Frotteurism (527)

302.2 Pedophilia (527)

*Specify if* Sexually Attracted to Males/Sexually Attracted to Females/ Sexually Attracted to Both

*Specify if* Limited to Incest

*Specify tvpe:* Exclusive Type/ Nonexclusive Type

**Eating Disorders** (539)

307.1 Anorexia Nervosa (539) *Specify type:* Restricting Type; Binge-Eating/Purging Type

307.51 Bulimia Nervosa (545) *Specify type:* Purging Type/ Nonpurging Type

307.50 Eating Disorder NOS (550)

**Sleep Disorders** (551)

**PRIMARY SLEEP DISORDERS** (553)

**Dyssomnias** (553)

|  |  |
| --- | --- |
| 307.42 | Primary Insomnia (553) |
| 307.44 | Primary Hypersomnia (557)  *Specify if:* Recurrent |
| 347 | Narcolepsy (562) |
| 780.59 | Breathing-Related Sleep |
|  | Disorder (567) |
| 307.45 | Circadian Rhythm Sleep |
|  | Disorder (573) |
|  | *Specify type:* Delayed Sleep Phase |
|  | Type/Jet Lag Type/Shift Work Type/ |
|  | Unspecified Type |
| 307.47 | Dyssomnia NOS (579) |

302.83

302.84

302.3

302.82

302.9

Sexual Masochism (529)

Sexual Sadism (530)

Transvestic Fetishism (530)

*Specify !f* With Gender Dysphoria

Voyeurism (532)

Paraphilia NOS (532)

**Parasomnias** (579)

307.47 Nightmare Disorder (580)

307.46 Sleep Terror Disorder (583)

* 1. Sleepwalking Disorder (587)
  2. Parasomnia NOS (592)

**SLEEP DISORDERS RELATED TO ANOTHER MENTAL DISORDER** (592)

**Personality Disorders** (629)

307.42 Insomnia Related to ... *[Indicate the Axis I or Axis II Disorder}* (592)

307.44 Hypersomnia Related to ... *[Indicate the Axis I or Axis II Disorder}* (592)

**OTHER SLEEP DISORDERS**

***Note:***

301.0

301.20

301.22

301.7

301.83

These *are coded on Axis II.*

Paranoid Personality Disorder (634) Schizoid Personality Disorder (638) Schizotypal Personality

Disorder (641)

Antisocial Personality Disorder (645) Borderline Personality

Disorder (650)

|  |  |  |  |
| --- | --- | --- | --- |
| 780.xx | Sleep Disorder Due to ... | 301.50 | Histrionic Personality |
|  | *[Indicate the General Medical* |  | Disorder (655) |
|  | *Condition}* (597) | 301.81 | Narcissistic Personality |
| .52 | Insomnia Type |  | Disorder (658) |
| .54 | Hypersomnia Type | 301.82 | Avoidant Personality |
| .59 | Parasomnia Type |  | Disorder (662) |
| .59 | Mixed Type | 301.6 | Dependent Personality |
|  | Substance-Induced Sleep Disorder |  | Disorder (665) |
|  | *(refer to Substance-Related* | 301.4 | Obsessive-Compulsive Personality |
|  | *Disorders for substance-specific* |  | Disorder (669) |
|  | *codes)* (601) | 301.9 | Personality Disorder NOS (673) |
|  | *Specify zype.-* Insomnia Type/ |  |  |
|  | Hypersomnia Type/Parasomnia Type/ |  |  |
| Mixed Type  *Specify if* With Onset During **Other Conditions That May**  Intoxication/With Onset During **Be a Focus of Clinical**  Withdrawal **Attention** t675) | | | |

**Impulse-Control Disorders Not Elsewhere Classified** (609)

312.34 Intermittent Explosive Disorder (609)

* 1. Kleptomania (612)
  2. Pyromania (614)

312.31 Pathological Gambling (615)

312.39 Trichotillomania (618)

312.30 Impulse-Control Disorder NOS (621)

**Adjustment Disorders** C(123J

**PSYCHOLOGICAL FACTORS AFFECTING MEDICAL CONDITION** (675)

316 ... *[Specified Psychological Factor}*

Affecting ... *(Indicate the General Medical Condition}* (675) *Choose name based on nature of factors:*

Mental Disorder Affecting Medical Condition

Psychological Symptoms Affecting Medical Condition

309.xx

.0

.24

.28

.3

.4

.9

Adjustment Disorder (623) With Depressed Mood With Anxiety

With Mixed Anxiety and Depressed Mood

With Disturbance of Conduct With Mixed Disturbance of Emotions and Conduct Unspecified

*Spec/fr !f* Acute/Chronic

Personality Traits or Coping Style Affecting Medical Condition

Maladaptive Health Behaviors Affecting Medical Condition

Stress-Related Physiological Response Affecting Medical Condition

Other or Unspecified Psychological Factors Affecting Medical Condition

**MEDICATION-INDUCED MOVEMENT DISORDERS** (678)

332.1 Neuroleptic-Induced Parkinsonism (679)

333.92 Neuroleptic Malignant Syndrome (679)

333.7 Neuroleptic-Induced Acute Dystonia (679)

333.99 Neuroleptic-Induced Acute

**ADDffiONAL CONDITIONS TIIAT MAY BE A FOCUS OF CLINICAL ATTENTION** (683)

V15.81 Noncompliance With

Treatment (683)

V65.2 Malingering (683)

V71.01 Adult Antisocial Behavior (683) V71.02 Child or Adolescent Antisocial

Behavior (684)

Akathisia (679)

333.82 Neuroleptic-Induced Tardive Dyskinesia (679)

333.1 Medication-Induced Postural Tremor (680)

333.90 Medication-Induced Movement Disorder NOS (680)

**OTHER MEDICATION-INDUCED DISORDER**

995.2 Adverse Effects of Medication

NOS (680)

V62.89

780.9

V62.82 V62.3 V62.2 313.82 V62.89 V62.4 V62.89

Borderline Intellectual Functioning (684)

***Note:*** *7bis is coded on Axis II.*

Age-Related Cognitive Decline (684) Bereavement (684)

Academic Problem (685)

Occupational Problem (685)

Identity Problem (685)

Religious or Spiritual Problem (685) Acculturation Problem (685) Phase of Life Problem (685)

**RELATIONAL PROBLEMS** (680)

**Additional Codes**

|  |  |  |  |
| --- | --- | --- | --- |
| V61.9 | Relational Problem Related to  a Mental Disorder or General | 300.9 | Unspecified Mental Disorder |
|  | Medical Condition (681) |  | (nonpsychotic) (687) |
| V61.20 | Parent-Child Relational | V71.09 | No Diagnosis or Condition on |
|  | Problem (681) |  | Axis I (687) |
| V61.1 | Partner Relational Problem (681) | 799.9 | Diagnosis or Condition Deferred |
| V61.8 | Sibling Relational Problem (681) |  | on Axis I (687) |
| V62.81 | Relational Problem NOS (681) | V71.09 | No Diagnosis on Axis II (687) |
|  |  | 799.9 | Diagnosis Deferred on Axis II (687) |

**PROBLEMS REIATED TO ABUSE OR NEGLECT** (682)

V61.21 Physical Abuse of Child (682) *(code 995.5 if focus of attention is on victim)*

V61.21 Sexual Abuse of Child (682) *(code 995.5 if focus of attention is on victim)*

V61.21 Neglect of Child (682)

*(code 995.5 if focus of attention is on victim)*

V61.l Physical Abuse of Adult (682) *(code 995.81 if focus of attention is on victim)*

V61.1 Sexual Abuse of Adult (682) *(code 995 .81 if focus of attention is on victim)*

**Multiaxial System**

Axis I Clinical Disorders

Other Conditions That May Be a Focus of Clinical Attention

Axis II Personality Disorders Mental Retardation

Axis III General Medical Conditions Axis IV Psychosocial and Environmental

Problems

Axis V Global Assessment of Functioning

## [Multiaxial Assessment](#_bookmark0)

multiaxial system involves an assessment on several axes, each of which refers to a different domain of information that may help the clinician plan treatment and

A

predict outcome. There are five axes included in the DSM-IV multiaxial classification:

Axis I Clinical Disorders

Other Conditions That May Be a Focus of Clinical Attention Axis II Personality Disorders

Mental Retardation

Axis III General Medical Conditions

Axis IV Psychosocial and Environmental Problems Axis V Global Assessment of Functioning

The use of the multiaxial system facilitates comprehensive and systematic evaluation with attention to the various mental disorders and general medical conditions, psycho­ social and environmental problems, and level of functioning that might be overlooked if the focus were on assessing a single presenting problem. A multiaxial system provides a convenient format for organizing and communicating clinical information, for capturing the complexity of clinical situations, and for describing the heterogeneity of individuals presenting with the same diagnosis. In addition, the multiaxial system promotes the application of the biopsychosocial model in clinical, educational, and research settings. The rest of this section provides a description of each of the DSM-IV axes. In some settings or situations, clinicians may prefer not to use the multiaxial system. For this reason, guidelines for reporting the results of a DSM-IV assessment without applying

the formal multiaxial system are provided at the end of this section.

***Axis L· Clinical Disorders***

***Other Conditions That May Be a Focus of Clinical Attention***

Axis I is for reporting all the various disorders or conditions in the Classification except for the Personality Disorders and Mental Retardation (which are reported on Axis II). The major groups of disorders to be reported on Axis I are listed in the box below. Also reported on Axis I are Other Conditions That May Be a Focus of Clinical Attention.

When an individual has more than one Axis I disorder, all of these should be reported (for examples, see p. 33). If more than one Axis I disorder is present, the principal diagnosis or the reason for visit (see p. 3) should be indicated by listing it first. When

**25**

an individual has both an Axis I and an Axis II disorder, the principal diagnosis or the reason for visit will be assumed to be on Axis I unless the Axis II diagnosis is followed by the qualifying phrase "(Principal Diagnosis)" or "(Reason for Visit)." If no Axis I disorder is present, this should be coded as V71.09. If an Axis I diagnosis is deferred, pending the gathering of additional information, this should be coded as 799.9.

* **Axisl** ■

**Clinical Disorders**

**Other Conditions That May Be a Focus of Clinical Attention**

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

*(excluding Mental Retardation, which is diagnosed on Axis II)* Delirium, Dementia, and Amnestic and Other Cognitive Disorders Mental Disorders Due to a General Medical Condition

Substance-Related Disorders

Schizophrenia and Other Psychotic Disorders Mood Disorders

Anxiety Disorders Somatoform Disorders Factitious Disorders Dissociative Disorders

Sexual and Gender Identity Disorders Eating Disorders

Sleep Disorders

Impulse-Control Disorders Not Elsewhere Classified Adjustment Disorders

Other Conditions That May Be a Focus of Clinical Attention

***Axis II: Personality Disorders Mental Retardation***

Axis II is for reporting Personality Disorders and Mental Retardation. It may also be used for noting prominent maladaptive personality features and defense mechanisms. The listing of Personality Disorders and Mental Retardation on a separate axis ensures that consideration will be given to the possible presence of Personality Disorders and Mental Retardation that might otherwise be overlooked when attention is directed to the usually more florid Axis I disorders. The coding of Personality Disorders on Axis II should not be taken to imply that their pathogenesis or range of appropriate treatment is funda­ mentally different from that for the disorders coded on Axis I. The disorders to be reported on Axis II are listed in the box below.

In the common situation in which an individual has more than one Axis II diagnosis, all should be reported (for examples, seep. 33). When an individual has both an Axis I and an Axis II diagnosis and the Axis II diagnosis is the principal diagnosis or the reason for visit, this should be indicated by adding the qualifying phrase "(Principal Diagnosis)"

or "(Reason for Visit)" after the Axis II diagnosis. If no Axis II disorder is present, this should be coded as V71.09. If an Axis II diagnosis is deferred, pending the gathering of additional information, this should be coded as 799.9.

Axis II may also be used to indicate prominent maladaptive personality features that do not meet the threshold for a Personality Disorder (in such instances, no code number should be used-see Example 3 on p. 33). The habitual use of maladaptive defense mechanisms may also be indicated on Axis II (see Appendix B, p. 751, for definitions and Example 1 on p. 33).

* Axis II ■

**Personality Disorders Mental Retardation**

Paranoid Personality Disorder Schizoid Personality Disorder Schizotypal Personality Disorder Antisocial Personality Disorder Borderline Personality Disorder Histrionic Personality Disorder Narcissistic Personality Disorder Avoidant Personality Disorder

Dependent Personality Disorder Obsessive-Compulsive Personality

Disorder

Personality Disorder Not Otherwise Specified

Mental Retardation

***Axis /IL· General Medical Conditions***

Axis III is for reporting current general medical conditions that are potentially relevant to the understanding or management of the individual's mental disorder. These conditions are classified outside the "Mental Disorders" chapter ofICD-9-CM (and outside Chapter V of ICD-10). A listing of the broad categories of general medical conditions is given in the box below. (For a more detailed listing including the specific ICD-9-CM codes, refer to Appendix G.)

As discussed in the "Introduction," the multiaxial distinction among Axis I, II, and III disorders does not imply that there are fundamental differences in their conceptual­ ization, that mental disorders are unrelated to physical or biological factors or processes, or that general medical conditions are unrelated to behavioral or psychosocial factors or processes. The purpose of distinguishing general medical conditions is to encourage thoroughness in evaluation and to enhance communication among health care providers. General medical conditions can be related to mental disorders in a variety of ways.

In some cases it is dear that the general medical condition is directly etiological to the development or worsening of mental symptoms and that the mechanism for this effect is physiological. When a mental disorder is judged to be a direct physiological consequence of the general medical condition, a Mental Disorder Due to a General Medical Condition should be diagnosed on Axis I and the general medical condition should be recorded on both Axis I and Axis III. For example, when hypothyroidism is a direct cause of depressive symptoms, the designation on Axis I is 293.83 Mood Disorder Due to Hypothyroidism, With Depressive Features, and the hypothyroidism is listed

again and coded on Axis III as 244.9 (see Example 3, p. 33). For a further discussion, seep. 165.

In those instances in which the etiological relationship between the general medical condition and the mental symptoms is insufficiently clear to warrant an Axis I diagnosis of Mental Disorder Due to a General Medical Condition, the appropriate mental disorder (e.g., Major Depressive Disorder) should be listed and coded on Axis I; the general medical condition should only be coded on Axis III.

There are other situations in which general medical conditions are recorded on Axis III because of their importance to the overall understanding or treatment of the individual with the mental disorder. An Axis I disorder may be a psychological reaction to an Axis Ill general medical condition (e.g., the development of 309.0 Adjustment Disorder With Depressed Mood as a reaction to the diagnosis of carcinoma of the breast). Some general medical conditions may not he directly related to the mental disorder but nonetheless have important prognostic or treatment implications (e.g., when the diagnosis on Axis I is 296.2 Major Depressive Disorder and on Axis Ill is 427.9 arrhythmia, the choice of pharmacotherapy is influenced by the general medical condition; or when a person with diabetes mellitus is admitted to the hospital for an exacerbation of Schizophrenia and insulin management must be monitored).

When an individual has more than one clinically relevant Axis III diagnosis, all should be reported. For examples, see p. 33. If no Axis III disorder is present, this should be indicated by the notation "Axis Ill: None." If an Axis III diagnosis is deferred, pending the gathering of additional information, this should be indicated by the notation "Axis III: Deferred."

* Axis III ■

**General Medical Conditions (with ICD-9-CM codes)**

Infectious and Parasitic Diseases (001-139) Neoplasms (140-239)

Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279)

Diseases of the Blood and Blood-Forming Organs (280-289) Diseases of the Nervous System and Sense Organs (320-389) Diseases of the Circulatory System (390-459)

Diseases of the Respiratory System (460-519) Diseases of the Digestive System (520-579) Diseases of the Genitourinary System (580-629)

Complications of Pregnancy, Childbirth, and the Puerperium (630-676) Diseases of the Skin and Subcutaneous Tissue (680-709)

Diseases of the Musculoskeletal System and Connective Tissue (710-739) Congenital Anomalies (740-759)

Certain Conditions Originating in the Perinatal Period (760-779) Symptoms, Signs, and Ill-Defined Conditions (780-799)

Injury and Poisoning (800-999)

***Axis IV: Psychosocial and Environmental Problems***

Axis IV is for reporting psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of mental disorders (Axes I and II). A psychosocial or environmental problem may be a negative life event, an environmental difficulty or deficiency, a familial or other interpersonal stress, an inadequacy of social support or personal resources, or other problem relating to the context in which a person's difficulties have developed. So-called positive stressors, such as job promotion, should be listed only if they constitute or lead to a problem, as when a person has difficulty adapting to the new situation. In addition to playing a role in the initiation or exacerbation of a mental disorder, psychosocial problems may also develop as a consequence of a person's psychopathology or may constitute problems that should be considered in the overall management plan.

When an individual has multiple psychosocial or environmental problems, the clinician may note as many as are judged to be relevant. In general, the clinician should note only those psychosocial and environmental problems that have been present during the year preceding the current evaluation. However, the clinician may choose to note psychosocial and environmental problems occurring prior to the previous year if these clearly contribute to the mental disorder or have become a focus of treatment-for example, previous combat experiences leading to Posttraumatic Stress Disorder.

In practice, most psychosocial and environmental problems will be indicated on Axis IV. However, when a psychosocial or environmental problem is the primary focus of clinical attention, it should also be recorded on Axis I, with a code derived from the section on Other Conditions That May Be a Focus of Clinical Attention (see p. 675).

For convenience, the problems are grouped together in the following categories:

* **Problems with primary support group-e.g.,** death of a family member; health problems in family; disruption of family by separation, divorce, or estrangement; removal from the home; remarriage of parent; sexual or physical abuse; parental overprotection; neglect of child; inadequate discipline; discord with siblings; birth of a sibling
* **Problems related to the social environment-e.g.,** death or loss of friend; inadequate social support; living alone; difficulty with acculturation; discrimina­ tion; adjustment to life-cycle transition (such as retirement)
* **Educational problems-e.g.,** illiteracy; academic problems; discord with teach­ ers or classmates; inadequate school environment
* **Occupational problems-e.g.,** unemployment; threat of job loss; stressful work schedule; difficult work conditions; job dissatisfaction; job change; discord with boss or co-workers
* **Housingproblems-e.g.,** homelessness; inadequate housing; unsafe neighbor­ hood; discord with neighbors or landlord
* **Economic problems-e.g.,** extreme poverty; inadequate finances; insufficient welfare support
* **Problems with access to health care services-e.g.,** inadequate health care services; transportation to health care facilities unavailable; inadequate health insurance
* **Problems related to interaction with the legal system/crime-e.g.,** arrest; incarceration; litigation; victim of crime
* **Other psychosocial and environmental problems-e.g.,** exposure to disas­ ters, war, other hostilities; discord with nonfamily caregivers such as counselor, social worker, or physician; unavailability of social service agencies

When using the Multiaxial Evaluation Report Form (see p. 34), the clinician should identify the relevant categories of psychosocial and environmental problems and indicate the specific factors involved. If a recording form with a checklist of problem categories is not used, the clinician may simply list the specific problems on Axis IV. (See examples on p. 33.)

* **AxisN** ■

**Psychosocial and Environmental Problems**

Problems with primary support group Problems related to the social environment Educational problems

Occupational problems Housing problems Economic problems

Problems with access to health care services

Problems related to interaction with the legal system/crime Other psychosocial and environmental problems

***Axis V.· Global Assessment of Functioning***

Axis V is for reporting the clinician's judgment of the individual's overall level of functioning. This information is useful in planning treatment and measuring its impact, and in predicting outcome.

The reporting of overall functioning on Axis V can be done using the Global Assessment of Functioning (GAF) Scale. The GAF Scale may be particularly useful in tracking the clinical progress of individuals in global terms, using a single measure. The GAF Scale is to be rated with respect only to psychological, social, and occupational functioning. The instructions specify, "Do not include impairment in functioning due to physical (or environmental) limitations." In most instances, ratings on the GAF Scale should be for the current period (i.e., the level of functioning at the time of the evaluation) because ratings of current functioning will generally reflect the need for treatment or care. In some settings, it may be useful to note the GAF Scale rating both at time of admission and at time of discharge. The GAF Scale may also be rated for other time periods (e.g., the highest level of functioning for at least a few months during the past year). The GAF Scale is reported on Axis V as follows: "GAF = ," followed by the GAF rating from 1 to 100, followed by the time period reflected in the rating in parentheses­ for example, "(current)," "(highest level in past year)," "(at discharge)." See examples on p. 33.

In some settings, it may be useful to assess social and occupational disability and

to track progress in rehabilitation independent of the severity of the psychological symptoms. For this purpose, a proposed Social and Occupational Functioning Assess­ ment Scale (SOFAS) (see p. 760) is included in Appendix B. Two additional proposed scales-Global Assessment of Relational Functioning (GARF) Scale (see p. 758) and Defensive Functioning Scale (seep. 751)-that may be useful in some settings are also included in Appendix B.

**Global Assessment of Functioning (GAF) Scale**

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

**Code**

100

I

91

90

I

81

80

I

71

70

I

61

60

I

51

so

I

41

40

I

31

30

I

21

20

I

11

10

I

1

0

**(Note:** Use intennediate codes when appropriate, e.g., 45, 68, 72.)

**Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.**

**Absentorminimalsymptoms(e.g.,** mild anxiety before an exam), **goodfunctioninginallareas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g., an occasional argument with family members).

***H* symptoms are present, they are transient and expectable reactions to psychosocial stressors** (e.g., difficulty concentrating after family argument); **no more than slight hnpairment in social, occupational, or school functioning** (e.g., temporarily falling behind in schoolwork).

**Some mild symptoms** (e.g., depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (e.g., occasional truancy, or theft within the household), **but generally functioning pretty well, has some meaningful interpersonal relationships.**

**Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks) **OR moderate difficulty in social, occupational, or school functioning** (e.g., few friends, conflicts with peers or co-workers).

**Serious symptoms** (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious hnpairment in social, occupational, or school functioning** (e.g., no friends, unable to keep a job).

**Some hnpairment in reality testing or communication** (e.g., speech is at times illogical, obscure, or irrelevant) **OR major impairment in several areas, suchas work or school, family relations, judgment, thinking, or mood** (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

**Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment** (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (e.g., stays in bed all day; no job, home, or friends).

**Some danger of hurting self or others** (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) **OR occasionally fails to maintain minimal personal hygiene** (e.g., smears feces) **OR gross hnpairment in communication** (e.g., largely incoherent or mute).

**Persistent danger of severely hurting self or others** (e.g., recurrent violence) **OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expecta­ tion of death.**

Inadequate information.

The rating of overall psychological functioning on a scale of 0-100 was operationalized by Luborsky in the Health-Sickness Rating Scale (Luborsky L: "Clinicians' Judgments of Mental Health." *Archives of General*

*Psychiatry* 7:407-417, 1962). Spitzer and colleagues developed a revision of the Health-Sickness Rating Scale called the Global Assessment Scale (GAS) (Endicott J, Spitzer RL, Pleiss JL, Cohen J: "The Global Assessment Scale: A Procedure for Measuring Overall Severity of Psychiatric Disturbance." *Archives of*

*General Psychiatry* 33:766--771, 1976). A modified version of the GAS was included in DSM-IIJ-R as the Global Assessment of Functioning (GAF) Scale.

**Examples of How to Record Results of a DSM.-IV Multiaxial Evaluation**

*Example 1:*

Axis I 296.23

Major Depressive Disorder, Single Episode, Severe Without Psychotic Features

|  |  |  |
| --- | --- | --- |
|  | 305.00 | Alcohol Abuse |
| Axis II | 301.6 | Dependent Personality Disorder |
|  |  | Frequent use of denial |
| Axis III |  | None |
| Axis IV |  | Threat of job loss |
| Axis V | GAF = 35 | (current) |
| *Example 2:* | | |
| Axis I | 300.4 | Dysthymic Disorder |
|  | 315.00 | Reading Disorder |
| Axis II | V71.09 | No diagnosis |
| Axis III | 382.9 | Otitis media, recurrent |
| Axis IV |  | Victim of child neglect |
| Axis V | GAF = 53 | (current) |
| *Example 3:* | | |
| Axis I | 293.83 | Mood Disorder Due to Hypothyroidism, With Depressive Features |
| Axis II | V71.09 | No diagnosis, histrionic personality features |
| Axis III | 244.9 | Hypothyroidism |
|  | 365.23 | Chronic angle-closure glaucoma |
| Axis IV |  | None |
| Axis V | GAF= 45 | (on admission) |
|  | GAF = 65 | (at discharge) |
| *Example 4:* | | |
| Axis I | V61.l | Partner Relational Problem |
| Axis II | V71.09 | No diagnosis |
| Axis III |  | None |
| Axis IV |  | Unemployment |
| Axis V | GAF = 83 | (highest level past year) |

**Multiaxial Evaluation Report Form**

The following form is offered as one possibility for reporting multiaxial evaluations. In some settings, this form may be used exactly as is; in other settings, the form may be adapted to satisfy special needs.

***AXIS L· Clinical Disorders***

***Other Conditions That May Be a Focus of Clinical Attention***

Diagnostic code DSM-IV name

*AXIS II:* ***Personality Disorders Mental Retardation***

Diagnostic code DSM-IV name

***AXIS IIL· General Medical Conditions***

ICD-9-CM code ICD-9-CM name

***AXIS /Vi Psychosocial and Environmental Problems***

*Check:*

D **Problems with primary support group** *Specify:* \_

D**Problems related to the social environment** *Specify:* ---------

D**Educational problems** *Specify:*

D**Occupational problems** *Specify: \_*

D**Housing problems** *Specify:* \_

D**Economic problems** *Specify:*

D**Problems with access to health care services** *Specify:* \_

□ **Problems related to interaction with the legal system/crime** *Specify:* \_

D **Other psychosocial and environmental problems** *Specify:* \_

***AXIS V.· Global Assessment of Functioning Scale Score:***

***Time frame:***

**Nonaxial Format**

Clinicians who do not wish to use the multiaxial format may simply list the appropriate diagnoses. Those choosing this option should follow the general rule of recording as many coexisting mental disorders, general medical conditions, and other factors as are relevant to the care and treatment of the individual. The Principal Diagnosis or the Reason for Visit should be listed first.

The examples below illustrate the reporting of diagnoses in a format that does not use the multiaxial system.

*Example 1:*

296.23 Major Depressive Disorder, Single Episode, Severe Without Psychotic Features

305.00 Alcohol Abuse

301.6 Dependent Personality Disorder Frequent use of denial

|  |  |
| --- | --- |
| *Example 2:* | |
| 300.4 | Dysthymic Disorder |
| 315.00 | Reading Disorder |
| 382.9 | Otitis media, recurrent |
| *Example 3:* | |
| 293.83 | Mood Disorder Due to Hypothyroidism, With Depressive Features |
| 244.9 | Hypothyroidism |
| 365.23 | Chronic angle-closure glaucoma  Histrionic personality features |

*Example 4:*

V61.1 Partner Relational Problem



**[Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence](#_bookmark0)**

he provision of a separate section for disorders that are usually first diagnosed in infancy, childhood, or adolescence is for convenience only and is not meant to suggest that there is any clear distinction between "childhood" and "adult" disorders. Although most individuals with these disorders present for clinical attention during childhood or adolescence, the disorders sometimes are not diagnosed until adulthood. Moreover, many disorders included in other sections of the manual often have an onset during childhood or adolescence. In evaluating an infant, child, or adolescent, the clinician should consider the diagnoses included in this section but also should refer to the disorders described elsewhere in this manual. Adults may also be diagnosed with disorders included in this section for Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence if their clinical presentation meets relevant diagnostic criteria (e.g., Stuttering, Pica). Moreover, if an adult had symptoms as a child that met full criteria for a disorder, but now presents with an attenuated or residual form, the In Partial Remission specifier may be indicated (e.g., Attention-Deficit/Hyperactivity Disorder, Combined Type, In Partial Remission). For most (but not all) DSM-IV disorders, a single criteria set is provided that applies to children, adolescents, and adults (e.g., if a child or adolescent has symptoms that meet the criteria for Major Depressive Disorder, this diagnosis should be given, regardless of the individual's age). The variations in the presentation of a disorder that are attributable to an individual's developmental stage are described in a section in the text titled "Specific Culture, Age, and Gender Features."

T

Specific issues related to the diagnosis of Personality Disorders in children or adolescents are discussed on p. 631.

The following disorders are included in this section:

**Mental Retardation.** This disorder is characterized by significantly subaverage intel­ lectual functioning (an IQ of approximately 70 or below) with onset before age 18 years and concurrent deficits or impairments in adaptive functioning. Separate codes are provided for **Mild, Moderate, Severe,** and **Profound Mental Retardation** and for **Mental Retardation, Severity Unspecified.**

**37**

**Learning Disorders.** These disorders are characterized by academic functioning that is substantially below that expected given the person's chronological age, measured intelligence, and age-appropriate education. The specific disorders included in this section are **Reading Disorder, Mathematics Disorder, Disorder of Written Expres­ sion,** and **Learning Disorder Not Otherwise Specified.**

**Motor Skills Disorder.** This includes **Developmental Coordination Disorder,** which is characterized by motor coordination that is substantially below that expected given the person's chronological age and measured intelligence.

**Communication Disorders.** These disorders are characterized by difficulties in speech or language and include **Expressive Language Disorder, Mixed Receptive­ Expressive Language Disorder, Phonological Disorder, Stuttering,** and **Commu­ nication Disorder Not Otherwise Specified.**

**Pervasive Developmental Disorders.** These disorders are characterized by severe deficits and pervasive impairment in multiple areas of development. These include impairment in reciprocal social interaction, impairment in communication, and the presence of stereotyped behavior, interests, and activities. The specific disorders included in this section are **Autistic Disorder, Rett's Disorder, Childhood Disinte­ grative Disorder, Asperger's Disorder,** and **Pervasive Developmental Disorder Not Otherwise Specified.**

**Attention-Deficit and Disruptive Behavior Disorders.** This section includes **At­ tention-Deficit/Hyperactivity Disorder,** which is characterized by prominent symp­ toms of inattention and/or hyperactivity-impulsivity. Subtypes are provided for specifying the predominant symptom presentation: **Predominantly Inattentive Type, Predominantly Hyperactive-Impulsive Type,** and **Combined Type.** Also included in this section are the Disruptive Behavior Disorders: **Conduct Disorder** is characterized by a pattern of behavior that violates the basic rights of others or major age-appropriate societal norms or rules; **Oppositional Defiant Disorder** is characterized by a pattern of negativistic, hostile, and defiant behavior. This section also includes two Not Otherwise Specified categories: **Attention-Deficit/Hyperactivity Disorder Not Oth­ erwise Specified** and **Disruptive Behavior Disorder Not Otherwise Specified.**

**Feeding and Eating Disorders of Infancy or Early Childhood.** These disorders are characterized by persistent disturbances in feeding and eating. The specific disorders included are **Pica, Rumination Disorder,** and **Feeding Disorder oflnfancy or Early Childhood.** Note that Anorexia Nervosa and Bulimia Nervosa are included in the "Eating Disorders" section presented later in the manual (seep. 539).

**Tic Disorders.** These disorders are characterized by vocal and/or motor tics. The specific disorders included are **Tourette's Disorder, Chronic Motor or Vocal Tic Disorder, Transient Tic Disorder,** and **Tic Disorder Not Otherwise Specified.**

**Elimination Disorders.** This grouping includes **Encopresis,** the repeated passage of feces into inappropriate places, and **Enuresis,** the repeated voiding of urine into inappropriate places.

**Other Disorders of Infancy, Childhood, or Adolescence.** This grouping is for disorders that are not covered in the sections listed above. **Separation Anxiety Disorder** is characterized by developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the child is attached. **Selective Mutism** is characterized by a consistent failure to speak in specific social situations despite speaking in other situations. **Reactive Attachment Disorder of Infancy or Early Childhood** is characterized by markedly disturbed and developmentally inap­ propriate social relatedness that occurs in most contexts and is associated with grossly pathogenic care. **Stereotypic Movement Disorder** is characterized by repetitive, seemingly driven, and nonfunctional motor behavior that markedly interferes with normal activities and at times may result in bodily injury. **Disorder of Infancy, Childhood, or Adolescence Not Otherwise Specified** is a residual category for coding disorders with onset in infancy, childhood, or adolescence that do not meet criteria for any specific disorder in the Classification.

Children or adolescents may present with problems requiring clinical attention that are not defined as mental disorders (e.g., Relational Problems, Problems Related to Abuse or Neglect, Bereavement, Borderline Intellectual Functioning, Academic Problem, Child or Adolescent Antisocial Behavior, Identity Problem). These are listed at the end of the manual in the section "Other Conditions That May Be a Focus of Clinical Attention" (see p. 675).

DSM-lll-R included two anxiety disorders specific to children and adolescents, Overanxious Disorder of Childhood and Avoidant Disorder of Childhood, that have been subsumed under Generalized Anxiety Disorder and Social Phobia, respectively, because of similarities in essential features.

**Mental Retardation**

***Di-agnostic Features***

The essential feature of Mental Retardation is significantly subaverage general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety (Criterion B). The onset must occur before age 18 years (Criterion C). Mental Retardation has many different etiologies and may be seen as a final common pathway of various pathological processes that affect the functioning of the central nervous system.

*General intellectual functioning* is defined by the intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individ­ ually administered intelligence tests (e.g., Wechsler Intelligence Scales for Children­ Revised, Stanford-Binet, Kaufman Assessment Battery for Children). Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below (approxi­ mately 2 standard deviations below the mean). It should be noted that there is a measurement error of approximately 5 points in assessing IQ, although this may vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75). Thus, it is possible to diagnose Mental Retardation in individuals with

IQs between 70 and 75 who exhibit significant deficits in adaptive behavior. Conversely, Mental Retardation would not be diagnosed in an individual with an IQ lower than 70 if there are no significant deficits or impairments in adaptive functioning. The choice of testing instruments and interpretation of results should take into account factors that may limit test performance (e.g., the individual's sociocultural background, native language, and associated communicative, motor, and sensory handicaps). When there is significant scatter in the subtest scores, the profile of strengths and weaknesses, rather than the mathematically derived full-scale IQ, will more accurately reflect the person's learning abilities. When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading.

Impairments in adaptive functioning, rather than a low IQ, are usually the presenting symptoms in individuals with Mental Retardation. *Adaptive functioning* refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting. Adaptive functioning may be influ­ enced by various factors, including education, motivation, personality characteristics, social and vocational opportunities, and the mental disorders and general medical conditions that may coexist with Mental Retardation. Problems in adaptation are more likely to improve with remedial efforts than is the cognitive IQ, which tends to remain a more stable attribute.

It is useful to gather evidence for deficits in adaptive functioning from one or more

reliable independent sources (e.g., teacher evaluation and educational, developmental, and medical history). Several scales have also been designed to measure adaptive functioning or behavior (e.g., the Vineland Adaptive Behavior Scales and the American Association on Mental Retardation Adaptive Behavior Scale). These scales generally provide a clinical cutoff score that is a composite of performance in a number of adaptive skill domains. It should be noted that scores for certain individual domains are not included in some of these instruments and that individual domain scores may vary considerably in reliability. As in the assessment of intellectual functioning, consideration should be given to the suitability of the instrument to the person's sociocultural background, education, associated handicaps, motivation, and cooperation. For instance, the presence of significant handicaps invalidates many adaptive scale norms. In addition, behaviors that would normally be considered maladaptive (e.g., dependency, passivity) may be evidence of good adaptation in the context of a particular individual's life (e.g., in some institutional settings).

***Degrees of Severity of Mental Retardation***

Four degrees of severity can be specified, reflecting the level of intellectual impairment: Mild, Moderate, Severe, and Profound.

**317 Mild Mental Retardation:**

* 1. **Moderate Retardation:**
  2. **Severe Mental Retardation:**
  3. **Profound Mental Retardation:**

IQ level 50-55 to approximately 70

IQ level 35-40 to 50-55

IQ level 20-25 to 35-40

IQ level below 20 or 25

**319 Mental Retardation, Severity Unspecified,** can be used when there is a strong presumption of Mental Retardation but the person's intelligence is untestable by standard tests (e.g., with individuals too impaired or uncooperative, or with infants).

**3I 7 Mild Mental Retardation**

Mild Mental Retardation is roughly equivalent to what used to be referred to as the educational category of "educable." This group constitutes the largest segment (about 85%) of those with the disorder. As a group, people with this level of Mental Retardation typically develop social and communication skills during the preschool years (ages 0-5 years), have minimal impairment in sensorimotor areas, and often are not distin­ guishable from children without Mental Retardation until a later age. By their late teens, they can acquire academic skills up to approximately the sixth-grade level. During their adult years, they usually achieve social and vocational skills adequate for minimum self-support, but may need supervision, guidance, and assistance, especially when under unusual social or economic stress. With appropriate supports, individuals with Mild Mental Retardation can usually live successfully in the community, either independently or in supervised settings.

**3 I 8.0 Moderate Mental Retardation**

Moderate Mental Retardation is roughly equivalent to what used to be referred to as the educational category of "trainable." This outdated term should not be used because it wrongly implies that people with Moderate Mental Retardation cannot benefit from educational programs. This group constitutes about 10% of the entire population of people with Mental Retardation. Most of the individuals with this level of Mental Retardation acquire communication skills during early childhood years. They profit from vocational training and, with moderate supervision, can attend to their personal care. They can also benefit from training in social and occupational skills but are unlikely to progress beyond the second-grade level in academic subjects. They may learn to travel independently in familiar places. During adolescence, their difficulties in recognizing social conventions may interfere with peer relationships. In their adult years, the majority are able to perform unskilled or semiskilled work under supervision in sheltered workshops or in the general work force. They adapt well to life in the community, usually in supervised settings.

**3 I 8. I Severe Mental Retardation**

The group with Severe Mental Retardation constitutes 3%-4% of individuals with Mental Retardation. During the early childhood years, they acquire little or no communicative speech. During the school-age period, they may learn to talk and can be trained in elementary self-care skills. They profit to only a limited extent from instruction in pre-academic subjects, such as familiarity with the alphabet and simple counting, but can master skills such as learning sight reading of some "survival" words. In their adult years, they may be able to perform simple tasks in closely supervised settings. Most adapt well to life in the community, in group homes or with their families, unless they have an associated handicap that requires specialized nursing or other care.

**3 I 8.2 Profound Mental Retardation**

The group with Profound Mental Retardation constitutes approximately 1%-2% of people with Mental Retardation. Most individuals with this diagnosis have an identified

neurological condition that accounts for their Mental Retardation. During the early childhood years, they display considerable impairments in sensorimotor functioning. Optimal development may occur in a highly structured environment with constant aid and supervision and an individualized relationship with a caregiver. Motor development and self-care and communication skills may improve if appropriate training is provided. Some can perform simple tasks in closely supervised and sheltered settings.

**319 Mental Retardation, Severity Unspecified**

The diagnosis of Mental Retardation, Severity Unspecified, should be used when there is a strong presumption of Mental Retardation but the person cannot be successfully tested by standard intelligence tests. This may be the case when children, adolescents, or adults are too impaired or uncooperative to be tested or, with infants, when there is a clinical judgment of significantly subaverage intellectual functioning, but the available tests (e.g., the Bayley Scales of Infant Development, Cattell Infant Intelligence Scales, and others) do not yield IQ values. In general, the younger the age, the more difficult it is to assess for the presence of Mental Retardation except in those with profound impairment.

***Recording Procedures***

The specific diagnostic code for Mental Retardation is selected based on the level of severity as indicated above and is coded on Axis II. If Mental Retardation is associated with another mental disorder (e.g., Autistic Disorder), the additional mental disorder is coded on Axis I. If Mental Retardation is associated with a general medical condition (e.g., Down's syndrome), the general medical condition is coded on Axis III.

***Associated Features and D/,Sorders***

**Associated descriptive features and mental disorders.** No specific personality and behavioral features are uniquely associated with Mental Retardation. Some individ­ uals with Mental Retardation are passive, placid, and dependent, whereas others can be aggressive and impulsive. Lack of communication skills may predispose to disruptive and aggressive behaviors that substitute for communicative language. Some general medical conditions associated with Mental Retardation are characterized by certain behavioral symptoms (e.g., the intractable self-injurious behavior associated with Lesch-Nyhan syndrome). Individuals with Mental Retardation may be vulnerable to exploitation by others (e.g., being physically and sexually abused) or being denied rights and opportunities.

Individuals with Mental Retardation have a prevalence of comorbid mental disorders that is estimated to be three to four times greater than in the general population. In some cases, this may result from a shared etiology that is common to Mental Retardation and the associated mental disorder (e.g., head trauma may result in Mental Retardation and in Personality Change Due to Head Trauma). All types of mental disorders may be seen, and there is no evidence that the nature of a given mental disorder is different in individuals who have Mental Retardation. The diagnosis of comorbid mental disorders is, however, often complicated by the fact that the clinical presentation may be modified

by the severity of the Mental Retardation and associated handicaps. Deficits in commu­ nication skills may result in an inability to provide an adequate history (e.g., the diagnosis of Major Depressive Disorder in a nonverbal adult with Mental Retardation is often based primarily on manifestations such as depressed mood, irritability, anorexia, or insomnia that are observed by others). More often than is the case in individuals without Mental Retardation, it may be difficult to choose a specific diagnosis and in such cases the appropriate Not Otherwise Specified category can be used (e.g., Depressive Disorder Not Otherwise Specified). The most common associated mental disorders are Attention­ Deficit/Hyperactivity Disorder, Mood Disorders, Pervasive Developmental Disorders, Stereotypic Movement Disorder, and Mental Disorders Due to a General Medical Condition (e.g., Dementia Due to Head Trauma). Individuals who have Mental Retar­ dation due to Down's syndrome may be at higher risk for developing Dementia of the Alzheimer's Type. Pathological changes in the brain associated with this disorder usually develop by the time these individuals are in their early 40s, although the clinical symptoms of dementia are not evident until later.

**Predisposing factors.** Etiological factors may be primarily biological or primarily psychosocial, or some combination of both. In approximately 30%---40% of individuals seen in clinical settings, no clear etiology for the Mental Retardation can be determined despite extensive evaluation efforts. The major predisposing factors include:

*Heredity* (approximately 5%): These factors include inborn errors of metabolism inherited mostly through autosomal recessive mechanisms (e.g., Tay-Sachs disease), other single-gene abnormalities with Mendelian inheritance and variable expression (e.g., tuberous sclerosis), and chromosomal aberrations (e.g., translocation Down's syndrome, fragile X syndrome).

*Early alterations of embryonic development* (approximately 30%): These factors include chromosomal changes (e.g., Down's syndrome due to trisomy 21) or prenatal damage due to toxins (e.g., maternal alcohol consumption, infections).

*Pregnancy and perinatal problems* (approximately 10%): These factors include fetal malnutrition, prematurity, hypoxia, viral and other infections, and trauma.

*General medical conditions acquired in infancy or childhood* (approximately 5%): These factors include infections, traumas, and poisoning (e.g., due to lead).

*Environmental influences and other mental disorders* (approximately 15%---20%): These factors include deprivation of nurturance and of social, linguistic, and other stimulation, and severe mental disorders (e.g., Autistic Disorder).

**Associated laboratory findings.** Other than the results of psychological and adap­ tive behavior tests that are necessary for the diagnosis of Mental Retardation, there are no laboratory findings that are uniquely associated with Mental Retardation. Diagnostic laboratory findings may be associated with a specific accompanying general medical condition (e.g., chromosomal findings in various genetic conditions, high blood phenyl­ alanine in phenylketonuria, or abnormalities on central nervous system imaging).

**Associated physical examination findings and general medical conditions.** There are no specific physical features associated with Mental Retardation. When Mental Retardation is part of a specific syndrome, the clinical features of that syndrome will be present (e.g., the physical features of Down's syndrome). The more severe the Mental Retardation (especially if it is severe or profound), the greater the likelihood of neurological (e.g., seizures), neuromuscular, visual, auditory, cardiovascular, and other conditions.

***Specific Culture, Age, and Gender Features***

Care should be taken to ensure that intellectual testing procedures reflect adequate attention to the individual's ethnic or cultural background. This is usually accomplished by using tests in which the individual's relevant characteristics are represented in the standardization sample of the test or by employing an examiner who is familiar with aspects of the individual's ethnic or cultural background. Individualized testing is always required to make the diagnosis of Mental Retardation. The prevalence of Mental Retardation due to known biological factors is similar among children of upper and lower socioeconomic classes, except that certain etiological factors are linked to lower socioeconomic status (e.g., lead poisoning and premature births). In cases in which no specific biological causation can be identified, lower socioeconomic classes are over­ represented and the Mental Retardation is usually milder, although all degrees of severity are represented. Developmental considerations should be taken into account in evalu­ ating impairment in adaptive skills because certain of the skill areas are less relevant at different ages (e.g., use of community resources or employment in school-age children). Mental Retardation is more common among males, with a male-to-female ratio of approximately 1.5:1.

***Prevalence***

The prevalence rate of Mental Retardation has been estimated at approximately 1%. However, different studies have reported different rates depending on definitions used, methods of ascertainment, and population studied.

***Course***

The diagnosis of Mental Retardation requires that the onset of the disorder be before age 18 years. The age and mode of onset depend on the etiology and severity of the Mental Retardation. More severe retardation, especially when associated with a syndrome with a characteristic phenotype, tends to be recognized early (e.g., Down's syndrome is usually diagnosed at birth). In contrast, Mild Retardation of unknown origin is generally noticed later. In more severe retardation resulting from an acquired cause, the intellectual impairment will develop more abruptly (e.g., retardation following an encephalitis). The course of Mental Retardation is influenced by the course of underlying general medical conditions and by environmental factors (e.g., educational and ocher opportunities, environmental stimulation, and appropriateness of management). If an underlying general medical condition is static, the course is more likely to be variable and to depend on environmental factors. Mental Retardation is not necessarily a lifelong disorder. Individuals who had Mild Mental Retardation earlier in their lives manifested by failure in academic learning tasks may, with appropriate training and opportunities, develop good adaptive skills in other domains and may no longer have the level of impairment required for a diagnosis of Mental Retardation.

***Familial Pattern***

Because of its heterogeneous etiology, no familial pattern is applicable to Mental Retardation as a general category. The heritability of Mental Retardation is discussed under "Predisposing Factors" (seep. 43).

***Differential Diagnosis***

The diagnostic criteria for Mental Retardation do not include an exclusion criterion; therefore, the diagnosis should be made whenever the diagnostic criteria are met, regardless of and in addition to the presence of another disorder. In **Learning Disorders** or **Communication Disorders** (unassociated with Mental Retardation), the develop­ ment in a specific area (e.g., reading, expressive language) is impaired but there is no generalized impairment in intellectual development and adaptive functioning. A Learn­ ing Disorder or Communication Disorder can be diagnosed in an individual with Mental Retardation if the specific deficit is out of proportion to the severity of the Mental Retardation. In **Pervasive Developmental Disorders,** there is qualitative impairment in the development of reciprocal social interaction and in the development of verbal and nonverbal social communication skills. Mental Retardation often accompanies Pervasive Developmental Disorders (75%-80% of individuals with a Pervasive Develop­ mental Disorder also have Mental Retardation).

Some cases of Mental Retardation have their onset after a period of normal functioning and may qualify for the additional diagnosis of **dementia.** A diagnosis of dementia requires that the memory impairment and other cognitive deficits represent a significant decline from a previously higher level of functioning. Because it may be difficult to determine the previous level of functioning in very young children, the diagnosis of dementia may not be appropriate until the child is between ages 4 and 6 years. In general, for individuals under age 18 years, the diagnosis of dementia is made only when the condition is not characterized satisfactorily by the diagnosis of Mental Retardation alone.

**Borderline Intellectual Functioning** (see p. 684) describes an IQ range that is higher than that for Mental Retardation (generally 71-84). As discussed earlier, an IQ score may involve a measurement error of approximately 5 points, depending on the testing instrument. Thus, it is possible to diagnose Mental Retardation in individuals with IQ scores between 71 and 75 if they have significant deficits in adaptive behavior that meet the criteria for Mental Retardation. Differentiating Mild Mental Retardation from Borderline Intellectual Functioning requires careful consideration of all available information.

***Relationship to Other Classifications of Mental Retardation***

The classification system of the American Association on Mental Retardation (AAMR) includes the same three criteria (i.e., significantly subaverage intelJectual functioning, limitations in adaptive skills, and onset prior to age 18 years). In the AAMR classification, the criterion of significantly subaverage intellectual functioning refers to a standard score of approximately 70-75 or below (which takes into account the potential measurement error of plus or minus 5 points in IQ testing). Furthermore, DSM-IV specifies levels of severity, whereas the AAMR 1992 classification system specifies "Patterns and Intensity of Supports Needed" (i.e., "Intermittent, Limited, Extensive, and Pervasive"), which are not directly comparable with the degrees of severity in DSM-IV. The definition of developmental disabilities in Public Law 95-602 0978) is not limited to Mental Retardation and is based on functional criteria. This law defines *developmental disability* as a disability attributable to a mental or physical impairment, manifested before age 22 years, likely to continue indefinitely, resulting in substantial limitation in three or more specified areas of functioning, and requiring specific and lifelong or extended care.

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| * **Diagnostic criteria for Mental Retardation**   1. Significantly subaverage intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test (for infants, a clinical judgment of significantly subaverage intellectual functioning).   2. Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his or her age by his or her cultural group) in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.   3. The onset is before age 18 years.   *Code* based on degree of severity reflecting level of intellectual impairment:  **317 Mild Mental Retardation:** IQ level 50-55 to approximately 70   * 1. **Moderate Mental Retardation:** IQ level 35-40 to 50-55   2. **Severe Mental Retardation:** IQ level 20-25 to 35-40   3. **Profound Mental Retardation:** IQ level below 20 or 25   **319 Mental Retardation, Severity Unspecified:** when there is strong presumption of Mental Retardation but the person's intelligence is untestable by standard tests |

**Learning Disorders**

***(formerly* Academic Skills Disorders)**

The section on Learning Disorders includes Reading Disorder, Mathematics Disorder, Disorder of Written Expression, and Learning Disorder Not Otherwise Specified.

***Diagnostic Features***

Learning Disorders are diagnosed when the individual's achievement on individually administered, standardized tests in reading, mathematics, or written expression is substantially below that expected for age, schooling, and level of intelligence. The learning problems significantly interfere with academic achievement or activities of daily living that require reading, mathematical, or writing skills. A variety of statistical approaches can be used to establish that a discrepancy is significant. *Substantially below* is usually defined as a discrepancy of more than 2 standard deviations between achievement and IQ. A smaller discrepancy between achievement and IQ (i.e., between 1 and 2 standard deviations) is sometimes used, especially in cases where an individual's performance on an IQ test may have been compromised by an associated disorder in cognitive processing, a comorbid mental disorder or general medical condition, or the individual's ethnic or cultural background. If a sensory deficit is present, the learning

difficulties must be in excess of those usually associated with the deficit. Learning Disorders may persist into adulthood.

***Associated Features and Di-Sorders***

Demoralization, low self-esteem, and deficits in social skills may be associated with Learning Disorders. The school drop-out rate for children or adolescents with Learning Disorders is reported at nearly 40% (or approximately 1.5 times the average). Adults with Learning Disorders may have significant difficulties in employment or social adjustment. Many individuals (10%-25%) with Conduct Disorder, Oppositional Defiant Disorder, Attention-Deficit/Hyperactivity Disorder, Major Depressive Disorder, or Dys­ thymic Disorder also have Learning Disorders. There is evidence that developmental delays in language may occur in association with Learning Disorders (particularly Reading Disorder), although these delays may not be sufficiently severe to warrant the separate diagnosis of a Communication Disorder. Learning Disorders may also be associated with a higher rate of Developmental Coordination Disorder.

There may be underlying abnormalities in cognitive processing (e.g., deficits in visual perception, linguistic processes, attention, or memory, or a combination of these) that often precede or are associated with Learning Disorders. Standardized tests to measure these processes are generally less reliable and valid than other psychoeduca­ tional tests. Although genetic predisposition, perinatal injury, and various neurological or other general medical conditions may be associated with the development of Learning Disorders, the presence of such conditions does not invariably predict an eventual Learning Disorder, and there are many individuals with Learning Disorders who have no such history. Learning Disorders are, however, frequently found in association with a variety of general medical conditions (e.g., lead poisoning, fetal alcohol syndrome, or fragile X syndrome).

***Specific Culture Features***

Care should be taken to ensure that intelligence testing procedures reflect adequate attention to the individual's ethnic or cultural background. This is usually accomplished by using tests in which the individual's relevant characteristics are represented in the standardization sample of the test or by employing an examiner who is familiar with aspects of the individual's ethnic or cultural background. Individualized testing is always required to make the diagnosis of a Learning Disorder.

***Prevalence***

Estimates of the prevalence of Learning Disorders range from 2% to 10% depending on the nature of ascertainment and the definitions applied. Approximately 5% of students in public schools in the United States are identified as having a Learning Disorder.

***Differential Diagnosis***

Learning Disorders must be differentiated from **normal variations in academic attainment** and from scholastic difficulties due to **lack of opportunity, poor teachlng,** or **cultural factors.** Inadequate schooling can result in poor performance on standard-

ized achievement tests. Children from ethnic or cultural backgrounds different from the prevailing school culture or in which English is not the primary language and children who have attended class in schools where teaching has been inadequate may score poorly on achievement tests. Children from these same backgrounds may also be at greater risk for absenteeism due to more frequent illnesses or impoverished or chaotic living environments.

**Impaired vision or hearing** may affect learning ability and should be investigated through audiometric or visual screening tests. A Learning Disorder may be diagnosed in the presence of such sensory deficits only if the learning difficulties are in excess of those usually associated with these deficits. Accompanying neurological or other general medical conditions should be coded on Axis III.

In **Mental Retardation,** learning difficulties are commensurate with general impair­ ment in intellectual functioning. However, in some cases of Mild Mental Retardation, the level of achievement in reading, mathematics, or written expression is significantly below expected levels given the person's schooling and severity of Mental Retardation. In such cases, the additional diagnosis of the appropriate Learning Disorder should be made.

An additional Learning Disorder diagnosis should be made in the context of a **Pervasive Developmental Disorder** only when academic impairment is significantly below expected levels given the individual's intellectual functioning and schooling. In individuals with **Communication Disorders,** intellectual functioning may have to be assessed using standardized measures of nonverbal intellectual capacity. In cases in which academic achievement is significantly below this measured capacity, the appro­ priate Learning Disorder should be diagnosed.

**Mathematics Disorder** and **Disorder of Written Expression** most commonly occur in combination with **Reading Disorder.** When criteria are met for more than one Learning Disorder, all should be diagnosed.

**315.00 Reading Disorder**

***Diagnostic Features***

The essential feature of Reading Disorder is reading achievement (i.e., reading accuracy, speed, or comprehension as measured by individually administered standardized tests) that falls substantially below that expected given the individual's chronological age, measured intelligence, and age-appropriate education (Criterion A). The disturbance in reading significantly interferes with academic achievement or with activities of daily living that require reading skills (Criterion B). If a sensory deficit is present, the reading difficulties are in excess of those usually associated with it (Criterion C). If a neurological or other general medical condition or sensory deficit is present, it should be coded on Axis III. In individuals with Reading Disorder (which has also been called "dyslexia"), oral reading is characterized by distortions, substitutions, or omissions; both oral and silent reading are characterized by slowness and errors in comprehension.

***Associated Features and Disorders***

See the "Associated Features and Disorders" section for Learning Disorders (p. 47). Mathematics Disorder and Disorder of Written Expression are commonly associated with

Reading Disorder, and it is relatively rare for either of these disorders to be found in the absence of Reading Disorder.

***Specific Gender Features***

From 60% to 80% of individuals diagnosed with Reading Disorder are males. Referral procedures may often be biased toward identifying males, because they more frequently display disruptive behaviors in association with Learning Disorders. The disorder has been found to occur at more equal rates in males and females when careful diagnostic ascertainment and stringent criteria are used rather than traditional school-based referral and diagnostic procedures.

***Prevalence***

The prevalence of Reading Disorder is difficult to establish because many studies focus on the prevalence of Learning Disorders without careful separation into specific disorders of Reading, Mathematics, or Written Expression. Reading Disorder, alone or in combi­ nation with Mathematics Disorder or Disorder of Written Expression, accounts for approximately four of every five cases of Learning Disorder. The prevalence of Reading Disorder in the United States is estimated at 4% of school-age children. Lower incidence and prevalence figures for Reac!ing Disorder may be found in other countries in which stricter criteria are used.

***Course***

Although symptoms of reading difficulty (e.g., inability to distinguish among common letters or to associate common phonemes with letter symbols) may occur as early as kindergarten, Reading Disorder is seldom diagnosed before the end of kindergarten or the beginning of first grade because formal reading instruction usually does not begin until this point in most school settings. Particularly when Reading Disorder is associated with high IQ, the child may function at or near grade level in the early grades, and the Reading Disorder may not be fully apparent until the fourth grade or later. With early identification and intervention, the prognosis is good in a significant percentage of cases. Reading Disorder may persist into adult life.

***Familial Pattern***

Reading Disorder aggregates familially and is more prevalent among first-degree biological relatives of individuals with Learning Disorders.

***Di,fferential magnosis***

See the "Differential Diagnosis" section for Learning Disorders (p. 47).

* **Diagnostic criteria for 3I 5.00 Reading Disorder**
  1. Reading achievement, as measured by individually administered stan­ dardized tests of reading accuracy or comprehension, is substantially below that expected given the person's chronological age, measured intelligence, and age-appropriate education.
  2. The disturbance in Criterion A significantly interferes with academic achievement or activities of daily living that require reading skills.
  3. If a sensory deficit is present, the reading difficulties are in excess of those usually associated with it.

**Coding note:** If a general medical (e.g., neurological) condition or sensory deficit is present, code the condition on Axis III.

* 1. **Mathematics Disorder**

***magnostic Features***

The essential feature of Mathematics Disorder is mathematical ability (as measured by individually administered standardized tests of mathematical calculation or reasoning) that falls substantially below that expected for the individual's chronological age, measured intelligence, and age-appropriate education (Criterion A). The disturbance in mathematics significantly interferes with academic achievement or with activities of daily living that require mathematical skills (Criterion B). If a sensory deficit is present, the difficulties in mathematical ability are in excess of those usually associated with it (Criterion C). If a neurological or other general medical condition or sensory deficit is present, it should be coded on Axis III. A number of different skills may be impaired in Mathematics Disorder, including "linguistic" skills (e.g., understanding or naming mathematical terms, operations, or concepts, and decoding written problems into mathematical symbols), "perceptual" skills (e.g., recognizing or reading numerical symbols or arithmetic signs, and clustering objects into groups), "attention" skills (e.g., copying numbers or figures correctly, remembering to add in "carried" numbers, and observing operational signs), and "mathematical" skills (e.g., following sequences of mathematical steps, counting objects, and learning multiplication tables).

***Associated Features and msorders***

See the "Associated Features and Disorders" section for Learning Disorders (p. 47). Mathematics Disorder is commonly found in combination with Reading Disorder or Disorder of Written Expression.

***Prevalence***

The prevalence of Mathematics Disorder is difficult to establish because many studies focus on the prevalence of Learning Disorders without careful separation into specific

disorders of Reading, Mathematics, or Written Expression. The prevalence of Mathemat­ ics Disorder alone (i.e., when not found in association with other Learning Disorders) has been estimated at approximately one in every five cases of Learning Disorder. It is estimated that 1% of school-age children have Mathematics Disorder.

***Course***

Although symptoms of difficulty in mathematics (e.g., confusion in number concepts or inability to count accurately) may appear as early as kindergarten or first grade, Mathematics Disorder is seldom diagnosed before the end of first grade because sufficient formal mathematics instruction has usually not occurred until this point in most school settings. It usually becomes apparent during second or third grade. Particularly when Mathematics Disorder is associated with high IQ, the child may be able to function at or near grade level in the early grades, and Mathematics Disorder may not be apparent until the fifth grade or later.

***Di-.[ferential Di-agnosis***

See the "Differential Diagnosis" section for Learning Disorders (p. 47).

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| * **Diagnostic criteria for 3I 5.I Mathematics Disorder**   1. Mathematical ability, as measured by individually administered stan­ dardized tests, is substantially below that expected given the person's chronological age, measured intelligence, and age-appropriate edu­ cation.   2. The disturbance in Criterion A significantly interferes with academic achievement or activities of daily living that require mathematical ability.   3. If a sensory deficit is present, the difficulties in mathematical ability are in excess of those usually associated with it.   **Coding note:** If a general medical (e.g., neurological) condition or sensory deficit is present, code the condition on Axis III. |

* 1. **Disorder of Written Expression**

***Di-agnostic Features***

The essential feature of Disorder of Written Expression is writing skills (as measured by an individually administered standardized test or functional assessment of writing skills) that fall substantially below those expected given the individual's chronological age, measured intelligence, and age-appropriate education (Criterion A). The disturbance in written expression significantly interferes with academic achievement or with activities

of daily living that require writing skills (Criterion B). If a sensory deficit is present, the difficulties in writing skills are in excess of those usually associated with it (Criterion C). If a neurological or other general medical condition or sensory deficit is present, it should be coded on Axis III. There is generally a combination of difficulties in the individual's ability to compose written texts evidenced by grammatical or punctuation errors within sentences, poor paragraph organization, multiple spelling errors, and excessively poor handwriting. This diagnosis is generally not given if there are only spelling errors or poor handwriting in the absence of other impairment in written expression. Compared with other Learning Disorders, relatively less is known about Disorders of Written Expression and their remediation, particularly when they occur in the absence of Reading Disorder. Except for spelling, standardized tests in this area are less well developed than tests of reading or mathematical ability, and the evaluation of impairment in written skills may require a comparison between extensive samples of the individual's written schoolwork and expected performance for age and IQ. This is especially the case for young children in the early elementary grades. Tasks in which the child is asked to copy, write to dictation, and write spontaneously may all be necessary to establish the presence and extent of this disorder.

***Associated Features and Disorders***

See the "Associated Features and Disorders" section for Learning Disorders (p. 47). Disorder of Written Expression is commonly found in combination with Reading Disorder or Mathematics Disorder. There is some evidence that language and percep­ tual-motor deficits may accompany this disorder.

***Prevalence***

The prevalence of Disorder of Written Expression is difficult to establish because many studies focus on the prevalence of Learning Disorders in general without careful separation into specific disorders of reading, mathematics, or written expression. Disorder of Written Expression is rare when not associated with other Learning Disorders.

***Course***

Although difficulty in writing (e.g., particularly poor handwriting or copying ability or inability to remember letter sequences in common words) may appear as early as the first grade, Disorder of Written Expression is seldom diagnosed before the end of first grade because sufficient formal writing instruction has usually not occurred until this point in most school settings. The disorder is usually apparent by second grade. Disorder of Written Expression may occasionally be seen in older children or adults, and little is known about its long-term prognosis.

***Infferential Inagnosis***

See the "Differential Diagnosis" section for Learning Disorders (p. 47). A disorder in spelling or handwriting alone, in the absence of other difficulties of written expression, generally does not qualify for a diagnosis of Disorder of Written Expression. If poor handwriting is due to impairment in motor coordination, a diagnosis of **Developmental Coordination Disorder** should be considered.

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| * **Diagnostic criteria for 315.2 Disorder of Written Expression**   1. Writing skills, as measured by individually administered standardized tests (or functional assessments of writing skills), are substantially below those expected given the person's chronological age, measured intelli­ gence, and age-appropriate education.   2. The disturbance in Criterion A significantly interferes with academic achievement or activities of daily living that require the composition of written texts (e.g., writing grammatically correct sentences and organ­ ized paragraphs).   3. If a sensory deficit is present, the difficulties in writing skills are in excess of those usually associated with it.   **Coding note:** If a general medical (e.g., neurological) condition or sensory deficit is present, code the condition on Axis III. |

**315.9 Learning Disorder Not Otherwise Specified**

This category is for disorders in learning that do not meet criteria for any specific Learning Disorder. This category might include problems in all three areas (reading, mathematics, written expression) that together significantly interfere with academic achievement even though performance on tests measuring each individual skill is not substantially below that expected given the person's chronological age, measured intelligence, and age­ appropriate education.

**Motor Skills Disorder**

**315.4 Developmental Coordination Disorder**

***Diagnostic Features***

The essential feature of Developmental Coordination Disorder is a marked impairment in the development of motor coordination (Criterion A). The diagnosis is made only if this impairment significantly interferes with academic achievement or activities of daily living (Criterion B). The diagnosis is made if the coordination difficulties are not due to a general medical condition (e.g., cerebral palsy, hemiplegia, or muscular dystrophy) and the criteria are not met for Pervasive Developmental Disorder (Criterion C). If Mental Retardation is present, the motor difficulties are in excess of those usually associated with it (Criterion D). The manifestations of this disorder vary with age and development. For example, younger children may display clumsiness and delays in achieving developmental motor milestones (e.g., wa1king, crawling, sitting, tying shoelaces,

buttoning shirts, zipping pants). Older children may display difficulties with the motor aspects of assembling puzzles, building models, playing ball, and printing or handwriting.

***Associated Features and Disorders***

Problems commonly associated with Developmental Coordination Disorder include delays in other nonmotor milestones. Associated disorders may include Phonological Disorder, Expressive Language Disorder, and Mixed Receptive-Expressive Language Disorder.

***Prevalence***

Prevalence of Developmental Coordination Disorder has been estimated to be as high as 6% for children in the age range of 5-11 years.

***Course***

Recognition of Developmental Coordination Disorder usually occurs when the child first attempts such tasks as running, holding a knife and fork, buttoning clothes, or playing ball games. The course is variable. In some cases, lack of coordination continues through adolescence and adulthood.

***Differential Diagnosis***

Developmental Coordination Disorder must be distinguished from motor impairments that are due to a general medical condition. Problems in coordination may be associated with **specific neurological disorders** (e.g., cerebral palsy, progressive lesions of the cerebellum), but in these cases there is definite neural damage and abnormal findings on neurological examination. If **Mental Retardation** is present, Developmental Coor­ dination Disorder can be diagnosed only if the motor difficulties are in excess of those usually associated with the Mental Retardation. A diagnosis of Developmental Coordi­ nation Disorder is not given if the criteria are met for a **Pervasive Developmental Disorder.** Individuals with **Attention-Deficit/HyperactivityDisorder** may fall, bump into things, or knock things over, but this is usually due to distractibility and impulsive­ ness, rather than to a motor impairment. If criteria for both disorders are met, both diagnoses can be given.

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| * **Diagnostic criteria for 3I 5.4 Developmental Coordination Disorder**   A. Performance in daily activities that require motor coordination is sub­ stantially below that expected given the person's chronological age and measured intelligence. This may be manifested by marked delays in achieving motor milestones (e.g., walking, crawling, sitting), dropping things, "clumsiness," poor performance in sports, or poor handwriting.  *(continued)* |

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| * **Diagnostic criteria for 315.4 Developmental Coordination Disorder** *(continued)*   1. The disturbance in Criterion A significantly interferes with academic achievement or activities of daily living.   2. The disturbance is not due to a general medical condition (e.g., cerebral palsy, hemiplegia, or muscular dystrophy) and does not meet criteria for a Pervasive Developmental Disorder.   3. If Mental Retardation is present, the motor difficulties are in excess of those usually associated with it.   **Coding note:** If a general medical (e.g., neurological) condition or sensory deficit is present, code the condition on Axis III. |

**Communication Disorders**

The following Communication Disorders are included in this section: Expressive Language Disorder, Mixed Receptive-Expressive Language Disorder, Phonological Dis­ order, Stuttering, and Communication Disorder Not Otherwise Specified. They are included in this classification to familiarize clinicians with the ways in which Commu­ nication Disorders present and to facilitate their differential diagnosis.

**315.31 Expressive Language Disorder**

***Diagnostic Features***

The essential feature of Expressive Language Disorder is an impairment in expressive language development as demonstrated by scores on standardized individually admin­ istered measures of expressive language development substantially below those ob­ tained from standardized measures of both nonverbal intellectual capacity and receptive language development (Criterion A). The difficulties may occur in communication involving both verbal language and sign language. The language difficulties interfere with academic or occupational achievement or with social communication (Criterion B). The symptoms do not meet criteria for Mixed Receptive-Expressive Language Disorder or a Pervasive Developmental Disorder (Criterion C). If Mental Retardation, a speech­ motor or sensory deficit, or environmental deprivation is present, the language difficulties are in excess of those usually associated with these problems (Criterion D). If a speech-motor or sensory deficit or neurological condition is present, it should be coded on Axis III.

The linguistic features of the disorder vary depending on its severity and the age of the child. These features include a limited amount of speech, limited range of vocabulary, difficulty acquiring new words, word-finding or vocabulary errors, shortened sentences,

simplified grammatical structures, limited varieties of grammatical structures (e.g., verb forms), limited varieties of sentence types (e.g., imperatives, questions), omissions of critical parts of sentences, use of unusual word order, and slow rate of language development. Nonlinguistic functioning (as measured by performance intelligence tests) and language comprehension skills are usually within normal limits. Expressive Lan­ guage Disorder may be either acquired or developmental. In the acquired type, an impairment in expressive language occurs after a period of normal development as a result of a neurological or other general medical condition (e.g., encephalitis, head trauma, irradiation). In the developmental type, there is an impairment in expressive language that is not associated with a neurological insult of known origin. Children with this type often begin speaking late and progress more slowly than usual through the various stages of expressive language development.

***Associated Features and Disorders***

The most common associated feature of Expressive Language Disorder in younger children is Phonological Disorder. There may also be a disturbance in fluency and language formulation involving an abnormally rapid rate and erratic rhythm of speech and disturbances in language structure ("cluttering"). When Expressive Language Disorder is acquired, additional speech difficulties are also common and may include motor articulation problems, phonological errors, slow speech, syllable repetitions, and monotonous intonation and stress patterns. Among school-age children, school and learning problems (e.g., writing to dictation, copying sentences, and spelling) that sometimes meet criteria for Learning Disorders are often associated with Expressive Language Disorder. There may also be some mild impairment in receptive language skills, but when this is significant, a diagnosis of Mixed Receptive-Expressive Language Disorder should be made. A history of delay in reaching some motor milestones, Developmental Coordination Disorder, and Enuresis are not uncommon. Social with­ drawal and some mental disorders such as Attention-Deficit/Hyperactivity Disorder are also commonly associated. Expressive Language Disorder may be accompanied by EEG abnormalities, abnormal findings on neuroimaging, dysarthric or apraxic behaviors, or other neurological signs.

***Specific Culture and Gender Features***

Assessments of the development of communication abilities must take into account the individual's cultural and language context, particularly for individuals growing up in bilingual environments. The standardized measures of language development and of nonverbal intellectual capacity must be relevant for the cultural and linguistic group. The developmental type of Expressive Language Disorder is more common in males than in females.

***Prevalence***

Estimates suggest that 3%--5% of children may be affected by the developmental type of Expressive Language Disorder. The acquired type is less common.

***Course***

The developmental type of Expressive Language Disorder is usually recognized by age 3 years, although milder forms of the disorder may not become apparent until early adolescence, when language ordinarily becomes more complex. The acquired type of Expressive Language Disorder due to brain lesions, head trauma, or stroke may occur at any age, and the onset is sudden. The outcome of the developmental type of Expressive Language Disorder is variable. Approximately one-half of the children with this disorder appear to outgrow it, whereas one-half appear to have more long-lasting difficulties. Most children ultimately acquire more or less normal language abilities by late adolescence, although subtle deficits may persist. In the acquired type of Expressive Language Disorder, the course and prognosis are related to the severity and location of brain pathology, as well as to the age of the child and the extent of language development at the time the disorder is acquired. Clinical improvement in language abilities is sometimes rapid and complete, whereas in other instances there may be incomplete recovery or progressive deficit.

***Familial Pattern***

It appears that the developmental type of Expressive Language Disorder is more likely to occur in individuals who have a family history of Communication or Learning Disorders. There is no evidence of familial aggregation in the acquired type.

***Differential Diagnosis***

Expressive Language Disorder is distinguished from **Mixed Receptive-Expressive Language Disorder** by the presence in the latter of significant impairment in receptive language. Expressive Language Disorder is not diagnosed if the criteria are met for Autistic Disorder or another Pervasive Developmental Disorder. **Autistic Disorder** also involves expressive language impairment but may be distinguished from Expressive and Mixed Receptive-Expressive Language Disorders by the characteristics of the communi­ cation impairment (e.g., stereotyped use oflanguage) and by the presence of a qualitative impairment in social interaction and restricted, repetitive, and stereotyped patterns of behavior. Expressive and receptive language development may be impaired due to **Mental Retardation, a hearing impairment or other sensory deficit, a speech­ motordeficit, or severeenvironmentaldeprivation.** The presence of these problems may be established by intelligence testing, audiometric testing, neurological testing, and history. If the language difficulties are in excess of those usually associated with these problems, a concurrent diagnosis of Expressive Language or Mixed Receptive-Expressive Language Disorder may be made. Children with expressive language delays due to environmental deprivation may show rapid gains once the environmental problems are ameliorated. In **Disorder of Written Expression,** there is a disturbance in writing skills. If deficits in oral expression are also present, an additional diagnosis of Expressive Language Disorder may be appropriate. **Selective Mutism** involves limited expressive output that may mimic Expressive or Mixed Receptive-Expressive Language Disorder; careful history and observation are necessary to determine the presence of normal language in some settings. **Acquired aphasia** associated with a general medical condition in childhood is often transient. A diagnosis of Expressive Language Disorder is appropriate only if the language disturbance persists beyond the acute recovery period for the etiological general medical condition (e.g., head trauma, viral infection).

* **Diagnostic criteria for 315.31 Expressive Language Disorder**

1. The scores obtained from standardized individually administered mea­ sures of expressive language development are substantially below those obtained from standardized measures of both nonverbal intellectual capacity and receptive language development. The disturbance may be manifest clinically by symptoms that include having a markedly limited vocabulary, making errors in tense, or having difficulty recalling words or producing sentences with developmentally appropriate length or complexity.
2. The difficulties with expressive language interfere with academic or occupational achievement or with social communication.
3. Criteria are not met for Mixed Receptive-Expressive Language Disorder or a Pervasive Developmental Disorder.
4. If Mental Retardation, a speech-motor or sensory deficit, or environmen­ tal deprivation is present, the language difficulties are in excess of those usually associated with these problems.

**Coding note:** If a speech-motor or sensoiy deficit or a neurological condition is present, code the condition on Axis III.

**315 .31 Mixed Receptive--Expressive Language Disorder**

***Diagnostic Features***

The essential feature of Mixed Receptive-Expressive Language Disorder is an impairment in both receptive and expressive language development as demonstrated by scores on standardized individually administered measures of both receptive and expressive language development that are substantially below those obtained from standardized measures of nonverbal intellectual capacity (Criterion A). The difficulties may occur in communication involving both verbal language and sign language. The language difficulties interfere with academic or occupational achievement or with social commu­ nication (Criterion B), and the symptoms do not meet criteria for a Pervasive Develop­ mental Disorder (Criterion C). If Mental Retardation, a speech-motor or sensory deficit, or environmental deprivation is present, the language difficulties are in excess of those usually associated with these problems (Criterion D). If a speech-motor or sensory deficit or neurological condition is present, it should be coded on Axis III.

An individual with this disorder has the difficulties associated with Expressive Language Disorder (e.g., a markedly limited vocabulary, errors in tense, difficulty recalling words or producing sentences with developmentally appropriate length or complexity, and general difficulty expressing ideas) and also has impairment in receptive language development (e.g., difficulty understanding words, sentences, or specific types of words). In mild cases, there may be difficulties only in understanding particular types

of words (e.g., spatial terms) or statements (e.g., complex "if-then" sentences). In more severe cases, there may be multiple disabilities, including an inability to understand basic vocabulary or simple sentences, and deficits in various areas of auditory processing (e.g., discrimination of sounds, association of sounds and symbols, storage, recall, and sequencing). Because the development of expressive language in childhood relies on the acquisition of receptive skills, a pure receptive language disorder (analogous to a Wernicke's aphasia in adults) is virtually never seen.

Mixed Receptive-Expressive Language Disorder may be either acquired or develop­ mental. In the acquired type, an impairment in receptive and expressive language occurs after a period of normal development as a result of a neurological or other general medical condition (e.g., encephalitis, head trauma, irradiation). In the developmental type, there is an impairment in receptive and expressive language that is not associated with a neurological insult of known origin. This type is characterized by a slow rate of language development in which speech may begin late and advance slowly through the stages of language development.

***Associated Features and Disorders***

The linguistic features of the production impairment in Mixed Receptive-Expressive Language Disorder are similar to those that accompany Expressive Language Disorder. The comprehension deficit is the primary feature that differentiates this disorder from Expressive Language Disorder and this can vary depending on the severity of the disorder and the age of the child. Impairments in language comprehension can be less obvious than those in language production because they are not as readily apparent to the observer and may appear only on formal assessment. The child may intermittently appear not to hear or to be confused or not paying attention when spoken to. The child may follow commands incorrectly, or not at all, and give tangential or inappropriate responses to questions. The child may be exceptionally quiet or, conversely, very talkative. Conversational skills (e.g., taking turns, maintaining a topic) are often quite poor or inappropriate. Deficits in various areas of sensory information processing are common, especially in temporal auditory processing (e.g., processing rate, association of sounds and symbols, sequence of sounds and memory, attention to and discrimination of sounds). Difficulty in producing motor sequences smoothly and quickly is also charac­ teristic. Phonological Disorder, Learning Disorders, and deficits in speech perception are often present and accompanied by memory impairments. Other associated disorders are Attention-Deficit/Hyperactivity Disorder, Developmental Coordination Disorder, and Enuresis. Mixed Receptive-Expressive Language Disorder may be accompanied by EEG abnormalities, abnormal findings on neuroimaging, and other neurological signs. A form of acquired Mixed Receptive-Expressive Language Disorder that has its onset at about ages 3-9 years and is accompanied by seizures is referred to as Landau-Kleffner syndrome.

***Specific Culture and Gender Features***

Assessments of the development of communication abilities must take into account the individual's cultural and language context, particularly for individuals growing up in bilingual environments. The standardized measures of language development and of nonverbal intellectual capacity must be relevant for the cultural and linguistic group. The developmental type is more prevalent in males than in females.

***Prevalence***

It is estimated that the developmental type of Mixed Receptive-Expressive Language Disorder may occur in up to 3% of school-age children but is probably less common than Expressive Language Disorder. Landau-Kleffner syndrome and other forms of the acquired type of the disorder are rarer.

***Course***

The developmental type of Mixed Receptive-Expressive Language Disorder is usually detectable before age 4 years. Severe forms of the disorder may be apparent by age 2 years. Milder forms may not be recognized until the child reaches elementary school, where deficits in comprehension become more apparent. The acquired type of Mixed Receptive-Expressive Language Disorder due to brain lesions, head trauma, or stroke may occur at any age. The acquired type due to Landau-Kleffner syndrome (acquired epileptic aphasia) usually occurs between ages 3 and 9 years. Many children with Mixed Receptive-Expressive Language Disorder eventually acquire normal language abilities, but the prognosis is worse than for those with Expressive Language Disorder. In the acquired type of Mixed Receptive-Expressive Language Disorder, the course and prognosis are related to the severity and location of brain pathology, as well as to the age of the child and the extent of language development at the time the disorder is acquired. Clinical improvement in language abilities is sometimes complete, whereas in other instances there may be incomplete recovery or progressive deficit. Children with more severe forms are likely to develop Learning Disorders.

***Familial Pattern***

The developmental type of Mixed Receptive-Expressive Language Disorder is more common among first-degree biological relatives of those with the disorder than in the general population. There is no evidence of familial aggregation in the acquired type of the disorder.

***Differential Diagnosis***

See the "Differential Diagnosis" section for Expressive Language Disorder (p. 57).

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| * **Diagnostic criteria for 315.31 Mixed Receptive Expressive Language Disorder**   A. The scores obtained from a battery of standardized individually admin­ istered measures of both receptive and expressive language develop­ ment are substantially below those obtained from standardized measures of nonverbal intellectual capacity. Symptoms include those for Expressive Language Disorder as well as difficulty understanding words, sentences, or specific types of words, such as spatial terms.  *(continued)* |

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| * **Diagnostic criteria for 315.31 Mixed Receptive Expressive Language Disorder** *(continued)*   1. The difficulties with receptive and expressive language significantly interfere with academic or occupational achievement or with social communication.   2. Criteria are not met for a Pervasive Developmental Disorder.   3. If Mental Retardation, a speech-motor or sensory deficit, or environmen­ tal deprivation is present, the language difficulties are in excess of those usually associated with these problems.   **Coding note:** If a speech-motor or sensory deficit or a neurological condition is present, code the condition on Axis Ill. |

**315.39 Phonological Disorder**

***(formerly* Developmental Articulation Disorder)**

***magnostic Features***

The essential feature of Phonological Disorder is a failure to use developmentally expected speech sounds that are appropriate for the individual's age and dialect (Criterion A). This may involve errors in sound production, use, representation, or organization such as, but not limited to, substitutions of one sound for another (use of *It/* for target /k/ sound) or omissions of sounds (e.g., final consonants). The difficulties in speech sound production interfere with academic or occupational achievement or with social communication (Criterion B). If Mental Retardation, a speech-motor or sensory deficit, or environmental deprivation is present, the speech difficulties are in excess of those usually associated with these problems (Criterion C). If a speech-motor or sensory deficit or neurological condition is present, it should he coded on Axis III.

Phonological Disorder includes phonological production (i.e., articulation) errors that involve the failure to form speech sounds correctly and cognitively based forms of phonological problems that involve a deficit in linguistic categorization of speech sounds (e.g., a difficulty in sorting out which sounds in the language make a difference in meaning). Severity ranges from little or no effect on speech intelligibility to completely unintelligible speech. Sound omissions are typically viewed as more severe than are sound substitutions, which in turn are more severe than sound distortions. The most frequently misarticulated sounds are those acquired later in the developmental sequence *(l, r, s, z, th, ch),* but in younger or more severely affected individuals, consonants and vowels that develop earlier may also be affected. Lisping (i.e., misarticulation of sibilants) is particularly common. Phonological Disorder may also involve errors of selection and ordering of sounds within syllables and words (e.g., *aks* for *ask).*

***Associated Features and Disorders***

Although there may be an association with clear causal factors such as hearing impairment, structural deficits of the oral peripheral speech mechanism (e.g., cleft palate), neurological conditions (e.g., cerebral palsy), cognitive limitations (e.g., Mental Retardation), or psychosocial problems, at least 2.5% of preschool children present with Phonological Disorders of unknown or suspect origin, which are often referred to as *functional* or *developmental.* There may be a delayed onset of speech.

***Specific Culture and Gender Features***

Assessments of the development of communication abilities must take into account the individual's cultural and language context, particularly for individuals growing up in bilingual environments. Phonological Disorder is more prevalent in males.

***Prevalence***

Approximately 2%--3% of 6- and 7-year-olds present with moderate to severe Phonolog­ ical Disorder, although the prevalence of milder forms of this disorder is higher. The prevalence falls to 0.5% by age 17 years.

***Course***

In severe Phonological Disorder, the child's speech may be relatively unintelligible even to family members. Less severe forms of the disorder may not be recognized until the child enters a preschool or school environment and has difficulty being understood by those outside the immediate family. The course of the disorder is variable depending on associated causes and severity. In mild presentations with unknown causes, spontaneous recovery often occurs.

***Familial Pattern***

A familial pattern has been demonstrated for some forms of Phonological Disorder.

***Di,fferential magnosis***

Speech difficulties may be associated with **Mental Retardation, a hearing impairment** or **other sensory deficit, a speech-motor deficit, or severe environmental depri­ vation.** The presence of these problems may be established by intelligence testing, audiometric testing, neurological testing, and history. If the speech difficulties are in excess of those usually associated with these problems, a concurrent diagnosis of Phonological Disorder may be made. Problems limited to **speech rhythm or voice** are not included as part of Phonological Disorder and instead are diagnosed as **Stuttering** or **Communication Disorder Not Otherwise Specified.** Children with speech diffi­ culties due to environmental deprivation may show rapid gains once the environmental problems are ameliorated.

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| * **Diagnostic criteria for 3 I 5.39 Phonological Disorder**   1. Failure to use developmentally expected speech sounds that are appro­ priate for age and dialect (e.g., errors in sound production, use, representation, or organization such as, but not limited to, substitutions of one sound for another [use of *It/* for target /k/ sound) or omissions of sounds such as final consonants).   2. The difficulties in speech sound production interfere with academic or occupational achievement or with social communication.   3. If Mental Retardation, a speech-motor or sensory deficit, or environmen­ tal deprivation is present, the speech difficulties are in excess of those usually associated with these problems.   **Coding note:** If a speech-motor or sensory deficit or a neurological condition is present, code the condition on Axis III. |

**307.0 Stuttering**

***magnostic Features***

The essential feature of Stuttering is a disturbance in the normal fluency and time patterning of speech that is inappropriate for the individual's age (Criterion A). This disturbance is characterized by frequent repetitions or prolongations of sounds or syllables (Criteria Al and AZ). Various other types of speech dysfluencies may also be involved, including interjections (Criterion A3), broken words (e.g., pauses within a word) (Criterion A4), audible or silent blocking (filled or unfilled pauses in speech) (Criterion AS), circumlocutions (i.e., word substitutions to avoid problematic words) (Criterion A6), words produced with an excess of physical tension (Criterion A7), and monosyllabic whole word repetitions (e.g., "I-I-I-I see him") (Criterion AS). The disturbance in fluency interferes with academic or occupational achievement or with social communication (Criterion B). If a speech-motor or sensory deficit is present, the speech difficulties are in excess of those usually associated with these problems (Criterion C). If a speech-motor or sensory deficit or neurological disorder is present, this condition should also be coded on Axis III. The extent of the disturbance varies from situation to situation and often is more severe when there is special pressure to communicate (e.g., giving a report at school, interviewing for a job). Stuttering is often absent during oral reading, singing, or talking to inanimate objects or to pets.

***Associated Features and Di,sorders***

At the onset of Stuttering, the speaker may not be aware of the problem, although awareness and even fearful anticipation of the problem may develop later. The speaker may attempt to avoid stuttering by linguistic mechanisms (e.g., altering the rate of speech, avoiding certain speech situations such as telephoning or public speaking, or avoiding

certain words or sounds). Stuttering may be accompanied by motor movements (e.g., eye blinks, tics, tremors of the lips or face, jerking of the head, breathing movements, or fist clenching). Stress or anxiety have been shown to exacerbate Stuttering. Impairment of social functioning may result from associated anxiety, frustration, or low self-esteem. In adults, Stuttering may limit occupational choice or advancement. Phonological Disorder and Expressive Language Disorder occur at a higher frequency in individuals with Stuttering than in the general population.

***Prevalence***

The prevalence of Stuttering in prepubertal children is 1% and drops to 0.8% in adolescence. The male-to-female ratio is approximately 3:1.

***Course***

Retrospective studies of individuals with Stuttering report onset typically between ages 2 and 7 years (with peak onset at around age 5 years). Onset occurs before age 10 years in 98% of cases. The onset is usually insidious, covering many months during which episodic, unnoticed speech dysfluencies become a chronic problem. Typically, the disturbance starts gradually, with repetition of initial consonants, words that are usually the first words of a phrase, or long words. The child is generally not aware of Stuttering. As the disorder progresses, there is a waxing and waning course. The dysfluencies become more frequent, and the Stuttering occurs on the most meaningful words or phrases in the utterance. As the child becomes aware of the speech difficulty, mechanisms for avoiding the dysfluencies and emotional responses may occur. Some research suggests that up to 80% of individuals with Stuttering recover, with up to 60% recovering spontaneously. Recovery typically occurs before age 16 years.

***Familial Pattern***

Family and twin studies provide strong evidence of a genetic factor in the etiology of Stuttering. The presence of a Phonological Disorder or the developmental type of Expressive Language Disorder, or a family history of these, increases the likelihood of Stuttering. The risk of Stuttering among first-degree biological relatives is more than three times the risk in the general population. For men with a history of Stuttering, about 10% of their daughters and 20% of their sons will stutter.

***Differential Diagnosis***

Speech difficulties may be associated with a **hearing impairment or other sensory deficit** or a **speech-motor deficit.** In instances where the speech difficulties are in excess of those usually associated with these problems, a concurrent diagnosis of Stuttering may be made. Stuttering must be distinguished from **normal dysfl.uencies that occur frequently in young children,** which include whole-word or phrase repetitions (e.g., "I want, I want ice cream"), incomplete phrases, interjections, unfilled pauses, and parenthetical remarks.

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| * **Diagnostic criteria for 307.0 Stuttering**   1. Disturbance in the normal fluency and time patterning of speech (inappropriate for the individual's age), characterized by frequent occurrences of one or more of the following:      1. sound and syllable repetitions      2. sound prolongations      3. interjections      4. broken words (e.g., pauses within a word)      5. audible or silent blocking (filled or unfilled pauses in speech)      6. circumlocutions (word substitutions to avoid problematic words)      7. words produced with an excess of physical tension      8. monosyllabic whole-word repetitions (e.g., "I-1-1-I see him")   2. The disturbance in fluency interferes with academic or occupational achievement or with social communication.   3. If a speech-motor or sensory deficit is present, the speech difficulties are in excess of those usually associated with these problems.   **Coding note:** If a speech-motor or sensory deficit or a neurological condition is present, code the condition on Axis III. |

**307.9 Communication Disorder Not Otherwise Specified**

This category is for disorders in communication that do not meet criteria for any specific Communication Disorder; for example, a voice disorder (i.e., an abnormality of vocal pitch, loudness, quality, tone, or resonance).

**Pervasive Developmental Disorders**

Pervasive Developmental Disorders are characterized by severe and pervasive impair­ ment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests, and activities. The qualitative impairments that define these conditions are distinctly deviant relative to the individual's developmental level or mental age. This section contains Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Devel­ opmental Disorder Not Otherwise Specified. These disorders are usually evident in the first years of life and are often associated with some degree of Mental Retardation, which, if present, should be coded on Axis II. The Pervasive Developmental Disorders are sometimes observed with a diverse group of other general medical conditions (e.g., chromosomal abnormalities, congenital infections, structural abnormalities of the central

nervous system). If such conditions are present, they should be noted on Axis III. Although terms like "psychosis" and "childhood schizophrenia" were once used to refer to individuals with these conditions, there is considerable evidence to suggest that the Pervasive Developmental Disorders are distinct from Schizophrenia (however, an individual with Pervasive Developmental Disorder may occasionally later develop Schizophrenia).

**299.00 Autistic Disorder**

***magnostic Features***

The essential features of Autistic Disorder are the presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests. Manifestations of the disorder vary greatly depending on the developmental level and chronological age of the individual. Autistic Disorder is sometimes referred to as *early infantile autism, childhood autism,* or *Kanner's autism.*

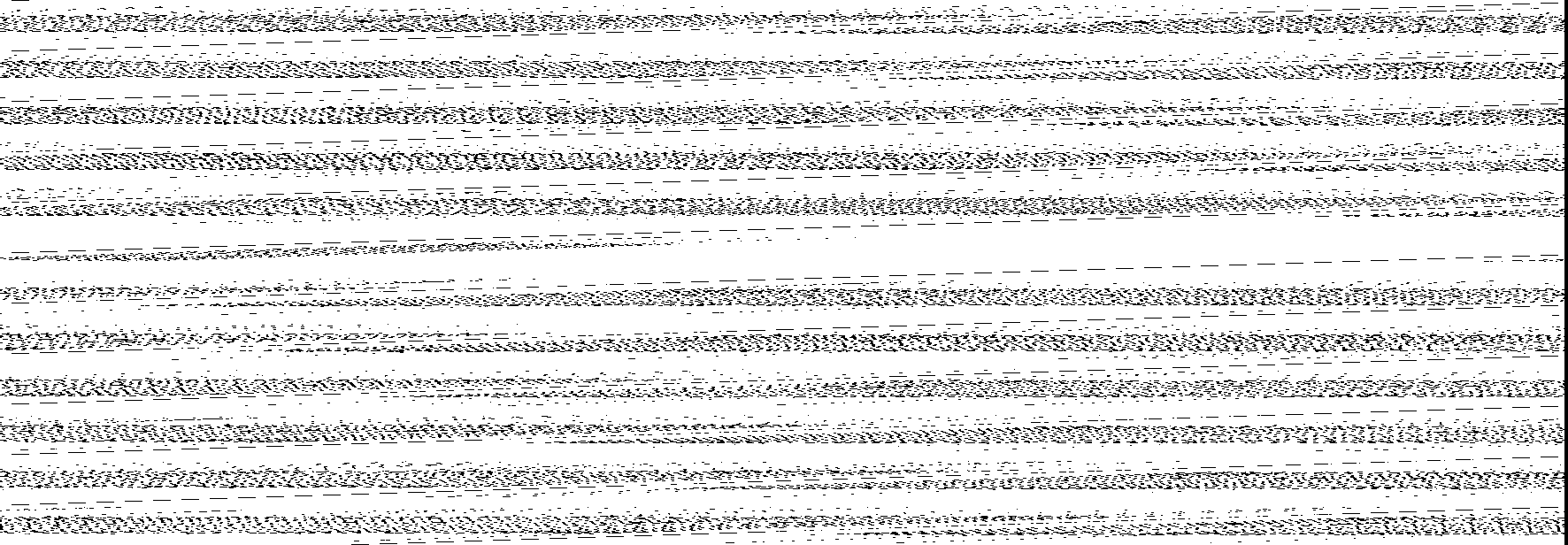
The impairment in reciprocal social interaction is gross and sustained. There may be marked impairment in the use of multiple nonverbal behaviors (e.g., eye-to-eye gaze, facial expression, body postures and gestures) to regulate social interaction and communication (Criterion Ala). There may be failure to develop peer relationships appropriate to developmental level (Criterion Alb) that may take different forms at different ages. Younger individuals may have little or no interest in establishing friendships. Older individuals may have an interest in friendship but lack understanding of the conventions of social interaction. There may be a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., not showing, bringing, or pointing out objects they find interesting) (Criterion Ale). Lack of social or emotional reciprocity may be present (e.g., not actively participating in simple social play or games, preferring solitary activities, or involving others in activities only as tools or "mechanical" aids) (Criterion Ald). Often an individual's awareness of others is markedly impaired. Individuals with this disorder may be oblivious to other children (including siblings), may have no concept of the needs of others, or may not notice another person's distress.

The impairment in communication is also marked and sustained and affects both verbal and nonverbal skills. There may be delay in, or total lack of, the development of spoken language (Criterion A2a). In individuals who do speak, there may be marked impairment in the ability to initiate or sustain a conversation with others (Criterion A2b), or a stereotyped and repetitive use of language or idiosyncratic language (Criterion A2c). There may also be a lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level (Criterion A2d). When speech does develop, the pitch, intonation, rate, rhythm, or stress may be abnormal (e.g., tone of voice may be monotonous or contain questionlike rises at ends of statements). Grammatical structures are often immature and include stereotyped and repetitive use of language (e.g., repetition of words or phrases regardless of meaning; repeating jingles or commercials) or metaphorical language (i.e., language that can only be understood clearly by those familiar with the individual's communication style). A disturbance in the comprehension of language may be evidenced by an inability to understand simple questions, directions, or jokes. Imaginative play is often absent or markedly impaired.

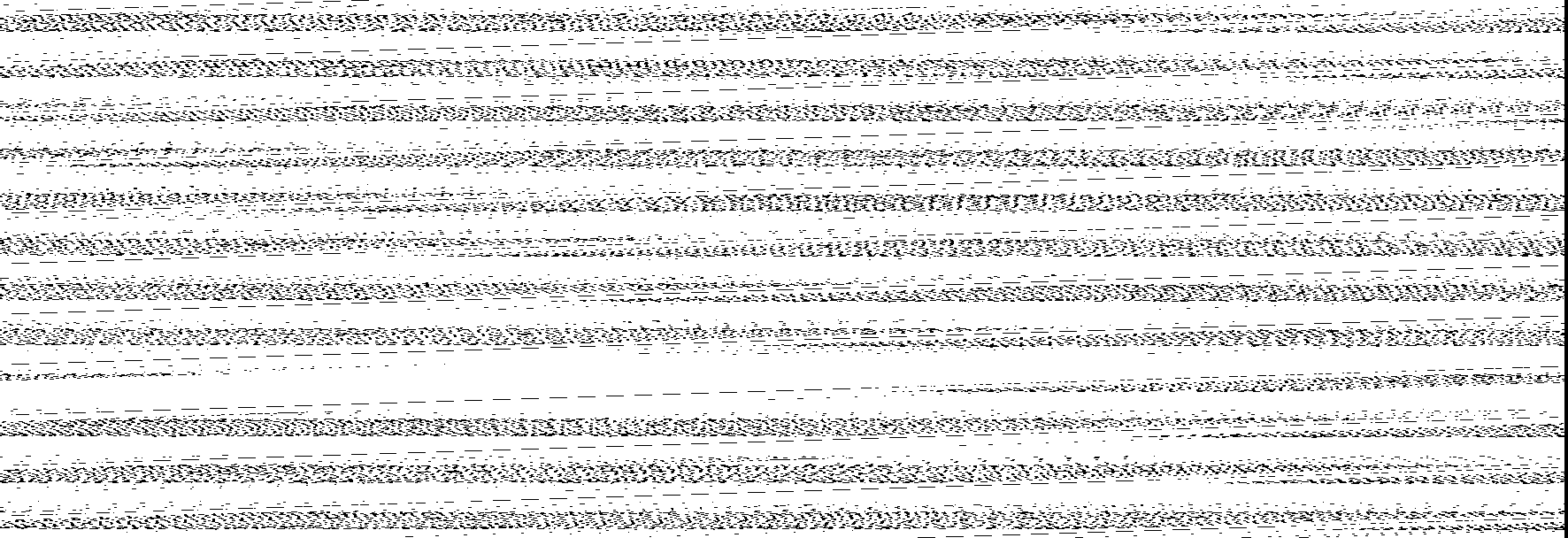
These individuals also tend not to engage in the simple imitation games or routines of infancy or early childhood or do so only out of context or in a mechanical way.

Individuals with Autistic Disorder have restricted, repetitive, and stereotyped patterns of behavior, interests, and activities. There may be an encompassing pre­ occupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus (Criterion A3a); an apparently inflexible adherence to specific, nonfunctional routines or rituals (Criterion A3b); stereotyped and repetitive motor mannerisms (Criterion A3c); or a persistent preoccupation with parts of objects (Criterion A3d). Individuals with Autistic Disorder display a markedly restricted range

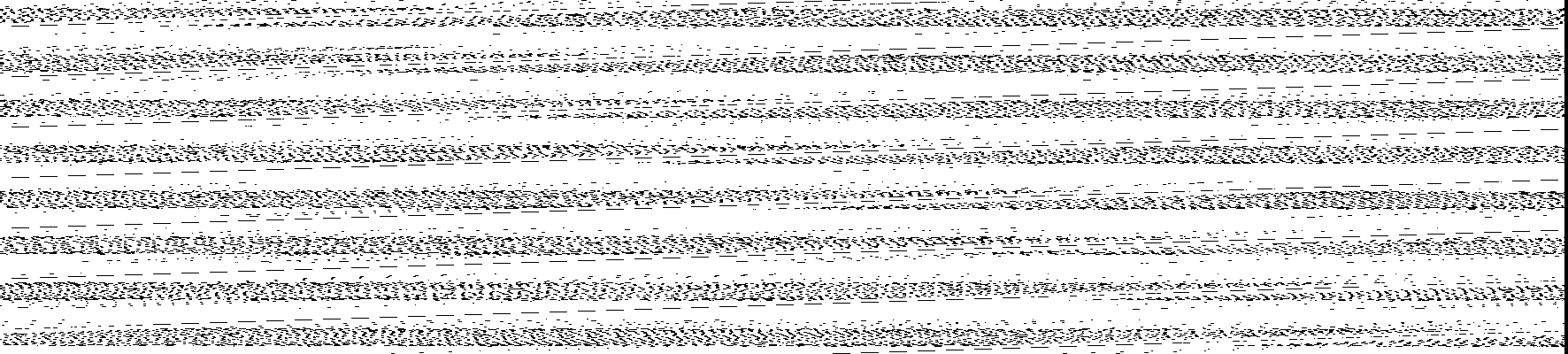


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(e.g., a high threshold for pain, oversensitivity to sounds or being touched, exaggerated reactions to light or odors, fascination with certain stimuli). There may be abnormalities in eating (e.g., limiting diet to a few foods, Pica) or sleeping (e.g., recurrent awakening at night with rocking). Abnormalities of mood or affect (e.g., giggling or weeping for no apparent reason, an apparent absence of emotional reaction) may be present. There may be a lack of fear in response to real dangers, and excessive fearfulness in response to harmless objects. A variety of self-injurious behaviors may be present (e.g., head banging or finger, hand, or wrist biting). In adolescence or early adult life, individuals with Autistic Disorder who have the intellectual capacity for insight may become depressed in response to the realization of their serious impairment.

**Associated laboratory findings.** When Autistic Disorder is associated with a general medical condition, laboratory findings consistent with the general medical condition will be observed. There have been reports of group differences in measures of serotonergic activity, but these are not diagnostic for Autistic Disorder. Imaging studies may be abnormal in some cases, but no specific pattern has been clearly identified. EEG abnormalities are common even in the absence of seizure disorders.

**Associated physical examination findings andgeneral medical conditions.** Various nonspecific neurological symptoms or signs may be noted (e.g., primitive reflexes, delayed development of hand dominance) in Autistic Disorder. The condition is sometimes observed in association with a neurological or other general medical condition (e.g., encephalitis, phenylketonuria, tuberous sclerosis, fragile X syndrome, anoxia during birth, maternal rubella). Seizures may develop (particularly in adoles­ cence) in as many as 25% of cases. When other general medical conditions are present, they should be noted on Axis III.

***Specific Age and Gender Features***

The nature of the impairment in social interaction may change over time in Autistic Disorder and may vary depending on the developmental level of the individual. In infants, there may be a failure to cuddle; an indifference or aversion to affection or physical contact; a lack of eye contact, facial responsiveness, or socially directed smiles; and a failure to respond to their parents' voices. As a result, parents may be concerned initially that the child is deaf. Young children with this disorder may treat adults as interchangeable or may cling mechanically to a specific person. Over the course of development, the child may become more willing to be passively engaged in social interaction and may even become more interested in social interaction. However, even in such instances, the child tends to treat other people in unusual ways (e.g., expecting other people to answer ritualized questions in specific ways, having little sense of other people's boundaries, and being inappropriately intrusive in social interaction). In older individuals, tasks involving long-term memory (e.g., train timetables, historical dates, chemical formulas, or recall of the exact words of songs heard years before) may be excellent, but the information tends to be repeated over and over again, regardless of the appropriateness of the information to the social context. Rates of the disorder are four to five times higher in males than in females. Females with the disorder are more likely, however, to exhibit more severe Mental Retardation.

***Prevalence***

Epidemiological studies suggest rates of Autistic Disorder of 2-5 cases per 10,000 individuals.

***Course***

By definition, the onset of Autistic Disorder is prior to age 3 years. In some instances, parents will report that they have been worried about the child since birth or shortly afterward because of the child's lack of interest in social interaction. Manifestations of the disorder in infancy are more subtle and difficult to define than those seen after age 2 years. In a minority of cases, the child may be reported to have developed normally for the first year (or even 2 years) of life. Autistic Disorder follows a continuous course. In school-age children and adolescents, developmental gains in some areas are common (e.g., increased interest in social functioning as the child reaches school age). Some individuals deteriorate behaviorally during adolescence, whereas others improve. Lan­ guage skills (e.g., presence of communicative speech) and overall intellectual level are the strongest factors related to ultimate prognosis. Available follow-up studies suggest that only a small percentage of individuals with the disorder go on as adults to live and work independently. In about one-third of cases, some degree of partial independence is possible. The highest functioning adults with Autistic Disorder typically continue to exhibit problems in social interaction and communication along with markedly restricted interests and activities.

***Familial Pattern***

There is an increased risk of Autistic Disorder among siblings of individuals with the disorder.

***Differential magnosis***

Periods of developmental regression may be observed in normal development, but these are neither as severe or as prolonged as in Autistic Disorder. Autistic Disorder must be differentiated from **other Pervasive Developmental Disorders. Rett's Disorder** differs from Autistic Disorder in its characteristic sex ratio and pattern of deficits. Rett's Disorder has been diagnosed only in females, whereas Autistic Disorder occurs much more frequently in males. In Rett's Disorder, there is a characteristic pattern of head growth deceleration, loss of previously acquired purposeful hand skills, and the appearance of poorly coordinated gait or trunk movements. Particularly during the preschool years, individuals with Rett's Disorder may exhibit difficulties in social interaction similar to those observed in Autistic Disorder, but these tend to be transient. Autistic Disorder differs from **Childhood Disintegrative Disorder,** which has a distinctive pattern of developmental regression following at least 2 years of normal development. In Autistic Disorder, developmental abnormalities are usually noted within the first year of life. When information on early development is unavailable or when it is not possible to document the required period of normal development, the diagnosis of Autistic Disorder should be made. **Asperger's Disorder** can be distinguished from Autistic Disorder by the lack of delay in language development. Asperger's Disorder is not diagnosed if criteria are met for Autistic Disorder.

**Schizophrenia** with childhood onset usually develops after years of normal, or near normal, development. An additional diagnosis of Schizophrenia can be made if an individual with Autistic Disorder develops the characteristic features of Schizophrenia (seep. 274) with active-phase symptoms of prominent delusions or hallucinations that last for at least 1 month. In **Selective Mutism,** the child usually exhibits appropriate communication skills in certain contexts and does not have the severe impairment in social interaction and the restricted patterns of behavior associated with Autistic Disorder. In **Expressive Language Disorder** and **Mixed Receptive-Expressive Language Disorder,** there is a language impairment, but it is not associated with the presence of a qualitative impairment in social interaction and restricted, repetitive, and stereotyped patterns of behavior. It is sometimes difficult to determine whether an additional diagnosis of Autistic Disorder is warranted in an individual with **Mental Retardation,** especially if the Mental Retardation is Severe or Profound. An additional diagnosis of Autistic Disorder is reserved for those situations in which there are qualitative deficits in social and communicative skills and the specific behaviors characteristic of Autistic Disorder are present. Motor stereotypies are characteristic of Autistic Disorder; an additional diagnosis of **Stereotypic Movement Disorder** is not given when these are better accounted for as part of the presentation of Autistic Disorder.

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| * **Diagnostic criteria for 299.00 Autistic Disorder**   A. A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):   * 1. qualitative impairment in social interaction, as manifested by at least two of the following:      1. marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction      2. failure to develop peer relationships appropriate to develop­ mental level      3. a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)      4. lack of social or emotional reciprocity   2. qualitative impairments in communication as manifested by at least one of the following:      1. delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)      2. in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others |

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| * **Diagnostic criteria for 299.00 Autistic Disorder** *(continued)*   1. restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:      1. encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus      2. apparently inflexible adherence to specific, nonfunctional routines or rituals      3. stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body move­ ments)      4. persistent preoccupation with parts of objects   B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.  C. The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder. |

**299.80 Rett's Disorder**

***magnostic Features***

The essential feature of Rett's Disorder is the development of multiple specific deficits following a period of normal functioning after birth. Individuals have an apparently normal prenatal and perinatal period (Criterion Al) with normal psychomotor develop­ ment through the first 5 months of life (Criterion A2). Head circumference at birth is also within normal limits (Criterion A3). Between ages 5 and 48 months, head growth decelerates (Criterion Bl). There is a loss of previously acquired purposeful hand skills between ages 5 and 30 months, with the subsequent development of characteristic stereotyped hand movements resembling hand-wringing or hand washing (Criterion B2). Interest in the social environment diminishes in the first few years after the onset of the disorder (Criterion B3), although social interaction may often develop later in the course. Problems develop in the coordination of gait or trunk movements (Criterion B4). There is also severe impairment in expressive and receptive language development, with severe psychomotor retardation (Criterion BS).

***Associated Features and Di,sorders***

Rett's Disorder is typically associated with Severe or Profound Mental Retardation, which, if present, should be coded on Axis II. There are no specific laboratory findings associated with the disorder. There may be an increased frequency of EEG abnormalities

and seizure disorder in individuals with Rett's Disorder. Nonspecific abnormalities on brain imaging have been reported.

***Prevalence***

Data are limited to mostly case series, and it appears that Rett's Disorder is much less common than Autistic Disorder. This disorder has been reported only in females.

***Course***

The pattern of developmental regression is highly distinctive. Rett's Disorder has its onset prior to age 4 years, usually in the first or second year of life. The duration of the disorder is lifelong, and the loss of skills is generally persistent and progressive. In most instances, recovery is quite limited, although some very modest developmental gains may be made and interest in social interaction may be observed as individuals enter later childhood or adolescence. The communicative and behavioral difficulties usually remain relatively constant throughout life.

***Differential Diagnosis***

Periods of developmental regression may be observed in normal development, but these are neither as severe or as prolonged as in Rett's Disorder. For the differential between Rett's Disorder and **Autistic Disorder,** see p. 69. Rett's Disorder differs from **Childhood Disintegrative Disorder** and **Asperger's Disorder** in its characteristic sex ratio, onset, and pattern of deficits. Rett's Disorder has been diagnosed only in females, whereas Childhood Disintegrative Disorder and Asperger's Disorder appear to be more common in males. The onset of symptoms in Rett's Disorder can begin as early as age 5 months, whereas in Childhood Disintegrative Disorder the period of normal development is typically more prolonged (i.e., at least until age 2 years). In Rett's Disorder, there is a characteristic pattern of head growth deceleration, loss of previously acquired purposeful hand skills, and the appearance of poorly coordinated gait or trunk movements. In contrast to Asperger's Disorder, Rett's Disorder is characterized by a severe impairment in expressive and receptive language development.

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| * **Diagnostic criteria for 299.80 Rett's Disorder**   1. All of the following:      1. apparently normal prenatal and perinatal development      2. apparently normal psychomotor development through the first 5 months after birth      3. normal head circumference at birth   2. Onset of all of the following after the period of normal development:      1. deceleration of head growth between ages 5 and 48 months   *(continued)* |

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| * **Diagnostic criteria for 299.80 Rett's Disorder** *(continued)*   1. loss of previously acquired purposeful hand skills between ages 5 and 30 months with the subsequent development of stereotyped hand movements (e.g., hand-wringing or hand washing)   2. loss of social engagement early in the course (although often social interaction develops later)   3. appearance of poorly coordinated gait or trunk movements   4. severely impaired expressive and receptive language development with severe psychomotor retardation |

**299.10 Childhood Disintegrative Disorder**

***Diagnostic Features***

The essential feature of Childhood Disintegrative Disorder is a marked regression in multiple areas of functioning following a period of at least 2 years of apparently normal development (Criterion A). Apparently normal development is reflected in age­ appropriate verbal and nonverbal communication, social relationships, play, and adaptive behavior. After the first 2 years of life (but before age 10 years), the child has a clinically significant loss of previously acquired skills in at least two of the following areas: expressive or receptive language, social skills or adaptive behavior, bowel or bladder control, play, or motor skills (Criterion B). Individuals with this disorder exhibit the social and communicative deficits and behavioral features generally observed in Autistic Disorder (see p. 66). There is qualitative impairment in social interaction (Criterion Cl) and in communication (Criterion C2), and restricted, repetitive, and stereotyped patterns of behavior, interests, and activities (Criterion C3). The disturbance is not better accounted for by another specific Pervasive Developmental Disorder or by Schizophrenia (Criterion D). This condition has also been termed *Heller's syndrome, dementia infantilis,* or *disintegrative psychosis.*

***Associated Features and Disorders***

Childhood Disintegrative Disorder is usually associated with Severe Mental Retardation, which, if present, should he coded on Axis II. Various nonspecific neurological symptoms or signs may be noted. There seems to be an increased frequency of EEG abnormalities and seizure disorder. Although it appears likely that the condition is the result of some insult to the developing central nervous system, no precise mechanism has been identified. The condition is occasionally observed in association with a general medical condition (e.g., metachromatic leukodystrophy, Schilder's disease) that might account for the developmental regression. In most instances, however, extensive investigation does not reveal such a condition. If a neurological or other general medical condition is associated with the disorder, it should be recorded on Axis III. The laboratory findings will reflect any associated general medical conditions.

***Prevalence***

Epidemiological data are limited, but Childhood Disintegrative Disorder appears to be very rare and much less common than Autistic Disorder. Although initial studies suggested an equal sex ratio, the most recent data suggest that the condition is more common among males.

***Course***

By definition, Childhood Disintegrative Disorder can only be diagnosed if the symptoms are preceded by at least 2 years of normal development and the onset is prior to age 10 years. When the period of normal development has been quite prolonged (5 or more years), it is particularly important to conduct a thorough physical and neurological examination to assess for the presence of a general medical condition. In most cases, the onset is between ages 3 and 4 years and may be insidious or abrupt. Premonitory signs can include increased activity levels, irritability, and anxiety followed by a loss of speech and other skills. Usually the loss of skills reaches a plateau, after which some limited improvement may occur, although improvement is rarely marked. In other instances, especially when the disorder is associated with a progressive neurological condition, the loss of skills is progressive. This disorder follows a continuous course, and in the majority of cases, the duration is lifelong. The social, communicative, and behavioral difficulties remain relatively constant throughout life.

***Differential Diagnosis***

Periods of regression may be observed in normal development, but these are neither as severe or as prolonged as in Childhood Disintegrative Disorder. Childhood Disintegrative Disorder must be differentiated from **other Pervasive Developmental Disorders.** For the differential diagnosis with **Autistic Disorder,** seep. 69. For the differential diagnosis with **Rett's Disorder,** see p. 72. In contrast to **Asperger's Disorder,** Childhood Disintegrative Disorder is characterized by a clinically significant loss in previously acquired skills and a greater likelihood of Mental Retardation. In Asperger's Disorder, there is no delay in language development and no marked loss of developmental skills. Childhood Disintegrative Disorder must be differentiated from a **dementia** with onset during infancy or childhood. Dementia occurs as a consequence of the direct physiological effects of a general medical condition (e.g., head trauma), whereas Childhood Disintegrative Disorder typically occurs in the absence of an associated

general medical condition.

* **Diagnostic criteria for 299.l O Childhood Disintegrative Disorder**

A. Apparently normal development for at least the first 2 years after birth as manifested by the presence of age-appropriate verbal and nonverbal communication, social relationships, play, and adaptive behavior.

*(continued)*

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| * **Diagnostic criteria for 299.IO Childhood Disintegrative Disorder** *(continued)*   1. Clinically significant loss of previously acquired skills (before age 10 years) in at least two of the following areas:      1. expressive or receptive language      2. social skills or adaptive behavior      3. bowel or bladder control      4. play      5. motor skills   2. Abnormalities of functioning in at least two of the following areas:      1. qualitative impairment in social interaction (e.g., impairment in nonverbal behaviors, failure to develop peer relationships, lack of social or emotional reciprocity)      2. qualitative impairments in communication (e.g., delay or lack of spoken language, inability to initiate or sustain a conversation, stereotyped and repetitive use of language, lack of varied make­ believe play)      3. restricted, repetitive, and stereotyped patterns of behavior, inter­ ests, and activities, including motor stereotypies and mannerisms   3. The disturbance is not better accounted for by another specific Pervasive Developmental Disorder or by Schizophrenia. |

**299.80 Asperger's Disorder**

***Di-agnostic Features***

The essential features of Asperger's Disorder are severe and sustained impairment in social interaction (Criterion A) and the development of restricted, repetitive patterns of behavior, interests, and activities (Criterion B) (see p. 66 in Autistic Disorder for a discussion of Criteria A and B). The disturbance must cause clinically significant impairment in social, occupational, or other important areas of functioning (Criterion C). In contrast to Autistic Disorder, there are no clinically significant delays in language (e.g., single words are used by age 2 years, communicative phrases are used by age 3 years) (Criterion D). In addition, there are no clinically significant delays in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), and curiosity about the environment in childhood (Criterion E). The diagnosis is not given if the criteria are met for any other specific Pervasive Developmental Disorder or for Schizophrenia (Criterion F).

***Associated Features and Disorders***

Asperger's Disorder is sometimes observed in association with general medical condi­ tions that should be coded on Axis Ill. Various nonspecific neurological symptoms or signs may be noted. Motor milestones may be delayed, and motor clumsiness is often observed.

***Prevalence***

Information on the prevalence of Asperger's Disorder is limited, but it appears to be more common in males.

***Course***

Asperger's Disorder appears to have a somewhat later onset than Autistic Disorder, or at least to be recognized somewhat later. Motor delays or motor clumsiness may be noted in the preschool period. Difficulties in social interaction may become more apparent in the context of school. It is during this time that particular idiosyncratic or circumscribed interests (e.g., a fascination with train schedules) may appear or be recognized as such. As adults, individuals with the condition may have problems with empathy and modulation of social interaction. This disorder apparently follows a continuous course and, in the vast majority of cases, the duration is lifelong.

***Familial Pattern***

Although the available data are limited, there appears to be an increased frequency of Asperger's Disorder among family members of individuals who have the disorder.

***Di,fferential magnosis***

Asperger's Disorder is not diagnosed if criteria are met for another **Pervasive Develop­ mental Disorder** or for **Schizophrenia.** For the differential diagnosis with **Autistic Disorder,** see p. 69. For the differential diagnosis with **Rett's Disorder,** see p. 72. For the differential diagnosis with **Childhood Disintegrative Disorder,** see p. 74. Asperger's Disorder must also be distinguished from **Obsessive-Compulsive Disorder** and **Schizoid Personality Disorder.** Asperger's Disorder and Obsessive-Compulsive Disorder share repetitive and stereotyped patterns of behavior. In contrast to Obsessive­ Compulsive Disorder, Asperger's Disorder is characterized by a qualitative impairment in social interaction and a more restricted pattern of interests and activities. In contrast to Schizoid Personality Disorder, Asperger's Disorder is characterized by stereotyped behaviors and interests and by more severely impaired social interaction.

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| * **Diagnostic criteria for 299.80 Asperger's Disorder**   1. Qualitative impairment in social interaction, as manifested by at least two of the following:      1. marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction      2. failure to develop peer relationships appropriate to developmental level      3. a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest to other people)      4. lack of social or emotional reciprocity   2. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:      1. encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus      2. apparently inflexible adherence to specific, nonfunctional routines or rituals      3. stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)      4. persistent preoccupation with parts of objects   3. The disturbance causes clinically significant impairment in social, occu­ pational, or other important areas of functioning.   4. There is no clinically significant general delay in language (e.g., single words used by age 2 years, communicative phrases used by age 3 years).   5. There is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), and curiosity about the environment in childhood.   6. Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia. |

**299.80 Pervasive Developmental Disorder**

**Not Otherwise Specified (Including Atypical Autism)**

This category should be used when there is a severe and pervasive impairment in the development of reciprocal social interaction or verbal and nonverbal communication skills, or when stereotyped behavior, interests, and activities are present, but the criteria

are not met for a specific Pervasive Developmental Disorder, Schizophrenia, Schizotypal Personality Disorder, or Avoidant Personality Disorder. For example, this category includes "atypical autism"-presentations that do not meet the criteria for Autistic Disorder because of late age at onset, atypical symptomatology, or subthreshold symptomatology, or all of these.

**Att enti on-Def icit and Disruptive Behavior Disorders Attention--Deficit/HyperactivityDisorder**

***magnostic Features***

The essential feature of Attention-Deficit/Hyperactivity Disorder is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development (Criterion A). Some hyperactive-impulsive or inattentive symptoms that cause impairment must have been present before age 7 years, although many individuals are diagnosed after the symptoms have been present for a number of years (Criterion B). Some impairment from the symptoms must be present in at least two settings (e.g., at home and at school or work) (Criterion C). There must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning (Criterion **D).** The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and is not better accounted for by another mental disorder (e.g., a Mood Disorder, Anxiety Disorder, Dissociative Disorder, or Personality Disorder) (Criterion E).

Inattention may be manifest in academic, occupational, or social situations. Individ­

uals with this disorder may fail to give close attention to details or may make careless mistakes in schoolwork or other tasks (Criterion Ala). Work is often messy and performed carelessly and without considered thought. Individuals often have difficulty sustaining attention in tasks or play activities and find it hard to persist with tasks until completion (Criterion Alb). They often appear as if their mind is elsewhere or as if they are not listening or did not hear what has just been said (Criterion Ale). There may be frequent shifts from one uncompleted activity to another. Individuals diagnosed with this disorder may begin a task, move on to another, then turn to yet something else, prior to completing any one task. They often do not follow through on requests or instructions and fail to complete schoolwork, chores, or other duties (Criterion Ald). Failure to complete tasks should be considered in making this diagnosis only if it is due to inattention as opposed to other possible reasons (e.g., a failure to understand instructions). These individuals often have difficulties organizing tasks and activities (Criterion Ale). Tasks that require sustained mental effort are experienced as unpleasant and markedly aversive. As a result, these individuals typically avoid or have a strong dislike for activities that demand sustained self-application and mental effort or that require organizational demands or close concentration (e.g., homework or paperwork) (Criterion AlD. This avoidance must be due to the person's difficulties with attention and not due to a primary oppositional attitude, although secondary oppositionalism may also occur. Work habits are often disorganized and the materials necessary for doing

the task are often scattered, lost, or carelessly handled and damaged (Criterion Alg). Individuals with this disorder are easily distracted by irrelevant stimuli and frequently interrupt ongoing tasks to attend to trivial noises or events that are usually and easily ignored by others (e.g., a car honking, a background conversation) (Criterion Alh). They are often forgetful in daily activities (e.g., missing appointments, forgetting to bring lunch) (Criterion Ali). In social situations, inattention may be expressed as frequent shifts in conversation, not listening to others, not keeping one's mind on conversations, and not following details or rules of games or activities.

Hyperactivity may be manifested by fidgetiness or squirming in one's seat (Criterion A2a), by not remaining seated when expected to do so (Criterion A2b), by excessive running or climbing in situations where it is inappropriate (Criterion A2c), by having difficulty playing or engaging quietly in leisure activities (Criterion A2d), by appearing to be often "on the go" or as if "driven by a motor" (Criterion A2e), or by talking excessively (Criterion A2f). Hyperactivity may vary with the individual's age and developmental level, and the diagnosis should be made cautiously in young children. Toddlers and preschoolers with this disorder differ from normally active young children by being constantly on the go and into everything; they dart back and forth, are "out of the door before their coat is on," jump or climb on furniture, run through the house, and have difficulty participating in sedentary group activities in preschool classes (e.g., listening to a story). School-age children display similar behaviors but usually with less frequency or intensity than toddlers and preschoolers. They have difficulty remaining seated, get up frequently, and squirm in, or hang on to the edge of, their seat. They fidget with objects, tap their hands, and shake their feet or legs excessively. They often get up from the table during meals, while watching television, or while doing homework; they talk excessively; and they make excessive noise during quiet activities. In adolescents and adults, symptoms of hyperactivity take the form of feelings of restless­ ness and difficulty engaging in quiet sedentary activities.

Impulsivity manifests itself as impatience, difficulty in delaying responses, blurting out answers before questions have been completed (Criterion A2g), difficulty awaiting one's turn (Criterion A2h), and frequently interrupting or intruding on others to the point of causing difficulties in social, academic, or occupational settings (Criterion A2i). Others may complain that they cannot get a word in edgewise. Individuals with this disorder typically make comments out of turn, fail to listen to directions, initiate conversations at inappropriate times, interrupt others excessively, intrude on others, grab objects from others, touch things they are not supposed to touch, and clown around. Impulsivity may lead to accidents (e.g., knocking over objects, banging into people, grabbing a hot pan) and to engagement in potentially dangerous activities without consideration of possible consequences (e.g., riding a skateboard over extremely rough terrain).

Behavioral manifestations usually appear in multiple contexts, including home, school, work, and social situations. To make the diagnosis, some impairment must be present in at least two settings (Criterion C). It is very unusual for an individual to display the same level of dysfunction in all settings or within the same setting at all times. Symptoms typically worsen in situations that require sustained attention or mental effort or that lack intrinsic appeal or novelty (e.g., listening to classroom teachers, doing class assignments, listening to or reading lengthy materials, or working on monotonous, repetitive tasks). Signs of the disorder may be minimal or absent when the person is under very strict control, is in a novel setting, is engaged in especially interesting activities, is in a one-to-one situation (e.g., the clinician's office), or while the person experiences frequent rewards for appropriate behavior. The symptoms are more likely

to occur in group situations (e.g., in playgroups, classrooms, or work environments). The clinician should therefore inquire about the individual's behavior in a variety of situations within each setting.

***Subtypes***

Although most individuals have symptoms of both inattention and hyperactivity­ impulsivity, there are some individuals in whom one or the other pattern is predominant. The appropriate subtype (for a current diagnosis) should be indicated based on the predominant symptom pattern for the past 6 months.

**314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type.** This subtype should be used if six (or more) symptoms of inattention and six (or more) symptoms of hyperactivity-impulsivity have persisted for at least 6 months. Most children and adolescents with the disorder have the Combined Type. It is not known whether the same is true of adults with the disorder.

* 1. **Attention Deficit/Hyperactivity Disorder, Predominantly Inatten­ tive Type.** This subtype should be used if six (or more) symptoms of inattention (but fewer than six symptoms of hyperactivity-impulsivity) have persisted for at least 6 months.
  2. **Attention-Deficit/Hyperactivity Disorder, Predominantly Hyper­ active-ImpulsiveType.** This subtype should be used if six (or more) symptoms of hyperactivity-impulsivity (but fewer than six symptoms of inattention) have persisted for at least 6 months. Inattention may often still be a significant clinical feature in such cases.

***Recording Procedures***

Individuals who at an earlier stage of the disorder had the Predominantly Inattentive Type or the Predominantly Hyperactive-Impulsive Type may go on to develop the Combined Type and vice versa. The appropriate subtype (for a current diagnosis) should be indicated based on the predominant symptom pattern for the past 6 months. If clinically significant symptoms remain but criteria are no longer met for any of the subtypes, the appropriate diagnosis is Attention-Deficit/Hyperactivity Disorder, In Partial Remission. When an individual's symptoms do not currently meet full criteria for the disorder and it is unclear whether criteria for the disorder have previously been met, Attention-Deficit/Hyperactivity Disorder Not Otherwise Specified should be diagnosed.

***Associated Features and Disorders***

**Associated descriptive features and mental disorders.** Associated features vary depending on age and developmental stage and may include low frustration tolerance, temper outbursts, bossiness, stubbornness, excessive and frequent insistence that requests be met, mood !ability, demoralization, dysphoria, rejection by peers, and poor self-esteem. Academic achievement is often impaired and devalued, typically leading to conflict with the family and school authorities. Inadequate self-application to tasks that require sustained effort is often interpreted by others as indicating laziness, a poor sense of responsibility, and oppositional behavior. Family relationships are often characterized by resentment and antagonism, especially because variability in the individual's symp-

tomatic status often leads parents to believe that all the troublesome behavior is willful. Individuals with Attention-Deficit/Hyperactivity Disorder may obtain less schooling than their peers and have poorer vocational achievement. Intellectual development, as assessed by individual IQ tests, appears to be somewhat lower in children with this disorder. In its severe form, the disorder is very impairing, affecting social, familial, and scholastic adjustment. A substantial proportion of children referred to clinics with Attention-Deficit/Hyperactivity Disorder also have Oppositional Defiant Disorder or Conduct Disorder. There may be a higher prevalence of Mood Disorders, Anxiety Disorders, Learning Disorders, and Communication Disorders in children with Atten­ tion-Deficit/Hyperactivity Disorder. This disorder is not infrequent among individuals with Tourette's Disorder; when the two disorders coexist, the onset of Attention-Deficit/ Hyperactivity Disorder often precedes the onset of the Tourette's Disorder. There may be a history of child abuse or neglect, multiple foster placements, neurotoxin exposure (e.g., lead poisoning), infections (e.g., encephalitis), drug exposure in utero, low birth weight, and Mental Retardation.

**Associated laboratory findings.** There are no laboratory tests that have been estab­ lished as diagnostic in the clinical assessment of Attention-Deficit/Hyperactivity Disorder. Tests that require effortful mental processing have been noted to be abnormal in groups of individuals with Attention-Deficit/Hyperactivity Disorder compared with control subjects, but it is not yet entirely clear what fundamental cognitive deficit is responsible for this.

**Associated physical examination findings and general medical conditions.** There are no specific physical features associated with Attention-Deficit/Hyperactivity Disorder, although minor physical anomalies (e.g., hypertelorism, highly arched palate, low-set ears) may occur at a higher rate than in the general population. There may also be a higher rate of physical injury.

***Specific Culture, Age, and Gender Features***

Attention-Deficit/Hyperactivity Disorder is known to occur in various cultures, with variations in reported prevalence among Western countries probably arising more from different diagnostic practices than from differences in clinical presentation.

It is especially difficult to establish this diagnosis in children younger than age 4 or 5 years, because their characteristic behavior is much more variable than that of older children and may include features that are similar to symptoms of Attention-Deficit/ Hyperactivity Disorder. Furthermore, symptoms of inattention in toddlers or preschool children are often not readily observed because young children typically experience few demands for sustained attention. However, even the attention of toddlers can be held in a variety of situations (e.g., the average 2- or 3-year-old child can typically sit with an adult looking through picture books). In contrast, young children with Attention­ Deficit/Hyperactivity Disorder move excessively and typically are difficult to contain. Inquiring about a wide variety of behaviors in a young child may be helpful in ensuring that a full clinical picture has been obtained. As children mature, symptoms usually become less conspicuous. By late childhood and early adolescence, signs of excessive gross motor activity (e.g., excessive running and climbing, not remaining seated) are less common, and hyperactivity symptoms may be confined to fidgetiness or an inner

feeling of jitteriness or restlessness. In school-age children, symptoms of inattention affect classroom work and academic performance. Impulsive symptoms may also lead to the breaking of familial, interpersonal, and educational rules, especially in adolescence. In adulthood, restlessness may lead to difficulty in participating in sedentary activities and to avoiding pastimes or occupations that provide limited opportunity for spontaneous movement (e.g., desk jobs).

The disorder is much more frequent in males than in females, with male-to-female ratios ranging from 4:1 to 9:1, depending on the setting (i.e., general population or clinics).

***Prevalence***

The prevalence of Attention-Deficit/Hyperactivity Disorder is estimated at 3%-5% in school-age children. Data on prevalence in adolescence and adulthood are limited.

***Course***

Most parents first observe excessive motor activity when the children are toddlers, frequently coinciding with the development of independent locomotion. However, because many overactive toddlers will not go on to develop Attention-Deficit/Hyperac­ tivity Disorder, caution should be exercised in making this diagnosis in early years. Usually, the disorder is first diagnosed during elementary school years, when school adjustment is compromised. In the majority of cases seen in clinical settings, the disorder is relatively stable through early adolescence. In most individuals, symptoms attenuate during late adolescence and adulthood, although a minority experience the full complement of symptoms of Attention-Deficit/Hyperactivity Disorder into mid­ adulthood. Other adults may retain only some of the symptoms, in which case the diagnosis of Attention-Deficit/Hyperactivity Disorder, In Partial Remission, should be used. This diagnosis applies to individuals who no longer have the full disorder but still retain some symptoms that cause functional impairment.

***Familial Pattern***

Attention-Deficit/Hyperactivity Disorder has been found to be more common in the first-degree biological relatives of children with Attention-Deficit/Hyperactivity Disorder. Studies also suggest that there is a higher prevalence of Mood and Anxiety Disorders, Learning Disorders, Substance-Related Disorders, and Antisocial Personality Disorder in family members of individuals with Attention-Deficit/Hyperactivity Disorder.

***Differential Diagnosis***

In early childhood, it may be difficult to distinguish symptoms of Attention-Deficit/ Hyperactivity Disorder from **age-appropriate behaviors in active children** (e.g., running around or being noisy).

Symptoms of inattention are common among children with low IQ who are placed in academic settings that are inappropriate to their intellectual ability. These behaviors must be distinguished from similar signs in children with Attention-Deficit/Hyperactivity Disorder. In children with **Mental Retardation,** an additional diagnosis of Attention-

Deficit/Hyperactivity Disorder should be made only if the symptoms of inattention or hyperactivity are excessive for the child's mental age. Inattention in the classroom may also occur when children with high intelligence are placed in academically **un­ derstimulating environments.** Attention-Deficit/Hyperactivity Disorder must also be distinguished from difficulty in goal-directed behavior in children from inadequate, disorganized, or chaotic environments. Reports from multiple informants (e.g., baby­ sitters, grandparents, or parents of playmates) are helpful in providing a confluence of observations concerning the child's inattention, hyperactivity, and capacity for develop­ mentally appropriate self-regulation in various settings.

Individuals with **oppositional behavior** may resist work or school tasks that require self-application because of an unwillingness to conform to others' demands. These symptoms must be differentiated from the avoidance of school tasks seen in individuals with Attention-Deficit/Hyperactivity Disorder. Complicating the differential diagnosis is the fact that some individuals with Attention-Deficit/Hyperactivity Disorder develop secondary oppositional attitudes toward such tasks and devalue their impor­ tance, often as a rationalization for their failure.

Attention-Deficit/Hyperactivity Disorder is not diagnosed if the symptoms are better accounted for by **another mental disorder** (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, Personality Disorder, Personality Change Due to a General Medical Condition, or a Substance-Related Disorder). In all these disorders, the symptoms of inattention typically have an onset after age 7 years, and the childhood history of school adjustment generally is not characterized by disruptive behavior or teacher complaints concerning inattentive, hyperactive, or impulsive behavior. When a Mood Disorder or Anxiety Disorder co-occurs with Attention-Deficit/Hyperactivity Disorder, each should be diagnosed. Attention-Deficit/Hyperactivity Disorder is not diagnosed if the symptoms of inattention and hyperactivity occur exclusively during the course of a **Pervasive Developmental Disorder** or a **Psychotic Disorder.** Symptoms of inatten­ tion, hyperactivity, or impulsivity related to the use of medication (e.g., bronchodilators, isoniazid, akathisia from neuroleptics) in children before age 7 years are not diagnosed as Attention-Deficit/Hyperactivity Disorder but instead are diagnosed as **Other Sub­ stance-Related Disorder Not Otherwise Specified.**

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| * **Diagnostic criteria for Attention.-Deficit/ Hyperactivity Disorder**   A. Either (1) or (2):   * 1. six (or more) of the following symptoms of **inattention** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:   *Inattention*   * + 1. often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities     2. often has difficulty sustaining attention in tasks or play activities   *(continued)* |

* **Diagnostic criteria for Attention Deficit/Hyperactivity Disorder** *(continued)*
  1. often does not seem to listen when spoken to directly
  2. often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
  3. often has difficulty organizing tasks and activities

CD often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or home­ work)

1. often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
2. is often easily distracted by extraneous stimuli
3. is often forgetful in daily activities

(2) six (or more) of the following symptoms of **hyperactivity­**

accounted tor by **another mental disorder** (e.g., Mood Disorder, Anxiety Disorder,

Dissociative Disorder, Personality Disorder, Personality Change Due to a General Medical Condition, or a Substance-Related Disorder). In all these disorders, the symptoms of inattention typically have an onset after age 7 years, and the childhood history of school adjustment generally is not characterized by disruptive behavior or teacher complaints concerning inattentive, hyperactive, or impulsive behavior. When a Mood Disorder or Anxiety Disorder co-occurs with Attention-Deficit/Hyperactivity Disorder, each should be diagnosed. Attention-Deficit/Hyperactivity Disorder is not diagnosed if the symptoms of inattention and hyperactivity occur exclusively during the course of a **Pervasive Developmental Disorder** or a **Psychotic Disorder.** Symptoms of inatten­ tion, hyperactivity, or impulsivity related to the use of medication (e.g., bronchodilators, isoniazid, akathisia from neuroleptics) in children before age 7 years are not diagnosed as Attention-Deficit/Hyperactivity Disorder but instead are diagnosed as **Other Sub­ stance-Related Disorder Not Otherwise Specified.**

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| * **Diagnostic criteria for Attention Deficit/ Hyperactivity Disorder**   A. Either (1) or (2):   * 1. six (or more) of the following symptoms of **inattention** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:   *Inattention*   * + 1. often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities     2. often has difficulty sustaining attention in tasks or play activities   *(continued)* |

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| □ **Diagnostic criteria for Attention--Deficit/Hyperactivity Disorder** *(continued)*  E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).  *Code* based on type  **314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type:**  if both Criteria Al and A2 are met for the past 6 months   * 1. **Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type:** if Criterion Al is met but Criterion A2 is not met for the past 6 months   2. **Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type:** if Criterion A2 is met but Criterion Al is not met for the past 6 months   **Coding note:** For individuals (especially adolescents and adults) who currently have symptoms that no longer meet full criteria, "In Partial Remission" should be specified. |

**314.9 Attention--Deficit/Hyperactivity Disorder Not Otherwise Specified**

This category is for disorders with prominent symptoms of inattention or hyperactivity­ impulsivity that do not meet criteria for Attention-Deficit/Hyperactivity Disorder.

**312.8 Conduct Disorder**

***Diagnostic Features***

The essential feature of Conduct Disorder is a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated (Criterion A). These behaviors fall into four main groupings: aggressive conduct that causes or threatens physical harm to other people or animals (Criteria Al-A7), nonaggressive conduct that causes property loss or damage (Criteria A8-A9), deceitful­ ness or theft (Criteria A10-A12), and serious violations of rules (Criteria A13-A15). Three (or more) characteristic behaviors must have been present during the past 12 months, with at least one behavior present in the past 6 months. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning (Criterion B). Conduct Disorder may be diagnosed in individuals who are older than age 18 years, but only if the criteria for Antisocial Personality Disorder are not met (Criterion C). The behavior pattern is usually present in a variety of settings such as home, school, or the community. Because individuals with Conduct Disorder are likely

to mm1m1ze their conduct problems, the clinician often must rely on additional informants. However, the informant's knowledge of the child's conduct problems may be limited by inadequate supervision or by the child's not having revealed them.

Children or adolescents with this disorder often initiate aggressive behavior and react aggressively to others. They may display bullying, threatening, or intimidating behavior (Criterion Al); initiate frequent physical fights (Criterion A2); use a weapon that can cause serious physical harm (e.g., a bat, brick, broken bottle, knife, or gun) (Criterion A3); be physically cruel to people (Criterion A4) or animals (Criterion AS); steal while confronting a victim (e.g., mugging, purse snatching, extortion, or armed robbery) (Criterion A6); or force someone into sexual activity (Criterion A7). Physical violence may take the form of rape, assault, or in rare cases, homicide.

Deliberate destruction of others' property is a characteristic feature of this disorder and may include deliberate fire setting with the intention of causing serious damage (Criterion A8) or deliberately destroying other people's property in other ways (e.g., smashing car windows, school vandalism) (Criterion A9).

Deceitfulness or theft is common and may include breaking into someone else's house, building, or car (Criterion AlO); frequently lying or breaking promises to obtain goods or favors or to avoid debts or obligations (e.g., "conning" other people) (Criterion Al1); or stealing items of nontrivial value without confronting the victim (e.g., shoplifting, forgery) (Criterion A12).

Characteristically, there are also serious violations of rules (e.g., school, parental) by individuals with this disorder. Children with this disorder often have a pattern, beginning before age 13 years, of staying out late at night despite parental prohibitions (Criterion A13). There may be a pattern of running away from home overnight (Criterion Al4). To be considered a symptom of Conduct Disorder, the running away must have occurred at least twice (or only once if the individual did not return for a lengthy period). Runaway episodes that occur as a direct consequence of physical or sexual abuse do not typically qualify for this criterion. Children with this disorder may often be truant from school, beginning prior to age 13 years (Criterion A15). In older individuals, this behavior is manifested by often being absent from work without good reason.

***Subtypes***

Two subtypes of Conduct Disorder are provided based on the age at onset of the disorder (i.e., Childhood-Onset Type and Adolescent-Onset Type). The subtypes differ in regard to the characteristic nature of the presenting conduct problems, developmental course and prognosis, and gender ratio. Both subtypes can occur in a mild, moderate, or severe form. In assessing the age at onset, information should preferably be obtained from the youth and from caregiver(s). Because many of the behaviors may be concealed, caregivers may underreport symptoms and overestimate the age at onset.

**Childhood-Onset Type.** This subtype is defined by the onset of at least one criterion characteristic of Conduct Disorder prior to age 10 years. Individuals with Childhood-Onset Type are usually male, frequently display physical aggression toward others, have disturbed peer relationships, may have had Oppositional Defiant Disorder during early childhood, and usually have symptoms that meet full criteria for Conduct Disorder prior to puberty. These individuals are more likely to have persistent Conduct Disorder and to develop adult Antisocial Personality Disorder than are those with Adolescent-Onset Type.

**Adolescent-OnsetType.** This subtype is defined by the absence of any criteria characteristic of Conduct Disorder prior to age 10 years. Compared with those with the Childhood-Onset Type, these individuals are less likely to display aggressive behaviors and tend to have more normative peer relationships (although they often display conduct problems in the company of others). These individuals are less likely to have persistent Conduct Disorder or to develop adult Antisocial Personality Disorder. The ratio of males to females with Conduct Disorder is lower for the Adolescent-Onset Type than for the Childhood-Onset Type.

***Severity Specifiers***

**Mild.** Few if any conduct problems in excess of those required to make the diagnosis are present, and conduct problems cause relatively minor harm to others (e.g., lying, truancy, staying out after dark without permission).

**Moderate.** The number of conduct problems and the effect on others are intermediate between "mild" and "severe" (e.g., stealing without confronting a victim, vandalism).

**Severe.** Many conduct problems in excess of those required to make the diagnosis are present, or conduct problems cause considerable harm to others (e.g., forced sex, physical cruelty, use of a weapon, stealing while confronting a victim, breaking and entering).

***Associated Features and Disorders***

**Associated descriptive features and mental disorders.** Individuals with Conduct Disorder may have little empathy and little concern for the feelings, wishes, and well-being of others. Especially in ambiguous situations, aggressive individuals with this disorder frequently misperceive the intentions of others as more hostile and threatening than is the case and respond with aggression that they then feel is reasonable and justified. They may be callous and lack appropriate feelings of guilt or remorse. It can be difficult to evaluate whether displayed remorse is genuine because these individuals learn that expressing guilt may reduce or prevent punishment. Individuals with this disorder may readily inform on their companions and try to blame others for their own misdeeds. Self-esteem is usually low, although the person may project an image of "toughness." Poor frustration tolerance, irritability, temper outbursts, and recklessness are frequent associated features. Accident rates appear to be higher in individuals with Conduct Disorder than in those without it.

Conduct Disorder is often associated with an early onset of sexual behavior, drinking, smoking, use of illegal substances, and reckless and risk-taking acts. Illegal drug use may increase the risk that Conduct Disorder will persist. Conduct Disorder behaviors may lead to school suspension or expulsion, problems in work adjustment, legal difficulties, sexually transmitted diseases, unplanned pregnancy, and physical injury from accidents or fights. These problems may preclude attendance in ordinary schools or living in a parental or foster home. Suicidal ideation, suicide attempts, and completed suicide occur at a higher than expected rate. Conduct Disorder may be associated with lower than average intelligence. Academic achievement, particularly in reading and other verbal skills, is often below the level expected on the basis of age and intelligence and may justify the additional diagnosis of a Leaming or Communication Disorder. Attention-

Deficit/Hyperactivity Disorder is common in children with Conduct Disorder. Conduct Disorder may also be associated with one or more of the following mental disorders: Learning Disorders, Anxiety Disorders, Mood Disorders, and Substance-Related Disor­ ders. The following factors may predispose the individual to the development of Conduct Disorder: parental rejection and neglect, difficult infant temperament, inconsistent child-rearing practices with harsh discipline, physical or sexual abuse, lack of supervi­ sion, early institutional living, frequent changes of caregivers, large family size, associ­ ation with a delinquent peer group, and certain kinds of familial psychopathology.

**Associated laboratory findings.** In some studies, lower heart rate and lower skin conductance have been noted in individuals with Conduct Disorder compared with those without the disorder. However, levels of physiological arousal are not diagnostic of the disorder.

***Specific Culture, Age, and Gender Features***

Concerns have been raised that the Conduct Disorder diagnosis may at times be misapplied to individuals in settings where patterns of undesirable behavior are sometimes viewed as protective (e.g., threatening, impoverished, high-crime). Consistent with the DSM-IV definition of mental disorder, the Conduct Disorder diagnosis should be applied only when the behavior in question is symptomatic of an underlying dysfunction within the individual and not simply a reaction to the immediate social context. Moreover, immigrant youth from war-ravaged countries who have a history of aggressive behaviors that may have been necessary for their survival in that context would not necessarily warrant a diagnosis of Conduct Disorder. It may be helpful for the clinician to consider the social and economic context in which the undesirable behaviors have occurred.

Symptoms of the disorder vary with age as the individual develops increased physical strength, cognitive abilities, and sexual maturity. Less severe behaviors (e.g., lying, shoplifting, physical fighting) tend to emerge first, whereas others (e.g., burglary) tend to emerge later. Typically, the most severe conduct problems (e.g., rape, theft while confronting a victim) tend to emerge last. However, there are wide differences among individuals, with some engaging in the more damaging behaviors at an early age.

Conduct Disorder, especially the Childhood-Onset Type, is much more common in males. Gender differences are also found in specific types of conduct problems. Males with a diagnosis of Conduct Disorder frequently exhibit fighting, stealing, vandalism, and school discipline problems. Females with a diagnosis of Conduct Disorder are more likely to exhibit lying, truancy, running away, substance use, and prostitution. Whereas confrontational aggression is more often displayed by males, females tend to use more nonconfrontational behaviors.

***Prevalence***

The prevalence of Conduct Disorder appears to have increased over the last decades and may be higher in urban than in rural settings. Rates vary widely depending on the nature of the population sampled and methods of ascertainment: for males under age 18 years, rates range from 6% to 16%; for females, rates range from 2% to 9%. Conduct Disorder is one of the most frequently diagnosed conditions in outpatient and inpatient mental health facilities for children.

***Course***

The onset of Conduct Disorder may occur as early as age 5-6 years hut is usually in late childhood or early adolescence. Onset is rare after age 16 years. The course of Conduct Disorder is variable. In a majority of individuals, the disorder remits by adulthood. However, a substantial proportion continue to show behaviors in adulthood that meet criteria for Antisocial Personality Disorder. Many individuals with Conduct Disorder, particularly those with Adolescent-Onset Type and those with few and milder symptoms, achieve adequate social and occupational adjustment as adults. Early onset predicts a worse prognosis and an increased risk in adult life for Antisocial Personality Disorder and Substance-Related Disorders. Individuals with Conduct Disorder are at risk for later Mood or Anxiety Disorders, Somatoform Disorders, and Substance-Related Disorders.

***Familial Pattern***

Estimates from twin and adoption studies show that Conduct Disorder has both genetic and environmental components. The risk for Conduct Disorder is increased in children with a biological or adoptive parent with Antisocial Personality Disorder or a sibling with Conduct Disorder. The disorder also appears to be more common in children of biological parents with Alcohol Dependence, Mood Disorders, or Schizophrenia or biological parents who have a history of Attention-Deficit/Hyperactivity Disorder or Conduct Disorder.

***Di-fferential magnosis***

Although **Oppositional Defiant Disorder** includes some of the features observed in Conduct Disorder (e.g., disobedience and opposition to authority figures), it does not include the persistent pattern of the more serious forms of behavior in which either the basic rights of others or age-appropriate societal norms or rules are violated. When the individual's pattern of behavior meets the criteria for both Conduct Disorder and Oppositional Defiant Disorder, the diagnosis of Conduct Disorder takes precedence and Oppositional Defiant Disorder is not diagnosed.

Although children with **Attention-Deficit/Hyperactivity Disorder** often exhibit hyperactive and impulsive behavior that may be disruptive, this behavior does not by itself violate age-appropriate societal norms and therefore does not usually meet criteria for Conduct Disorder. When criteria are met for both Attention-Deficit/Hyperactivity Disorder and Conduct Disorder, both diagnoses should be given.

Irritability and conduct problems often occur in children or adolescents having a **Manic Episode.** These can usually be distinguished from the pattern of conduct problems seen in Conduct Disorder hased on the episodic course and accompanying symptoms characteristic of a Manic Episode. If criteria for both are met, diagnoses of both Conduct Disorder and Bipolar I Disorder can be given.

The diagnosis of **Adjustment Disorder** (With Disturbance of Conduct or With Mixed Disturbance of Emotions and Conduct) should be considered if clinically significant conduct problems that do not meet the criteria for another specific disorder develop in clear association with the onset of a psychosocial stressor. Isolated conduct problems that do not meet criteria for Conduct Disorder or Adjustment Disorder may be coded as **Child or Adolescent Antisocial Behavior** (see "Other Conditions That May Be a Focus of Clinical Attention," p. 684). Conduct Disorder is diagnosed only if the

conduct problems represent a repetitive and persistent pattern that is associated with impairment in social, academic, or occupational functioning.

For individuals over age 18 years, a diagnosis of Conduct Disorder can be given only if the criteria are not also met for **AntisocialPersonalityDisorder.** The diagnosis of Antisocial Personality Disorder cannot be given to individuals under age 18 years.

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| * **Diagnostic criteria for 3 I 2.8 Conduct Disorder**   A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:  **Aggression to people and animals**   * 1. often bullies, threatens, or intimidates others   2. often initiates physical fights   3. has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)   4. has been physically cruel to people   5. has been physically cruel to animals   6. has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)   7. has forced someone into sexual activity   **Destruction of property**   * 1. has deliberately engaged in fire setting with the intention of causing serious damage   2. has deliberately destroyed others' property (other than by fire setting)   **Deceitfulness or theft**   * 1. has broken into someone else's house, building, or car   2. often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)   3. has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)   **Serious violations of rules**   * 1. often stays out at night despite parental prohibitions, beginning before age 13 years   2. has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)   3. is often truant from school, beginning before age 13 years   *(continued)* |

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| * **Diagnostic criteria for 312.8 Conduct Disorder** *(continued)*   B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.  C. If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.  *Specify* type based on age at onset:  **Childhood-Onset Type:** onset of at least one criterion characteristic of Conduct Disorder prior to age 10 years  **Adolescent-OnsetType:** absence of any criteria characteristic of Conduct Disorder prior to age 10 years  *Specify* severity:  **Mild:** few if any conduct problems in excess of those required to make the diagnosis **and** conduct problems cause only minor harm to others  **Moderate:** number of conduct problems and effect on others intermediate between "mild" and "severe"  **Severe:** many conduct problems in excess of those required to make the diagnosis **or** conduct problems cause considerable harm to others |

313.81 Oppositional Defiant Disorder

***Di,agnostic Features***

The essential feature of Oppositional Defiant Disorder is a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists for at least 6 months (Criterion A) and is characterized by the frequent occurrence of at least four of the following behaviors: losing temper (Criterion Al), arguing with adults (Criterion A2), actively defying or refusing to comply with the requests or rules of adults (Criterion A3), deliberately doing things that will annoy other people (Criterion A4), blaming others for his or her own mistakes or misbehavior (Criterion A5), being touchy or easily annoyed by others (Criterion A6), being angry and resentful (Criterion A7), or being spiteful or vindictive (Criterion AS). To qualify for Oppositional Defiant Disorder, the behaviors must occur more frequently than is typically observed in individuals of comparable age and developmental level and must lead to significant impairment in social, academic, or occupational functioning (Criterion B). The diagnosis is not made if the disturbance in behavior occurs exclusively during the course of a Psychotic or Mood Disorder (Criterion C) or if criteria are met for Conduct Disorder or Antisocial Personality Disorder (in an individual over age 18 years).

Negativistic and defiant behaviors are expressed by persistent stubbornness, resis­ tance to directions, and unwillingness to compromise, give in, or negotiate with adults or peers. Defiance may also include deliberate or persistent testing of limits, usually by ignoring orders, arguing, and failing to accept blame for misdeeds. Hostility can be directed at adults or peers and is shown by deliberately annoying others or by verbal

aggression (usually without the more serious physical aggression seen in Conduct Disorder). Manifestations of the disorder ,are almost invariably present in the home setting, but may not be evident at school or in the community. Symptoms of the disorder are typically more evident in interactions with adults or peers whom the individual knows well, and thus may not be apparent during clinical examination. Usually individuals with this disorder do not regard themselves as oppositional or defiant, but justify their behavior as a response to unreasonable demands or circumstances.

***Associated Features and Disorders***

Associated features and disorders vary as a function of the individual's age and the severity of the Oppositional Defiant Disorder. In males, the disorder has been shown to be more prevalent among those who, in the preschool years, have problematic temperaments (e.g., high reactivity, difficulty being soothed) or high motor activity. During the school years, there may be low self-esteem, mood !ability, low frustration tolerance, swearing, and the precocious use of alcohol, tobacco, or illicit drugs. There are often conflicts with parents, teachers, and peers. There may be a vicious cycle in which the parent and child bring out the worst in each other. Oppositional Defiant Disorder is more prevalent in families in which child care is disrupted by a succession of different caregivers or in families in which harsh, inconsistent, or neglectful child­ rearing practices are common. Attention-Deficit/Hyperactivity Disorder is common in children with Oppositional Defiant Disorder. Learning Disorders and Communication Disorders also tend to be associated with Oppositional Defiant Disorder.

***Specific Age and Gender Features***

Because transient oppositional behavior is very common in preschool children and in adolescents, caution should be exercised in making the diagnosis of Oppositional Defiant Disorder especially during these developmental periods. The number of oppositional symptoms tends to increase with age. The disorder is more prevalent in males than in females before puberty, but the rates are probably equal after puberty. Symptoms are generally similar in each gender, except that males may have more confrontational behavior and more persistent symptoms.

***Prevalence***

Rates of Oppositional Defiant Disorder from 2% to 16% have been reported, depending on the nature of the population sample and methods of ascertainment.

***Course***

Oppositional Defiant Disorder usually becomes evident before age 8 years and usually not later than early adolescence. The oppositional symptoms often emerge in the home setting but over time may appear in other settings as well. Onset is typically gradual, usually occurring over the course of months or years. In a significant proportion of cases, Oppositional Defiant Disorder is a developmental antecedent to Conduct Disorder.

***Familial Pattern***

Oppositional Defiant Disorder appears to be more common in families in which at least one parent has a history of a Mood Disorder, Oppositional Defiant Disorder, Conduct Disorder, Attention-Deficit/Hyperactivity Disorder, Antisocial Personality Disorder, or a Substance-Related Disorder. In addition, some studies suggest that mothers with a Depressive Disorder are more likely to have children with oppositional behavior, but it is unclear to what extent maternal depression results from or causes oppositional behavior in children. Oppositional Defiant Disorder is more common in families in which there is serious marital discord.

***m.{ferential magnosis***

The disruptive behaviors of individuals with Oppositional Defiant Disorder are of a less severe nature than those of individuals with Conduct Disorder and typically do not include aggression toward people or animals, destruction of property, or a pattern of theft or deceit. Because all of the features of Oppositional Defiant Disorder are usually present in **Conduct Disorder,** Oppositional Defiant Disorder is not diagnosed if the criteria are met for Conduct Disorder. Oppositional behavior is a common associated feature of **Mood Disorders** and **Psychotic Disorders** presenting in children and adolescents and should not be diagnosed separately if the symptoms occur exclusively during the course of a Mood or Psychotic Disorder. Oppositional behaviors must also be distinguished from the disruptive behavior resulting from inattention and impulsivity in **Attention-Deficit/HyperactivityDisorder.** When the two disorders co-occur, both diagnoses should be made. In individuals with **Mental Retardation,** a diagnosis of Oppositional Defiant Disorder is given only if the oppositional behavior is markedly greater than is commonly observed among individuals of comparable age, gender, and severity of Mental Retardation. Oppositional Defiant Disorder must also be distinguished from a failure to follow directions that is the result of **impaired language comprehen­ sion** (e.g., hearing loss, Mixed Receptive-Expressive Language Disorder). Oppositional behavior is a **typical feature of certain developmental stages** (e.g., early childhood and adolescence). A diagnosis of Oppositional Defiant Disorder should be considered only if the behaviors occur more frequently and have more serious consequences than is typically observed in other individuals of comparable developmental stage and lead to significant impairment in social, academic, or occupational functioning. New onset of oppositional behaviors in adolescence may be due to the process of normal individuation.

A. A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:

1. often loses temper
2. often argues with adults

*( continued)*

**Disorder**

* **Diagnostic criteria for 3I 3.8 I Oppositional Defiant**

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| * **Diagnostic criteria for 3I 3.81 Oppositional Defiant Disorder** *(continued)*   1. often actively defies or refuses to comply with adults' requests or rules   2. often deliberately annoys people   3. often blames others for his or her mistakes or misbehavior   4. is often touchy or easily annoyed by others   5. is often angry and resentful   6. is often spiteful or vindictive   **Note:** Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.   1. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning. 2. The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder. 3. Criteria are not met for Conduct Disorder, and, if the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder. |

**312.9 Disruptive Behavior Disorder Not Otherwise Specified**

This category is for disorders characterized by conduct or oppositional defiant behaviors that do not meet the criteria for Conduct Disorder or Oppositional Defiant Disorder. For example, include clinical presentations that do not meet full criteria either for Opposi­ tional Defiant Disorder or Conduct Disorder, but in which there is clinically significant impairment.

**Feeding and Eating Disorders of Infancy or Early Childhood**

The Feeding and Eating Disorders of Infancy or Early Childhood are characterized by persistent feeding and eating disturbances. The specific disorders included are Pica, Rumination Disorder, and Feeding Disorder of Infancy or Early Childhood. Note that Anorexia Nervosa and Bulimia Nervosa are included in the "Eating Disorders" section (see p. 539).

* 1. **Pica**

***magnostic Features***

The essential feature of Pica is the persistent eating of nonnutritive substances for a period of at least 1 month (Criterion A). The typical substance ingested tends to vary with age. Infants and younger children typically eat paint, plaster, string, hair, or cloth. Older children may eat animal droppings, sand, insects, leaves, or pebbles. Adolescents and adults may consume clay or soil. There is no aversion to food. This behavior must be developmentally inappropriate (Criterion B) and not part of a culturally sanctioned practice (Criterion C). The eating of nonnutritive substances is an associated feature of other mental disorders (e.g., Pervasive Developmental Disorder, Mental Retardation). If the eating behavior occurs exclusively during the course of another mental disorder, a separate diagnosis of Pica should be made only if the eating behavior is sufficiently severe to warrant independent clinical attention (Criterion D).

***Associated Features and Disorders***

Pica is frequently associated with Mental Retardation. Although vitamin or mineral deficiencies have been reported in some instances, usually no specific biological abnormalities are found. In some cases, Pica comes to clinical attention only when the individual presents with any of the various general medical complications that may result (e.g., lead poisoning as a result of ingesting paint or paint-soaked plaster, mechanical bowel problems, intestinal obstruction as a result of hair ball tumors, intestinal perforation, or infections such as toxoplasmosis and toxocariasis as a result of ingesting feces or dirt). Poverty, neglect, lack of parental supervision, and developmental delay increase the risk for the condition.

***Specific Culture, Age, and Gender Features***

In some cultures, the eating of dirt or other seemingly nonnutritive substances is believed

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Before approximately ages 18-24 months, mouthing and sometimes eating of nonnutri­ tive substances are relatively common and do not imply the presence of Pica. Pica is diagnosed only when the behavior is judged to be persistent (i.e., present for at least 1 month) and inappropriate given the individual's developmental level. Eating of non­ nutritive substances may occur during the course of other mental disorders (e.g., in a **Pervasive Developmental Disorder, in Schizophrenia** as a result of delusional beliefs, and in **Kleine-Levin syndrome).** In such instances, an additional diagnosis of Pica should be given only if the eating behavior is sufficiently severe to warrant independent clinical attention. Pica can be distinguished from **other eating disorders** (e.g., Rumination Disorder, Feeding Disorder of Infancy or Early Childhood, Anorexia Nervosa, and Bulimia Nervosa) by the consumption of nonnutritive substances.

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| * **Diagnostic criteria for 307.52 Pica**   1. Persistent eating of nonnutritive substances for a period of at least 1 month.   2. The eating of nonnutritive substances is inappropriate to the develop­ mental level.   3. The eating behavior is not part of a culturally sanctioned practice.   4. If the eating behavior occurs exclusively during the course of another mental disorder (e.g., Mental Retardation, Pervasive Developmental Disorder, Schizophrenia), it is sufficiently severe to warrant independent clinical attention. |

* 1. **Rumination Disorder**

***magnostic Features***

The essential feature of Rumination Disorder is the repeated regurgitation and rechewing of food that develops in an infant or child after a period of normal functioning and lasts for at least 1 month (Criterion A). Partially digested food is brought up into the mouth without apparent nausea, retching, disgust, or associated gastrointestinal disorder. The food is then either ejected from the mouth or, more frequently, chewed and reswallowed. The symptoms are not due to an associated gastrointestinal or other general medical condition (e.g., Sandifer's syndrome, esophageal reflux) (Criterion B) and do not occur exclusively during the course of Anorexia Nervosa or Bulimia Nervosa. If the symptoms occur exclusively during the course of Mental Retardation or a Pervasive Developmental Disorder, they must be sufficiently severe to warrant independent clinical attention

(Criterion C). The disorder is most commonly observed in infants but may be seen in older individuals, particularly those who also have Mental Retardation. Infants with the disorder display a characteristic position of straining and arching the back with the head held back, make sucking movements with their tongues, and give the impression of gaining satisfaction from the activity.

***Associated Features and Disorders***

Infants with Rumination Disorder are generally irritable and hungry between episodes of regurgitation. Although the infant is apparently hungry and ingests large amounts of food, malnutrition may occur because regurgitation immediately follows the feedings. Weight loss, failure to make expected weight gains, and even death can result (with mortality rates as high as 25% reported). Malnutrition appears to be less likely in older children and adults in whom the disorder may be either continuous or episodic. Psychosocial problems such as lack of stimulation, neglect, stressful life situations, and problems in the parent-child relationship may be predisposing factors. Understimulation of the infant may result if the caregiver becomes discouraged and alienated because of the unsuccessful feeding experiences or the noxious odor of the regurgitated material. In some instances, Feeding Disorder of Infancy or Early Childhood may also develop. In older children and adults, Mental Retardation is a predisposing factor.

***Prevalence***

Rumination Disorder appears to be uncommon. It may occur more often in males than in females.

***Course***

The onset of Rumination Disorder may occur in the context of developmental delays. The age at onset is between ages 3 and 12 months, except in individuals with Mental Retardation in whom the disorder may occur at a somewhat later developmental stage. In infants, the disorder frequently remits spontaneously. In some severe cases, however, the course is continuous.

***Differential Diagnosis***

In infants, **congenital anomalies** (e.g., pyloric stenosis or gastroesophageal reflux) or **other general medical conditions** (e.g., infections of the gastrointestinal system) can cause regurgitation of food and should be ruled out by appropriate physical examina­ tions and laboratory tests. Rumination can be distinguished from **normal vomiting of early infancy** by the apparently voluntary nature of the rumination (e.g., observation of characteristic preparatory movements followed by regurgitation and sucking or chewing movements that appear to be pleasurable). Rumination Disorder is not diagnosed if the symptoms occur exclusively during the course of **Anorexia Nervosa** or **Bulimia Nervosa.**

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| * **Diagnostic criteria for 307.53 Rumination Disorder**   1. Repeated regurgitation and rechewing of food for a period of at least 1 month following a period of normal functioning.   2. The behavior is not due to an associated gastrointestinal or other general medical condition (e.g., esophageal reflux).   3. The behavior does not occur exclusively during the course of Anorexia Nervosa or Bulimia Nervosa. If the symptoms occur exclusively during the course of Mental Retardation or a Pervasive Developmental Disorder, they are sufficiently severe to warrant independent clinical attention. |

**307.59 Feeding Disorder of Infancy or Early Childhood**

***Di-agnostic Features***

The essential feature of Feeding Disorder of Infancy or Early Childhood is the persistent failure to eat adequately, as reflected in significant failure to gain weight or significant weight loss over at least 1 month (Criterion A). There is no gastrointestinal or other general medical condition (e.g., esophageal reflux) severe enough to account for the feeding disturbance (Criterion B). The feeding disturbance is also not better accounted for by another Mental Disorder (e.g., Rumination Disorder) or by lack of available food (Criterion C). The onset of the disorder must be before age 6 years (Criterion D).

***Associated Features and Disorders***

**Associated descriptive features and mental disorders.** Infants with feeding disor­ ders are often especially irritable and difficult to console during feeding. They may appear apathetic and withdrawn and may also exhibit developmental delays. In some instances, parent-child interaction problems may contribute to or exacerbate the infant's feeding problem (e.g., presenting food inappropriately or responding to the infant's food refusal as if it were an act of aggression or rejection). Inadequate caloric intake may exacerbate the associated features (e.g., irritability, developmental lags) and further contribute to feeding difficulties. Factors in the infant that may be associated with the condition include neuroregulatory difficulties (e.g., sleep-wake difficulties, frequent regurgitation, unpredictable periods of alertness) and preexisting developmental im­ pairments that make the infant less responsive. Other factors that may be associated with the condition include parental psychopathology and child abuse or neglect.

**Associated laboratory findings.** There may be nonspecific findings associated with the malnutrition that is sometimes seen with Feeding Disorder of Infancy or Early Childhood (e.g., anemia and low serum albumin and total protein).

**Associated physical examination findings and general medical conditions.** There may be malnutrition that, in severe cases, can be life threatening in Feeding Disorder of Infancy or Early Childhood.

***Specific Age and Gender Features***

A later onset (e.g., age 2 or 3 years rather than infancy) is associated with lesser degrees of developmental delay and malnutrition, although growth retardation may be observed. Feeding Disorder of Infancy or Early Childhood is equally common in males and females.

***Prevalence***

Of all pediatric hospital admissions, 1%-5% are for failure to gain adequate weight, and up to one-half of these may reflect feeding disturbances without any apparent predis­ posing general medical condition.

***Course***

Feeding Disorder of Infancy or Early Childhood commonly has its onset in the first year of life, but may have an onset in children ages 2-3 years. The majority of children have improved growth after variable lengths of time.

***Differential Diagnosis***

Minor problems in feeding are common in infancy. The diagnosis of Feeding Disorder of Infancy or Early Childhood should be made only if the eating problem results in significant failure to gain weight or loss of weight.

This disorder is not diagnosed if the feeding disturbances are fully explained by a **gastrointestinal, endocrinological, or neurological condition.** Children with an underlying general medical condition may be more difficult to feed, and the diagnosis of Feeding Disorder of Infancy or Early Childhood should not be made in such cases unless the degree of disturbance is of greater severity than would be expected on the basis of the general medical condition alone. The diagnosis is suggested if there is improvement in feeding and weight gain in response to changing caregivers.

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| * **Diagnostic criteria for 307.59 Feeding Disorder of Infancy or Early Childhood**   1. Feeding disturbance as manifested by persistent failure to eat adequately with significant failure to gain weight or significant loss of weight over at least 1 month.   2. The disturbance is not due to an associated gastrointestinal or other general medical condition (e.g., esophageal reflux).   *(continued)* |

* **Diagnostic criteria for 307.59 Feeding Disorder of Infancy or Early Childhood** *(continued)*

C. The disturbance is not better accounted for by another mental disorder (e.g., Rumination Disorder) or by lack of available food.

D. The onset is before age 6 years.

**Tic Disorders**

Four disorders are included in this section: Tourette's Disorder, Chronic Motor or Vocal Tic Disorder, Transient Tic Disorder, and Tic Disorder Not Otherwise Specified. A *tic* is a sudden, rapid, recurrent, nonrhythmic, stereotyped motor movement or vocalization. It is experienced as irresistible but can be suppressed for varying lengths of time. All forms of tic may be exacerbated by stress and attenuated during absorbing activities (e.g., reading or sewing). Tics are usually markedly diminished during sleep. Both motor and vocal tics may be classified as either simple or complex, although the boundary is not well defined. Common *simple motor tics* include eye blinking, neck jerking, shoulder shrugging, facial grimacing, and coughing. Common *simple vocal tics* include throat clearing, grunting, sniffing, snorting, and barking. Common *complex motor tics* include facial gestures, grooming behaviors, jumping, touching, stamping, and smelling an object. Common *complex vocal tics* include repeating words or phrases out of context, coprolalia (use of socially unacceptable words, frequently obscene), palilalia (repeating one's own sounds or words), and echolalia (repeating the last-heard sound, word, or phrase). Other complex tics include echokinesis (imitation of someone else's move­ ments).

***Di.fferential magnosis***

Tic Disorders must be distinguished from other types of **abnormal movements that may accompany general medical conditions** (e.g., Huntington's disease, stroke, Lesch-Nyhan syndrome, Wilson's disease, Sydenham's chorea, multiple sclerosis, post­ viral encephalitis, head injury) or may be due to the **directeffectsofasubstance** (e.g., a neuroleptic medication). **Choreiform movements** are dancing, random, irregular, nonrepetitive movements. **Dystonic movements** are slower, twisting movements interspersed with prolonged states of muscular tension. **Athetoid movements** are slow, irregular, writhing movements, most frequently in the fingers and toes, but often involving the face and neck. **Myoclonic movements** are brief, shocklike muscle contractions that may affect parts of muscles or muscle groups but not synergistically. **Hemiballismic movements** are intermittent, coarse, large-amplitude, unilateral move­ ments of the limbs. **Spasms** are stereotypic, slower, and more prolonged than tics and involve groups of muscles. **Hemifacialspasm** consists of irregular, repetitive, unilateral jerks of facial muscles. **Synkinesis** involves an involuntary movement accompanying a voluntary one (e.g., movement of the corner of the mouth when the person intends to

close the eye). This differentiation is further facilitated by considering the presence of features of the underlying general medical condition (e.g., characteristic family history in Huntington's disease) or a history of medication use.

When the tics are a direct physiological consequence of medication use, a **Medication-Induced Movement Disorder Not Otherwise Specified** would be diagnosed instead of a Tic Disorder. In some cases, certain medications (e.g., methyl­ phenidate) may exacerbate a preexisting Tic Disorder, in which case no additional diagnosis of a medication-induced disorder is necessary.

Tics must also be distinguished from stereotyped movements seen in **Stereotypic Movement Disorder** and **Pervasive Developmental Disorders.** Differentiating sim­ ple tics (e.g., eye blinking) from the complex movements characteristic of stereotyped movements is relatively straightforward. The distinction between complex motor tics and stereotyped movements is less clear-cut. In general, stereotyped movements appear to be more driven and intentional, whereas tics have a more involuntary quality and are not rhythmic. Tics must be distinguished from **compulsions** (as in Obsessive-Compulsive Disorder). Compulsions are typically quite complex and are performed in response to an obsession or according to rules that must be applied rigidly. In contrast to a compulsion, tics are typically less complex and are not aimed at neutralizing the anxiety resulting from an obsession. Some individuals manifest symptoms of both Obsessive­ Compulsive Disorder and a Tic Disorder (especially Tourette's Disorder), so that both diagnoses may be warranted. Certain vocal or motor tics (e.g., barking, echolalia, palilalia) must be distinguished from disorganized or catatonic behavior in **Schizophrenia.** The Tic Disorders can be distinguished from one another based on duration and variety of tics and age at onset. **Transient Tic Disorder** includes motor and/or vocal tics lasting for at least 4 weeks but for no longer than 12 consecutive months. **Tourette's Disorder** and **Chronic Motor or Vocal Tic Disorder** each have a duration of more than 12 months but are distinguished by the requirement for Tourette's Disorder that there be multiple motor tics and at least one vocal tic. **Tic Disorder Not Otherwise Specified** would be appropriate for clinically significant presentations lasting less than 4 weeks, for presentations with an age at onset above age 18 years, and for the unusual

case of an individual with only one motor tic and only one vocal tic.

**307.23 Tourette's Disorder**

***Di-agnostic Features***

The essential features of Tourette's Disorder are multiple motor tics and one or more vocal tics (Criterion A). These may appear simultaneously or at different periods during the illness. The tics occur many times a day, recurrently throughout a period of more than 1 year (Criterion B). During this period, there is never a tic-free period of more than 3 consecutive months. The disturbance causes marked distress or significant impairment in social, occupational, or other important areas of functioning (Criterion *C).* The onset of the disorder is before age 18 years (Criterion D). The tics are not due to the direct physiological effects of a substance (e.g., stimulants) or a general medical condition (e.g., Huntington's disease or postviral encephalitis) (Criterion E).

The anatomical location, number, frequency, complexity, and severity of the tics change over time. The tics typically involve the head and, frequently, other parts of the body, such as the torso and upper and lower limbs. The vocal tics include various words

or sounds such as clicks, grunts, yelps, barks, sniffs, snorts, and coughs. Coprolalia, a complex vocal tic involving the uttering of obscenities, is present in a few individuals (less than 10%) with this disorder. Complex motor tics involving touching, squatting, deep knee bends, retracing steps, and twirling when walking may be present. In approximately one-half the individuals with this disorder, the first symptoms to appear are bouts of a single tic, most frequently eye blinking, less frequently tics involving another part of the face or the body. Initial symptoms can also include tongue protrusion, squatting, sniffing, hopping, skipping, throat clearing, stuttering, uttering sounds or words, and coprolalia. The other cases begin with multiple symptoms.

***Associated Features and Disorders***

The most common associated symptoms of Tourette's Disorder are obsessions and compulsions. Hyperactivity, distractibility, and impulsivity are also relatively common. Social discomfort, shame, self-consciousness, and depressed mood frequently occur. Social, academic, and occupational functioning may be impaired because of rejection by others or anxiety about having tics in social situations. In severe cases of Tourette's Disorder, the tics may directly interfere with daily activities (e.g., reading or writing). Rare complications ofTourette's Disorder include physical injury, such as blindness due to retinal detachment (from head banging or striking oneselD, orthopedic problems (from knee bending, neck jerking, or head turning), and skin problems (from picking). The severity of the tics may be exacerbated by administration of central nervous system stimulants, which may be a dose-related phenomenon. Obsessive-Compulsive Disorder, Attention-Deficit/Hyperactivity Disorder, and Learning Disorders may be associated with Tourette's Disorder.

***Specific Culture and Gender Features***

Tourette's Disorder has been widely reported in diverse racial and ethnic groups. The disorder is approximately 1.5-3 times more common in males than in females.

***Prevalence***

Tourette's Disorder occurs in approximately 4-5 individuals per 10,000.

***Course***

The age at onset of Tourette's Disorder may be as early as age 2 years, is usually during childhood or early adolescence, and is by definition before age 18 years. The median age at onset for motor tics is 7 years. The duration of the disorder is usually lifelong, though periods of remission lasting from weeks to years may occur. In most cases, the severity, frequency, and variability of the symptoms diminish during adolescence and adulthood. In other cases, the symptoms disappear entirely, usually by early adulthood.

***Familial Pattern***

The vulnerability to Tourette's Disorder and related disorders is transmitted in an autosomal dominant pattern. "Vulnerability" implies that the child receives the genetic

or constitutional basis for developing a Tic Disorder; the precise type or severity of disorder may be different from one generation to another. Not everyone who inherits the genetic vulnerability will express symptoms of a Tic Disorder. Penetrance in female gene carriers is about 70%; penetrance in male gene carriers is about 99%. The range of forms in which the vulnerability may be expressed includes full-blown Tourette's Disorder, Chronic Motor or Vocal Tic Disorder, some forms of Obsessive-Compulsive Disorder, and, perhaps, Attention-Deficit/Hyperactivity Disorder. In about 10% of those with Tourette's Disorder, there is no evidence of a familial pattern. Individuals with these "nongenetic" forms of Tourette's Disorder or another tic disorder often have another mental disorder (e.g., Pervasive Developmental Disorder) or a general medical condition (e.g., a seizure disorder).

***Di,fferential magnosis***

Refer to the "Differential Diagnosis" section for Tic Disorders (p. 100).

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| * **Diagnostic criteria for 307.23 Tourette's Disorder**   1. Both multiple motor and one or more vocal tics have been present at some time during the illness, although not necessarily concurrently. (A *tic* is a sudden, rapid, recurrent, nonrhythmic, stereotyped motor movement or vocalization.)   2. The tics occur many times a day (usually in bouts) nearly every day or intermittently throughout a period of more than 1 year, and during this period there was never a tic-free period of more than 3 consecutive months.   3. The disturbance causes marked distress or significant impairment in social, occupational, or other important areas of functioning.   4. The onset is before age 18 years.   5. The disturbance is not due to the direct physiological effects of a substance (e.g., stimulants) or a general medical condition (e.g., Huntington's disease or postviral encephalitis). |

**307.22 Chronic Motor or Vocal Tic Disorder**

***magnostic Features***

The essential feature of Chronic Motor or Vocal Tic Disorder is the presence of either motor tics orvocal tics, but *not both* (Criterion A). This differs from Tourette's Disorder in which there must be both multiple motor and one or more vocal tics. The other

essential features (Criteria B, C, D, and E) are the same as for Tourette's Disorder. A diagnosis of Chronic Motor or Vocal Tic Disorder cannot be made if the criteria for Tourette's Disorder have ever been met (Criterion F). The other characteristics of Chronic Motor or Vocal Tic Disorder are generally the same as for Tourette's Disorder (seep. 101), except that the severity of the symptoms and the functional impairment are usually much less. It appears that Chronic Motor or Vocal Tic Disorder and Tourette's Disorder may be genetically related because they often occur in the same families.

***Di,fferential magnosis***

Refer to the "Differential Diagnosis" section for Tic Disorders (p. 100).

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| * **Diagnostic criteria for 307.22 Chronic Motor or Vocal Tic Disorder**   1. Single or multiple motor or vocal tics (i.e., sudden, rapid, recurrent, nonrhythmic, stereotyped motor movements or vocalizations), but not both, have been present at some time during the illness.   2. The tics occur many times a day nearly every day or intermittently throughout a period of more than 1 year, and during this period there was never a tic-free period of more than 3 consecutive months.   3. The disturbance causes marked distress or significant impairment in social, occupational, or other important areas of functioning.   4. The onset is before age 18 years.   5. The disturbance is not due to the direct physiological effects of a substance (e.g., stimulants) or a general medical condition (e.g., Huntington's disease or postviral encephalitis).   6. Criteria have never been met for Tourette's Disorder. |

**307.21 Transient Tic Disorder**

***magnostic Features***

The essential feature of Transient Tic Disorder is the presence of single or multiple motor tics and/or vocal tics (Criterion A). The tics occur many times a day, nearly every day for at least 4 weeks, but for no longer than 12 consecutive months (Criterion B). The other essential features (Criteria C, D, and E) are the same as for Tourette's Disorder. Transient Tic Disorder is not diagnosed if the criteria for Tourette's Disorder or Chronic Motor or Vocal Tic Disorder (both of which require a duration of at least 1 year) have

ever been met (Criterion F). The other characteristics of the disorder are generally the same as for Tourette's Disorder (see p. 101), except that the severity of the symptoms and the functional impairment are usually much less.

***Specifiers***

The course of Transient Tic Disorder may be indicated by specifying **Single Episode**

or **Recurrent.**

***Di,fferential magnosis***

Refer to the "Differential Diagnosis" section for Tic Disorders (p. 100).

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| * **Diagnostic criteria for 307.21 Transient Tic Disorder**   1. Single or multiple motor and/or vocal tics (i.e., sudden, rapid, recurrent, nonrhythmic, stereotyped motor movements or vocalizations)   2. The tics occur many times a day, nearly every day for at least 4 weeks, but for no longer than 12 consecutive m mths.   3. The disturbance causes marked distress or significant impairment in social, occupational, or other important areas of functioning.   4. The onset is before age 18 years.   5. The disturbance is not due to the direct physiological effects of a substance (e.g., stimulants) or a general medical condition (e.g., Huntington's disease or postviral encephalitis).   6. Criteria have never been met for Tourette's Disorder or Chronic Motor or Vocal Tic Disorder.   *Specify* if:  **Single Episode or Recurrent** |

**307.20 Tic Disorder Not Otherwise Specified**

This category is for disorders characterized by tics that do not meet criteria for a specific Tic Disorder. Examples include tics lasting less than 4 weeks or tics with an onset after age 18 years.

**Elimination Disorders**

**Encopresis**

***Di.agnostic Features***

The essential feature of Encopresis is repeated passage of feces into inappropriate places (e.g., clothing or floor) (Criterion A). Most often this is involuntary but occasionally may be intentional. The event must occur at least once a month for at least 3 months (Criterion B), and the chronological age of the child must be at least 4 years (or for children with developmental delays, a mental age of at least 4 years) (Criterion C). The fecal incontinence must not be due exclusively to the direct physiological effects of a substance (e.g., laxatives) or a general medical condition except through a mechanism involving constipation (Criterion D).

When the passage of feces is involuntary rather than intentional, it is often related to constipation, impaction, and retention with subsequent overflow. The constipation may develop for psychological reasons (e.g., anxiety about defecating in a particular place or a more general pattern of anxious or oppositional behavior) leading to avoidance of defecation. Physiological predispositions to constipation include dehydra­ tion associated with a febrile illness, hypothyroidism, or a medication side effect. Once constipation has developed, it may be complicated by an anal fissure, painful defecation, and further fecal retention. The consistency of the stool may vary. In some individuals it may be of normal or near-normal consistency. It may be liquid in other individuals who have overflow incontinence secondary to fecal retention.

***Subtypes***

Encopresis is coded according to the subtype that characterizes the presentation:

**787.6 With Constipation and Overflow Incontinence.** There is evidence of constipation on physical examination or by history. Feces are characteristically (but not invariably) poorly formed and leakage is continuous, occurring both during the day and during sleep. Only small amounts of feces are passed during toiletting, and the incontinence resolves after treatment of the constipation.

**307.7 Without Constipation and Overflow Incontinence.** There is no evidence of constipation on physical examination or by history. Feces are likely to be of normal form and consistency, and soiling is intermittent. Feces may be deposited in a prominent location. This is usually associated with the presence of Oppositional Defiant Disorder or Conduct Disorder or may be the consequence of anal masturbation.

***Associated Features and Di.sorders***

The child with Encopresis often feels ashamed and may wish to avoid situations (e.g., camp or school) that might lead to embarrassment. The amount of impairment is a function of the effect on the child's self-esteem, the degree of social ostracism by peers, and the anger, punishment, and rejection on the part of caregivers. Smearing feces may be deliberate or accidental resulting from the child's attempt to clean or hide feces that

were passed involuntarily. When the incontinence is clearly deliberate, features of Oppositional Defiant Disorder or Conduct Disorder may also be present. Many children with Encopresis also have Enuresis.

***Prevalence***

It is estimated that approximately 1% of 5-year-olds have Encopresis, and the disorder is more common in males than in females.

***Course***

Encopresis is not diagnosed until a child has reached a chronological age of at least 4 years (or for children with developmental delays, a mental age of at least 4 years). Inadequate, inconsistent toilet training and psychosocial stress (e.g., entering school or the birth of a sibling) may be predisposing factors. Two types of course have been described: a "primary" type in which the individual has never established fecal continence, and a "secondary" type in which the disturbance develops after a period of established fecal continence. Encopresis can persist with intermittent exacerbations for years but rarely becomes chronic.

***Di,fferential magnosis***

A diagnosis of Encopresis in the presence of a general medical condition is appropriate only if the mechanism involves constipation. Fecal incontinence related to other general medical conditions (e.g., chronic diarrhea) would not warrant a DSM-IV diagnosis of Encopresis.

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| * **Diagnostic criteria for Encopresis**   1. Repeated passage of feces into inappropriate places (e.g., clothing or floor) whether involuntary or intentional.   2. At least one such event a month for at least 3 months.   3. Chronological age is at least 4 years (or equivalent developmental level).   4. The behavior is not due exclusively to the direct physiological effects of a substance (e.g., laxatives) or a general medical condition except through a mechanism involving constipation.   *Code* as follows:  **787.6 With Constipation and Overflow Incontinence**  **307.7 Without Constipation and Overflow Incontinence** |

**307.6 Enuresis (Not Due to a General Medical Condition)**

***Diagnostic Features***

The essential feature of Enuresis is repeated voiding of urine during the day or at night into bed or clothes (Criterion A). Most often this is involuntary but occasionally may be intentional. To qualify for a diagnosis of Enuresis, the voiding of urine must occur at least twice per week for at least 3 months or else must cause clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning (Criterion B). The individual must have reached an age at which continence is expected (i.e., the chronological age of the child must be at least 5 years, or, for children with developmental delays, a mental age of at least 5 years) (Criterion C). The urinary incontinence is not due exclusively to the direct physiological effects of a substance (e.g., diuretics) or a general medical condition (e.g., diabetes, spina bifida, a seizure disorder) (Criterion D).

***Subtypes***

The situation in which the Enuresis occurs may be noted by one of the following subtypes:

**Nocturnal Only.** This is the most common subtype and is defined as passage of urine only during nighttime sleep. The enuretic event typically occurs during the first one-third of the night. Occasionally the voiding takes place during the rapid eye movement (REM) stage of sleep, and the child may recall a dream that involved the act of urinating.

**Diurnal Only.** This subtype is defined as the passage of urine during waking hours. Diurnal Enuresis is more common in females than in males and is uncommon after age 9 years. The enuretic event most commonly occurs in the early afternoon on school days. Diurnal enuresis is sometimes due to a reluctance to use the toilet because of social anxiety or a preoccupation with school or play activity.

**Nocturnal and Diurnal.** This subtype is defined as a combination of the two subtypes above.

***Associated Features and Disorders***

The amount of impairment associated with Enuresis is a function of the limitation on the child's social activities (e.g., ineligibility for sleep-away camp) or its effect on the child's self-esteem, the degree of social ostracism by peers, and the anger, punishment, and rejection on the part of caregivers. Although most children with Enuresis do not have a coexisting mental disorder, the prevalence of coexisting mental and other developmental disorders is higher than in the general population. Encopresis, Sleep­ walking Disorder, and Sleep Terror Disorder may be present. Urinary tract infections are more common in children with Enuresis, especially the Diurnal Type, than in those who are continent. The Enuresis commonly persists after appropriate treatment of an associated infection. A number of predisposing factors have been suggested, including delayed or lax toilet training, psychosocial stress, a dysfunction in the ability to concentrate urine, and a lower bladder volume threshold for involuntary voiding.

***Prevaknce***

The prevalence of Enuresis at age 5 years is 7% for males and 3% for females; at age 10 years the prevalence is 3% for males and 2% for females. At age 18 years, the prevalence is 1% for males and less among females.

***Course***

Two types of course of Enuresis have been described: a "primary" type in which the individual has never established urinary continence, and a "secondary" type in which the disturbance develops after a period of established urinary continence. By definition, primary Enuresis begins at age 5 years. The most common time for the onset of secondary Enuresis is between the ages of 5 and 8 years, but it may occur at any time. After age 5 years, the rate of spontaneous remission is between 5% and 10% per year. Most children with the disorder become continent by adolescence, but in approximately 1% of cases the disorder continues into adulthood.

***Familial Pattern***

Approximately 75% of all children with Enuresis have a first-degree biological relative who has had the disorder. The concordance for the disorder is greater in monozygotic than in dizygotic twins.

***Dif.ferential Diagnosis***

The diagnosis of Enuresis is not made in the presence of a **neurogenic bladder** or the presence of a **general medical condition that causes polyuria or urgency** (e.g., untreated diabetes mellitus or diabetes insipidus) or during an **acute urinary tract infection.** However, a diagnosis of Enuresis is compatible with such conditions if urinary incontinence was regularly present prior to the development of the general medical condition or if it persists after the institution of appropriate treatment.

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| * **Diagnostic criteria for 307.6 Enuresis**   1. Repeated voiding of urine into bed or clothes (whether involuntary or intentional).   2. The behavior is clinically significant as manifested by either a frequency of twice a week for at least 3 consecutive months or the presence of clinically significant distress or impairment in social, academic (occupa­ tional), or other important areas of functioning.   3. Chronological age is at least 5 years (or equivalent developmental level).   *(continued)* |

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| □ **Diagnostic criteria for 307.6 Enuresis** *(continued)*  D. The behavior is not due exclusively to the direct physiological effect of a substance (e.g., a diuretic) or a general medical condition (e.g., diabetes, spina bifida, a seizure disorder).  *Specify* type: **Nocturnal Only Diurnal Only**  **Nocturnal and Diurnal** |

**Other Disorders of Infancy, Childhood, or Adolescence**

**309.21 Separation Anxiety Disorder**

***Diagnostic Features***

The essential feature of Separation Anxiety Disorder is excessive anxiety concerning separation from the home or from those to whom the person is attached (Criterion A). This anxiety is beyond that which is expected for the individual's developmental level. The disturbance must last for a period of at least 4 weeks (Criterion B), begin before age 18 years (Criterion C), and cause clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning (Criterion D). The diagnosis is not made if the anxiety occurs exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder or, in adolescents or adults, if it is better accounted for by Panic Disorder With Agoraphobia (Criterion E). Individuals with this disorder may experience recurrent excessive distress on separation from home or major attachment figures (Criterion Al). When separated from attachment figures, they often need to know their whereabouts and need to stay in touch with them (e.g., by telephone calls). Some individuals become extremely homesick and uncomfortable to the point of misery when away from home. They may yearn to return home and be preoccupied with reunion fantasies. When separated from major attach­ ment figures, these individuals are often preoccupied with fears that accidents or illness will befall the attachment figures or themselves (Criterion AZ). Children with this disorder often express fear of being lost and never being reunited with their parents (Criterion A3). They are often uncomfortable when traveling independently away from the house or from other familiar areas and may avoid going places by themselves. They may be reluctant or refuse to attend school or camp, to visit or sleep at friends' homes, or to go on errands (Criterion A4). These children may be unable to stay in a room by themselves and may display "clinging" behavior, staying close to and "shadowing" the parent around

the house (Criterion A5).

Children with this disorder often have difficulty at bedtime and may insist that someone stay with them until they fall asleep (Criterion A6). During the night, they may make their way to their parents' bed (or that of another significant person, such as a

sibling); if entry to the parental bedroom is barred, they may sleep outside the parents' door. There may be nightmares whose content expresses the individual's fears (e.g., destruction of the family through fire, murder, or other catastrophe) (Criterion A7). Physical complaints, such as stomachaches, headaches, nausea, and vomiting are common when separation occurs or is anticipated (Criterion A8). Cardiovascular symptoms such as palpitations, dizziness, and feeling faint are rare in younger children but may occur in older individuals.

***Specifier***

**EarlyOnset.** This specifier may be used to indicate onset of the disorder before age 6 years.

***Associated Features and Mental Disorders***

Children with Separation Anxiety Disorder tend to come from families that are close-knit. When separated from home or major attachment figures, they may recurrently exhibit social withdrawal, apathy, sadness, or difficulty concentrating on work or play. Depending on their age, individuals may have fears of animals, monsters, the dark, muggers, burglars, kidnappers, car accidents, plane travel, and other situations that are perceived as presenting danger to the integrity of the family or themselves. Concerns about death and dying are common. School refusal may lead to academic difficulties and social avoidance. Children may complain that no one loves them or cares about them and that they wish they were dead. When extremely upset at the prospect of separation, they may show anger or occasionally hit out at someone who is forcing separation. When alone, especially in the evening, young children may report unusual perceptual experiences (e.g., seeing people peering into their room, scary creatures reaching for them, feeling eyes staring at them). Children with this disorder are often described as demanding, intrusive, and in need of constant attention. The child's excessive demands often become a source of parental frustration, leading to resentment and conflict in the family. Sometimes, children with the disorder are described as unusually conscientious, compliant, and eager to please. The children may have somatic complaints that result in physical examinations and medical procedures. Depressed mood is frequently present and may become more persistent over time, justifying an additional diagnosis of Dysthymic Disorder or Major Depressive Disorder. The disorder may precede the development of Panic Disorder With Agoraphobia.

***Specific Culture, Age, and Gender Features***

There are cultural variations in the degree to which it is considered desirable to tolerate separation. It is important to differentiate Separation Anxiety Disorder from the high value some cultures place on strong interdependence among family members.

The manifestations of the disorder may vary with age. Younger children may not express specific fears of definite threats to parents, home, or themselves. As children get older, worries or fears are often of specific dangers (e.g., kidnapping, mugging). Anxiety and anticipation of separation become manifest in mid-childhood. Although adolescents with this disorder, especially males, may deny anxiety about separation, it may be reflected in their limited independent activity and reluctance to leave home. In older

individuals, the disorder may limit the person's ability to handle changes in circumstances (e.g., moving, getting married). Adults with the disorder are typically overconcerned about their offspring and spouses and experience marked discomfort when separated from them. In clinical samples, the disorder is apparently equally common in males and females. In epidemiological samples, the disorder is more frequent in females.

***Prevalence***

Separation Anxiety Disorder is not uncommon; prevalence estimates average about 4% in children and young adolescents.

***Course***

Separation Anxiety Disorder may develop after some life stress (e.g., the death of a relative or pet, an illness of the child or a relative, a change of schools, a move to a new neighborhood, or immigration). Onset may be as early as preschool age and may occur at any time before age 18 years, but onset as late as adolescence is uncommon. Typically there are periods of exacerbation and remission. Both the anxiety about possible separation and the avoidance of situations involving separation (e.g., going away to college) may persist for many years.

***Familial Pattern***

Separation Anxiety Disorder is apparently more common in first-degree biological relatives than in the general population and may be more frequent in children of mothers with Panic Disorder.

***Differential Diagnosis***

Separation anxiety can be an associated feature of **Pervasive Developmental Disor­ ders, Schizophrenia, or other Psychotic Disorders.** If the symptoms of Separation Anxiety Disorder occur exclusively during the course of one of these disorders, a separate diagnosis of Separation Anxiety Disorder is not given. Separation Anxiety Disorder is distinguished from **Generalized Anxiety Disorder** in that the anxiety predominantly concerns separation from home and attachment figures. In children or adolescents with Separation Anxiety Disorder, threats of separation may lead to extreme anxiety and even a Panic Attack. In contrast to Panic Disorder, the anxiety concerns separation from attachment figures or from home rather than being incapacitated by an unexpected Panic Attack. In adults, Separation Anxiety Disorder is rare and should not be given as an additional diagnosis if the separation fears are better accounted for by Agoraphobia in **Panic Disorder With Agoraphobia or Agoraphobia Without History of Panic Disorder.** Truancy is common in **Conduct Disorder,** but anxiety about separation is not responsible for school absences and the child usually stays away from, rather than returns to, the home. Some cases of school refusal, especially in adolescence, are due to Social Phobia or Mood Disorders rather than separation anxiety. Unlike the halluci­ nations in **Psychotic Disorders,** the unusual perceptual experiences in Separation Anxiety Disorder are usually based on a misperception of an actual stimulus, occur only in certain situations (e.g., nighttime), and are reversed by the presence of an attachment

figure. Clinical judgment must be used in distinguishing **developmentallyappropriate levels of separation anxiety** from the clinically significant concerns about separation seen in Separation Anxiety Disorder.

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| * **Diagnostic criteria for 309.2 I Separation Anxiety Disorder**   1. Developmentally inappropriate and excessive anxiety concerning sep­ aration from home or from those to whom the individual is attached, as evidenced by three (or more) of the following:      1. recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated      2. persistent and excessive worry about losing, or about possible harm befalling, major attachment figures      3. persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)      4. persistent reluctance or refusal to go to school or elsewhere because of fear of separation      5. persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings      6. persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home      7. repeated nightmares involving the theme of separation      8. repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated   2. The duration of the disturbance is at least 4 weeks.   3. The onset is before age 18 years.   4. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.   5. The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and, in adolescents and adults, is not better accounted for by Panic Disorder With Agoraphobia.   *Specify* if:  **Early Onset:** if onset occurs before age 6 years |

313.23 Selective Mutism

***(formerly* Elective Mutism)**

***magnostic Features***

The essential feature of Selective Mutism is the persistent failure to speak in specific social situations (e.g., school, with playmates) where speaking is expected, despite speaking in other situations (Criterion A). The disturbance interferes with educational or occupational achievement or with social communication (Criterion B). The distur­ bance must last for at least 1 month and is not limited to the first month of school (during which many children may be shy and reluctant to speak) (Criterion C). Selective Mutism should not be diagnosed if the individual's failure to speak is due solely to a lack of knowledge of, or comfort with, the spoken language required in the social situation (Criterion D). It is also not diagnosed if the disturbance is better accounted for by embarrassment related to having a Communication Disorder (e.g., Stuttering) or if it occurs exclusively during a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder (Criterion E). Instead of communicating by standard verbalization, children with this disorder may communicate by gestures, nodding or shaking the head, or pulling or pushing, or, in some cases, by monosyllabic, short, or monotone utterances, or in an altered voice.

***Associated Features and msorders***

Associated features of Selective Mutism may include excessive shyness, fear of social embarrassment, social isolation and withdrawal, clinging, compulsive traits, negativism, temper tantrums, or controlling or oppositional behavior, particularly at home. There may be severe impairment in social and school functioning. Teasing or scapegoating by peers is common. Although children with this disorder generally have normal language skills, there may occasionally be an associated Communication Disorder (e.g., Phono­ logical Disorder, Expressive Language Disorder, or Mixed Receptive-Expressive Lan­ guage Disorder) or a general medical condition that causes abnormalities of articulation. Anxiety Disorders (especially Social Phobia), Mental Retardation, hospitalization, or extreme psychosocial stressors may be associated with the disorder.

***Specific Culture and Gender Features***

Immigrant children who are unfamiliar with or uncomfortable in the official language of their new host country may refuse to speak to strangers in their new environment. This behavior should not be diagnosed as Selective Mutism. Selective Mutism is slightly more common in females than in males.

***Prevalence***

Selective Mutism is apparently rare and is found in fewer than 1% of individuals seen in mental health settings.

***Course***

Onset of Selective Mutism is usually before age 5 years, but the disturbance may not come to clinical attention until entry into school. Although the disturbance usually lasts for only a few months, it may sometimes persist longer and may even continue for several years.

***Di,.fferential magnosis***

Selective Mutism should be distinguished from speech disturbances that are better accounted for by a **Communication Disorder,** such as **Phonological Disorder, Expressive Language Disorder, Mixed Receptive-Expressive Language Disorder,** or **Stuttering.** Unlike Selective Mutism, the speech disturbance in these conditions is not restricted to a specific social situation. Children in families who have immigrated to a country where a different language is spoken may refuse to speak the new language because of **lack of knowledge of the language.** If comprehension of the new language is adequate, but refusal to speak persists, a diagnosis of Selective Mutism may be warranted. Individuals with a **Pervasive Developmental Disorder, Schizophrenia** or **other Psychotic Disorder, or severe Mental Retardation** may have problems in social communication and be unable to speak appropriately in social situations. In contrast, Selective Mutism should only be diagnosed in a child who has an established capacity to speak in some social situations (e.g., typically at home). The social anxiety and social avoidance in **Social Phobia** may be associated with Selective Mutism. In such cases, both diagnoses may be given.

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| * **Diagnostic criteria for 3 I 3.23 Selective Mutism**   1. Consistent failure to speak in specific social situations (in which there is an expectation for speaking, e.g., at school) despite speaking in other situations.   2. The disturbance interferes with educational or occupational achieve­ ment or with social communication.   3. The duration of the disturbance is at least 1 month (not limited to the first month of school).   4. The failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language required in the social situation.   5. The disturbance is not better accounted for by a Communication Disorder (e.g., Stuttering) and does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder. |

**313.89 Reactive Attachment Disorder of Infancy or Early Childhood**

***Di-agnostic Features***

The essential feature of Reactive Attachment Disorder is markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before age 5 years and is associated with grossly pathological care (Criterion A). There are two types of presentations. In the Inhibited Type, the child persistently fails to initiate and to respond to most social interactions in a developmentally appropriate way. The child shows a pattern of excessively inhibited, hypervigilant, or highly ambivalent responses (e.g., frozen watchfulness, resistance to comfort, or a mixture of approach and avoidance) (Criterion Al). In the Disinhibited Type, there is a pattern of diffuse attachments. The child exhibits indiscriminate sociability or a lack of selectivity in the choice of attachment figures (Criterion A2). The disturbance is not accounted for solely by developmental delay (e.g., as in Mental Retardation) and does not meet criteria for Pervasive Developmental Disorder (Criterion B). By definition, the condition is associ­ ated with grossly pathological care that may take the form of persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection (Criterion Cl); persistent disregard of the child's basic physical needs (Criterion C2); or repeated changes of primary caregiver that prevent formation of stable attachments (e.g., frequent changes in foster care) (Criterion C3). The pathological care is presumed to be responsible for the disturbed social relatedness (Criterion D).

***Subtypes***

The predominant type of disturbance in social relatedness may be indicated by specifying one of the following subtypes for Reactive Attachment Disorder:

**Inhibited Type.** In this subtype, the predominant disturbance in social related­ ness is the persistent failure to initiate and to respond to most social interactions in a developmentally appropriate way.

**Disinhibited Type.** This subtype is used if the predominant disturbance in social relatedness is indiscriminate sociability or a lack of selectivity in the choice of attachment figures.

***Associated Features and msorders***

**Associated descriptive features and mental disorders.** Certain situations (e.g., prolonged hospitalization of the child, extreme poverty, or parental inexperience) may predispose to the development of pathological care. However, grossly pathological care does not always result in the development of Reactive Attachment Disorder; some children may form stable attachments and social relationships even in the face of marked neglect or abuse. Reactive Attachment Disorder may be associated with developmental delays, Feeding Disorder of Infancy or Early Childhood, Pica, or Rumination Disorder.

**Associated laboratory findings.** Laboratory findings consistent with malnutrition may be present.

**Associated physical examination findings and general medical conditions.** Physical examination may document associated general medical conditions that might contribute to, or result from, difficulties in caring for the child (e.g., growth delay, evidence of physical abuse).

***Prevalence***

Epidemiological data are limited, but Reactive Attachment Disorder appears to be very uncommon.

***Course***

The onset of Reactive Attachment Disorder is usually in the first several years of life and, by definition, begins before age 5 years. The course appears to vary depending on individual factors in child and caregivers, the severity and duration of associated psychosocial deprivation, and the nature of intervention. Considerable improvement or remission may occur if an appropriately supportive environment is provided. Otherwise, the disorder follows a continuous course.

***m.{ferential magnosis***

In **Mental Retardation,** appropriate attachments to caregivers usually develop consis­ tent with the child's general developmental level. However, some infants and young children with Severe Mental Retardation may present particular problems for caregivers and exhibit symptoms characteristic of Reactive Attachment Disorder. Reactive Attach­ ment Disorder should be diagnosed only if it i clear that the characteristic problems in formation of selective attachments are not a function of the retardation.

Reactive Attachment Disorder must be differentiated from **Autistic Disorder** and **other Pervasive Developmental Disorders.** In the Pervasive Developmental Disor­ ders, selective attachments either fail to develop or are highly deviant, but this usually occurs in the face of a reasonably supportive psychosocial environment. Autistic Disorder and other Pervasive Developmental Disorders are also characterized by the presence of a qualitative impairment in communication and restricted, repetitive, and stereotyped patterns of behavior. Reactive Attachment Disorder is not diagnosed if the criteria are met for a Pervasive Developmental Disorder. The Disinhibited Type must be distin­ guished from the impulsive or hyperactive behavior characteristic of **Attention-Deficit/ Hyperactivity Disorder.** In contrast to Attention-Deficit/Hyperactivity Disorder, the disinhibited behavior in Reactive Attachment Disorder is characteristically associated with attempting to form a social attachment after a very brief acquaintance.

Grossly pathogenic care is a defining feature of Reactive Attachment Disorder. An

additional notation of Child Abuse, Child Neglect, or a Parent-Child Relational Problem may be warranted. When grossly pathogenic care does not result in marked disturbances in social relatedness, Child Neglect or Parent-Child Relational Problem may be noted rather than Reactive Attachment Disorder.

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| * **Diagnostic criteria for 313.89 Reactive Attachment Disorder of Infancy or Early Childhood**   1. Markedly disturbed and developmentally inappropriate social related­ ness in most contexts, beginning before age 5 years, as evidenced by either (1) or (2):      1. persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hypervigilant, or highly ambivalent and contradictory responses (e.g., the child may respond to caregivers with a mixture of approach, avoidance, and resistance to comfort­ ing, or may exhibit frozen watchfulness)      2. diffuse attachments as manifest by indiscriminate sociability with marked inability to exhibit appropriate selective attachments (e.g., excessive familiarity with relative strangers or lack of selectivity in choice of attachment figures)   2. The disturbance in Criterion A is not accounted for solely by develop­ mental delay (as in Mental Retardation) and does not meet criteria for a Pervasive Developmental Disorder.   3. Pathogenic care as evidenced by at least one of the following:      1. persistent disregard of the child's basic emotional needs for com­ fort, stimulation, and affection      2. persistent disregard of the child's basic physical needs      3. repeated changes of primary caregiver that prevent formation of stable attachments (e.g., frequent changes in foster care)   4. There is a presumption that the care in Criterion C is responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).   *Specify* type:  **Inhibited Type:** if Criterion Al predominates in the clinical presentation  **Disinhibited Type:** if Criterion A2 predominates in the clinical presentation |

**307.3 Stereotypic Movement Disorder**

***(formerly* Stereotypy/Habit Disorder)**

***magnostic Features***

The essential feature of Stereotypic Movement Disorder is motor behavior that is repetitive, often seemingly driven, and nonfunctional (Criterion A). This motor behavior markedly interferes with normal activities or results in self-inflicted bodily injury that is significant enough to require medical treatment (or would result in such injury if

protective measures were not used) (Criterion B). If Mental Retardation is present, the stereotypic or self-injurious behavior is sufficiently severe to become a focus of treatment (Criterion C). The behavior is not better accounted for by a compulsion (as in Obsessive-Compulsive Disorder), a tic (as in the Tic Disorders), a stereotypy that is part of a Pervasive Developmental Disorder, or hair pulling (as in Trichotillomania) (Criterion D). The behavior is also not due to the direct physiological effects of a substance or a general medical condition (Criterion E). The motor behaviors must persist for at least 4 weeks (Criterion F).

The stereotypic movements may include hand waving, rocking, playing with hands, fiddling with fingers, twirling objects, head banging, self-biting, picking at skin or bodily orifices, or hitting various parts of one's own body. Sometimes the individual uses an object in performing these behaviors. The behaviors may cause permanent and disabling tissue damage and may sometimes be life-threatening. For instance, severe head banging or hitting may lead to cuts, bleeding, infection, retinal detachment, and blindness.

***Specifiers***

The clinician may specify **WithSelf-InjuriousBehavior** if the behavior results in bodily damage that requires specific treatment (or that would result in bodily damage if protective measures were not used).

***Associated Features and Disorders***

**Associated descriptive features and mental disorders.** The individual may de­ velop methods of self-restraint (e.g., holding hands inside shirts, trousers, or in pockets) to attempt to control the self-injurious behaviors. When the self-restraint is interfered with, the behaviors return. If the behaviors are extreme or repulsive to others, there may be psychosocial complications due to the individual's exclusion from social and community activities. Stereotypic Movement Disorder occurs most commonly in associ­ ation with Mental Retardation. The more severe the retardation, the higher the risk for self-injurious behaviors. This disorder may also occur in association with severe sensory deficits (blindness and deafness) and may be more common in institutional environments in which the individual receives insufficient stimulation. Self-injurious behaviors occur in certain general medical conditions associated with Mental Retardation (e.g., fragile X syndrome, de Lange syndrome, and especially Lesch-Nyhan syndrome, which is characterized by severe self-biting).

**Associated laboratory findings.** If there is self-injury, the laboratory findings will reflect its nature and severity (e.g., anemia may be present if there is a chronic blood loss from self-inflicted rectal bleeding).

**Associated physical examination findings and general medical conditions.** Signs of chronic tissue damage may be present (e.g., bruises, bite marks, cuts, scratches, skin infections, rectal fissures, foreign bodies in bodily orifices, visual impairment due to eye gouging or traumatic cataract, and fractures or deformed bones). In less severe cases, there may be a chronic skin irritation or calluses from biting, pinching, scratching, or saliva smearing.

***Specific Age and Gender Features***

Self-injurious behaviors occur in individuals of all ages. There are indications that head banging is more prevalent in males (with about a 3:1 ratio), and self-biting may be more prevalent in females.

***Prevalence***

There is limited information on the prevalence of Stereotypic Movement Disorder. The estimates of prevalence of self-injurious behaviors in individuals with Mental Retardation vary from 2% and 3% in children and adolescents living in the community to approxi­ mately 25% in adults with severe or profound Mental Retardation living in institutions.

***Course***

There is no typical age at onset or pattern of onset for Stereotypic Movement Disorder. The onset may follow a stressful environmental event. In nonverbal individuals with Severe Mental Retardation, stereotypic movements may be triggered by a painful general medical condition (e.g., a middle ear infection leading to head banging). The stereotypic movements often peak in adolescence and then may gradually decline. However, especially in individuals with Severe or Profound Mental Retardation, the movements may persist for years. The focus of these behaviors often changes (e.g., a person may engage in hand biting that may then subside and head hitting may emerge).

***Differential Diagnosis***

Stereotypic movements may be associated with **Mental Retardation,** especially for individuals in nonstimulating environments. Stereotypic Movement Disorder should be diagnosed only in individuals in whom the stereotypic or self-injurious behavior is of sufficient severity to become a focus of treatment. Repetitive stereotyped movements are a characteristic feature of **Pervasive Developmental Disorders.** Stereotypic Movement Disorder is not diagnosed if the stereotypies are better accounted for by a Pervasive Developmental Disorder. Compulsions in **Obsessive-Compulsive Disorder** are generally more complex and ritualistic and are performed in response to an obsession or according to rules that must be applied rigidly. Differentiating the complex movements characteristic of Stereotypic Movement Disorder from **simple tics** (e.g., eye blinking) is relatively straightforward, but the differential diagnosis with **complex motor tics** is less clear-cut. In general, stereotyped movements appear to be more driven and intentional, whereas tics have a more involuntary quality and are not rhythmic. In **Trichotillomania,** by definition, the repetitive behavior is limited to hair pulling. The self-induced injuries in Stereotypic Movement Disorder should be distinguished from **Factitious Disorder With Predominantly Physical Signs and Symptoms,** in which the motivation of the self-injury is to assume the sick role. **Self-mutilation associated with certain Psy­ chotic Disorders and Personality Disorders** is premeditated, complex, and sporadic and has a meaning for the individual within the context of the underlying, severe mental disorder (e.g., is the result of delusional thinking). **Involuntary movements associated with neurological conditions** (such as Huntington's disease) usually follow a typical pattern, and the signs and symptoms of the neurological condition are present.

**Developmentallyappropriate self-stimulatorybehaviors in young children** (e.g., thumb sucking, rocking, and head banging) are usually self-limited and rarely result in tissue damage requiring treatment. **Self-stimulatory behaviors in individuals with sensory deficits** (e.g., blindness) usually do not result in dysfunction or in self-injury.

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| * **Diagnostic criteria for 307.3 Stereotypic Movement Disorder**   1. Repetitive, seemingly driven, and nonfunctional motor behavior (e.g., hand shaking or waving, body rocking, head banging, mouthing of objects, self-biting, picking at skin or bodily orifices, hitting own body).   2. The behavior markedly interferes with normal activities or results in self-inflicted bodily injury that requires medical treatment (or would result in an injury if preventive measures were not used).   3. If Mental Retardation is present, the stereotypic or self-injurious behavior is of sufficient severity to become a focus of treatment.   4. The behavior is not better accounted for by a compulsion (as in Obsessive-Compulsive Disorder), a tic (as in Tic Disorder), a stereotypy that is part of a Pervasive Developmental Disorder, or hair pulling (as in Trichotillomania).   5. The behavior is not due to the direct physiological effects of a substance or a general medical condition.   6. The behavior persists for 4 weeks or longer.   *Specify* if  **With Self-Injurious Behavior:** if the behavior results in bodily damage that requires specific treatment (or that would result in bodily damage if protective measures were not used) |

**313.9 Disorder of Infancy, Childhood, or Adolescence Not Otherwise Specified**

This category is a residual category for disorders with onset in infancy, childhood, or adolescence that do not meet criteria for any specific disorder in the Classification.



#### [Delirium, Dementia, and Amnestic and Other Cognitive Disorders](#_bookmark0)

his section includes Delirium, Dementia, Amnestic Disorders, and Cognitive Disorder Not Otherwise Specified. The predominant disturbance is a clinically significant deficit in cognition or memory that represents a significant change from a previous level of functioning. For each disorder in this section, the etiology is either a general medical condition (although the specific general medical condition may not be identifiable) or a substance (i.e., a drug of abuse, medication, or toxin), or a combination

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of these factors.

In DSM-III-R, these disorders were placed in a section titled "Organic Mental Syndromes and Disorders." The term *organic mental disorder* is no longer used in DSM-IV because it incorrectly implies that "nonorganic" mental disorders do not have a biological basis. In DSM-IV, disorders formerly called "organic mental disorders" have been grouped into three sections: 1) Delirium, Dementia, and Amnestic and Other Cognitive Disorders; 2) Mental Disorders Due to a General Medical Condition; and

1. Substance-Related Disorders.

A **delirium** is characterized by a disturbance of consciousness and a change in cognition that develop over a short period of time. The disorders included in the "Delirium" section are listed according to presumed etiology: Delirium Due to a General Medical Condition, Substance-Induced Delirium (i.e., due to a drug of abuse, a medication, or toxin exposure), Delirium Due to Multiple Etiologies, or Delirium Not Otherwise Specified (if the etiology is indeterminate).

A **dementia** is characterized by multiple cognitive deficits that include impairment in memory. The dementias are also listed according to presumed etiology: Dementia of the Alzheimer's Type, Vascular Dementia, Dementia Due to Other General Medical Conditions (e.g., human immunodeficiency virus [HIV] disease, head trauma, Parkinson's disease, Huntington's disease), Substance-Induced Persisting Dementia (i.e., due to a drug of abuse, a medication, or toxin exposure), Dementia Due to Multiple Etiologies, or Dementia Not Otherwise Specified (if the etiology is indeterminate).

An **amnestic disorder** is characterized by memory impairment in the absence of other significant cognitive impairments. The disorders in the "Amnestic Disorders" section also are listed according to presumed etiology: Amnestic Disorder Due to a

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General Medical Condition, Substance-Induced Persisting Amnestic Disorder, or Amnes­ tic Disorder Not Otherwise Specified.

**Cognitive Disorder Not Otherwise Specified** is for presentations that are characterized by cognitive dysfunction presumed to be due to either a general medical condition or substance use that do not meet criteria for any of the disorders listed elsewhere in this section.

Introductory text is provided that discusses the general features for each group of disorders, regardless of etiology. This is followed by text and criteria for each disorder with specific etiology.

**Delirium**

The disorders in the "Delirium" section share a common symptom presentation of a disturbance in consciousness and cognition, but are differentiated based on etiology: **Delirium Due to a General Medical Condition, Substance-Induced Delirium** (including medication side effects), and **Delirium Due to Multiple Etiologies.** In addition, **Delirium Not Otherwise Specified** is included in this section for presenta­ tions in which the clinician is unable to determine a specific etiology for the delirium.

***magnostic Features***

The essential feature of a delirium is a disturbance of consciousness that is accompanied by a change in cognition that cannot be better accounted for by a preexisting or evolving dementia. The disturbance develops over a short period of time, usually hours to days, and tends to fluctuate during the course of the day. There is evidence from the history, physical examination, or laboratory tests that the delirium is a direct physiological consequence of a general medical condition, Substance Intoxication or Withdrawal, use of a medication, or toxin exposure, or a combination of these factors.

The disturbance in consciousness is manifested by a reduced clarity of awareness of the environment. The ability to focus, sustain, or shift attention is impaired (Criterion A). Questions must be repeated because the individual's attention wanders, or the individual may perseverate with an answer to a previous question rather than appropri­ ately shift attention. The person is easily distracted by irrelevant stimuli. Because of these problems, it may be difficult (or impossible) to engage the person in conversation.

There is an accompanying change in cognition (which may include memory impairment, disorientation, or language disturbance) or development of a perceptual disturbance (Criterion B). Memory impairment is most commonly evident in recent memory and can be tested by asking the person to remember several unrelated objects or a brief sentence, and then to repeat them after a few minutes of distraction. Disorientation is usually manifested by the individual being disoriented to time (e.g., thinking it is morning in the middle of the night) or being disoriented to place (e.g., thinking he or she is home rather than in a hospital). In mild delirium, disorientation to time may be the first symptom to appear. Disorientation to self is less common. Language disturbance may be evident as dysnomia (i.e., the impaired ability to name objects) or dysgraphia (i.e., the impaired ability to write). In some cases, speech is rambling and irrelevant, in others pressured and incoherent, with unpredictable switching from subject

to subject. It may be difficult for the clinician to assess for changes in cognitive function because the individual may be inattentive and incoherent. Under these circumstances, it is helpful to review carefully the individual's history and to obtain information from other informants, particularly family members.

Perceptual disturbances may include misinterpretations, illusions, or hallucinations. For example, the banging of a door may be mistaken for a gunshot (misinterpretation); the folds of the bedclothes may appear to be animate objects (illusion); or the person may "see" a group of people hovering over the bed when no one is actually there (hallucination). Although sensory misperceptions are most commonly visual, they may occur in other sensory modalities as well. Misperceptions range from simple and uniform to highly complex. The individual may have a delusional conviction of the reality of the hallucinations and exhibit emotional and behavioral responses in keeping with their content.

The disturbance develops over a short period of time and tends to fluctuate during the course of the day (Criterion C). For example, during morning hospital rounds, the person may be coherent and cooperative, but at night might insist on pulling out intravenous lines and going home to parents who died years ago.

***Associated Features and Disorders***

Delirium is often associated with a disturbance in the sleep-wake cycle. This disturbance can include daytime sleepiness or nighttime agitation and difficulty falling asleep. In some cases, complete reversal of the night-day sleep-wake cycle can occur. Delirium is frequently accompanied by disturbed psychomotor behavior. Many individuals with delirium are restless or hyperactive. Manifestations of increased psychomotor activity may include groping or picking at the bedclothes, attempting to get out of bed when it is unsafe or untimely, and sudden movements. On the other hand, the individual may show decreased psychomotor activity, with sluggishness and lethargy that approach stupor. Psychomotor activity can shift from one extreme to the other over the course of a day. Impaired judgment may interfere with proper medical treatment.

The individual may exhibit emotional disturbances such as anxiety, fear, depression, irritability, anger, euphoria, and apathy. There may be rapid and unpredictable shifts from one emotional state to another, although some individuals with delirium have a constant emotional tone. Fear often accompanies threatening hallucinations or transient delusions. If fear is marked, the person may attack those who are falsely perceived as threatening. Injuries may be sustained from falling out of bed or trying to escape while attached to intravenous lines, respiratory tubes, urinary catheters, or other medical equipment. The disturbed emotional state may also be evident in calling out, screaming, cursing, muttering, moaning, or other sounds. These behaviors are especially prevalent at night and under conditions in which stimulation and environmental cues are lacking. In addition to laboratory findings that are characteristic of associated or etiological general medical conditions (or intoxication or withdrawal states), the EEG is typically

abnormal, showing either generalized slowing or fast activity.

***Specific Culture, Age, and Gender Features***

Cultural and educational background should be taken into consideration in the evaluation of an individual's mental capacity. Individuals from certain backgrounds may

not be familiar with the information used in certain tests of general knowledge (e.g., names of presidents, geographical knowledge), memory (e.g., date of birth in cultures that do not routinely celebrate birthdays), and orientation (e.g., sense of placement and location may be conceptualized differently in some cultures).

Children may be more susceptible to delirium than adults, especially when it is related to febrile illnesses and certain medications (e.g., anticholinergics). In children, delirium may be mistaken for uncooperative behavior, and eliciting the distinctive cognitive signs may be difficult. If familiar figures cannot soothe the child, this may be suggestive of delirium. The sex ratio for delirium reflects that of the elderly population in general (in which the ratio of women to men increases with increasing age), the group at highest risk for developing delirium.

***Prevalence***

In individuals over age 65 years who are hospitalized for a general medical condition, approximately 10% are reported to exhibit delirium on admission and another 10%-15% may develop delirium while in the hospital.

***Course***

The symptoms of delirium usually develop over hours to days. They may begin abruptly (e.g., after a head injury). More typically, single symptoms progress to full-blown delirium within a 3-day period. The delirium may resolve in a few hours, or symptoms may persist for weeks, particularly in individuals with coexisting dementia. If the underlying etiological factor is promptly corrected or is self-limited, recovery is more likely to be complete.

***Di.fferential Di.agnosis***

The most common differential diagnostic issue is whether the person has a **dementia** rather than a delirium, has a delirium alone, or has a delirium superimposed on a preexisting dementia. Memory impairment is common to both a delirium and a dementia, but the person with a dementia alone is alert and does not have the disturbance in consciousness that is characteristic of a delirium. When symptoms of a delirium are present, information from family members, other caretakers, or medical records may be helpful in determining whether the symptoms of a dementia were preexisting. Coding of a delirium superimposed on the different types of dementias is discussed under "Recording Procedures" for each type of delirium.

The presumed etiology determines the specific delirium diagnosis (text and criteria for each delirium diagnosis are provided separately later in this section). If it is judged that the delirium is a consequence of the direct physiological effects of a general medical condition, then Delirium Due to a General Medical Condition is diagnosed. If the delirium results from the direct physiological effects of a drug of abuse, then Substance Intoxication Delirium or Substance Withdrawal Delirium is diagnosed, depending on whether the delirium occurred in association with Substance Intoxication or Substance Withdrawal. If the delirium results from medication use or toxin exposure, then Substance-Induced Delirium is diagnosed. It is not uncommon for the delirium to be due to both a general medical condition and substance (including medication) use. This

may be seen, for example, in an elderly individual with a serious general medical condition that is being treated with multiple medications. When there is more than one etiology (e.g., both a substance and a general medical condition), **Delirium Due to Multiple Etiologies** is diagnosed. If it is not possible to establish a specific etiology (i.e., substance induced or due to a general medical condition), Delirium Not Otherwise Specified is diagnosed.

The diagnosis of Substance Intoxication Delirium or Substance Withdrawal Delirium is made instead of **Substance Intoxication or Substance Withdrawal** only if the symptoms of the delirium are in excess of those usually associated with the intoxication or withdrawal syndrome and are sufficiently severe to warrant independent clinical attention. Even in individuals with obvious signs of intoxication or withdrawal, other possible causes of the delirium (i.e., **Delirium Due to a General Medical Condition)** must not be overlooked. For example, a head injury that occurs as a result of falls or fighting during intoxication may be responsible for the delirium.

Delirium that is characterized by vivid hallucinations, delusions, language distur­ bances, and agitation must be distinguished from **Brief Psychotic Disorder, Schizo­ phrenia, Schizophreniform Disorder,** and **other Psychotic Disorders,** as well as from **Mood Disorders With Psychotic Features.** In delirium, the psychotic symptoms fluctuate, are fragmented and unsystematized, occur in the context of a reduced ability to appropriately maintain and shift attention, and are usually associated with EEG abnormalities. There is often memory impairment and disorientation in delirium, but generally not in these other disorders. Finally, in delirium, the person generally shows evidence of an underlying general medical condition, Substance Intoxication or With­ drawal, or medication use.

Delirium must be distinguished from **Malingering** and from **Factitious Disorder.** This distinction is made based on the often atypical presentation in Malingering and Factitious Disorder and the absence of a general medical condition or substance that is etiologically related to the apparent cognitive disturbance.

Individuals may present with some but not all symptoms of delirium. Subsyndromal presentations need to be carefully assessed because they may be harbingers of a full-blown delirium or may signal an as yet undiagnosed underlying general medical condition. Such presentations should be coded as **Cognitive Disorder Not Otherwise Specified.**

**293.0 Delirium Due to a General Medical Condition**

***magnostic and Associated Features***

The descriptive features of Delirium Due to a General Medical Condition (Criteria A-C) are discussed on pp. 124-125. In addition, to diagnose Delirium Due to a General Medical Condition, there must be evidence from the history, physical examination, or laboratory findings that the cognitive disturbance is the direct physiological consequence of a general medical condition (Criterion D).

In determining whether the delirium is due to a general medical condition, the clinician must first establish the presence of a general medical condition. Further, the clinician must establish that the delirium is etiologically related to the general medical condition. A careful and comprehensive assessment of multiple factors is necessary to make this judgment. Although there are no infallible guidelines, several considerations

provide some guidance in this area. One consideration is the presence of a temporal association between the onset, exacerbation, or remission of the general medical condition and that of the delirium. Evidence from the literature that suggests that there can be a direct association between the general medical condition in question and the development of a delirium can provide a useful context in the assessment of a particular situation. In addition, the clinician must also judge that the disturbance is not better accounted for by a Substance-Induced Delirium or a primary mental disorder (e.g., a Manic Episode). This determination is explained in greater detail in the "Mental Disorders Due to a General Medical Condition" section (p. 165).

Delirium can be associated with many different general medical conditions, each of which has characteristic physical examination and laboratory findings. In systemic illnesses, focal neurological signs are not usually found. Various forms of tremor may be present. Asterixis, a flapping movement of the hyperextended hands, was originally described in hepatic encephalopathy but may also be found in association with other causes of delirium. Signs of autonomic hyperactivity (e.g., tachycardia, sweating, flushed face, dilated pupils, and elevated blood pressure) commonly occur. In addition to laboratory findings that are characteristic of etiological general medical conditions (or intoxication or withdrawal states), the EEG is generally abnormal, showing either generalized slowing or fast activity.

***Recording Procedures***

In recording the diagnosis of Delirium Due to a General Medical Condition, the clinician should note both the delirium and the identified general medical condition judged to be causing the disturbance on Axis I (e.g., 293.0 Delirium Due to Hypoglycemia). The ICD-9-CM code for the general medical condition should also be noted on Axis III (e.g.,

* 1. hypoglycemia.) (See Appendix G for a list of selected ICD-9-CM diagnostic codes for general medical conditions.) In an individual with an established history of Dementia of the Alzheimer's Type or Vascular Dementia, a superimposed delirium should be noted by coding the appropriate subtype of the dementia (e.g., 290.3 Dementia of the Alzheimer's Type, With Late Onset, With Delirium). For other dementias, both dementia and delirium should be coded on Axis I (e.g., 294.1 Dementia Due to Parkinson's Disease and 293.0 Delirium Due to Hepatic Encephalopathy). In situations in which it is unclear whether the cognitive deficits are due to delirium or to dementia, it may be useful to make a provisional diagnosis of delirium and observe the person carefully while continuing efforts to identify the nature of the disturbance.

***Associated General Medical Conditions***

Etiological general medical conditions for delirium include systemic infections, metabolic disorders (e.g., hypoxia, hypercarbia, hypoglycemia), fluid or electrolyte imbalances, hepatic or renal disease, thiamine deficiency, postoperative states, hypertensive enceph­ alopathy, postictal states, and sequelae of head trauma. Certain focal lesions of the right parietal lobe and inferomedial surface of the occipital lobe also may lead to a delirium.

***Differential Diagnosis***

See p. 126 for a general discussion of the differential diagnosis of delirium.

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| * **Diagnostic criteria for 293.0 Delirium Due to** .   ***[Indicate the General Medical Condition)***   * 1. Disturbance of consciousness (i.e., reduced clarity of awareness of the environment) with reduced ability to focus, sustain, or shift attention.   2. A change in cognition (such as memory deficit, disorientation, language disturbance) or the development of a perceptual disturbance that is not better accounted for by a preexisting, established, or evolving dementia.   3. The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day.   4. There is evidence from the history, physical examination, or laboratory findings that the disturbance is caused by the direct physiological consequences of a general medical condition.   **Coding note:** If delirium is superimposed on a preexisting Dementia of the Alzheimer's Type or Vascular Dementia, indicate the delirium by coding the appropriate subtype of the dementia, e.g., 290.3 Dementia of the Alzheimer's Type, With Late Onset, With Delirium.  **Coding note:** Include the name of the general medical condition on Axis I, e.g.,  293.0 Delirium Due to Hepatic Encephalopathy; also code the general medical condition on Axis Ill (see Appendix G for codes). |

**Substance--Induced Delirium**

***magnostic and Associated Features***

The descriptive features of Substance-Induced Delirium (Criteria A-C) are discussed on pp. 124--125. In addition, to diagnose Substance-Induced Delirium, there must be evidence from the history, physical examination, or laboratory findings of Substance Intoxication or Withdrawal, medication side effects, or toxin exposure judged to be etiologically related to the delirium (Criterion D). A delirium that occurs during Substance Intoxication is diagnosed as Substance Intoxication Delirium; a delirium that occurs during Substance Withdrawal is diagnosed as Substance Withdrawal Delirium; and a delirium that is associated with medication side effects or toxin exposure is diagnosed as Substance-Induced Delirium (see criteria set for Substance Intoxication Delirium,

p. 131).

Delirium that occurs during Substance Intoxication may arise within minutes to hours after taking relatively high doses of certain drugs such as cannabis, cocaine, and hallucinogens. With other drugs such as alcohol, barbiturates, or meperidine, delirium sometimes develops only after intoxication is sustained for some days. Usually the delirium resolves as the intoxication ends or within a few hours to days thereafter (although the duration may be longer after intoxication with phencyclidine).

Delirium that is associated with Substance Withdrawal develops as tissue and fluid concentrations of the substance decrease after reduction or termination of sustained,

usually high-dose use of certain substances. The duration of the delirium tends to vary with the half-life of the substance involved: longer-acting substances usually are associated with more protracted withdrawal. Substance Withdrawal Delirium may continue for only a few hours or may persist for as long as 2-4 weeks.

This diagnosis should be made instead of a diagnosis of Substance Intoxication or Substance Withdrawal only when the cognitive symptoms are in excess of those usually associated with the intoxication or withdrawal syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention. For a more detailed discussion of the features associated with Substance-Related Disorders, seep. 175.

***Recording Procedures***

A diagnosis of Substance-Induced Delirium begins with the name of the specific substance (rather than the class of substances) that is presumed to be causing the delirium (e.g., "Diazepam" rather than "Sedative, Hypnotic, or Anxiolytic"). The diagnostic code is selected from the listing of classes of substances provided in the criteria set. For substances that do not fit into any of the classes (e.g., digitalis), the code for "Other Substance" should be used. In addition, for medications prescribed at therapeutic doses, the specific medication can be indicated by listing the appropriate E-code (see Appendix G). For substances that produce intoxication or withdrawal, the name of the substance is followed by the context in which the symptoms developed (e.g., 292.81 Dextro­ amphetamine Intoxication Delirium; 291.0 Alcohol Withdrawal Delirium). For medica­ tion side effects and toxin exposure, the term "-Induced" is used (e.g., 292.81 Digitalis-Induced Delirium). When more than one substance is judged to play a significant role in the development of the delirium, each should be listed separately. If a substance is judged co be the etiological factor but the specific substance or class of substances is unknown, the diagnosis is 292.81 Unknown Substance-Induced Delirium.

***Specific Substances***

**Substance Intoxication Delirium** can occur with the following classes of substances: alcohol; amphetamines and related substances; cannabis; cocaine; hallucinogens; inhal­ ants; opioids; phencyclidine and related substances; sedatives, hypnotics, and anxioly­ tics; and other or unknown substances. **Substance Withdrawal Delirium** can occur with the following classes of substances: alcohol (often called "delirium tremens"); sedatives, hypnotics, and anxiolytics; and other or unknown substances.

Medications reported to cause delirium include anesthetics, analgesics, antiasthmatic agents, anticonvulsants, antihistamines, antihypertensive and cardiovascular medi­ cations, antimicrobials, antiparkinsonian drugs, corticosteroids, gastrointestinal medica­ tions, muscle relaxants, and psychotropic medications with anticholinergic side effects. Toxins reported to cause delirium include anticholinesterase, organophosphate insecti­ cides, carbon monoxide, carbon dioxide, and volatile substances such as fuel or paint.

***Differential Diagnosis***

See p. 126 for a general discussion of the differential diagnosis of delirium and p. 190 for a discussion of the differential diagnosis of Substance Intoxication and Withdrawal.

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| * **Diagnostic criteria for Substance Intoxication Delirium**   1. Disturbance of consciousness (i.e., reduced clarity of awareness of the environment) with reduced ability to focus, sustain, or shift attention.   2. A change in cognition (such as memory deficit, disorientation, language disturbance) or the development of a perceptual disturbance that is not better accounted for by a preexisting, established, or evolving dementia.   3. The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day.   4. There is evidence from the history, physical examination, or laboratory findings of either (1) or (2):      1. the symptoms in Criteria A and **B** developed during Substance Intoxication      2. medication use is etiologically related to the disturbance•   **Note:** This diagnosis should be made instead of a diagnosis of Substance Intoxication only when the cognitive symptoms are in excess of those usually associated with the intoxication syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention.  **•Note:** The diagnosis should be recorded as Substance-Induced Delirium if related to medication use. Refer to Appendix G for E-codes indicating specific medications.  *Code* [Specific Substance I Intoxication Delirium:  (291.0 Alcohol; 292.81 Amphetamine [or Amphetamine-Like Substance];  292.81 Cannabis; 292.81 Cocaine; 292.81 Hallucipogen; 292.81 Inhalant;  292.81 Opioid; 292.81 Phencyclidine [or Phencyclidine-Like Substance];  292.81 Sedative, Hypnotic, or Anxiolytic; 292.81 Other [or Unknown] Substance [e.g., cimetidine, digitalis, benztropine]) |

* **Diagnostic criteria for Substance Withdrawal Delirium**
  1. Disturbance of consciousness (i.e., reduced clarity of awareness of the environment) with reduced ability to focus, sustain, or shift attention.
  2. A change in cognition (such as memory deficit, disorientation, language disturbance) or the development of a perceptual disturbance that is not better accounted for by a preexisting, established, or evolving dementia.
  3. The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day.

*(continued)*

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| □ **Diagnostic criteria for Substance Withdrawal Delirium**  *(continued)*  D. There is evidence from the history, physical examination, or laboratory findings that the symptoms in Criteria A and B developed during, or shortly after, a withdrawal syndrome.  **Note:** This diagnosis should be made instead of a diagnosis of Substance Withdrawal only when the cognitive symptoms are in excess of those usually associated with the withdrawal syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention.  *Code* [Specific Substancej Withdrawal Delirium:  (291.0 Alcohol; 292.81 Sedative, Hypnotic, or Anxiolytic; 292.81 Other [or Unknown] Substance) |

**Delirium Due to Multiple Etiologies**

The Delirium Due to Multiple Etiologies category is included to alert clinicians to the common situation in which the delirium has more than one etiology. There may be more than one general medical condition etiologically related to the delirium (e.g., Delirium Due to Hepatic Encephalopathy, Delirium Due to Head Trauma), or the delirium may be due to the combined effects of a general medical condition (e.g., viral encephalitis) and substance use (e.g., Alcohol Withdrawal).

***Recording Procedures***

Delirium Due to Multiple Etiologies does not have its own separate code and should not be recorded as a diagnosis. For example, to code a delirium due to both hepatic encephalopathy and withdrawal from alcohol, the clinician would list both 293.0 Delirium Due to Hepatic Encephalopathy and 291.0 Alcohol Withdrawal Delirium on Axis I and 572.2 hepatic encephalopathy on Axis III.

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| * **Diagnostic criteria for Delirium Due to Multiple Etiologies**   1. Disturbance of consciousness (i.e., reduced clarity of awareness of the environment) with reduced ability to focus, sustain, or shift attention.   2. A change in cognition (such as memory deficit, disorientation, language disturbance) or the development of a perceptual disturbance that is not better accounted for by a preexisting, established, or evolving dementia.   *( continued)* |

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| * **Diagnostic criteria for Delirium Due to Multiple Etiologies**   (*continued)*  C. The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day.  D. There is evidence from the history, physical examination, or laboratory findings that the delirium has more than one etiology (e.g., more than one etiological general medical condition, a general medical condition plus Substance Intoxication or medication side effect).  **Coding note:** Use multiple codes reflecting specific delirium and specific etiolo­ gies, e.g., 293.0 Delirium Due to Viral Encephalitis; 291.0 Alcohol Withdrawal Delirium. |

**780.09 Delirium Not Otherwise Specified**

This category should be used to diagnose a delirium that does not meet criteria for any of the specific types of delirium described in this section.

Examples include

* + 1. A clinical presentation of delirium that is suspected to be due to a general medical condition or substance use but for which there is insufficient evidence to establish a specific etiology
    2. Delirium due to causes not listed in this section (e.g., sensory deprivation)

**Dementia**

The disorders in the "Dementia" section are characterized by the development of multiple cognitive deficits (including memory impairment) that are due to the direct physiological effects of a general medical condition, to the persisting effects of a substance, or to multiple etiologies (e.g., the combined effects of cerebrovascular disease and Alzheimer's disease). The disorders in this section share a common symptom presentation but are differentiated based on etiology. The diagnostic features listed in the next section pertain to **Dementia of the Alzheimer's Type, Vascular Dementia, Dementia Due to HIV Disease, Dementia Due to Head Trauma, Dementia Due to Parkinson's Disease, Dementia Due to Huntington's Disease, Dementia Due to Pick's Disease, Demen­ tia Due to Creutzfeldt-Jakob Disease, Dementia Due to Other General Medical Conditions, Substance-Induced Persisting Dementia,** and **Dementia Due to Mul­ tiple Etiologies.** In addition, **Dementia Not Otherwise Specified** is included in this section for presentations in which the clinician is unable to determine a specific etiology for the multiple cognitive deficits.

***Di-agnostic Features***

The essential feature of a dementia is the development of multiple cognitive deficits that include memory impairment and at least one of the following cognitive disturbances: aphasia, apraxia, agnosia, or a disturbance in executive functioning. The cognitive deficits must be sufficiently severe to cause impairment in occupational or social functioning and must represent a decline from a previously higher level of functioning. A diagnosis of a dementia should not be made if the cognitive deficits occur exclusively during the course of a delirium. However, a dementia and a delirium may both be diagnosed if the dementia is present at times when the delirium is not present. Dementia may be etiologically related to a general medical condition, to the persisting effects of substance use (including toxin exposure), or to a combination of these factors.

Memory impairment is required to make the diagnosis of a dementia and is a prominent early symptom (Criterion Al). Individuals with dementia become impaired in their ability to learn new material, or they forget previously learned material. Most individuals with dementia have both forms of memory impairment, although it is sometimes difficult to demonstrate the loss of previously learned material early in the course of the disorder. They may lose valuables like wallets and keys, forget food cooking on the stove, and become lost in unfamiliar neighborhoods. In advanced stages of dementia, memory impairment is so severe that the person forgets his or her occupation, schooling, birthday, family members, and sometimes even name.

Memory may be formally tested by asking the person to register, retain, recall, and recognize information. The ability to learn new information may be assessed by asking the individual to learn a list of words. The individual is requested to repeat the words (registration), to recall the information after a delay of several minutes (retention, recall), and to recognize the words from a multiple list (recognition). Individuals with difficulty learning new information are not helped by clues or prompts (e.g., multiple-choice questions) because they did not learn the material initially. In contrast, individuals with primarily retrieval deficits can be helped by clues and prompts because their impairment is in the ability to access their memories. Remote memory may be tested by asking the individual to recall personal information or past material that the individual found of interest (e.g., politics, sports, entertainment). It is also useful to determine (from the individual and informants) the impact of the memory disturbances on the individual's functioning (e.g., ability to work, shop, cook, pay bills, return home without getting lost).

Deterioration of language function (aphasia) may be manifested by difficulty producing the names of individuals and objects (Criterion A2a). The speech of individuals with aphasia may become vague or empty, with long circumlocutory phrases and excessive use of terms of indefinite reference such as "thing" and "it." Comprehension of spoken and written language and repetition of language may also be compromised. In the advanced stages of dementia, individuals may be mute or have a deteriorated speech pattern characterized by echolalia (i.e., echoing what is heard) or palilalia (i.e., repeating sounds or words over and over). Language is tested by asking the individual to name objects in the room (e.g., tie, dress, desk, lamp) or body parts (e.g., nose, chin, shoulder), follow commands ("Point at the door and then at the table"), or repeat phrases ("no ifs, ands, or buts").

Individuals with dementia may exhibit apraxia (i.e., impaired ability to execute motor activities despite intact motor abilities, sensory function, and comprehension of the required task) (Criterion A2b). They will be impaired in their ability to pantomime the use of objects (e.g., combing hair) or to execute known motor acts (e.g., waving

goodbye). Apraxia may contribute to deficits in cooking, dressing, and drawing. Motor skill disturbances may be tested by asking the individual to execute motor functions (e.g., to show how to brush teeth, to copy intersecting pentagons, to assemble blocks, or to arrange sticks in specific designs).

Individuals with dementia may exhibit agnosia (i.e., failure to recognize or identify objects despite intact sensory function) (Criterion A2c). For example, the individual may have normal visual acuity but lose the ability to recognize objects such as chairs or pencils. Eventually they may be unable to recognize family members or even their own reflection in the mirror. Similarly, they may have normal tactile sensation, but be unable to identify objects placed in their hands by touch alone (e.g., a coin or keys).

Disturbances in executive functioning are a common manifestation of dementia (Criterion A2d) and may be related especially to disorders of the frontal lobe or associated subcortical pathways. Executive functioning involves the ability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behavior. Impairment in abstract thinking may be manifested by the individual having difficulty coping with novel tasks and avoiding situations that require the processing of new and complex information. The ability to abstract can be formally assessed by asking the person to find similarities or differences between related words. Executive dysfunction is also evident in a reduced ability to shift mental sets, to generate novel verbal or nonverbal information, and to execute serial motor activities. Tests for executive function include asking the individual to count to 10, recite the alphabet, subtract serial 7s, state as many animals as possible in 1 minute, or draw a continuous line consisting of alternating m's and n's. It is also useful to determine (from the individual and informants) the impact of the disturbances in executive functioning on the individual's daily life (e.g., ability to work, plan activities, budget).

The items in both Criterion Al (memory impairment) and Criterion A2 (aphasia, apraxia, agnosia, or disturbance in executive functioning) must be severe enough to cause significant impairment in social or occupational functioning (e.g., going to school, working, shopping, dressing, bathing, handling finances, and other activities of daily living) and must represent a decline from a previous level of functioning (Criterion B). The nature and degree of impairment are variable and often depend on the particular social setting of the individual. The same level of cognitive impairment may significantly impair an individual's ability to perform a complex job, but not a job that is less demanding. Standardized published rating scales that measure physical maintenance (e.g., personal hygiene), intellectual functioning, and the ability to use implements or tools (e.g., telephone, washing machine) can be used to measure the severity of impairment.

Dementia is not diagnosed if these symptoms occur exclusively during the course of a delirium. However, a delirium may be superimposed on a preexisting dementia, in which case both diagnoses should be given.

***Associated Features and Disorders***

**Associated descriptive features and mental disorders.** Individuals with dementia may become spatially disoriented and have difficulty with spatial tasks. Visuospatial functioning can be assessed by asking the individual to copy drawings, such as a circle, overlapping pentagons, and a cube. Poor judgment and poor insight are common in dementia. Individuals may exhibit little or no awareness of memory loss or other cognitive abnormalities. They may make unrealistic assessments of their abilities and

make plans that are not congruent with their deficits and prognosis (e.g., planning to start a new business). They may underestimate the risks involved in activities (e.g., driving). Occasionally, they may harm others by becoming violent. Suicidal behavior may occur, particularly in early stages when the individual is more capable of carrying out a plan of action. Dementia is sometimes accompanied by motor disturbances of gait leading to falls. Some individuals with dementia show disinhibited behavior, including making inappropriate jokes, neglecting personal hygiene, exhibiting undue familiarity with strangers, or disregarding conventional rules of social conduct. Slurred speech may occur in dementia that is associated with subcortical pathology such as Parkinson's disease, Huntington's disease, and some cases of Vascular Dementia. The multiple cognitive impairments of dementia are often associated with anxiety, mood, and sleep disturbances. Delusions are common, especially those involving themes of persecution (e.g., that misplaced possessions have been stolen). Hallucinations can occur in all sensory modalities, but visual hallucinations are most common. Delirium is frequently superimposed on dementia because the underlying brain disease may increase suscep­ tibility to confusional states that may be produced by medications or other concurrent general medical conditions. Individuals with dementia may be especially vulnerable to physical stressors (e.g., illness or minor surgery) and psychosocial stressors (e.g., going to the hospital, bereavement), which may exacerbate their intellectual deficits and other associated problems.

**Associated laboratory f'tndings.** A discussion of associated laboratory findings that are specific to types of dementia is included in the text for each dementia. Invariably there are abnormalities in cognitive and memory functioning, which can be assessed using mental status examinations and neuropsychological testing. Neuroimaging may aid in the differential diagnosis of dementia. Computed tomography (CD or magnetic resonance imaging (MRI) may reveal cerebral atrophy, focal brain lesions (cortical strokes, tumors, subdural hematomas), hydrocephalus, or periventricular ischemic brain injury. Functional imaging such as positron-emission tomography (PET) or single photon emission computed tomography (SPECT) are not routinely used in the evaluation of dementia, but may provide useful differential diagnostic information (e.g., parietal lobe changes in Alzheimer's disease or frontal lobe alterations in frontal lobe degenerations) in individuals without evidence of structural changes on CT or MRI scans.

**Associated physical examination findings andgeneral medical conditions.** The associated physical examination findings of dementia depend on the nature, locarion, and stage of progression of the underlying pathology. The most common cause of dementia is Alzheimer's disease, followed by vascular disease, and then by multiple etiologies. Other causes of dementia include Pick's disease, normal-pressure hydroceph­ alus, Parkinson's disease, Huntington's disease, traumatic brain injury, brain tumors, anoxia, infectious disorders (e.g., human immunodeficiency virus [HIV], syphilis), prion diseases (e.g., Creutzfeldt-Jakob disease), endocrine conditions (e.g., hypothyroidism, hypercalcemia, hypoglycemia), vitamin deficiencies (e.g., deficiencies of thiamine, niacin, vitamin B12), immune disorders (e.g., polymyalgia rheumatica, systemic lupus erythematosus), hepatic conditions, metabolic conditions (e.g., Kufs' disease, adreno­ leukodystrophy, metachromatic leukodystrophy, and other storage diseases of adult­ hood and childhood), and other neurological conditions (e.g., multiple sclerosis).

***Specific Culture and Age Features***

Cultural and educational background should be taken into consideration in the evaluation of an individual's mental capacity. Individuals from certain backgrounds may not be familiar with the information used in certain tests of general knowledge (e.g., names of presidents, geographical knowledge), memory (e.g., date of birth in cultures that do not routinely celebrate birthdays), and orientation (e.g., sense of place and location may be conceptualized differently in some cultures). The prevalence of different causes of dementia (e.g., infections, nutritional deficiencies, traumatic brain injury, endocrine conditions, cerebrovascular diseases, seizure disorders, brain tumors, sub­ stance abuse) varies substantially across cultural groups.

The age at onset of dementia depends on the etiology, but is usually late in life, with highest prevalence above age 85 years. A significant deterioration in memory and in multiple cognitive skills, which is necessary for the diagnosis of dementia, may be difficult to document in very young children. Thus, the diagnosis of dementia may not be practical until the child is older (usually between ages 4 and 6 years). In individuals under age 18 years with Mental Retardation, an additional diagnosis of a dementia should be made only if the condition is not characterized satisfactorily by the diagnosis of Mental Retardation alone. Dementia is uncommon in children and adolescents, but can occur as a result of general medical conditions (e.g., head injury, brain tumors, HIV infection, strokes, adrenoleukodystrophies). Dementia in children may present as a deterioration in functioning (as in adults) or as a significant delay or deviation in normal development. Deteriorating school performance may be an early sign.

***Prevalence***

Reported prevalence of dementia varies among epidemiological studies, depending on the ages of the subjects sampled; methods of determining the presence, severity, and type of cognitive impairment; and the regions or countries studied. Community studies estimated a 1-year prospective prevalence of almost 3.0% with severe cognitive impairment in the adult population. The study assessed individuals with a brief instrument that assessed current cognitive status (the Mini-Mental State Exam), which does not identify specific diagnoses. It is estimated that 2%--4% of the population over age 65 years have Dementia of the Alzheimer's Type, with other types being much less common. The prevalence of dementia, especially Dementia of the Alzheimer's Type and Vascular Dementia, increases with age, particularly after age 75 years, with a prevalence of 20% or more over age 85 years.

***Course***

Historically, the term *dementia* implied a progressive or irreversible course. The DSM-IV definition of *dementia,* however, is based on the pattern of cognitive deficits and carries no connotation concerning prognosis. Dementia may be progressive, static, or remitting. The reversibility of a dementia is a function of the underlying pathology and of the availability and timely application of effective treatment. The mode of onset and subsequent course of dementia also depend on the underlying etiology. The level of disability depends not only on the severity of the individual's cognitive impairments but also on the available social supports. In advanced dementia, the individual may become totally oblivious to his or her surroundings

and require constant care. Individuals with severe dementia are susceptible to accidents and infectious diseases, which often prove fatal.

***Differential Diagnosis***

Memory impairment occurs in both **delirium** and dementia. Delirium is also character­ ized by a reduced ability to maintain and shift attention appropriately. The clinical course can help to differentiate between delirium and dementia. Typically, symptoms in delirium fluctuate and symptoms in dementia are relatively stable. Multiple cognitive impairments that persist in an unchanged form for more than a few months suggest dementia rather than delirium. Delirium may be superimposed on a dementia, in which case both disorders are diagnosed. In situations in which it is unclear whether the cognitive deficits are due to a delirium or a dementia, it may be useful to make a provisional diagnosis of delirium and observe the person carefully while continuing efforts to identify the nature of the disturbance.

An **amnestic disorder** is characterized by severe memory impairment without other significant impairments of cognitive functioning (i.e., aphasia, apraxia, agnosia, or disturbances in executive functioning).

The presumed etiology determines the specific dementia diagnosis. If the clinician has determined that the dementia is due to **multiple etiologies,** multiple codes based on the specific dementias and their etiologies should be used (see Dementia Due to Multiple Etiologies, p. 154). In **Vascular Dementia,** focal neurological signs (e.g., exaggeration of deep tendon reflexes, extensor plantar response) and laboratory evidence of vascular disease judged to be related to the dementia are present. The clinical course of Vascular Dementia is variable and typically progresses in stepwise fashion. The presence of **Dementia Due to Other General Medical Conditions** (e.g., Pick's disease, HIV) requires evidence from the history, physical examination, and appropriate laboratory tests that a general medical condition is etiologically related to the dementia. The onset of the deterioration (gradual or sudden) and its course (acute, subacute, or chronic) may be useful in suggesting the etiology. For example, the severity of the impairment in cognitive functioning often remains static after head injury, encephalitis, or stroke.

Multiple cognitive deficits that occur only in the context of substance use are diagnosed as **Substance Intoxication or Substance Withdrawal.** If the dementia results from the persisting effects of a substance (i.e., a drug of abuse, a medication, or toxin exposure), then **Substance-Induced Persisting Dementia** is diagnosed. Other causes of dementia (e.g., Dementia Due to a General Medical Condition) should always be considered, even in a person with Substance Dependence. For example, head injury is not infrequent during substance use and may underlie the dementia. **Dementia of the Alzheimer's Type** is currently a diagnosis of exclusion, and other causes for the cognitive deficits (see above) must first be ruled out. In addition, the course is characterized by gradual onset and continuing cognitive declin . In those cases in which there is insufficient evidence to determine whether the dementia is due to a general medical condition or is substance induced, **Dementia Not Otherwise Specified** should be coded. Individuals may present with some but not all of the symptoms of dementia. Such presentations should be coded as **Cognitive Disorder Not Otherwise Specified. Mental Retardation** is characterized by significantly subaverage current general intellectual functioning, with concurrent impairments in adaptive functioning and with

an onset before age 18 years. Mental Retardation is not necessarily associated with memory impairment. In contrast, the age at onset of dementia is usually late in life. If the onset of the dementia is before age 18 years, both dementia and Mental Retardation may be diagnosed if the criteria for both disorders are met. Documenting a significant deterioration in memory and in other cognitive skills, which is necessary for the diagnosis of dementia, may be difficult in persons under age 4 years. In individuals under age 18 years, the diagnosis of dementia should be made only if the condition is not characterized satisfactorily by the diagnosis of Mental Retardation alone.

**Schizophrenia** can also be associated with multiple cognitive impairments and a decline in functioning, but Schizophrenia is unlike dementia in its generally earlier age at onset, its characteristic symptom pattern, and the absence of a specific etiological general medical condition or substance. Typically, the cognitive impairment associated with Schizophrenia is less severe than that seen in Dementia.

**Major Depressive Disorder** may be associated with complaints of memory impairment, difficulty thinking and concentrating, and an overall reduction in intellectual abilities. Individuals sometimes perform poorly on mental status examinations and neuropsychological testing. Particularly in elderly persons, it is often difficult to determine whether cognitive symptoms are better accounted for by a dementia or by a Major Depressive Episode. This differential diagnosis may be informed by a thorough medical evaluation and an evaluation of the onset of the disturbance, the temporal sequencing of depressive and cognitive symptoms, the course of illness, family history, and treatment response. The premorbid state of the individual may help to differentiate "pseudodementia" (i.e., cognitive impairments due to the Major Depressive Episode) from dementia. In dementia, there is usually a premorbid history of declining cognitive function, whereas the individual with a Major Depressive Episode is much more likely to have a relatively normal premorbid state and abrupt cognitive decline associated with the depression. If the clinician determines that both a dementia and Major Depressive Disorder are present with independent etiologies, both should be diagnosed.

Dementia must be distinguished from **Malingering** and **Factitious Disorder.** The patterns of cognitive deficits presented in Malingering and Factitious Disorder are usually not consistent over time and are not characteristic of those typically seen in dementia. For example, individuals with Factitious Disorder or Malingering manifesting as dementia may perform calculations while keeping score during a card game, but then claim to be unable to perform similar calculations during a mental status examination.

Dementia must be distinguished from the normal decline in cognitive functioning that occurs with **aging** (as in Age-Related Cognitive Decline). The diagnosis of dementia is warranted only if there is demonstrable evidence of greater memory and other cognitive impairment than would be expected due to normal aging processes and the symptoms cause impairment in social or occupational functioning.

**Dementia of the Alzheimer's Type**

***Diagnostic Features***

The cognitive deficits (Criterion A) and the required impairment (Criterion B) are discussed on pp. 133-135. The onset of Dementia of the Alzheimer's Type is gradual and involves continuing cognitive decline (Criterion C). Because of the difficulty of obtaining direct pathological evidence of the presence of Alzheimer's disease, the diagnosis can be made only when other etiologies for the dementia have been ruled

out. Specifically, the cognitive deficits are not due to other central nervous system conditions that cause progressive deficits in memory or cognition (e.g., cerebrovascular disease, Parkinson's disease, Huntington's disease), systemic conditions that are known to cause dementia (e.g., hypothyroidism, vitamin B12 deficiency, HIV infection), or the persisting effects of a substance (e.g., alcohol) (Criterion D). If there is an additional etiology (e.g., head trauma worsening a Dementia of the Alzheimer's Type), both types of dementia should be coded (see Dementia Due to Multiple Etiologies, p. 154). Dementia of the Alzheimer's Type should not be diagnosed if the symptoms occur exclusively during delirium (Criterion E). However, delirium may be superimposed on a preexisting Dementia of the Alzheimer's Type, in which case the With Delirium subtype should be indicated. Finally, the cognitive deficits are not better accounted for by another Axis I disorder (e.g., Major Depressive Disorder or Schizophrenia) (Criterion F).

***Subtypes and Specifiers***

The age at onset of Dementia of the Alzheimer's Type can be indicated by the use of one of the following subtypes:

**With Early Onset.** This subtype is used if the onset of the dementia is age 65 years or under.

**With Late Onset.** This subtype is used if the onset of the dementia is after age 65 years.

The following subtypes (each of which has its own separate code) must be used to indicate the predominant feature of the current clinical presentation:

**With Delirium.** This subtype is used if delirium is superimposed on the dementia.

**With Delusions.** This subtype is used if delusions are the predominant feature. **With Depressed Mood.** This subtype is used if depressed mood (including presentations that meet symptom criteria for a Major Depressive Episode) is the predominant feature. A separate diagnosis of Mood Disorder Due to a General Medical Condition is not given.

**Uncomplicated.** This subtype is used if none of the above predominates in the current clinical presentation.

The specifier **With Behavioral Disturbance** (which cannot be coded) can also be used to indicate clinically significant behavioral disturbances (e.g., wandering).

***Recording Procedures***

By ICD-9-CM convention, only Dementia of the Alzheimer's Type and Vascular Dementia have codable subtypes. The diagnostic codes are selected as follows:

* For Dementia of the Alzheimer's Type, With Early Onset, the code depends on the subtype for predominant features: 290.11 for With Delirium, 290.12 for With Delusions, 290.13 for With Depressed Mood, 290.10 for Uncomplicated.
* For Dementia of the Alzheimer's Type, With Late Onset, the code also depends on the subtype for predominant features: 290.3 for With Delirium, 290.20 for With Delusions, 290.21 for With Depressed Mood, and 290.0 for Uncomplicated.

The specifier With Behavioral Disturbance is uncoded and can be applied to each of the above subtypes (e.g., 290.21 Dementia of the Alzheimer's Type, With Late Onset, With Depressed Mood, With Behavioral Disturbance). In addition, 331.0 Alzheimer's disease should be coded on Axis III.

***Associated Features and Di,sorders***

**Associated descriptive features and mental disorders.** See p. 135 for a general discussion of features and disorders associated with dementia. The prevalence of Dementia of the Alzheimer's Type is increased in individuals with Down's syndrome and in individuals with a history of head trauma. Pathological changes that are characteristic of Alzheimer's disease are present in the brains of individuals with Down's syndrome by the time they are in their early 40s, although the clinical symptoms of dementia are not usually evident until later.

**Associated laboratory findings.** In the majority of cases, brain atrophy is present in Dementia of the Alzheimer's Type, with wider cortical sulci and larger cerebral ventricles than would be expected given the normal aging process. This may be demonstrated by computed tomography (CT) or magnetic resonance imaging (MRI). Microscopic examination usually reveals histopathological changes, including senile plaques, neurofibrillary tangles, granulovascular degeneration, neuronal loss, astrocytic gliosis, and amyloid angiopathy. Lewy bodies are sometimes seen in the cortical neurons.

**Associated physical examination findings and general medical conditions.** In the first years of illness, few motor and sensory signs are associated with Dementia of the Alzheimer's Type. Later in the course, myoclonus and gait disorder may appear. Seizures occur in approximately 10% of individuals with the disorder.

***Specific Culture, Age, and Gender Features***

Seep. 137 for a general discussion of culture and age features associated with dementia. Late onset (after age 65 years) of Dementia of the Alzheimer's Type is much more common than early onset. Few cases develop before age 50 years. The disorder is slightly more common in females than in males.

***Prevalence***

Between 2% and 4% of the population over age 65 years is estimated to have Dementia of the Alzheimer's Type. The prevalence increases with increasing age, particularly after age 75 years.

***Course***

Seep. 137 for a general discussion of the course of dementia. The course of Dementia of the Alzheimer's Type tends to be slowly progressive, with a loss of 3-4 points per year on a standard assessment instrument such as the Mini-Mental State Exam. Various patterns of deficits are seen. A common pattern is an insidious onset, with early deficits in recent memory followed by the development of aphasia, apraxia, and agnosia after several years. Some individuals may show personality changes or increased irritability

in the early stages. In the later stages of the disease, individuals may develop gait and motor disturbances and eventually become mute and bedridden. The average duration of the illness from onset of symptoms to death is 8-10 years.

***Familial Pattern***

Compared with the general population, first-degree biological relatives of individuals with Dementia of the Alzheimer's Type, With Early Onset, are more likely to develop the disorder. Late-onset cases may also have a genetic component. Dementia of the Alzheimer's Type in some families has been shown to be inherited as a dominant trait with linkage to several chromosomes, including chromosomes 21, 14, and 19. However, the proportion of cases that are related to specific inherited abnormalities is not known.

***Di,fferential magnosis***

See p. 138 for a general discussion of the differential diagnosis of dementia.

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| * **Diagnostic criteria for Dementia of the Alzheimer's Type**   1. The development of multiple cognitive deficits manifested by both      1. memory impairment (impaired ability to learn new information or to recall previously learned information)      2. one (or more) of the following cognitive disturbances:         1. aphasia (language disturbance)         2. apraxia (impaired ability to carry out motor activities despite intact motor function)         3. agnosia (failure to recognize or identify objects despite intact sensory function)         4. disturbance in executive functioning (i.e., planning, organiz­ ing, sequencing, abstracting)   2. The cognitive deficits in Criteria Al and A2 each cause significant impairment in social or occupational functioning and represent a significant decline from a previous level of functioning.   3. The course is characterized by gradual onset and continuing cognitive decline.   4. The cognitive deficits in Criteria Al and A2 are not due to any of the following:      1. other central nervous system conditions that cause progressive deficits in memory and cognition (e.g., cerebrovascular disease, Parkinson's disease, Huntington's disease, subdural hematoma, normal-pressure hydrocephalus, brain tumor)   *(continued)* |

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| **D Diagnostic criteria for Dementia of the Alzheimer's Type**  *(continued)*   1. systemic conditions that are known to cause dementia (e.g., hypothyroidism, vitamin B12 or folic acid deficiency, niacin defi­ ciency, hypercalcemia, neurosyphilis, HIV infection) 2. substance-induced conditions   E. The deficits do not occur exclusively during the course of a delirium.  F. The disturbance is not better accounted for by another Axis I disorder (e.g., Major Depressive Disorder, Schizophrenia).  *Code* based on type of onset and predominant features:  **With Early Onset:** if onset is at age 65 years or below   * 1. **With Delirium:** if delirium is superimposed on the dementia   2. **With Delusions:** if delusions are the predominant feature   3. **With Depressed Mood:** if depressed mood (including presen- tations that meet full symptom criteria for a Major Depressive Episode) is the predominant feature. A separate diagnosis of Mood Disorder Due to a General Medical Condition is not given.   **290.10 Uncomplicated:** if none of the above predominates in the current clinical presentation  **With Late Onset:** if onset is after age 65 years  **290.3 With Delirium:** if delirium is superimposed on the dementia   * 1. **With Delusions:** if delusions are the predominant feature   2. **With Depressed Mood:** if depressed mood (including pre- sentations that meet full symptom criteria for a Major Depressive Episode) is the predominant feature. A separate diagnosis of Mood Disorder Due to a General Medical Condition is not given.   **290.0 Uncomplicated:** if none of the above predominates in the current clinical presentation  *Specify* if:  **With Behavioral Disturbance**  **Coding note:** Also code 331.0 Alzheimer's disease on Axis III. |

**290.4x Vascular Dementia**

***(formerly* Multi--Infarct Dementia)**

***magnostic Features***

The cognitive deficits (Criterion A) and the required impairment (Criterion B) in Vascular Dementia are discussed on pp. 133-135. There must be evidence of cerebrovascular disease (i.e., focal neurological signs and symptoms or laboratory evidence) that is

judged to be etiologically related to the dementia (Criterion C). The focal neurological signs and symptoms include extensor plantar response, pseudobulbar palsy, gait abnormalities, exaggeration of deep tendon reflexes, or weakness of an extremity. Computed tomography (CT) of the head and magnetic resonance imaging (MRI) usually demonstrate multiple vascular lesions of the cerebral cortex and subcortical structures. Vascular Dementia is not diagnosed if the symptoms occur exclusively during delirium (Criterion D). However, delirium may be superimposed on a preexisting Vascular Dementia, in which case the subtype With Delirium should be indicated.

***Subtypes***

The following subtypes (each of which has its own separate code) must be used to indicate the predominant feature of the current clinical presentation:

**With Delirium.** This subtype is used if delirium is superimposed on the dementia.

**With Delusions.** This subtype is used if delusions are the predominant feature. **With Depressed Mood.** This subtype is used if depressed mood (including presentations that meet symptom criteria for a Major Depressive Episode) is the predominant feature. A separate diagnosis of Mood Disorder Due to a General Medical Condition is not given.

**Uncomplicated.** This subtype is used if none of the above predominates in the current clinical presentation.

The specifier **With Behavioral Disturbance** (which cannot be coded) can also be used to indicate clinically significant behavioral disturbances (e.g., wandering).

***Recording Procedures***

By ICD-9-CM convention, only Vascular Dementia and Dementia of the Alzheimer's Type have codable subtypes. The diagnostic codes for Vascular Dementia depend on the subtype for predominant features: 290.41 for With Delirium, 290.42 for With Delusions, 290.43 for With Depressed Mood, 290.40 for Uncomplicated. The specifier With Behavioral Disturbance is uncoded and can be applied to each of the above subtypes (e.g., 290.43 Vascular Dementia, With Depressed Mood, With Behavioral Disturbance). In addition, the cerebrovascular condition (e.g., 436 stroke) should be coded on Axis III.

***Associated Features and Disorders***

**Associated descriptive features and mental disorders.** See p. 135 for a general discussion of features and disorders associated with dementia.

**Associated laboratory findings.** The extent of central nervous system lesions de­ tected by CT and MRI in Vascular Dementia typically exceeds the extent of changes detected in the brains of healthy elderly persons (e.g., periventricular and white matter hyperintensities noted on MRI scans). Lesions often appear in both white matter and gray matter structures, including subcortical regions and nuclei. Evidence of old infarctions (e.g., focal atrophy) may be detected, as well as findings of more recent

disease. EEG findings may reflect focal lesions in the brain. In addition, there may be laboratory evidence of associated cardiac and systemic vascular conditions (e.g., ECG abnormalities, laboratory evidence of renal failure).

**Associated physical examination findings andgeneral medical conditions.** Common neurological signs (e.g., abnormal reflexes, weakness of an extremity, gait disturbance) are discussed in the "Diagnostic Features" section. There is often evidence of longstanding arterial hypertension (e.g., funduscopic abnormalities, enlarged heart), valvular heart disease (e.g., abnormal heart sounds), or extracranial vascular disease that may be sources of cerebral emboli. A single stroke may cause a relatively circumscribed change in mental state (e.g., an aphasia following damage to the left hemisphere, or an amnestic disorder from infarction in the distribution of the posterior cerebral arteries), but generally does not cause Vascular Dementia, which typically results from the occurrence of multiple strokes, usually at different times.

***Specific Culture, Age, and Gender Features***

See p. 137 for a general discussion of culture and age features of dementia.

The onset of Vascular Dementia is typically earlier than that of Dementia of the Alzheimer's Type. The disorder is apparently more common in males than in females.

***Prevalence***

Vascular Dementia is reportedly much less common than Dementia of the Alzheimer's Type.

***Course***

Seep. 137 for a general discussion of the course of dementia.

The onset of Vascular Dementia is typically abrupt, followed by a stepwise and fluctuating course that is characterized by rapid changes in functioning rather than slow progression. The course, however, may be highly variable, and an insidious onset with gradual decline is also encountered. Usually the pattern of deficits is "patchy," depending on which regions of the brain have been destroyed. Certain cognitive functions may be affected early, whereas others remain relatively unimpaired. Early treatment of hyper­ tension and vascular disease may prevent further progression.

***Differential Diagnosis***

Seep. 138 for a general discussion of the differential diagnosis of dementia.

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| * **Diagnostic criteria for 290.4x Vascular Dementia**   1. The development of multiple cognitive deficits manifested by both      1. memory impairment (impaired ability to learn new information or to recall previously learned information)      2. one (or more) of the following cognitive disturbances:         1. aphasia (language disturbance)         2. apraxia (impaired ability to carry out motor activities despite intact motor function)         3. agnosia (failure to recognize or identify objects despite intact sensory function)         4. disturbance in executive functioning (i.e., planning, organiz­ ing, sequencing, abstracting)   2. The cognitive deficits in Criteria Al and A2 each cause significant impairment in social or occupational functioning and represent a significant decline from a previous level of functioning.   3. Focal neurological signs and symptoms (e.g., exaggeration of deep tendon reflexes, extensor plantar response, pseudobulbar palsy, gait abnormalities, weakness of an extremity) or laboratory evidence indic­ ative of cerebrovascular disease (e.g., multiple infarctions involving cortex and underlying white matter) that are judged to be etiologically related to the disturbance.   4. The deficits do not occur exclusively during the course of a delirium.   *Code* based on predominant features:   * 1. **With Delirium:** if delirium is superimposed on the dementia   2. **With Delusions:** if delusions are the predominant feature   3. **With Depressed Mood:** if depressed mood (including presentations that meet full symptom criteria for a Major Depressive Episode) is the predominant feature. A separate diagnosis of Mood Disorder Due to a General Medical Condition is not given.   **290.40 Uncomplicated:** if none of the above predominates in the current clinical presentation  *Specify* if:  **With Behavioral Disturbance**  **Coding note:** Also code cerebrovascular condition on Axis III. |

***Dementia Due to Other General Medical Conditions***

***magnostic Features***

The cognitive deficits (Criterion A) and the required impairment (Criterion B) of Dementia Due to Other General Medical Conditions are discussed on pp. 133-135. There

must be evidence from the history, physical examination, or laboratory findings that a general medical condition is etiologically related to the dementia (e.g., infection with human immunodeficiency virus (HIV), traumatic brain injury, Parkinson's disease, Huntington's disease, Pick's disease, Creutzfeldt-Jakob disease, normal-pressure hydro­ cephalus, hypothyroidism, brain tumor, or vitamin B12 deficiency) (Criterion C). Demen­ tia Due to a General Medical Condition is not diagnosed if the symptoms occur exclusively during delirium (Criterion D). However, delirium may be superimposed on a preexisting Dementia Due to a General Medical Condition, in which case both diagnoses should be given.

In determining whether the dementia is due to a general medical condition, the clinician must first establish the presence of a general medical condition. Further, the clinician must establish that the dementia is etiologically related to the general medical condition through a physiological mechanism. A careful and comprehensive assessment of multiple factors is necessary to make this judgment. Although there are no infallible guidelines for determining whether the relationship between the dementia and the general medical condition is etiological, several considerations provide some guidance in this area. One consideration is the presence of a temporal association between the onset or exacerbation of the general medical condition and that of the cognitive deficits. Evidence from the literature that suggests that there can be a direct association between the general medical condition in question and the development of a dementia can provide a useful context in the assessment of a particular situation. In addition, the clinician must also judge that the disturbance is not better accounted for by Dementia of the Alzheimer's Type, Vascular Dementia, a Substance-Induced Persisting Dementia, or another mental disorder (e.g., Major Depressive Disorder). These determinations are explained in greater detail in the "Mental Disorders Due to a General Medical Condition" section (p. 165).

See p. 135 for a general discussion of the features and disorders associated with dementia.

***Recording Procedures***

Specific codes are available for some of the Dementias Due to a General Medical Condition (see criteria set). The diagnostic codes and terms are selected depending on the specific etiological condition (e.g., 294.1 Dementia Due to Parkinson's disease). The etiological condition (e.g., 332.0 Parkinson's Disease) should also be recorded on Axis Ill. An "other" category (coded 294.1) is included for etiological conditions not specifically listed and is recorded by noting both the dementia and the specific etiological condition (e.g., 294.1 Dementia Due to Hypothyroidism) on Axis I. The ICD-9-CM code for the etiological condition should also be noted on Axis III (e.g., 244.9 hypothyroidism). (See Appendix G for a list of selected ICD-9-CM diagnostic codes for general medical conditions.)

In an individual with an established history of a dementia, a superimposed Delirium Due to a General Medical Condition should be noted by coding both the dementia and the delirium on Axis I (e.g., 294.1 Dementia Due to Parkinson's Disease and 293.0 Delirium Due to Hepatic Encephalopathy). This is in contrast to Dementia of the Alzheimer's Type and Vascular Dementia, in which the With Delirium subtype is specified.

**294.9 Dementia Due to HIV Disease**

The essential feature of Dementia Due to HIV Disease is the presence of a dementia that is judged to be the direct pathophysiological consequence of human immunodefici­ ency virus (HIV) disease. Neuropathological findings most commonly involve diffuse, multifocal destruction of the white matter and subcortical structures. The spinal fluid may show normal or slightly elevated protein and a mild lymphocytosis, and HIV can usually be isolated directly from cerebrospinal fluid. Dementia that is associated with direct HIV infection of the central nervous system is typically characterized by forgetful­ ness, slowness, poor concentration, and difficulties with problem solving. Behavioral manifestations most commonly include apathy and social withdrawal, and occasionally these may be accompanied by delirium, delusions, or hallucinations. Tremor, impaired rapid repetitive movements, imbalance, ataxia, hypertonia, generalized hyperreflexia, positive frontal release signs, and impaired pursuit and saccadic eye movements may be present on physical examination. Children may also develop Dementia Due to HIV Disease, typically manifested by developmental delay, hypertonia, microcephaly, and basal ganglia calcification. Dementia in association with HIV infection may also result from accompanying central nervous system tumors (e.g., primary central nervous system lymphoma) and from opportunistic infections (e.g., toxoplasmosis, cytomegalovirus infection, cryptococcosis, tuberculosis, and syphilis), in which case the appropriate type of dementia should be diagnosed (e.g., 294.1 Dementia Due to Toxoplasmosis). Unusual systemic infections (e.g., Pneumocystis carinii pneumonia) or neoplasms (e.g., Kaposi's sarcoma) may also be present.

**294. I Dementia Due to Head Trauma**

The essential feature of Dementia Due to Head Trauma is the presence of a dementia that is judged to be the direct pathophysiological consequence of head trauma. The degree and type of cognitive impairments or behavioral disturbances depend on the location and extent of the brain injury. Posttraumatic amnesia is frequently present, along with persisting memory impairment. A variety of other behavioral symptoms may be evident, with or without the presence of motor or sensory deficits. These symptoms include aphasia, attentional problems, irritability, anxiety, depression or affective !ability, apathy, increased aggression, or other changes in personality. Alcohol or other Substance Intoxication is often present in individuals with acute head injuries, and concurrent Substance Abuse or Dependence may be present. Head injury occurs most often in young males and has been associated with risk-taking behaviors. When it occurs in the context of a single injury, Dementia Due to Head Trauma is usually nonprogressive, but repeated head injury (e.g., from boxing) may lead to a progressive dementia (so called dementia pugilistica). A single head trauma that is followed by a progressive decline in cognitive function should raise the possibility of another superimposed process such as hydrocephalus or a Major Depressive Episode.

**294. I Dementia Due to Parkinson's Disease**

The essential feature of Dementia Due to Parkinson's Disease is the presence of a dementia that is judged to be the direct pathophysiological consequence of Parkinson's disease. Parkinson's disease is a slowly progressive neurological condition, characterized

by tremor, rigidity, bradykinesia, and postural instability. Dementia has been reported to occur in approximately 20%--60% of individuals with Parkinson's disease and is more likely to be present in older individuals or those with more severe or advanced disease. The dementia associated with Parkinson's disease is characterized by cognitive and motoric slowing, executive dysfunction, and impairment in memory retrieval. Declining cognitive performance in individuals with Parkinson's disease is frequently exacerbated by depression. Findings on physical examination include the characteristic abnormal motor signs of resting tremor, evidence of slowness and poverty of movement (such as micrographia), or muscular rigidity and loss of associated movements. At autopsy, neuronal loss and Lewy bodies are evident in the substantia nigra. There are a number of syndromes that may manifest with dementia, parkinsonian movement disorders, and additional neurological features (e.g., progressive supranudear palsy, olivoponto­ cerebellar degeneration, and Vascular Dementia). Some individuals with Parkinson's disease and dementia are found at autopsy to have coexisting neuropathology indicative of Alzheimer's disease or of diffuse Lewy body disease.

**294.1 Dementia Due to Huntington's Disease**

The essential feature of Dementia Due to Huntington's Disease is the presence of a dementia that is judged to be the direct pathophysiological consequence of Huntington's disease. Huntington's disease is an inherited progressive degenerative disease of cognition, emotion, and movement. The disease affects men and women equally and is transmitted by a single autosomal dominant gene on the short arm of chromosome 4. The disease is usually diagnosed in the late 30s to early 40s but may begin as early as age 4 years in the juvenile form or as late as age 85 years in the late-onset form. The onset of Huntington's disease is often heralded by insidious changes in behavior and personality, including depression, irritability, and anxiety. Some individuals present with abnormalities of movement that resemble increased fidgeting and that later progress to characteristic generalized choreoathetosis. Difficulties with memory retrieval, executive functioning, and judgment are common early in the course, with more severe memory deficits occurring as the disease progresses. Disorganized speech and psychotic features are sometimes present. Late in the disease, characteristic "boxcar ventricles" may be seen on structural brain imaging due to the atrophy of the striatum. Positron-emission tomography (PET) may show striatal hypometabolism early in the disease. Offspring of individuals with Huntington's disease have a 50% chance of developing the disease. A genetic test is available to determine with relative certainty whether a given at-risk individual is likely to develop the disease; however, such testing may be best adminis­ tered by centers with experience in counseling and follow-up of individuals at risk for Huntington's disease.

**290.10 Dementia Due to Pick's Disease**

The essential feature of Dementia Due to Pick's Disease is the presence of a dementia that is judged to be the direct pathophysiological consequence of Pick's disease. Pick's disease is a degenerative disease of the brain that particularly affects the frontal and temporal lobes. As in other frontal lobe dementias, Pick's disease is characterized

clinically by changes in personality early in the course, deterioration of social skills, emotional blunting, behavioral disinhibition, and prominent language abnormalities. Difficulties with memory, apraxia, and other features of dementia usually follow later in the course. Prominent primitive reflexes (snout, suck, grasp) may be present. As the dementia progresses, it may be accompanied by either apathy or extreme agitation. Individuals may develop such severe problems in language, attention, or behavior that it may be difficult to assess their degree of cognitive impairment. Structural brain imaging typically reveals prominent frontal and/or temporal atrophy, and functional brain imaging may localize frontotemporal hypometabolism, even in the absence of clear structural atrophy. The disorder most commonly manifests itself in individuals between ages 50 and 60 years, although it can occur among older individuals. Pick's disease is one of the pathologically distinct etiologies among the heterogeneous group of dementing processes that are associated with frontotemporal brain atrophy. The specific diagnosis of a frontal lobe dementia such as Pick's disease is usually established at autopsy with the pathological finding of characteristic intraneuronal argentophilic Pick inclusion bodies. Clinically, Pick's disease often cannot be distinguished with certainty from atypical cases of Alzheimer's disease or from other dementias that affect the frontal lobes.

**290.10 Dementia Due to Creutzfeldt.-Jakob Disease**

The essential feature of Dementia Due to Creutzfeldt-Jakob Disease is the presence of a dementia that is judged to be the direct pathophysiological consequence of Creutzfeldt­ Jakob disease. Jacob-Creutzfeldt disease is one of the subacute spongiform encephalop­ athies, a group of central nervous system diseases caused by transmissible agents known as "slow viruses" or prions. Typically, individuals with Creutzfeldt-Jakob disease manifest the clinical triad of dementia, involuntary movements (particularly myoclonus), and periodic EEG activity. However, up to 25% of individuals with the disorder may have atypical presentations, and the disease can be confirmed only by biopsy or at autopsy with the demonstration of spongiform neuropathological changes. Creutzfeldt-Jakob disease may develop at any age in adults, but most typically when they are between ages 40 and 60 years. From 5% to 15% of cases may have a familial component. Prodromal symptoms of Creutzfeldt-Jakob disease may include fatigue, anxiety, or problems with appetite, sleeping, or concentration and may be followed after several weeks by incoordination, altered vision, or abnormal gait or other movements that may be myoclonic, choreoathetoid, or ballistic, along with a rapidly progressive dementia. The disease typically progresses very rapidly over several months, although more rarely it can progress over years and appear similar in its course to other dementias. There are no distinctive findings on cerebrospinal fluid analysis, and nonspecific atrophy may be apparent on neuroimaging. In most individuals, the EEG typically reveals periodic sharp, often triphasic and synchronous discharges at a rate of 0.5-2 Hz at some point during the course of the disorder. The transmissible agent thought to be responsible for Creutzfeldt-Jakob disease is resistant to boiling, formalin, alcohol, and ultraviolet radiation, but it can be inactivated by pressured autoclaving or by bleach. Transmission by corneal transplantation and human growth factor injection has been documented, and anecdotal cases of transmission to health care workers have been reported. Therefore, when neurosurgery, brain biopsy, or brain autopsy is undertaken,

universal precautions should be taken with both tissue and equipment that comes in contact with tissue.

**294.1 Dementia Due to Other General Medical Conditions**

In addition to the specific categories described above, a number of other general medical conditions can cause dementia. These conditions include structural lesions (primary or secondary brain tumors, subdural hematoma, slowly progressive or normal-pressure hydrocephalus), endocrine conditions (hypothyroidism, hypercalcemia, hypoglycemia), nutritional conditions (deficiencies of thiamine, niacin, and vitamin Biz), other infectious conditions (neurosyphilis, cryptococcosis), derangements of renal and hepatic function, and other neurological conditions such as multiple sclerosis. Unusual causes of central nervous system injury, such as electrical shock or intracranial radiation, are generally evident from the history. Rare disorders such as the childhood and adult storage diseases have a distinctive family history or clinical presentation. Associated physical examination and laboratory findings and other clinical features depend on the nature and severity of the general medical condition.

***D/,fferential magnosis***

See p. 138 for a general discussion of the differential diagnosis of dementia.

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| * **Diagnostic criteria for Dementia Due to Other General Medical Conditions**   1. The development of multiple cognitive deficits manifested by both      1. memory impairment (impaired ability to learn new information or to recall previously learned information)      2. one (or more) of the following cognitive disturbances:         1. aphasia (language disturbance)         2. apraxia (impaired ability to carry out motor activities despite intact motor function)         3. agnosia (failure to recognize or identify objects despite intact sensory function)         4. disturbance in executive functioning (i.e., planning, organiz­ ing, sequencing, abstracting)   2. The cognitive deficits in Criteria Al and A2 each cause significant impairment in social or occupational functioning and represent a significant decline from a previous level of functioning.   *(continued)* |

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| * **Diagnostic criteria for Dementia Due to Other General Medical Conditions** *(continued)*   C. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of one of the general medical conditions listed below.  D. The deficits do not occur exclusively during the course of a delirium.   * **294.9 Dementia Due to HIV Disease**   **Coding note:** Also code 043.1 HIV infection affecting central nervous system on Axis III.   * **294. l Dementia Due to Head Trauma**   **Coding note:** Also code 854.00 head injury on Axis III.   * **294.l Dementia Due to Parkinson's Disease**   **Coding note:** Also code 332.0 Parkinson's disease on Axis III.   * **294. l Dementia Due to Huntington's Disease**   **Coding note:** *Also* code 333.4 Huntington's disease on Axis III.   * **290. l O Dementia Due to Pick's Disease**   **Coding note:** Also code 331.1 Pick's disease on Axis III.   * **290.l O Dementia Due to Creutzfeldt--Jakob Disease**   **Coding note:** Also code 046.1 Creutzfeldt-Jakob disease on Axis III.   * **294.l Dementia Due to** ... ***(Indicate the General Medical Condition not listed a6ove)***   For example, normal-pressure hydrocephalus, hypothyroidism, brain tumor, vitamin B12 deficiency, intracranial radiation  **Coding note:** Also code the general medical condition on Axis III (see Appendix G for codes). |

**Substance--Induced Persisting Dementia**

***magnostic and Associated Features***

The cognitive deficits (Criterion A) and the required impairment (Criterion **B)** are discussed on pp. 133-135. Substance-Induced Persisting Dementia is not diagnosed if the symptoms persist beyond the usual duration of Substance Intoxication or Withdrawal or if they occur exclusively during the course of a delirium (Criterion C). However, delirium may be superimposed on a preexisting Substance-Induced Persisting Dementia,

**in** which case both diagnoses should be given. There must be evidence from the history, physical examination, or laboratory findings that the deficits are etiologically related to the persisting effects of substance use (e.g., a drug of abuse, a medication, toxin exposure) (Criterion D). This disorder is termed "persisting" because the dementia persists long after the individual has experienced the effects of Substance Intoxication or Substance Withdrawal.

Features that are associated with Substance-Induced Persisting Dementia are those associated with dementias generally (see p. 135). Even if currently abstinent from substance use, most individuals with this disorder have previously had a pattern of prolonged and heavy substance use that met criteria for Substance Dependence. Because these disorders persist long after use of the substance has stopped, blood or urine screens may be negative for the etiological substance. The age at onset of Substance-Induced Persisting Dementia is rarely before age 20 years. This disorder usually has an insidious onset and slow progression, typically during a period when the person qualifies for a Substance Dependence diagnosis. The deficits are usually permanent and may worsen even if the substance use stops, although some cases do show improvement.

For a more detailed discussion of the features associated with Substance-Related Disorders, see p. 175.

***Recording Procedures***

The name of the diagnosis begins with the specific substance (e.g., alcohol) that is presumed to have caused the dementia. The diagnostic code is selected from the listing of classes of substances provided in the criteria set. For substances that do not fit into any of the classes, the code for "Other Substance" should be used. In addition, for medications prescribed at therapeutic doses, the specific medication can be indicated by listing the appropriate E-code (see Appendix G). When more than one substance is judged to play a significant role in the development of the persisting dementia, each should be listed separately (e.g., 291.2 Alcohol-Induced Persisting Dementia; 292.82 Inhalant-Induced Persisting Dementia). If a substance is judged to be the etiological factor, but the specific substance or class of substances is unknown, the diagnosis is

292.82 Unknown Substance-Induced Persisting Dementia.

***Specific Substances***

Substance-Induced Persisting Dementia can occur **in** association with the following classes of substances: alcohol; inhalants; sedatives, hypnotics, and anxiolytics; or other or unknown substances. Medications reported to cause dementia include anticonvulsants and intrathecal methotrexate. Toxins reported to evoke symptoms of dementia include lead, mercury, carbon monoxide, organophosphate insecticides, and industrial solvents.

***Differential Diagnosis***

Seep. 138 for a general discussion of the differential diagnosis of dementia.

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| * **Diagnostic criteria for Substance..-Induced Persisting Dementia**   1. The development of multiple cognitive deficits manifested by both      1. memory impairment (impaired ability to learn new information or to recall previously learned information)      2. one (or more) of the following cognitive disturbances:         1. aphasia (language disturbance)         2. apraxia (impaired ability to carry out motor activities despite intact motor function)         3. agnosia (failure to recognize or identify objects despite intact sensory function)         4. disturbance in executive functioning (i.e., planning, organiz­ ing, sequencing, abstracting)   2. The cognitive deficits in Criteria Al and A2 each cause significant impairment in social or occupational functioning and represent a significant decline from a previous level of functioning.   3. The deficits do not occur exclusively during the course of a delirium and persist beyond the usual duration of Substance Intoxication or Withdrawal.   4. There is evidence from the history, physical examination, or laboratory findings that the deficits are etiologically related to the persisting effects of substance use (e.g., a drug of abuse, a medication).   *Code* [Specific Substance I-Induced Persisting Dementia:  (291.2 Alcohol; 292.82 Inhalant; 292.82 Sedative, Hypnotic, or Anxiolytic;  292.82 Other [or Unknown] Substance) |

Dementia Due to Multiple Etiologies

The Dementia Due to Multiple Etiologies category is included to alert clinicians to the common situation in which the dementia has more than one etiology. More than one general medical condition may be etiologically related to the dementia (e.g., Dementia of the Alzheimer's Type and Dementia Due to Head Trauma), or the dementia may be due to the combined effects of a general medical condition (e.g., Parkinson's disease) and the long-term use of a substance (e.g., Alcohol-Induced Persisting Dementia).

***Recording Procedures***

Dementia Due to Multiple Etiologies does not have its own separate code and should not be recorded as a diagnosis. For example, both Dementia of the Alzheimer's Type and Vascular Dementia should be diagnosed for an individual with Dementia of the

Alzheimer's Type, With Late Onset, Uncomplicated, who, over the course of several strokes, develops a significant further decline in cognitive functioning. In this example, the clinician would list both 290.0 Dementia of the Alzheimer's Type, With Late Onset, Uncomplicated, and 290.40, Vascular Dementia, Uncomplicated, on Axis I, and 331.0 Alzheimer's Disease and 436 Stroke on Axis Ill.

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| * **Diagnostic criteria for Dementia Due to Multiple Etiologies**   1. The development of multiple cognitive deficits manifested by both      1. memory impairment (impaired ability to learn new information or to recall previously learned information)      2. one (or more) of the following cognitive disturbances:         1. aphasia (language disturbance)         2. apraxia (impaired ability to carry out motor activities despite intact motor function)         3. agnosia (failure to recognize or identify objects despite intact sensory function)         4. disturbance in executive functioning (i.e., planning, organiz­ ing, sequencing, abstracting)   2. The cognitive deficits in Criteria Al and A2 each cause significant impairment in social or occupational functioning and represent a significant decline from a previous level of functioning.   3. There is evidence from the history, physical examination, or laboratory findings that the disturbance has more than one etiology (e.g., head trauma plus chronic alcohol use, Dementia of the Alzheimer's Type with the subsequent development of Vascular Dementia).   4. The deficits do not occur exclusively during the course of a delirium.   **Coding note:** Use multiple codes based on specific dementias and specific etiologies, e.g., 290.0 Dementia of the Alzheimer's Type, With Late Onset, Uncom­ plicated; 290.40 Vascular Dementia, Uncomplicated. |

**294.8 Dementia Not Otherwise Specified**

This category should be used to diagnose a dementia that does not meet criteria for any of the specific types described in this section.

An example is a clinical presentation of dementia for which there is insufficient evidence to establish a specific etiology.

**Amnestic Disorders**

The disorders in the "Amnestic Disorders" section are characterized by a disturbance in memory that is either due to the direct physiological effects of a general medical condition or due to the persisting effects of a substance (i.e., a drug of abuse, a medication, or toxin exposure). The disorders in this section share the common symptom presentation of memory impairment, but are differentiated based on etiology. The diagnostic features listed below pertain to **Amnestic Disorder Due to a General Medical Condition** (e.g., physical trauma and vitamin deficiency) and **Substance­ Induced Persisting Amnestic Disorder** (including medication side effects). In addi­ tion, **Amnestic Disorder Not Otherwise Specified** is included in this section for presentations in which the clinician is unable to determine a specific etiology for the memory disturbance. Text and criteria for Dissociative Disorders involving memory loss are not included here and instead are contained in the Dissociative Disorders section (see p. 477).

***Di-agnostic Features***

Individuals with an amnestic disorder are impaired in their ability to learn new information or are unable to recall previously learned information or past events (Criterion A). The memory disturbance must be sufficiently severe to cause marked impairment in social or occupational functioning and must represent a significant decline from a previous level of functioning (Criterion B). The memory disturbance must not occur exclusively during the course of a delirium or a dementia (Criterion C). The ability to learn and recall new information is always affected in an amnestic disorder, whereas problems remembering previously learned information occur more variably, depending on the location and severity of brain damage. The memory deficit is most apparent on tasks that require spontaneous recall and may also be evident when the examiner provides stimuli for the person to recall at a later time. Depending on the specific area of the brain affected, deficits may be predominantly related to verbal or visual stimuli. In some forms of an amnestic disorder, the individual may remember things from the very remote past better than more recent events (e.g., a person may remember in vivid detail a hospital stay that took place a decade before the examination, but may have no idea that he or she is currently in the hospital).

The diagnosis is not made if the memory impairment occurs exclusively during the course of a delirium (i.e., occurs only in the context of reduced ability to maintain and shift attention). The ability to immediately repeat a sequential string of information (e.g., digit span) is typically not impaired in an amnestic disorder. When such impairment is evident, it suggests the presence of an attentional disturbance that may be indicative of a delirium. The diagnosis is also not made in the presence of other cognitive deficits (e.g., aphasia, apraxia, agnosia, disturbance in executive functioning) that are charac­ teristic of a dementia. Individuals with an amnestic disorder may experience major impairment in their social and vocational functioning as a result of their memory deficits, which, at its extreme, may necessitate supervised living situations to ensure appropriate feeding and care.

***Associated Features and D/,Sorders***

An amnestic disorder is often preceded by an evolving clinical picture that includes confusion and disorientation, occasionally with attentional problems that suggest a delirium (e.g., Amnestic Disorder Due to Thiamine Deficiency). Confabulation, often evidenced by the recitation of imaginary events to fill gaps in memory, may be noted during the early stages of an amnestic disorder but tends to disappear with time. It may therefore be important to obtain corroborating information from family members or other informants. Profound amnesia may result in disorientation to place and time, but rarely to self. Disorientation to self may be encountered in individuals with a dementia but is unusual in an amnestic disorder. Most individuals with a severe Amnestic Disorder lack insight into their memory deficits and may explicitly deny the presence of severe memory impairment despite evidence to the contrary. This lack of insight may lead to accusations against others or, in rare instances, to agitation. Some individuals may acknowledge that they have a problem but appear unconcerned. Apathy, lack of initiative, emotional blandness, or other changes suggestive of altered personality function may be encoun­ tered. Individuals may be superficially friendly or agreeable, but they may have a shallow or diminished range of affective expression. Individuals with transient global amnesia often appear bewildered or befuddled. Subtle deficits in other cognitive functions may be noted, but, by definition, they are not severe enough to cause clinically significant impairment. Quantitative neuropsychological testing often demonstrates specific mem­ ory deficits in the absence of other cognitive disturbances. Performance on standardized tests that assess recall of well-known historical events or public figures may be variable among individuals with an Amnestic Disorder, depending on the nature and extent of the deficit.

***Specific Culture Features***

Cultural and educational background should be taken into consideration in the evaluation of memory. Individuals from certain backgrounds may not be familiar with the information used in certain tests of memory (e.g., date of birth in cultures that do not routinely celebrate birthdays).

***Course***

Age at onset and subsequent course of amnestic disorders may be quite variable, depending on the primary pathological process causing the amnestic disorder. Traumatic brain injury, stroke or other cerebrovascular events, or specific types of neurotoxic exposure (e.g., carbon monoxide poisoning) may lead to an acute onset of an amnestic disorder. Other conditions such as prolonged substance abuse, chronic neurotoxic exposure, or sustained nutritional deficiency may lead to an insidious onset. Transient amnesia due to a cerebrovascular etiology may be recurrent, with episodes lasting from several hours to several days. Amnestic Disorders Due to Head Trauma may last for variable amounts of time, with a characteristic pattern of greatest deficit immediately after injury and improvement during the ensuing 2 years (further improvement beyond

24 months has been noted, but less commonly). Disorders due to destruction of middle-temporal lobe structures (e.g., from infarction, surgical ablation, or malnutrition occurring in the context of Alcohol Dependence) may cause persisting impairments.

***Dif.ferential Diagnosis***

Memory impairment is also a feature of **delirium** and **dementia.** In delirium, memory dysfunction occurs in association with impaired consciousness, with reduced ability to focus, sustain, or shift attention. In dementia, memory impairment must be accompanied by multiple cognitive deficits (i.e., aphasia, apraxia, agnosia, or a disturbance in executive functioning) that lead to clinically significant impairment.

An amnestic disorder must be distinguished from **Dissociative Amnesia** and amnesia occurring in the context of **other Dissociative Disorders** (e.g., **Dissociative Identity Disorder).** By definition, an amnestic disorder is due to the direct physiological effects of a general medical condition or substance use. Furthermore, amnesia in Dissociative Disorders typically does not involve deficits in learning and recalling new information; rather, individuals present with a circumscribed inability to recall previous memories, usually of a traumatic or stressful nature.

For memory disturbances (e.g., blackouts) that occur only during intoxication with or withdrawal from a drug of abuse, the appropriate **Substance Intoxication** or **Substance Withdrawal** should be diagnosed and a separate amnestic disorder diagnosis is not made. For memory disturbances that are associated with the use of medication, Adverse Effects of Medication Not Otherwise Specified (p. 680) may be noted, with the medication indicated by the use of an E-code (see Appendix G).

The presumed etiology of the amnestic disorder determines the diagnosis (text and criteria for each amnestic disorder diagnosis are provided separately later in this section). If it is judged that the memory disturbance is a consequence of the direct physiological effects of a general medical condition (including head trauma), then **Amnestic Disorder Due to a General Medical Condition** is diagnosed. If the memory disturbance results from the persisting effects of a substance (i.e., a drug of abuse, a medication, or toxin exposure), then **Substance-Induced Persisting Amnestic Disorder** is diagnosed. When both a substance (e.g., alcohol) and a general medical condition (e.g., head trauma) have had an etiological role in the development of the memory disturbance, both diagnoses are given. If it is not possible to establish a specific etiology (i.e., dissociative, substance induced, or due to a general medical condition), **Amnestic Disorder Not Otherwise Specified** is diagnosed.

Amnestic disorder must be distinguished from **Malingering** and from **Factitious Disorder.** This difficult distinction can be assisted by systematic memory testing (which often yields inconsistent results in Factitious Disorder or Malingering) and by the absence of a general medical condition or substance use that is etiologically related to the memory impairment.

Amnestic disorder should be distinguished from the less efficient memory charac­ teristic of **Age-Related Cognitive Decline,** which is within the expected age-adjusted normative range for the individual.

**294.0 Amnestic Disorder**

**Due to a General Medical Condition**

***Diagnostic and Associated Features***

The descriptive features of Amnestic Disorder Due to a General Medical Condition (Criteria A-C) are discussed on p. 156. In addition, the diagnosis requires that there must

be evidence from the history, physical examination, or laboratory findings that the memory disturbance is the direct physiological consequence of a general medical condition (including physical trauma) (Criterion D).

In determining whether the amnestic disturbance is due to a general medical condition, the clinician must first establish the presence of a general medical condition. Further, the clinician must establish that the amnestic disturbance is etiologically related to the general medical condition through a physiological mechanism. A careful and comprehensive assessment of multiple factors is necessary to make this judgment. Although there are no infallible guidelines for determining whether the relationship between the amnestic disturbance and the general medical condition is etiological, several considerations provide some guidance in this area. One consideration is the presence of a temporal association between the onset, exacerbation, or remission of the general medical condition and that of the amnestic disturbance. A second consideration is the presence of features that are atypical of memory impairment in the context of a dissociative or other mental disorder (e.g., atypical age at onset or course). Evidence from the literature that suggests that there can be a direct association between the general medical condition in question and the development of memory impairment can provide a useful context in the assessment of a particular situation. In addition, the clinician must also judge that the disturbance is not better accounted for by a Dissociative Disorder, Substance-Induced Persisting Amnestic Disorder, or another primary mental disorder (e.g., Major Depressive Disorder). These determinations are explained in greater detail in the "Mental Disorders Due to a General Medical Condition" section (p. 165).

Individuals with Amnestic Disorder Due to a General Medical Condition often show other features of the primary systemic or cerebral disease that caused the memory impairment. However, disordered mental status may be the sole presenting feature. There are no specific or diagnostic features detectable with procedures such as magnetic resonance imaging (MRI) or computed tomography (CT). However, damage to mediotemporal lobe structures is common and may be reflected by enlargement of third ventricle or temporal horns or by structural atrophy detected on MRI.

***Specifiers***

The following specifiers may be noted to indicate the duration of the disturbance.

**Transient.** This specifier is used to indicate durations usually from several hours to a few days and for no more than 1 month. When the diagnosis is made within the first month without waiting for recovery, the term "provisional" may be added. "Transient global amnesia" is a specific form of transient amnestic disorder, characterized by a dense, transitory inability to learn new information and a variable impaired ability to recall events that occurred just before, or in the midst of, the etiological cerebrovascular problem.

**Chronic.** This specifier is used for disturbances that last for more than 1 month.

***Recording Procedures***

In recording the diagnosis of Amnestic Disorder Due to a General Medical Condition, the clinician should note the identified general medical condition judged to be causing the disturbance on Axis I (e.g., 294.0 Amnestic Disorder Due to Stroke). The ICD-9-CM code for the general medical condition should also be noted on Axis III (e.g., 436 stroke).

(See Appendix G for a list of selected ICD-9-CM diagnostic codes for general medical conditions.)

***Associated General Medical Conditions***

An amnestic disorder often occurs as the result of pathological processes (e.g., closed head trauma, penetrating missile wounds, surgical intervention, hypoxia, infarction of the distribution of the posterior cerebral artery, and herpes simplex encephalitis) that cause damage to specific diencephalic and mediotemporal lobe structures (e.g., mammillary bodies, hippocampus, fornix). Pathology is most often bilateral, but deficits may arise from unilateral lesions. Transient Amnestic Disorder, when encountered as "transient global amnesia," is typically associated with cerebrovascular disease and pathology in the vertebrobasilar system. Transient Amnestic Disorder may also arise from episodic general medical conditions (e.g., metabolic conditions or seizures).

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Seep. 158 for a discussion of the differential diagnosis of amnestic disorders.

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| * **Diagnostic criteria for 294.0 Amnestic Disorder Due to** ... ***[Indicate the General Medical Condition)***   1. The development of memory impairment as manifested by impairment in the ability to learn new information or the inability to recall previously learned information.   2. The memory disturbance causes significant impairment in social or occupational functioning and represents a significant decline from a previous level of functioning.   3. The memory disturbance does not occur exclusively during the course of a delirium or a dementia.   4. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition (including physical trauma).   *Specify* if:  **Transient:** if memory impairment lasts for 1 month or less  **Chronic:** if memory impairment lasts for more than 1 month  **Coding note:** Include the name of the general medical condition on Axis I, e.g.,  294.0 Amnestic Disorder Due to Head Trauma; also code the general medical condition on Axis III (see Appendix G for codes). |

**Substance-Induced Persisting Amnestic Disorder**

***Diagnostic and Associated Features***

The descriptive features of Substance-Induced Persisting Amnestic Disorder (Criteria A and B) are discussed on p. 156. The memory disturbance does not occur exclusively during the course of a delirium or a dementia and persists beyond the usual duration of Substance Intoxication or Withdrawal (Criterion C). In addition, to diagnose Sub­ stance-Induced Persisting Amnestic Disorder, there must be evidence from the history, physical examination, or laboratory findings that the memory disturbance is etiologically related to the persisting effects of substance use (e.g., a drug of abuse, a medication, toxin exposure) (Criterion D). This disorder is termed "persisting" because the memory disturbance persists long after the individual is no longer experiencing the effects of Substance Intoxication or Substance Withdrawal.

Features that are associated with Substance-Induced Persisting Amnestic Disorder are those associated with amnestic disorders generally (see p. 156). Even if currently abstinent from substance use, most individuals with this disorder have previously had a pattern of prolonged and heavy substance use that met criteria for Substance Dependence. Because these disorders persist long after use of the substance has stopped, blood or urine screens may be negative for the etiological substance. The age at onset is rarely before age 20 years. The resulting impairment may remain stable or worsen, even if substance use stops.

For a more detailed discussion of the features associated with Substance-Related Disorders, see p. 175.

***Recording Procedures***

The name of the diagnosis begins with the specific substance (e.g., alcohol, secobarbital) that is presumed to be causing the memory disturbance. The diagnostic code is selected from the listing of classes of substances provided in the criteria set. For substances that do not fit into any of the classes, the code for "Other Substance" should be used. In addition, for medications prescribed at therapeutic doses, the specific medication can be indicated by listing the appropriate E-code (see Appendix G). When more than one substance is judged to play a significant role in the development of the memory disturbance, each should be listed separately (e.g., 291.1 Alcohol-Induced Persisting Amnestic Disorder; 292.83 Secobarbital-Induced Persisting Amnestic Disorder). If a substance is judged to be the etiological factor but the specific substance or class of substances is unknown, the diagnosis is 292.83 Unknown Substance-Induced Persisting Amnestic Disorder.

***Specific Substances***

Substance-Induced Persisting Amnestic Disorder can occur in association with the following classes of substances: alcohol; sedatives, hypnotics, and anxiolytics; and other or unknown substances.

Alcohol-Induced Persisting Amnestic Disorder is apparently due to the vitamin deficiency that is associated with prolonged, heavy ingestion of alcohol. Neurological disturbances such as peripheral neuropathy, cerebellar ataxia, and myopathy are among the associated features. Alcohol-Induced Persisting Amnestic Disorder due to thiamine

deficiency (Korsakoff's syndrome) often follows an acute episode of Wernicke's encephalopathy, a neurological condition manifested by confusion, ataxia, eye­ movement abnormalities (gaze palsies, nystagmus), and other neurological signs. Gradually, these manifestations subside, but a major impairment of memory remains. If Wernicke's encephalopathy is treated early with large doses of thiamine, Alcohol­ Induced Persisting Amnestic Disorder may not develop. Although age is not a specific etiological factor in the condition, individuals who develop Alcohol-Induced Persisting Amnestic Disorder generally have histories of many years of heavy alcohol use and are most often over age 40 years. Although the mode of onset is typically abrupt, some individuals may develop deficits insidiously over many years, due to repeated toxic and nutritional insults, prior to the emergence of a final, more dramatically impairing episode apparently related to thiamine deficiency. Once established, Alcohol-Induced Persisting Amnestic Disorder usually persists indefinitely, although there may be slight improve­ ment over time and in a minority of the cases the condition can remit. Impairment is usually quite severe, and lifelong custodial care may be necessary. Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Amnestic Disorder can follow prolonged and heavy use of drugs from this class. The course is variable, and, unlike Alcohol-Induced Persisting Amnestic Disorder, full recovery can occur. Medications reported to cause amnestic disorders include anticonvulsants and intrathecal methotrexate. Toxins reported to evoke symptoms of amnesia include lead, mercury, carbon monoxide, organophosphate insecticides, and industrial solvents.

***Differential Diagnosis***

Seep. 158 for a general discussion of the differential diagnosis of amnestic disorders.

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| * **Diagnostic criteria for Substance-Induced Persisting Amnestic Disorder**   1. The development of memory impairment as manifested by impairment in the ability to learn new information or the inability to recall previously learned information.   2. The memory disturbance causes significant impairment in social or occupational functioning and represents a significant decline from a previous level of functioning.   3. The memory disturbance does not occur exclusively during the course of a delirium or a dementia and persists beyond the usual duration of Substance Intoxication or Withdrawal.   4. There is evidence from the history, physical examination, or laboratory findings that the memory disturbance is etiologically related to the persisting effects of substance use (e.g., a drug of abuse, a medication).   *Code* [Specific Substance ]-Induced Persisting Amnestic Disorder:  (291.1 Alcohol; 292.83 Sedative, Hypnotic, or Anxiolytic; 292.83 Other [or Unknown] Substance) |

* 1. **Amnestic Disorder Not Otherwise Specified**

This category should be used to diagnose an amnestic disorder that does not meet criteria for any of the specific types described in this section.

An example is a clinical presentation of amnesia for which there is insufficient evidence to establish a specific etiology (i.e., dissociative, substance induced, or due to a general medical condition).

**Other Cognitive Disorders**

* 1. **Cognitive Disorder Not Otherwise Specified**

This category is for disorders that are characterized by cognitive dysfunction presumed to be due to the direct physiological effect of a general medical condition that do not meet criteria for any of the specific deliriums, dementias, or amnestic disorders listed in this section and that are not better classified as Delirium Not Otherwise Specified, Dementia Not Otherwise Specified, or Amnestic Disorder Not Otherwise Specified. For cognitive dysfunction due to a specific or unknown substance, the specific Substance­ Related Disorder Not Otherwise Specified category should be used.

Examples include

1. Mild neurocognitive disorder: impairment in cognitive functioning as evidenced by neuropsychological testing or quantified clinical assessment, accompanied by objective evidence of a systemic general medical condition or central nervous system dysfunction (see p. 706 for suggested research criteria)
2. Postconcussional disorder: following a head trauma, impairment in memory or attention with associated symptoms (see p. 704 for suggested research criteria)



**[Mental Disorders Due to a General Medical Condition](#_bookmark0)**

Me ntal Disorder Due to a General Medical Condition is characterized by the presence of mental symptoms that are judged to be the direct physiological consequence of a general medical condition. The term *general medical condition* refers to conditions that are coded on Axis III and that are listed outside the "Mental Disorders" chapter of ICD. (See Appendix G for a condensed list of these conditions.) As discussed in the "Introduction" to this manual, maintaining the distinction between mental disorders and general medical conditions does not imply that there are fundamental differences in their conceptualization, that mental disorders are unrelated to physical or biological factors or processes, or that general medical conditions are unrelated to behavioral or psychosocial factors or processes. The purpose of distinguishing general medical conditions from mental disorders is to encourage thoroughness in evaluation and to provide a shorthand term to enhance communication among health care providers. However, in clinical practice, it is expected that more specific terminology

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will be used to identify the specific condition involved.

In DSM-III-R, the Mental Disorders Due to a General Medical Condition and the Substance-Induced Disorders were called "organic" disorders and were listed together in a single section. This differentiation of "organic" mental disorders as a separate class implied that "nonorganic" or "functional" mental disorders were somehow unrelated to physical or biological factors or processes. DSM-IV eliminates the term *organic* and distinguishes those mental disorders that are due to a general medical condition from those that are substance induced and those that have no specified etiology. The term *primary mental disorder* is used as a shorthand to indicate those mental disorders that are not due to a general medical condition and that are not substance induced.

Text and criteria for three of these disorders (i.e., **Catatonic Disorder Due to a General Medical Condition, Personality Change Due to a General Medical Condition,** and **Mental Disorder Not Otherwise Specified Due to a General Medical Condition)** are included in this section. The text and criteria for the conditions listed below are placed in other sections of the manual with disorders with which they share phenomenology. The manual has been organized in this fashion to alert clinicians to consider these disorders in making a differential diagnosis.

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**293.0 Delirium Due to a General Medical Condition** Text and criteria are in­ cluded in the "Delirium, Dementia, and Amnestic and Other Cognitive Disorders" section, p. 127.

-.- **Dementia Due to a General Medical Condition** Text and criteria are in­ cluded in the "Delirium, Dementia, and Amnestic and Other Cognitive Disorders" section, p. 139.

**294.0 Amnestic Disorder Due to a General Medical Condition** Text and criteria are included in the "Delirium, Dementia, and Amnestic and Other Cognitive Disorders" section, p. 158.

**293.8x Psychotic Disorder Due to a General Medical Condition** Text and cri­ teria are included in the "Schizophrenia and Other Psychotic Disorders" section, p. 306.

**293.83 Mood Disorder Due to a General Medical Condition** Text and criteria are included in the "Mood Disorders" section, p. 366.

**293.89 Anxiety Disorder Due to a General Medical Condition** Text and criteria are included in the "Anxiety Disorders" section, p. 436.

-.- **Sexual Dysfunction Due to a General Medical Condition** Text and criteria are included in the "Sexual and Gender Identity Disorders" section, p. 515.

**780.Sx Sleep Disorder Due to a General Medical Condition** Text and criteria are included in the "Sleep Disorders" section, p. 597.

***Diagnostic Features***

Three criteria appear in the criteria sets for each of the Mental Disorders Due to a General Medical Condition:

1. **There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition.**

Application of this criterion requires two separate judgments: that a general medical condition is present (ascertained by history, physical examination, or laboratory assess­ ment) and that the disturbance (e.g., psychotic, mood, anxiety symptoms) is etiologically related to the general medical condition through a physiological mechanism. Although there are no infallible guidelines for determining whether the relationship between the disturbance and the general medical condition is etiological, several considerations provide guidance in this area. One consideration is the presence of a temporal association between the onset, exacerbation, or remission of the general medical condition and that of the mental disorder (e.g., symptoms of anxiety in an individual with a parathyroid adenoma that resolve after surgical excision restores a normal serum calcium level). Although evidence of a close temporal relationship is often useful in making a judgment about etiology, there are many exceptions. For example, Psychotic Disorder Due to Epilepsy can emerge many years after the onset of seizures. Alternatively, symptoms

and signs of a mental disorder can be among the first manifestations of a systemic or cerebral disease, appearing months or more before the detection of the underlying pathological process (e.g., depressed mood preceding choreiform movements in Huntington's disease). Mental Disorders Due to a General Medical Condition can also persist after the general medical condition has resolved (e.g., depressed mood persisting after thyroid hormone replacement). Moreover, a Mental Disorder Due to a General Medical Condition can be amenable to symptomatic treatment even while the general medical condition remains active (e.g., depression in epilepsy). Treatment targeted to the general medical condition that alleviates the symptoms of both the general medical condition and the mental disturbance may provide stronger evidence of an etiological relationship.

A second important consideration is the presence of features that are atypical of the primary mental disorder. The most common example is an atypical age at onset or course (e.g., first appearance of schizophrenic-like symptoms in a 75-year-old individual). There may be unusual associated features (e.g., visual or tactile hallucinations accompanying major depressive-like episodes) or diagnostic features that are disproportionately more severe than would be expected given the overall presentation (e.g., a SO-pound weight loss in an individual with otherwise mild depressive symptoms might suggest the presence of a underlying general medical condition). The clinician should be alerted especially by the presence of significant cognitive deficits that are out of proportion to those typically encountered with the primary mental disorder.

Evidence from the literature of a well-established or frequently encountered association between the general medical condition and the phenomenology of a specific mental disorder may be useful in the evaluation of a particular situation. Such studies may provide evidence of a plausible etiological association between the mental symptoms and the general medical condition (e.g., lesion location or a known pathophysiological mechanism likely to affect brain function) and of an elevated prevalence rate of the mental symptoms (i.e., above the base rate in an appropriate control population) in individuals with the general medical condition. Although such evidence suggests a possible causal link between a mental disorder and a particular general medical condition, it is not sufficient for making a determination in an individual case because research studies generally reflect group means, whereas the clinician seeks to make a decision regarding an individual. The text for each of the specific Mental Disorders Due to a General Medical Condition contains a list of some of the general medical conditions noted in the literature to be associated with that specific mental disorder.

1. **The disturbance is not better accounted for by another mental disorder.**

In making the diagnosis of a Mental Disorder Due to a General Medical Condition, it is necessary to rule out primary mental disorders and mental disorders that are substance induced. Ruling out primary mental disorders is often difficult because individuals with primary mental disorders commonly have co-occurring general medical conditions that are *not* causing the mental symptoms through direct physiological mechanisms. There may be a number of other relationships between a mental disorder and a general medical condition: the general medical condition may exacerbate the symptoms or complicate treatment of the mental disorder; the two may be related through nonphysiological mechanisms; or the co-occurrence may be coincidental. For example, when depressive symptoms are precipitated by the general medical condition

acting as a psychosocial stressor, rather than resulting from the direct physiological effects of the general medical condition, the diagnosis would be Major Depressive Disorder or Adjustment Disorder With Depressed Mood. In an individual with depressive symptoms that co-occur with a general medical condition, a history of many Major Depressive Episodes or a family history of depression would suggest a diagnosis of Major Depressive Disorder, rather than a Mood Disorder Due to a General Medical Condition. Finally, the clinician should also consider whether the mental symptoms are caused by a drug of abuse, a medication, or toxin exposure (see p. 192 for guidelines). This is especially important because many individuals with general medical conditions receive medica­ tions that may have the potential to cause a Substance-Induced Mental Disorder.

1. **The disturbance does not occur exclusively during the course of a delirium.**

If symptoms (e.g., psychotic, mood, anxiety) occur only during periods of delirium, they are considered to be associated features of the delirium and do not warrant a separate diagnosis. These conditions (e.g., Mood Disorder Due to a General Medical Condition) can be diagnosed separately only if they occur at times other than during the delirium.

***Recording Procedures***

In recording a Mental Disorder Due to a General Medical Condition, the clinician should note both the type of mental disturbance and the etiological general medical condition on Axis I (e.g., 293.83 Mood Disorder Due to Hypothyroidism, With Depressive Features). The ICD-9-CM code for the general medical condition (e.g., 244.9 hypo­ thyroidism) should also be noted on Axis III. In situations in which the clinician has determined that the mental symptoms are not a direct physiological consequence of the general medical condition, the primary mental disorder should be coded on Axis I and the general medical condition should be coded on Axis III. (See Appendix G for a list of selected ICD-9-CM diagnostic codes for general medical conditions.)

***Differential Diagnosis***

A Mental Disorder Due to a General Medical Condition is distinguished from a **primary mental disorder** by applying the criteria discussed earlier in this section under "Diagnostic Features." When symptoms of a mental disorder and a general medical condition co-occur, it is especially important to determine whether the etiological relationship, if any, is directly physiological (in which case the diagnosis is Mental Disorder Due to a General Medical Condition) or through another mechanism (in which case the diagnosis is a primary mental disorder). In some cases, the development of a general medical condition or the presence of associated disability may precipitate or exacerbate a mental disorder, with no known physiological link (e.g., the disability associated with osteoarthritis may play a role in the development of depressive symptoms or a Major Depressive Episode, but there is no known physiological mechanism underlying the etiological relationship between the arthritis and the depressive symp­ toms). In this situation, the primary mental disorder (i.e., Adjustment Disorder or Major Depressive Disorder) should be diagnosed on Axis I and the general medical condition (i.e., osteoarthritis) should be listed on Axis III.

A Mental Disorder Due to a General Medical Condition must also be distinguished from a **Substance-Induced Disorder.** If there is evidence of recent or prolonged use of a substance (including medications with psychoactive effects), withdrawal from a substance, or exposure to a toxin, a Substance-Induced Disorder should be considered. It may be useful to obtain a urine or blood drug screen or other appropriate laboratory evaluation. Symptoms that occur during or shortly after (i.e., within 4 weeks of) significant substance intoxication or withdrawal or medication use may be especially indicative of a Substance-Induced Disorder, depending on the type or the amount of the substance used or the duration of use.

Delirium, dementia, psychotic, mood, anxiety, or sleep symptoms or a sexual dysfunction may be caused by the **combined effects of a general medical condition and substance use** (including medications). In such situations, both diagnoses (e.g., Mood Disorder Due to a General Medical Condition and Substance-Induced Mood Disorder) should be listed. If it is not possible to ascertain whether the mental symptoms are due to a general medical condition or are substance induced, the Not Otherwise Specified category may be used (see discussion below).

When, as often happens, the presentation of a Mental Disorder Due to a General Medical Condition contains a mix of different symptoms (e.g., mood and anxiety), it is generally desirable to assign a single diagnosis based on which symptoms predominate in the clinical presentation. In some situations, it is not possible to determine whether the mental symptoms are primary, due to a general medical condition, or substance induced. The Not Otherwise Specified category should be used in such situations.

**293.89 Catatonic Disorder Due to a General Medical Condition**

***Diagnostic Features***

The essential feature of Catatonic Disorder Due to a General Medical Condition is the presence of catatonia that is judged to be due to the direct physiological effects of a general medical condition. Catatonia is manifested by any of the following: motoric immobility, excessive motor activity, extreme negativism or mutism, peculiarities of voluntary movement, echolalia, or echopraxia (Criterion A). There must be evidence from the history, physical examination, or laboratory findings that the catatonia is the direct physiological consequence of a general medical condition (Criterion B). The diagnosis is not given if the catatonia is better accounted for by another mental disorder (e.g., Manic Episode) (Criterion C) or if it occurs exclusively during the course of a delirium (Criterion D).

Motoric immobility may be manifested by catalepsy (waxy flexibility) or stupor. The excessive motor activity is apparently purposeless and is not influenced by external stimuli. There may be extreme negativism that is manifested by resistance to all instructions or the maintenance of a rigid posture against attempts to be moved. Peculiarities of voluntary movement are manifested by the voluntary assumption of inappropriate or bizarre postures or by prominent grimacing. Echolalia is the patholog­ ical, parrotlike, and apparently senseless repetition of a word or phrase just spoken by another person. Echopraxia is the repetitive imitation of the movements of another person.

***Recording Procedures***

In recording Catatonic Disorder Due to a General Medical Condition, the clinician should note both the specific phenomenology of the disturbance and the identified general medical condition judged to be causing the disturbance on Axis I (e.g., 293.89 Catatonic Disorder Due to Malignant Neoplasm of Brain). The ICD-9-CM code for the general medical condition (e.g., 191.9 malignant neoplasm of brain) should also be noted on Axis III. (See Appendix G for a list of selected ICD-9-CM diagnostic codes for general medical conditions.)

***Associated General Medical Conditions***

A variety of general medical conditions may cause catatonia, especially neurological conditions (e.g., neoplasms, head trauma, cerebrovascular disease, encephalitis) and metabolic conditions (e.g., hypercalcemia, hepatic encephalopathy, homocystinuria, diabetic ketoacidosis).The associated physical examination findings, laboratory findings, and patterns of prevalence and onset reflect those of the etiological general medical condition.

***Di,fferential magnosis***

A separate diagnosis of Catatonic Disorder Due to a General Medical Condition is not given if the catatonia occurs exclusively during the course of a **delirium.** If the individual is currently taking neuroleptic medication, **Medication-Induced Movement Disorders** should be considered (e.g., abnormal positioning may be due to Neuroleptic-Induced Acute Dystonia). Catatonic symptoms may also be present in Schizophrenia and Mood Disorders. **Schizophrenia,Catatonic Type,** is distinguished by the absence of evidence of a general medical condition that is etiologically related to the catatonia, and by the presence of other symptoms characteristic of Schizophrenia (e.g., delusions, hallucina­ tions, disorganized speech, negative symptoms). A **Mood Disorder With Catatonic Features** is likewise differentiated by the absence of evidence of a general medical condition that is etiologically related to the catatonia, and by the presence of symptoms that meet the criteria for a Major Depressive or Manic Episode.

* **Diagnostic criteria for 293.89 Catatonic Disorder Due to** ... ***(Indicate the General Medical Condition)***
  1. The presence of catatonia as manifested by motoric immobility, exces­ sive motor activity (that is apparently purposeless and not influenced by external stimuli), extreme negativism or mutism, peculiarities of voluntary movement, or echolalia or echopraxia.
  2. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition.

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| **D Diagnostic criteria for 293.89 Catatonic Disorder Due to** ... ***[Indicate tlie General Medical Condition]*** *(continued)*  C. The disturbance is not better accounted for by another mental disorder (e.g., a Manic Episode).  D. The disturbance does not occur exclusively during the course of a delirium.  **Coding note:** Include the name of the general medical condition on Axis I, e.g.,  293.89 Catatonic Disorder Due to Hepatic Encephalopathy; also code the general medical condition on Axis III (see Appendix G for codes). |

**310.1 Personality Change**

**Due to a General Medical Condition**

***magnostic Features***

The essential feature of a Personality Change Due to a General Medical Condition is a persistent personality disturbance that is judged to be due to the direct physiological effects of a general medical condition. The personality disturbance represents a change from the individual's previous characteristic personality pattern. In children, this condition may be manifested as a marked deviation from normal development rather than as a change in a stable personality pattern (Criterion A). There must be evidence from the history, physical examination, or laboratory findings that the personality change is the direct physiological consequence of a general medical condition (Criterion B). The diagnosis is not given if the disturbance is better accounted for by another mental disorder (Criterion C). The diagnosis is not given if the disturbance occurs exclusively during the course of a delirium or if symptoms meet the criteria for a dementia (Criterion D). The disturbance must also cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion E).

Common manifestations of the personality change include affective instability, poor impulse control, outbursts of aggression or rage grossly out of proportion to any precipitating psychosocial stressor, marked apathy, suspiciousness, or paranoid ideation. The phenomenology of the change is indicated using the subtypes listed below. An individual with the disorder is often characterized by others as "not himself [or herself]." Although it shares the term "personality" with the Axis II Personality Disorders, this diagnosis is coded on Axis I and is distinct by virtue of its specific etiology, different phenomenology, and more variable onset and course.

The clinical presentation in a given individual may depend on the nature and localization of the pathological process. For example, injury to the frontal lobes may yield such symptoms as lack of judgment or foresight, facetiousness, disinhibition, and euphoria. Right hemisphere strokes have often been shown to evoke personality changes in association with unilateral spatial neglect, anosognosia (inability of the individual to recognize a bodily or functional deficit such as the existence of hemiparesis), motor impersistence, and other neurological deficits.

***Subtypes***

The particular personality change can be specified by indicating the symptom presen­ tation that predominates in the clinical presentation:

**Labile Type.** This subtype is used if the predominant feature is affective !ability. **Disinhibited Type.** This subtype is used if the predominant feature is poor impulse control (e.g., as evidenced by sexual indiscretions).

**Aggressive Type.** This subtype is used if the predominant feature is aggressive behavior.

**Apathetic Type.** This subtype is used if the predominant feature is marked apathy and indifference.

**Paranoid Type.** This subtype is used if the predominant feature is suspicious­ ness or paranoid ideation.

**Other Type.** This subtype would be used, for example, for a personality change associated with a seizure disorder.

**Combined Type.** This subtype is used if more than one feature predominates in the clinical picture.

**Unspecified Type.**

***Recording Procedures***

In recording Personality Change Due to a General Medical Condition, the clinician should note both the specific phenomenology of the disturbance, including appropriate subtype, and the general medical condition judged to be causing the disturbance on Axis I (e.g., 310.1 Personality Change Due to Systemic Lupus Erythematosus, Paranoid Type). The ICD-9-CM code for the general medical condition (e.g., 710.0 systemic lupus erythematosus) should also be noted on Axis III. (See Appendix G for a list of selected ICD-9-CM diagnostic codes for general medical conditions.)

***Associated General Medical Conditions***

A variety of neurological and other general medical conditions may cause personality changes, including central nervous system neoplasms, head trauma, cerebrovascular disease, Huntington's disease, epilepsy, infectious conditions with central nervous system involvement (e.g., human immunodeficiency virus), endocrine conditions (e.g., hypothyroidism, hypo- and hyperadrenocorticism), and autoimmune conditions with central nervous system involvement (e.g., systemic lupus erythematosus). The associated physical examination findings, laboratory findings, and patterns of prevalence and onset reflect those of the neurological or other general medical condition involved.

***Differential Diagnosis***

**Chronic general medical conditions** associated with pain and disability can also be associated with changes in personality. The diagnosis of Personality Change Due to a General Medical Condition is given only if a direct pathophysiological mechanism can be established. Personality change is a frequent associated feature of a **dementia** (e.g., Dementia of the Alzheimer's Type). A separate diagnosis of Personality Change Due to a General Medical Condition is not given if criteria are also met for a dementia or if the

change occurs exclusively during the course of a **delirium.** Furthermore, the diagnosis of Personality Change Due to a General Medical Condition is not given if the disturbance is better accounted for by **another Mental Disorder Due to a General Medical Condition** (e.g., Mood Disorder Due to Brain Tumor, With Depressive Features).

Personality changes may also occur in the context of **Substance Dependence,** especially if the dependence is long-standing. The clinician should inquire carefully about the nature and extent of substance use. If the clinician wishes to indicate an etiological relationship between the personality change and substance use, the Not Otherwise Specified category for the specific substance (e.g., Cocaine-Related Disorder Not Otherwise Specified) can be used.

Marked personality changes may also be an **associated feature of other mental disorders** (e.g., Schizophrenia, Delusional Disorder, Mood Disorders, Impulse-Control Disorders Not Elsewhere Classified, Panic Disorder). However, in these disorders, no specific physiological factor is judged to be etiologically related to the personality change. Personality Change Due to a General Medical Condition can be distinguished from a **Personality Disorder** by the requirement for a clinically significant change from baseline personality functioning and the presence of a specific etiological general medical condition.

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| * **Diagnostic criteria for 310.1 Personality Change Due to** ... ***[Indicate the General Medical Condition]***   1. A persistent personality disturbance that represents a change from the individual's previous characteristic personality pattern. (In children, the disturbance involves a marked deviation from normal development or a significant change in the child's usual behavior patterns lasting at least 1 year).   2. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition.   3. The disturbance is not better accounted for by another mental disorder (including other Mental Disorders Due to a General Medical Condition).   4. The disturbance does not occur exclusively during the course of a delirium and does not meet criteria for a dementia.   5. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.   *Specify* type:  **Labile Type:** if the predominant feature is affective !ability  **Disinhibited Type:** if the predominant feature is poor impulse control as evidenced by sexual indiscretions, etc.  **Aggressive Type:** if the predominant feature is aggressive behavior  *(continued)* |

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| □ **Diagnostic criteria for 310.1 Personality Change Due to** ...  ***[Indicate the General Medical Condition]*** *(continued)*  **Apathetic Type:** if the predominant feature is marked apathy and indifference  **Paranoid Type:** if the predominant feature is suspiciousness or paranoid ideation  **Other Type:** if the predominant feature is not one of the above, e.g., personality change associated with a seizure disorder  **Combined Type:** if more than one feature predominates in the clinical picture  **Unspecified Type**  **Coding note:** Include the name of the general medical condition on Axis I, e.g.,  310.1 Personality Change Due to Temporal Lobe Epilepsy; also code the general medical condition on Axis III (see Appendix G for codes). |

**293.9 Mental Disorder Not Otherwise Specified Due to a General Medical Condition**

This residual category should be used for situations in which it has been established that the disturbance is caused by the direct physiological effects of a general medical condition, but the criteria are not met for a specific Mental Disorder Due to a General Medical Condition (e.g., dissociative symptoms due to complex partial seizures).

**Coding note:** Include the name of the general medical condition on Axis I, e.g., 293.9 Mental Disorder Not Otherwise Specified Due to HIV Disease; also code the general medical condition on Axis III (see Appendix G for codes).

**[Substance Related Disorders](#_bookmark0)**

he Substance-Related Disorders include disorders related to the taking of a drug of abuse (including alcohol), to the side effects of a medication, and to toxin exposure.

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In this manual, the term *substance* can refer to a drug of abuse, a medication, or a toxin. The substances discussed in this section are grouped into 11 classes: alcohol; amphet­ amine or similarly acting sympathomimetics; caffeine; cannabis; cocaine; hallucinogens; inhalants; nicotine; opioids; phencyclidine (PCP) or similarly acting arylcyclohexyl­ amines; and sedatives, hypnotics, or anxiolytics. Although these 11 classes appear in alphabetical order, the following classes share similar features: alcohol shares features with the sedatives, hypnotics, and anxiolytics; and cocaine shares features with amphetamines or similarly acting sympathomimetics. Also included in this section are Polysubstance Dependence and Other or Unknown Substance-Related Disorders (which include most disorders related to medications or toxins).

Many prescribed and over-the-counter medications can also cause Substance­ Related Disorders. Symptoms are often related to the dosage of the medication and usually disappear when the dosage is lowered or the medication is stopped. However, there may sometimes be an idiosyncratic reaction to a single dose. Medications that may cause Substance-Related Disorders include, but are not limited to, anesthetics and analgesics, anticholinergic agents, anticonvulsants, antihistamines, antihypertensive and cardiovascular medications, antimicrobial medications, antiparkinsonian medications, chemotherapeutic agents, corticosteroids, gastrointestinal medications, muscle relaxants, nonsteroidal anti-inflammatory medications, other over-the-counter medications, anti­ depressant medications, and disulfiram.

Exposure to a wide range of other chemical substances can also lead to the development of a Substance-Related Disorder. Toxic substances that may cause Sub­ stance-Related Disorders include, but are not limited to, heavy metals (e.g., lead or aluminum), rat poisons containing strychnine, pesticides containing acetylcholinesterase inhibitors, nerve gases, ethylene glycol (antifreeze), carbon monoxide, and carbon dioxide. The volatile substances (e.g., fuel, paint) are classified as "inhalants" (seep. 236) if they are used for the purpose of becoming intoxicated; they are considered "toxins" if exposure is accidental or part of intentional poisoning. Impairments in cognition or mood are the most common symptoms associated with toxic substances, although anxiety, hallucinations, delusions, or seizures can also result. Symptoms usually disap­ pear when the individual is no longer exposed to the substance, but resolution of

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symptoms can take weeks or months and may require treatment.

The Substance-Related Disorders are divided into two groups: the Substance Use Disorders (Substance Dependence and Substance Abuse) and the Substance-Induced Disorders (Substance Intoxication, Substance Withdrawal, Substance-Induced Delirium, Substance-Induced Persisting Dementia, Substance-Induced Persisting Amnestic Disor­ der, Substance-Induced Psychotic Disorder, Substance-Induced Mood Disorder, Sub­ stance-Induced Anxiety Disorder, Substance-Induced Sexual Dysfunction, and Substance-Induced Sleep Disorder). The section begins with the text and criteria sets for Substance Dependence, Abuse, Intoxication, and Withdrawal that are applicable across classes of substances. This is followed by general comments concerning associated features; culture, age, and gender features; course; impairment and complications; familial pattern; differential diagnosis; and recording procedures that apply to all substance classes. The remainder of the section is organized by class of substance and describes the specific aspects of Dependence, Abuse, Intoxication, and Withdrawal for each of the 11 classes of substances. To facilitate differential diagnosis, the text and criteria for the remaining Substance-Induced Disorders are included in the sections of the manual with disorders with which they share phenomenology (e.g., Substance­ Induced Mood Disorder is included in the "Mood Disorders" section). The diagnoses associated with each specific group of substances are shown in Table 1.

**Substance Use Disorders Substance Dependence**

***Features***

The essential feature of Substance Dependence is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self­ administration that usually results in tolerance, withdrawal, and compulsive drug-taking behavior. A diagnosis of Substance Dependence can be applied to every class of substances except caffeine. The symptoms of Dependence are similar across the various categories of substances, but for certain classes some symptoms are less salient, and in a few instances not all symptoms apply (e.g., withdrawal symptoms are not specified for Hallucinogen Dependence). Although not specifically listed as a criterion item, "craving" (a strong subjective drive to use the substance) is likely to be experienced by most (if not all) individuals with Substance Dependence. Dependence is defined as a cluster of three or more of the symptoms listed below occurring at any time in the same 12-month period.

Tolerance (Criterion 1) is the need for greatly increased amounts of the substance to achieve intoxication (or the desired effect) or a markedly diminished effect with continued use of the same amount of the substance. The degree to which tolerance develops varies greatly across substances. Individuals with heavy use of opioids and stimulants can develop substantial (e.g., tenfold) levels of tolerance, often to a dosage that would be lethal to a nonuser. Alcohol tolerance can also be pronounced, but is usually much less extreme than for amphetamine. Many individuals who smoke

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| **Table 1.** Diagnoses associated with class of substances | | | | | | | | | | | | |
| **Depen- dence** | | **Abuse** | **Intoxi- cation** | **With- drawal** | **Intoxi- cation Delirium** | **With- drawal Delirium** | **Dementia** | **Amnestic Disorder** | **Psychotic Mood Anxiety Disorders Disorders Disorders** | | | **Sexual Dysfunc- Sleep**  **tions Disorders** |
| Alcohol | X | X | X | X | w | | p | p | 1/W | 1/W | 1/W | I/W |
| Amphetamines | X | X | X | X |  | |  |  |  | 1/W |  | 1/W |
| Caffeine |  |  | X |  |  | |  |  |  |  |  |  |
| Cannabis | X | X | X |  |  | |  |  |  |  |  |  |
| Cocaine  Hallucinogens | X  X | X  X | X  X | X |  | |  |  | .  I | 1/W | 1/W | I/W |
| Inhalants | X | X | X |  |  | | p |  |  |  |  |  |
| Nicotine | X |  |  | X |  | |  |  |  |  |  |  |
| Opioids | X | X | X | X |  | |  |  |  |  |  | 1/W |
| Phencyclidine | X | X | X |  |  | |  |  |  |  |  |  |
| Sedatives, hypnotics, | X | X | X | X | w | | p | p | I/W | 1/W | w | 1/W |
| or anxiolytics |  |  |  |  |  | |  |  |  |  |  |  |
| Polysubstance | X |  |  |  |  | |  |  |  |  |  |  |
| Other | X | X | X | X | w | | p | p | I/W | 1/W | I/W | l/W |
| \*Also Hallucinogen Persisting Perception Disorder (Flashbacks).  **Note:** X, I, W, I/W, or P indicates that the category is recognized in DSM-IV. In addition, !indicates that the specifier With Onset During Intoxication may be noted for the category (except for Intoxication Delirium); Windicates that the specifier With Onset During Withdrawal may be noted for the category (except for Withdrawal Delirium); and *YW* indicates that either With Onset During Intoxication or With Onset During Withdrawal may be noted for the catego1y. *P* indicates that the disorder is | | | | | | | | | | | | |

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cigarettes consume more than 20 cigarettes a day, an amount that would have produced symptoms of toxicity when they first started smoking. Individuals with heavy use of cannabis are generally not aware of having developed tolerance (although it has been demonstrated in animal studies and in some individuals). It is uncertain whether any tolerance develops to phencyclidine (PCP). Tolerance may be difficult to determine by history alone when the substance used is illegal and perhaps mixed with various diluents or with other substances. In such situations, laboratory tests may be helpful (e.g., high blood levels of the substance coupled with little evidence of intoxication suggest that tolerance is likely). Tolerance must also be distinguished from individual variability in the initial sensitivity to the effects of particular substances. For example, some first-time drinkers show very little evidence of intoxication with three or four drinks, whereas others of similar weight and drinking histories have slurred speech and incoordi­ nation.

Withdrawal (Criterion 2a) is a maladaptive behavioral change, with physiological and cognitive concomitants, that occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged heavy use of the substance. After developing unpleasant withdrawal symptoms, the person is likely to take the substance to relieve or to avoid those symptoms (Criterion 26), typically using the substance throughout the day beginning soon after awakening. Withdrawal symp­ toms vary greatly across the classes of substances, and separate criteria sets for Withdrawal are provided for most of the classes. Marked and generally easily measured physiological signs of withdrawal are common with alcohol, opioids, and sedatives, hypnotics, and anxiolytics. Withdrawal signs and symptoms are often present, but may be less apparent, with stimulants such as amphetamines and cocaine, as well as with nicotine. No significant withdrawal is seen even after repeated use of hallucinogens. Withdrawal from phencyclidine and related substances has not yet been described in humans (although it has been demonstrated in animals).

Neither tolerance nor withdrawal is necessary or sufficient for a diagnosis of Substance Dependence. Some individuals (e.g., those with Cannabis Dependence) show a pattern of compulsive use without any signs of tolerance or withdrawal. Conversely, some postsurgical patients without Opioid Dependence may develop a tolerance to prescribed opioids and experience withdrawal symptoms without showing any signs of compulsive use. The specifiers With Physiological Dependence and Without Physiolog­ ical Dependence are provided to indicate the presence or absence of tolerance or withdrawal.

The following items describe the pattern of compulsive substance use that is characteristic of Dependence. The individual may take the substance in larger amounts or over a longer period than was originally intended (e.g., continuing to drink until severely intoxicated despite having set a limit of only one drink) (Criterion 3). The individual may express a persistent desire to cut down or regulate substance use. Often, there have been many unsuccessful efforts to decrease or discontinue use (Criterion 4). The individual may spend a great deal of time obtaining the substance, using the substance, or recovering from its effects (Criterion 5). In some instances of Substance Dependence, virtually all of the person's daily activities revolve around the substance. Important social, occupational, or recreational activities may be given up or reduced because of substance use (Criterion 6). The individual may withdraw from family activities and hobbies in order to use the substance in private or to spend more time with substance-using friends. Despite recognizing the contributing role of the substance to a psychological or physical problem (e.g., severe depressive symptoms or damage to

organ systems), the person continues to use the substance (Criterion 7). The key issue in evaluating this criterion is not the existence of the problem, but rather the individual's failure to abstain from using the substance despite having evidence of the difficulty it is causing.

***Specifiers***

Tolerance and withdrawal may be associated with a higher risk for immediate general medical problems and a higher relapse rate. Specifiers are provided to note their presence or absence:

**With Physiological Dependence.** This specifier should be used when Sub­ stance Dependence is accompanied by evidence of tolerance (Criterion 1) or withdrawal (Criterion 2).

**Without Physiological Dependence.** This specifier should be used when there is no evidence of tolerance (Criterion 1) or withdrawal (Criterion 2). In these individuals, Substance Dependence is characterized by a pattern of compulsive use (at least three items from Criteria 3-7).

***Course SpeciJiers***

Six course specifiers are available for Substance Dependence. The four Remission specifiers can be applied only after none of the criteria for Substance Dependence or Substance Abuse have been present for at least 1 month. The definition of these four types of Remission is based on the interval of time that has elapsed since the cessation of Dependence (Early versus Sustained Remission) and whether there is continued presence of one or more of the items included in the criteria sets for Dependence or Abuse (Partial versus Full Remission). Because the first 12 months following Dependence is a time of particularly high risk for relapse, this period is designated Early Remission. After 12 months of Early Remission have passed without relapse to Dependence, the person enters into Sustained Remission. For both Early Remission and Sustained Remission, a further designation of Full is given if no criteria for Dependence or Abuse have been met during the period of remission; a designation of Partial is given if at least one of the criteria for Dependence or Abuse has been met, intermittently or continuously, during the period of remission. The differentiation of Sustained Full Remission from recovered (no current Substance Use Disorder) requires consideration of the length of time since the last period of disturbance, the total duration of the disturbance, and the need for continued evaluation. If, after a period of remission or recovery, the individual again becomes dependent, the application of the Early Remission specifier requires that there again be at least 1 month in which no criteria for Dependence or Abuse are met. Two additional specifiers have been provided: On Agonist Therapy and In a Controlled Environment. For an individual to qualify for Early Remission after cessation of agonist therapy or release from a controlled environment, there must be a 1-month period in which none of the criteria for Dependence or Abuse are met.

The following Remission specifiers can be applied only after no criteria for Dependence or Abuse have been met for at least 1 month. Note that these specifiers do not apply if the individual is on agonist therapy or in a controlled environment (see below).

**Early Full Remission.** This specifier is used if, for at least 1 month, but for less than 12 months, no criteria for Dependence or Abuse have been met.

* **Dependence - 1 - 0-11 months +I**

**month**

**Early Partial Remission.** This specifier is used if, for at least 1 month, but less than 12 months, one or more criteria for Dependence or Abuse have been met (but the full criteria for Dependence have not been met).

* **Dependence - 1 - 0-11 months**

**month**

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**Sustained Full Remission.** This specifier is used if none of the criteria for Dependence or Abuse have been met at any time during a period of 12 months or longer.

* **Dependence - 1 - 11+ months**

**month**

**Sustained Partial Remission.** This specifier is used if full criteria for Depen­ dence have not been met for a period of 12 months or longer; however, one or more criteria for Dependence or Abuse have been met.

* **Dependence - 1 - 11+ months**

**month**

The following specifiers apply if the individual is on agonist therapy or in a controlled environment:

**On Agonist Therapy.** This specifier is used if the individual is on a prescribed agonist medication, and no criteria for Dependence or Abuse have been met for that class of medication for at least the past month (except tolerance to, or withdrawal from, the agonist). This category also applies to those being treated for Dependence using a partial agonist or an agonist/antagonist.

**In a Controlled Environment.** This specifier is used if the individual is in an environment where access to alcohol and controlled substances is restricted, and no criteria for Dependence or Abuse have been met for at least the past month. Examples of these environments are closely supervised and substance-free jails, therapeutic communities, or locked hospital units.

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| * **Criteria for Substance Dependence**   A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:   * 1. tolerance, as defined by either of the following:      1. a need for markedly increased amounts of the substance to achieve intoxication or desired effect      2. markedly diminished effect with continued use of the same amount of the substance   2. withdrawal, as manifested by either of the following:      1. the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)   Cb) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms   * 1. the substance is often taken in larger amounts or over a longer period than was intended   2. there is a persistent desire or unsuccessful efforts to cut down or control substance use   3. a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects   4. important social, occupational, or recreational activities are given up or reduced because of substance use   5. the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depres­ sion, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)   *Specify* if:  **With Physiological Dependence:** evidence of tolerance or withdrawal (i.e., either Item 1 or 2 is present)  **Without Physiological Dependence:** no evidence of tolerance or withdrawal (i.e., neither Item 1 nor 2 is present)  *Course specifiers* (see text for definitions):  **Early Full Remission Early Partial Remission Sustained Full Remission**  **Sustained Partial Remission On Agonist Therapy**  **In a Controlled Environment** |

**Substance Abuse**

***Features***

The essential feature of Substance Abuse is a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. There may be repeated failure to fulfill major role obligations, repeated use in situations in which it is physically hazardous, multiple legal problems, and recurrent social and interpersonal problems (Criterion A). These problems must occur recurrently during the same 12-month period. Unlike the criteria for Substance Depen­ dence, the criteria for Substance Abuse do not include tolerance, withdrawal, or a pattern of compulsive use and instead include only the harmful consequences of repeated use. A diagnosis of Substance Abuse is preempted by the diagnosis of Substance Dependence if the individual's pattern of substance use has ever met the criteria for Dependence for that class of substances (Criterion B). Although a diagnosis of Substance Abuse is more likely in individuals who have only recently started taking the substance, some individuals continue to have substance-related adverse social consequences over a long period of time without developing evidence of Substance Dependence. The category of Substance Abuse does not apply to caffeine and nicotine.

The individual may repeatedly demonstrate intoxication or other substance-related symptoms when expected to fulfill major role obligations at work, school, or home (Criterion Al). There may be repeated absences or poor work performance related to recurrent hangovers. A student might have substance-related absences, suspensions, or expulsions from school. While intoxicated, the individual may neglect children or household duties. The person may repeatedly be intoxicated in situations that are physically hazardous (e.g., while driving a car, operating machinery, or engaging in risky recreational behavior such as swimming or rock climbing) (Criterion A2). There may be recurrent substance-related legal problems (e.g., arrests for disorderly conduct, assault and battery, driving under the influence) (Criterion A3). The person may continue to use the substance despite a history of undesirable persistent or recurrent social or interpersonal consequences (e.g., marital difficulties or divorce, verbal or physical fights) (Criterion A4).

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| * **Criteria for Substance Abuse**   A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:   * 1. recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)   *(continued)* |

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| * **Criteria for Substance Abuse** *(continued)*   1. recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)   2. recurrent substance-related legal problems (e.g., arrests for sub­ stance-related disorderly conduct)   3. continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about conse­ quences of intoxication, physical fights)   B. The symptoms have never met the criteria for Substance Dependence for this class of substance. |

**Substance-Induced Disorders**

**Substance Intoxication**

***Diagnostic Features***

The essential feature of Substance Intoxication is the development of a reversible substance-specific syndrome due to the recent ingestion of (or exposure to) a substance (Criterion A). The clinically significant maladaptive behavioral or psychological changes associated with intoxication (e.g., belligerence, mood !ability, cognitive impairment, impaired judgment, impaired social or occupational functioning) are due to the direct physiological effects of the substance on the central nervous system and develop during or shortly after use of the substance (Criterion B). The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder (Criterion C). Substance Intoxication is often associated with Substance Abuse or Dependence. This category does not apply to nicotine. Evidence for recent intake of the substance can be obtained from the history, physical examination (e.g., smell of alcohol on the breath), or toxicological analysis of body fluids (e.g., urine or blood).

The most common changes involve disturbances of perception, wakefulness, attention, thinking, judgment, psychomotor behavior, and interpersonal behavior. The specific clinical picture in Substance Intoxication varies dramatically among individuals and also depends on which substance is involved, the dose, the duration or chronicity of dosing, the person's tolerance for the substance, the period of time since the last dose, the expectations of the person as to the substance's effects, and the environment or setting in which the substance is taken. Short-term or "acute" intoxications may have different signs and symptoms from sustained or "chronic" intoxications. For example, moderate cocaine doses may initially produce gregariousness, but social withdrawal may develop if such doses are frequently repeated over days or weeks. Different substances (sometimes even different substance classes) may produce identical symptoms. For

example, Amphetamine and Cocaine Intoxication can both present with grandiosity and hyperactivity, accompanied by tachycardia, pupillary dilation, elevated blood pressure, and perspiration or chills.

When used in the physiological sense, the term *intoxication* is broader than Substance Intoxication as defined here. Many substances may produce physiological or psychological changes that are not necessarily maladaptive. For example, an individual with tachycardia from excessive caffeine use has a physiological intoxication, but if this is the only symptom in the absence of maladaptive behavior, the diagnosis of Caffeine Intoxication would not apply. The maladaptive nature of a substance-induced change in behavior depends on the social and environmental context. The maladaptive behavior generally places the individual at significant risk for adverse effects (e.g., accidents, general medical complications, disruption in social and family relationships, vocational or financial difficulties, legal problems). Signs and symptoms of intoxication may sometimes persist for hours or days beyond the time when the substance is detectable in body fluids. This may be due to continuing low concentrations of the substance in certain areas of the brain or to a **"hit** and run" effect in which the substance alters a physiological process, the recovery of which takes longer than the time for elimination of the substance. These longer-term effects of intoxication must be distinguished from withdrawal (i.e., symptoms initiated by a decline in blood or tissue concentrations of a substance).

* **Criteria for Substance Intoxication**
  1. The development of a reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance. **Note:** Different substances may produce similar or identical syndromes.
  2. Clinically significant maladaptive behavioral or psychological changes that are due to the effect of the substance on the central nervous system (e.g., belligerence, mood !ability, cognitive impairment, impaired judg­ ment, impaired social or occupational functioning) and develop during or shortly after use of the substance.
  3. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

**Substance Withdrawal**

***Diagnostic Features***

The essential feature of Substance Withdrawal is the development of a substance-specific maladaptive behavioral change, with physiological and cognitive concomitants, that is due to the cessation of, or reduction in, heavy and prolonged substance use (Criterion A). The substance-specific syndrome causes clinically significant distress or impairment in

social, occupational, or other important areas of functioning (Criterion B). The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder (Criterion C). Withdrawal is usually, but not always, associated with Substance Dependence (see p. 178). Most (perhaps all) individuals with Withdrawal have a craving to readminister the substance to reduce the symptoms. The diagnosis of Withdrawal is recognized for the following groups of substances: alcohol; amphetamines and other related substances; cocaine; nicotine; opioids; and sedatives, hypnotics, or anxiolytics. The signs and symptoms of Withdrawal vary according to the substance used, with most symptoms being the opposite of those observed in Intoxication with the same substance. The dose and duration of use and other factors such as the presence or absence of additional illnesses also affect withdrawal symptoms. Withdrawal develops when doses are reduced or stopped, whereas signs and symptoms of Intoxication improve (gradually in some cases) after dosing stops.

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| * **Criteria for Substance Withdrawal**   1. The development of a substance-specific syndrome due to the cessation of (or reduction in) substance use that has been heavy and prolonged.   2. The substance-specific syndrome causes clinically significant distress or impairment in social, occupational, or other important areas of func­ tioning.   3. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder. |

***Associated Features of Substance Dependence, Abuse, Intoxication, and Withdrawal***

**Assessment issues.** The diagnosis of Substance Dependence requires obtaining a detailed history from the individual and, whenever possible, from additional sources of information (e.g., medical records; a spouse, relative, or close friend). In addition, physical examination findings and laboratory test results can be helpful.

**Route of administration.** The route of administration of a substance is an important factor in determining its effects (including the time course of developing Intoxication, the probability that its use will produce physiological changes associated with With­ drawal, the likelihood that use will lead to Dependence or Abuse, and whether consumption patterns will be characterized by periodic binges or daily use). Routes of administration that produce more rapid and efficient absorption into the bloodstream (e.g., intravenous, smoking, or "snorting") tend to result in a more intense intoxication and an increased likelihood of an escalating pattern of substance use leading to Dependence. Routes of administration that quickly deliver a large amount of the substance to the brain are also associated with higher levels of substance consumption

and an increased likelihood of toxic effects. For example, a person who uses intravenous amphetamine is more likely to consume large amounts of the substance and thereby risk an overdose than the person who only takes amphetamine orally or intranasally.

**Speed of onset within a class of substance.** Rapidly acting substances are more likely than slower-acting substances to produce immediate intoxication and lead to Dependence or Abuse. For example, because diazepam and alprazolam both have a more rapid onset than oxazepam, they may consequently be more likely to lead to Substance Dependence or Abuse.

**Duration of effects.** The duration of effects associated with a particular substance is also important in determining the time course of Intoxication and whether use of the substance will lead to Dependence or Abuse. Relatively short-acting substances (e.g., certain anxiolytics) tend to have a higher potential for the development of Dependence or Abuse than substances with similar effects that have a longer duration of action (e.g., phenobarbital). The half-life of the substance parallels aspects of Withdrawal: the longer the duration of action, the longer the time between cessation and the onset of withdrawal symptoms and the longer the Withdrawal is likely to last.

**Use of multiple substances.** Substance Dependence, Abuse, Intoxication, and With­ drawal often involve several substances used simultaneously or sequentially. For example, individuals with Cocaine Dependence frequently also use alcohol, anxiolytics, or opioids, often to counteract lingering cocaine-induced anxiety symptoms. Similarly, individuals with Opioid Dependence or Cannabis Dependence usually have several other Substance-Related Disorders, most often involving alcohol, anxiolytics, amphet­ amine, or cocaine. When criteria for more than one Substance-Related Disorder are met, multiple diagnoses should be given. The situations in which a diagnosis of Polysubstance Dependence should be given are described on p. 270.

**Associated laboratory findings.** Laboratory analyses of blood and urine samples can help determine recent use of a substance. Blood levels offer additional information on the amount of substance still present in the body. It should be noted that a positive blood or urine test does not by itself indicate that the individual has a pattern of substance use that meets criteria for a Substance-Related Disorder and that a negative blood or urine test does not by itself rule out a diagnosis of a Substance-Related Disorder.

In the case of Intoxication, blood and urine tests can help to determine the relevant substance(s) involved. Specific confirmation of the suspected substance may require toxicological analysis, because various substances have similar Intoxication syndromes; individuals often take a number of different substances; and because substitution and contamination of street drugs are frequent, those who obtain substances illicitly often do not know the specific contents of what they have taken. Toxicological tests may also be helpful in differential diagnosis to determine the role of Substance Intoxication or Withdrawal in the etiology (or exacerbation) of symptoms of a variety of mental disorders (e.g., Mood Disorders, Psychotic Disorders). Furthermore, serial blood levels help to differentiate Intoxication from Withdrawal.

The blood level of a substance may be a useful clue in determining whether the person has a high tolerance to a given group of substances (e.g., a person presenting with a blood alcohol level of over 150 mg/di without signs of Alcohol Intoxication has a significant tolerance to alcohol and is likely to be a chronic user of either alcohol or

a sedative, hypnotic, or an:xiolytic). Another method for assessing tolerance is to determine the individual's response to an agonist or antagonist medication. For example, a person who does not exhibit any signs of intoxication from a dose of pentobarbital of 200 mg or higher has a significant tolerance to sedatives, hypnotics, or anxiolytics and may need treatment to prevent the development of Withdrawal. Similarly, in cases in which opioid tolerance or Dependence cannot be clearly confirmed by history, the use of an antagonist (e.g., naloxone) to demonstrate whether withdrawal symptoms are induced may be informative.

Laboratory tests can be useful in identifying Withdrawal in individuals with Substance Dependence. Evidence for cessation or reduction of dosing may be obtained by history or by toxicological analysis of body fluids (e.g., urine or blood). Although most substances and their metabolites clear the urine within 48 hours of ingestion, certain metabolites may be present for a longer period in those who use the substance chronically. If the person presents with Withdrawal from an unknown substance, urine tests may help identify the substance from which the person is withdrawing and make it possible to initiate appropriate treatment. Urine tests may also be helpful in differentiating Withdrawal from other mental disorders, because withdrawal symptoms can mimic the symptoms of mental disorders unrelated to use of a substance.

**Associated physical examination findings and general medical conditions.** As presented in the sections specific to the 11 classes of substance, intoxication and withdrawal states are likely to include physical signs and symptoms that are often the first clue to a substance-related state. In general, intoxication with amphetamines or cocaine is accompanied by increases in blood pressure, respiratory rate, pulse, and body temperature. Intoxication with sedative, hypnotic, or anxiolytic substances or with opioid medication often involves the opposite pattern. Substance Dependence and Abuse are often associated with general medical conditions often related to the toxic effects of the substances on particular organ systems (e.g., cirrhosis in Alcohol Dependence) or the routes of administration (e.g., human immunodeficiency virus [HIV] infection from shared needles).

**Associated mental disorders.** Substance use is often a component of the presenta­ tion of symptoms of mental disorders. When the symptoms are judged to be a direct physiological consequence of a substance, a Substance-Induced Disorder is diagnosed (see p. 192). Substance-Related Disorders are also commonly comorbid with, and complicate the course and treatment of, many mental disorders (e.g., Conduct Disorder in adolescents; Antisocial and Borderline Personality Disorders, Schizophrenia, Mood Disorders).

***Recording Procedures for Dependence, Abuse, Intoxication, and Withdrawal***

**For drugs of abuse.** The clinician should use the code that applies to the class of substances, but record the name of the specific substance rather than the name of the class. For example, the clinician should record 292.0 Secobarbital Withdrawal (rather than Sedative, Hypnotic, or Anxiolytic Withdrawal) or 305.70 Methamphetamine Abuse (rather than Amphetamine Abuse). For substances that do not fit into any of the classes (e.g., amyl nitrite), the appropriate code for "Other Substance Dependence," "Other

Substance Abuse," "Other Substance Intoxication," or "Other Substance Withdrawal" should be used and the specific substance indicated (e.g., 305.90 Amyl Nitrite Abuse). If the substance taken by the individual is unknown, the code for the class "Other (or Unknown)" should be used (e.g., 292.89 Unknown Substance Intoxication). For a particular substance, if criteria are met for more than one Substance-Related Disorder, all should be diagnosed (e.g., 292.0 Heroin Withdrawal; 304.10 Heroin Dependence). If there are symptoms or problems associated with a particular substance but criteria are not met for any of the substance-specific disorders, the Not Otherwise Specified category can be used (e.g., 292.9 Cannabis-Related Disorder Not Otherwise Specified). If multiple substances are used, all relevant Substance-Related Disorders should be diagnosed (e.g., 292.89 Mescaline Intoxication; 304.20 Cocaine Dependence). The situations in which a diagnosis of 304.80 Polysubstance Dependence should be given are described on p. 270.

**For medications and toxins.** For medications not covered above (as well as for toxins), the code for "Other Substance" should be used. The specific medication can coded by also listing the appropriate E-code on Axis I (see Appendix G) (e.g., 292.89 Benztropine Intoxication; E941.1 Benztropine). E-codes should also be used for classes of substances listed above when they are taken as prescribed medications (e.g., opioids).

***Specific Culture, Age, and Gender Features***

There are wide cultural variations in attitudes toward substance consumption, patterns of substance use, accessibility of substances, physiological reactions to substances, and prevalence of Substance-Related Disorders. Some groups forbid use of alcohol, whereas in others the use of various substances for mood-altering effects is widely accepted. The evaluation of any individual's pattern of substance use must take these factors into account. Patterns of medication use and toxin exposure also vary widely within and between countries.

Individuals between ages 18 and 24 years have relatively high prevalence rates for the use of virtually every substance, including alcohol. For drugs of abuse, Intoxication is usually the initial Substance-Related Disorder and usually begins in the teens. Withdrawal can occur at any age as long as the relevant drug has been taken in high-enough doses over a long-enough period of time. Dependence can also occur at any age, but typically has its initial onset for most drugs of abuse in the 20s, 30s, and 40s. When a Substance-Related Disorder other than Intoxication begins in early adolescence, it is often associated with Conduct Disorder and failure to complete school. For drugs of abuse, Substance-Related Disorders are usually diagnosed more commonly in males than in females, but the sex ratios vary with class of substance.

***Course***

The course of Dependence, Abuse, Intoxication, and Withdrawal varies with the class of substance, route of administration, and other factors. The "Course" sections for the various classes of substances indicate the specific features characteristic of each. However, some generalizations across substances can be made.

Intoxication usually develops within minutes to hours after a sufficiently large single dose and continues or intensifies with frequently repeated doses. Intoxication usually

begins to abate as blood or tissue concentrations of the substance decline, but signs and symptoms may resolve slowly, in some situations lasting for hours or days after the substance is no longer detectable in bodily fluids. The onset of Intoxication may be delayed with slowly absorbed substances or with those that must be metabolized to active compounds. Long-acting substances may produce prolonged intoxications.

Withdrawal develops with the decline of the substance in the central nervous system. Early symptoms of Withdrawal usually develop a few hours after dosing stops for substances with short elimination half-lives (e.g., alcohol, lorazepam, or heroin), although withdrawal seizures may develop several weeks after termination of high doses of long-half-life anxiolytic substances. The more intense signs of Withdrawal usually end within a few days to a few weeks after the cessation of substance use, although some subtle physiological signs may be detectable for many weeks or even months as part of a protracted withdrawal syndrome.

A diagnosis of Substance Abuse is more likely in individuals who have begun using substances only recently. For many individuals, Substance Abuse with a particular class of substances evolves into Substance Dependence for the same class of substance. This is particularly true for those substances that have a high potential for the development of tolerance, withdrawal, and patterns of compulsive use. Some individuals have episodes of Substance Abuse that occur over an extended period of time without ever developing Substance Dependence. This is more true for those substances that have a lower potential for the development of tolerance, withdrawal, and patterns of compulsive use. Once criteria for Substance Dependence are met, a subsequent diagnosis of Substance Abuse cannot be given for any substance in the same class. For a person with Substance Dependence in full remission, any relapses that meet criteria for Substance Abuse would be considered Dependence in partial remission (see course specifiers, p. 179).

The course of Substance Dependence is variable. Although relatively brief and self-limited episodes may occur (particularly during periods of psychosocial stress), the course is usually chronic, lasting years, with periods of exacerbation and partial or full remission. There may be periods of heavy intake and severe problems, periods of total abstinence, and times of nonproblematic use of the substance, sometimes lasting for months. Substance Dependence is sometimes associated with spontaneous, long-term remissions. For example, follow-ups reveal that 20% (or more) of individuals with Alcohol Dependence become permanently abstinent, usually following a severe life stress (e.g., the threat or imposition of social or legal sanctions, discovery of a life-threatening medical complication). During the first 12 months after the onset of remission, the individual is particularly vulnerable to having a relapse. Many individuals underestimate their vulnerability to developing a pattern of Dependence. When in a period of remission, they incorrectly assure themselves that they will have no problem regulating substance use and may experiment with gradually less restrictive rules governing the use of the substance, only to experience a return to Dependence. The presence of co-occurring mental disorders (e.g., Antisocial Personality Disorder, Major Depressive Disorder) often increases the risk of complications and a poor outcome.

***Impairment and Complications***

Although many individuals with substance-related problems have good functioning (e.g., in personal relationships, job performance, earning abilities), these disorders often cause marked impairment and severe complications. Individuals with Substance-Related

Disorders frequently experience a deterioration in their general health. Malnutrition and other general medical conditions may result from improper diet and inadequate personal hygiene. Intoxication or Withdrawal may be complicated by trauma related to impaired motor coordination or faulty judgment. The materials used to "cut" certain substances can produce toxic or allergic reactions. Using substances intranasally ("snorting") may cause erosion of the nasal septum. Stimulant use can result in sudden death from cardiac arrhythmias, myocardial infarction, a cerebrovascular accident, or respiratory arrest. The use of contaminated needles during intravenous administration of substances can cause human immunodeficiency virus (HIV) infection, hepatitis, tetanus, vasculitis, septicemia, subacute bacterial endocarditis, embolic phenomena, and malaria.

Substance use can be associated with violent or aggressive behavior, which may be manifested by fights or criminal activity, and can result in injury to the person using the substance or to others. Automobile, home, and industrial accidents are a major complication of Substance Intoxication and result in an appreciable rate of morbidity and mortality. Approximately one-half of all highway fatalities involve either a driver or a pedestrian who is intoxicated. In addition, perhaps 10% of individuals with Substance Dependence commit suicide, often in the context of a Substance-Induced Mood Disorder. Finally, because most, if not all, of the substances described in this section cross the placenta, they may have potential adverse effects on the developing fetus (e.g., fetal alcohol syndrome). When taken repeatedly in high doses by the mother, a number of substances (e.g., cocaine, opioids, alcohol, and sedatives, hypnotics, and anxiolytics) are capable of causing physiological dependence in the fetus and a withdrawal syndrome in the newborn.

***Familial Pattern***

Information about familial associations has been best studied for the Alcohol-Related Disorders (see the detailed discussion on p. 203). There is some evidence for genetically determined differences among individuals in the doses required to produce Alcohol Intoxication. Although Substance Abuse and Dependence appear to aggregate in families, some of this effect may be explained by the concurrent familial distribution of Antisocial Personality Disorder, which may predispose individuals to the development of Substance Abuse or Dependence.

***Differential Diagnosis***

Substance-Related Disorders are distinguished from **nonpathological substance use** (e.g., **"social" drinking)** and from the **use of medications for appropriate medical purposes** by the presence of tolerance, withdrawal, compulsive use, or substance­ related problems (e.g., medical complications, disruption in social and family relation­ ships, vocational or financial difficulties, legal problems). Repeated episodes of **Substance Intoxication** are almost invariably prominent features of **Substance Abuse** or **Dependence.** However, one or more episodes of Intoxication alone are not sufficient for a diagnosis of either Substance Dependence or Abuse.

It may sometimes be difficult to distinguish between **Substance Intoxication** and **Substance Withdrawal.** If a symptom arises during the time of dosing and then gradually abates after dosing stops, it is likely to be part of Intoxication. If the symptom arises after stopping the substance, or reducing its use, it is likely to be part of Withdrawal.

Individuals with Substance-Related Disorders often take more than one substance and may be intoxicated with one substance (e.g., heroin) while withdrawing from another (e.g., diazepam). This differential is further complicated by the fact that the signs and symptoms of Withdrawal from some substances (e.g., sedatives) may partially mimic Intoxication with others (e.g., amphetamines). Substance Intoxication is differentiated from **Substance Intoxication Delirium** (p. 129), **Substance-Induced Psychotic Disorder, With Onset During Intoxication** (p. 310), **Substance-Induced Mood Disorder, With Onset During Intoxication** (p. 370), **Substance-Induced Anxiety Disorder, With Onset During Intoxication** (p. 439), **Substance-Induced Sexual Dysfunction, With Onset During Intoxication** (p. 519), and **Substance-Induced Sleep Disorder, With Onset During Intoxication** (p. 601), by the fact that the symptoms in these latter disorders are in excess of those usually associated with Substance Intoxication and are severe enough to warrant independent clinical attention. Substance Withdrawal is distinguished from **Substance Withdrawal Delirium** (p. 129), **Substance-Induced Psychotic Disorder, With Onset During Withdrawal** (p. 310), **Substance-Induced Mood Disorder, With Onset During Withdrawal** (p. 370), **Substance-Induced Anxiety Disorder, With Onset During Withdrawal** (p. 439), and **Substance-Induced Sleep Disorder, With Onset During Withdrawal** (p. 601), by the fact that the symptoms in these latter disorders are in excess of those usually associated with Substance Withdrawal and are severe enough to warrant independent clinical attention.

The additional Substance-Induced Disorders described above present with symp­ toms that resemble **non-substance-induced** (i.e., **primary) mental disorders.** See

p. 193 for a discussion of this important but often difficult differential diagnosis. An additional diagnosis of a Substance-Induced Disorder is usually not made when **symptoms of preexisting mental disorders are exacerbated by Substance Intox­ ication or Substance Withdrawal** (although a diagnosis of Substance Intoxication or Withdrawal might be appropriate). For example, Intoxication with some substances may exacerbate the mood swings in Bipolar Disorder, the auditory hallucinations and paranoid delusions in Schizophrenia, the intrusive thoughts and terrifying dreams in Posttraumatic Stress Disorder, and the anxiety symptoms in Panic Disorder, Generalized Anxiety Disorder, Social Phobia, and Agoraphobia. Intoxication or Withdrawal may also increase the risk of suicide, violence, and impulsive behavior in individuals with a preexisting Antisocial or Borderline Personality Disorder.

Many neurological (e.g., head injuries) or metabolic conditions produce symptoms

that resemble, and are sometimes misattributed to, Intoxication or Withdrawal (e.g., fluctuating levels of consciousness, slurred speech, incoordination). The symptoms of infectious diseases may also resemble Withdrawal from some substances (e.g., viral gastroenteritis can be similar to Opioid Withdrawal). If the symptoms are judged to be a direct physiological consequence of a general medical condition, the appropriate **Mental Disorder Due to a General Medical Condition** should be diagnosed. If the symptoms are judged to be a direct physiological consequence of both substance use and a general medical condition, both a Substance-Related Disorder and a Mental Disorder Due to a General Medical Condition may be diagnosed. If the clinician is unable to determine whether the presenting symptoms are substance induced, due to a general medical condition, or primary, the appropriate **Not Otherwise Specified Category** should be diagnosed (e.g., psychotic symptoms with indeterminate etiology would be diagnosed as Psychotic Disorder Not Otherwise Specified).

**Substance...Jnduced Mental Disorders Included Elsewhere in the Manual**

Substance-Induced Disorders cause a variety of symptoms that are characteristic of other mental disorders (see Table 1, p. 177). To facilitate differential diagnosis, the text and criteria for these other Substance-Induced Disorders are included in the sections of the manual with disorders with which they share phenomenology:

**Substance-Induced Delirium** (seep. 129) is included in the "Delirium, Dementia, and Amnestic and Other Cognitive Disorders" section.

**Substance-InducedPersisting Dementia** (seep. 152) is included in the "Delirium, Dementia, and Amnestic and Other Cognitive Disorders" section.

**Substance-InducedPersistingAmnestic Disorder** (seep. 161) is included in the "Delirium, Dementia, and Amnestic and Other Cognitive Disorders" section.

**Substance-Induced Psychotic Disorder** (seep. 310) is included in the "Schizo­ phrenia and Other Psychotic Disorders" section. (In DSM-III-R these disorders were classified as "organic hallucinosis" and "organic delusional disorder.")

**Substance-Induced Mood Disorder** (see p. 370) is included in the "Mood Disorders" section.

**Substance-Induced Anxiety Disorder** (see p. 439) is included in the "Anxiety Disorders" section.

**Substance-Induced Sexual Dysfunction** (seep. 519) is included in the "Sexual and Gender Identity Disorders" section.

**Substance-Induced Sleep Disorder** (see p. 601) is included in the "Sleep Disorders" section.

In addition, **Hallucinogen Persisting Perception Disorder (Flashbacks)**

(p. 233) is included under "Hallucinogen-Related Disorders" in this section.

In DSM-III-R, the Substance-Induced Disorders and the Mental Disorders Due to a General Medical Condition were called "organic" disorders and were listed together in a single section. This differentiation of "organic" mental disorders as a separate class implied that "nonorganic" or "functional" mental disorders were somehow unrelated to physical or biological factors or processes. DSM-IV eliminates the term *organic* and distinguishes those mental disorders that are substance induced from those that are due to a general medical condition and those that have no specified etiology. The term *primary mental disorder* is used as a shorthand to indicate those mental disorders that are not substance induced and that are not due to a general medical condition.

The context in which a Substance-Induced Disorder develops can have important management implications. Substance-Induced Disorders can develop in the context of Substance Intoxication or Substance Withdrawal, or they can persist long after the substance has been eliminated from the body (Substance-Induced Persisting Disorders). Substance-induced presentations that develop in the context of Substance Intoxication can be indicated by using the specifier With Onset During Intoxication. Substance­ induced presentations that develop in the context of Substance Withdrawal can be indicated by the specifier With Onset During Withdrawal. It should be noted that a diagnosis of a Substance-Induced Disorder, With Onset During Intoxication or With­ drawal, should be made instead of a diagnosis of Substance Intoxication or Substance Withdrawal only when the symptoms are in excess of those usually associated with the intoxication or withdrawal syndrome that is characteristic of the particular substance and when they are sufficiently severe to warrant independent clinical attention. Three

Substance-Induced Persisting Disorders are included: Substance-Induced Persisting Dementia (see p. 152) and Substance-Induced Persisting Amnestic Disorder (seep. 161) in the "Delirium, Dementia, and Amnestic and Other Cognitive Disorders" section and Hallucinogen Persisting Perception Disorder under "Hallucinogen-Related Disorders" in this section (seep. 233). The essential feature of a Substance-Induced Persisting Disorder is prolonged or permanent persistence of substance-related symptoms that continue long after the usual course of Intoxication or Withdrawal has ended.

For drugs of abuse, a diagnosis of a Substance-Induced Mental Disorder requires that there be evidence from the history, physical examination, or laboratory findings of Substance Intoxication or Substance Withdrawal. In evaluating whether the symptoms of a mental disorder are the direct physiological effect of substance use, it is important to note the temporal relationship between the onset and offset of substance use and the onset and offset of the symptoms. If the symptoms precede the onset of substance use or persist during extended periods of abstinence from the substance, it is likely that the symptoms are not substance induced. As a rule of thumb, symptoms that persist for more than 4 weeks after the cessation of acute Intoxication or Withdrawal should be considered to be manifestations of an independent non-substance-induced mental disorder or of a Substance-Induced Persisting Disorder. Clinical judgment is necessary in making this distinction, particularly because different substances have different characteristic durations of intoxication and withdrawal and varying relationships with symptoms of mental disorders. Because the withdrawal state for some substances can be relatively protracted, it is useful to carefully observe the course of symptoms for an extended period of time (e.g., 4 weeks or more) after the cessation of acute Intoxication or Withdrawal, making all possible efforts to maintain the individual's abstinence. This can be accomplished in various ways, including inpatient hospitalization or residential treatment, requiring frequent follow-up visits, recruiting friends and family members to help keep the person substance free, regularly evaluating urine or blood for the presence of substances, and, if alcohol is involved, routinely evaluating changes in state markers of heavy drinking such as gamma-glutamyltransferase (GGT).

Another consideration in differentiating a primary mental disorder from a Substance­ Induced Disorder is the presence of features that are atypical of the primary disorder (e.g., atypical age at onset or course). For example, the onset of a Manic Episode after age 45 years may suggest a substance-induced etiology. In contrast, factors that suggest that the symptoms are better accounted for by a primary mental disorder include a history of prior episodes of the disturbance that were not substance induced. Finally, the presence or absence of the substance-specific physiological and behavioral features of Intoxication or Withdrawal should be considered. For example, the presence of paranoid delusions would not be surprising in the context of Phencyclidine Intoxication, but would be unusual with Sedative Intoxication, increasing the likelihood that a primary Psychotic Disorder accounts for the symptoms. Furthermore, the dosage of the substance used should be taken into account. For example, the presence of paranoid delusions would be unusual after a single puff of marijuana, but might be compatible with high doses of hashish.

Substance-Induced Disorders can also occur as a side effect of a medication or from exposure to a toxin. Substance-Induced Disorders due to a prescribed treatment for a mental disorder or general medical condition must have their onset while the person is receiving the medication (or during withdrawal if the medication is associated with a withdrawal syndrome). Once the treatment is discontinued, the symptoms will usually remit within days to several weeks (depending on the half-life of the substance, the

presence of a withdrawal synd rome, and individual variability). If symptoms persist , a primary mental disorder (not related to a medication) should be considered. Because individuals with general medical conditions often take medications for those conditions, the clinician must consider th e possibility that the symptoms are caused by the physiological consequences of the general medical condition rather than the medication, in which case Mental Disorder Due to a General Medical Condition is diagnosed. The history may provide a basis for making this judgment, but a change in the treatment for the general medical condition (e.g., medication substitution or discontinuation) may be needed to determine empirically for that person whether or not the medication is the causative agent.

***Recording Procedures for Substance-Induced Mental Disorders Included Elsewhere in the Manual***

The name of the diagnosis begins with the specific substance (e.g., cocaine, diazepam, dexamethasone) that is presum ed to be causing the symptoms. The diagnostic code is sele cted from the listing of classes of substances provided in the criteria sets for the particular Substance-Induced Disorder. For substances that do not fit into any of the classes (e.g., dexamethaso ne), the code for "Othe r Sub stance" should be used . In addition , for medications prescribed at therapeutic doses, the specific medication can be indicated by listing the appropriate E-code on Axis I (se e Appendix G). The name of the disorder (e.g., Cocain e-Induc ed Psychotic Disorder; Diazepam-Induced Anxiety Dis orde r) is followed by the specification of the predominant symptom presentation and the context in which the symptoms developed (e.g., 292.11 Cocaine-Induced Psychotic Disorder, With Delusions, With On set During Intoxication ; 292.89 Diazepam-Induced Anxi e ty Disorder , With Onset During Withdrawal). When more than one substance is judged to play a significant role in the develop ment of symptoms , each should be listed separately . If a substance is judged to be the etiological factor, but the specific substance or class of substances is unknown , the class "Unknown Substance " should be used.

**Alcohol-Related Disorders**

In most cultures, alcohol is the most frequently used brain depressant and a cause of considerable morbidity and mo rtali ty. At some time in their lives, as many as 90% of adults in the United States have had some experience with alcoho l, and a substantial number (60% of males and 30% of fe males) have had one or more alcohol-related adverse life events (e.g., driving after consuming too much alcoho l, missing school or work due to a hangover). Fortunately , most individuals learn from these experiences **to** moderate their drinking and do not develo p Alcohol Depende nce or Abu se.

This section contains discussions specific to the Alcohol-Related Disorders. Texts and crite ria sets have already been provided earlier for the generic aspects of Substance Dependence (p. 176) and Substance Abuse (p. 182) that apply across all substances. Texts specific to Alcohol Dependen ce and Abuse are provided below; however, there are no additional specific criteria sets for Alcohol Dependence or Alcohol Abuse. Specific texts and criteria sets for Alcohol Into xication and Alcohol Withdrawal are also provided below. The Alcohol-Induced Disorders (other than Alcohol Intoxication and Withdrawal)

are described in the sections of the manual with disorders with which they share phenomenology (e.g., Alcohol-Induced Mood Disorder is included in the "Mood Disorders" section). Listed below are the Alcohol Use Disorders and the Alcohol-Induced Disorders.

***Alcohol Use Disorders***

**303.90 Alcohol Dependence** (see p. 195)

**305.00 Alcohol Abuse** (see p. 196)

***Alcohol-Induced Disorders***

**303.00**

**291.8**

**291.0**

**291.0**

**291.2**

**291.1**

**291.5**

**291.3**

**291.8**

**291.8**

**291.8**

**291.8**

**291.9**

**Alcohol Intoxication** (seep. 196)

**Alcohol Withdrawal** (seep. 197) *Specify if* With Perceptual Disturbances

**Alcohol Intoxication Delirium** (seep. 129) **Alcohol Withdrawal Delirium** (see p. 129) **Alcohol-Induced Persisting Dementia** (see p. 152)

**Alcohol-Induced Persisting Amnestic Disorder** (see p. 161)

**Alcohol-Induced Psychotic Disorder, With Delusions** (seep. 310) *Specify if* With Onset During Intoxication/With Onset During Withdrawal **Alcohol-Induced Psychotic Disorder, With Hallucinations** (seep. 310) *Specify if* With Onset During Intoxication/With Onset During Withdrawal **Alcohol-Induced Mood Disorder** (see p. 370)

*Specify if* With Onset During Intoxication/With Onset During Withdrawal

**Alcohol-Induced Anxiety Disorder** (see p. 439)

*Specify if* With Onset During Intoxication/With Onset During Withdrawal

**Alcohol-Induced Sexual Dysfunction** (seep. 519)

*Specify if* With Onset During Intoxication

**Alcohol-Induced Sleep Disorder** (seep. 601)

*Specify if* With Onset During Intoxication/With Onset During Withdrawal

**Alcohol-Related Disorder Not Otherwise Specified** (see p. 204)

***Alcohol Use Disorders***

**303.90 Alcohol Dependence**

Also refer to the text and criteria for Substance Dependence (seep. 176). Physiological dependence on alcohol is indicated by evidence of tolerance or symptoms of With­ drawal. Alcohol Withdrawal (see p. 197) is characterized by the development of withdrawal symptoms 12 hours or so after the reduction of intake following prolonged, heavy, ak:ohol ingestion. Because Withdrawal from alcohol can be unpleasant and intense, individuals with Alcohol Dependence may continue to consume alcohol, despite adverse consequences, often to avoid or to relieve the symptoms of withdrawal. A substantial minority of individuals who have Alcohol Dependence never experience clinically relevant levels of Alcohol Withdrawal, and only about 5% of individuals with Alcohol Dependence ever experience severe complications of withdrawal (e.g., delirium,

grand mal seizures). Once a pattern of compulsive use develops, individuals with Dependence may devote substantial periods of time to obtaining and consuming alcoholic beverages. These individuals often continue to use alcohol despite evidence of adverse psychological or physical consequences (e.g., depression, blackouts, liver disease, or other sequelae).

***Specifiers***

The following specifiers may be applied to a diagnosis of Alcohol Dependence (see

p. 179 for more details):

**With Physiological Dependence Without Physiological Dependence**

**Early Full Remission Early Partial Remission Sustained Full Remission**

**Sustained Partial Remission On Agonist Therapy**

**In a Controlled Environment**

**305.00 Alcohol Abuse**

Also refer to the text and criteria for Substance Abuse (see p. 182). School and job performance may suffer either from the aftereffects of drinking or from actual intoxication on the job or at school; child care or household responsibilities may be neglected; and alcohol-related absences may occur from school or job. The person may use alcohol in physically hazardous circumstances (e.g., driving an automobile or operating machinery while drunk). Legal difficulties may arise because of alcohol use (e.g., arrests for intoxicated behavior or for driving under the influence). Finally, individuals with Alcohol Abuse may continue to consume alcohol despite the knowledge that continued consumption poses significant social or interpersonal problems for them (e.g., violent arguments with spouse while intoxicated, child abuse). When these problems are accompanied by evidence of tolerance, withdrawal, or compulsive behavior related to alcohol use, a diagnosis of Alcohol Dependence, rather than Alcohol Abuse, should be considered.

***Alcohol-Induced Disorders***

**303.00 Alcohol Intoxication**

Refer to the text and criteria for Substance Intoxication (seep. 183). The essential feature of Alcohol Intoxication is the presence of clinically significant maladaptive behavioral or psychological changes (e.g., inappropriate sexual or aggressive behavior, mood

!ability, impaired judgment, impaired social or occupational functioning) that develop during, or shortly after, the ingestion of alcohol (Criteria A and B). These changes are accompanied by evidence of slurred speech, incoordination, unsteady gait, nystagmus, impairment in attention or memory, or stupor or coma (Criterion C). The symptoms must not be due to a general medical condition and are not better accounted for by another

mental disorder (Criterion D). The resulting picture is similar to what is observed during Benzodiazepine or Barbiturate Intoxication. The levels of incoordination can interfere with driving abilities and with performing usual activities to the point of causing accidents. Evidence of alcohol use can be obtained by smelling alcohol on the individual's breath, eliciting a history from the individual or another observer, and, when needed, having the individual undertake breath, blood, or urine toxicology analyses.

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| * **Diagnostic criteria for 303.00 Alcohol Intoxication**   1. Recent ingestion of alcohol.   2. Clinically significant maladaptive behavioral or psychological changes (e.g., inappropriate sexual or aggressive behavior, mood !ability, im­ paired judgment, impaired social or occupational functioning) that developed during, or shortly after, alcohol ingestion.   3. One (or more) of the following signs, developing during, or shortly after, alcohol use:      1. slurred speech      2. incoordination      3. unsteady gait      4. nystagmus      5. impairment in attention or memory      6. stupor or coma   4. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder. |

* 1. **Alcohol Withdrawal**

Also refer to the text and criteria for Substance Withdrawal (see p. 184). The essential feature of Alcohol Withdrawal is the presence of a characteristic withdrawal syndrome that develops after the cessation of (or reduction in) heavy and prolonged alcohol use (Criteria A and B). The withdrawal syndrome includes two or more of the following symptoms: autonomic hyperactivity (e.g., sweating or pulse rate greater than 100); increased hand tremor; insomnia; nausea or vomiting; transient visual, tactile, or auditory hallucinations or illusions; psychomotor agitation; anxiety; and grand ma! seizures. When hallucinations or illusions are observed, the clinician can specify With Perceptual Disturbances (see below). The symptoms cause clinically significant distress or impair­ ment in social, occupational, or other important areas of functioning (Criterion C). The symptoms must not be due to a general medical condition and are not better accounted for by another mental disorder (e.g., Sedative, Hypnotic, or Anxiolytic Withdrawal or Generalized Anxiety Disorder) (Criterion D).

Symptoms are usually relieved by administering alcohol or any other brain depres­ sant. The withdrawal symptoms typically begin when blood concentrations of alcohol decline sharply (i.e., within 4--12 hours) after alcohol use has been stopped or reduced. However, withdrawal symptoms can develop after longer periods of time (i.e., for up to a few days). Because of the short half-life of alcohol, symptoms of Alcohol Withdrawal usually peak in intensity during the second day of abstinence and are likely to improve markedly by the fourth or fifth day. Following acute Withdrawal, however, symptoms of anxiety, insomnia, and autonomic dysfunction may persist for up to 3-6 months at lower levels of intensity.

Fewer than 5% of individuals who develop Alcohol Withdrawal develop dramatic symptoms (e.g., severe autonomic hyperactivity, tremors, and Alcohol Withdrawal Delirium). Grand ma! seizures occur in fewer than 3% of individuals. Alcohol Withdrawal Delirium (p. 129) includes disturbances in consciousness and cognition and visual, tactile, or auditory hallucinations ("delirium tremens," or "DTs"). When Alcohol With­ drawal Delirium develops, it is likely that a clinically relevant general medical condition may be present (e.g., liver failure, pneumonia, gastrointestinal bleeding, sequelae of head trauma, hypoglycemia, an electrolyte imbalance, or postoperative status).

***Specifier***

The following specifier may be applied to a diagnosis of Alcohol Withdrawal:

**With Perceptual Disturbances.** This specifier may be noted when hallucina­ tions with intact reality testing or auditory, visual, or tactile illusions occur in the absence of a delirium. *Intact reality testing* means that the person knows that the hallucinations are induced by the substance and do not represent external reality. When hallucinations occur in the absence of intact reality testing, a diagnosis of Substance-Induced Psychotic Disorder, With Hallucinations, should be considered.

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| * **Diagnostic criteria for 291.8 Alcohol Withdrawal**   1. Cessation of (or reduction in) alcohol use that has been heavy and prolonged.   2. Two (or more) of the following, developing within several hours to a few days after Criterion A:      1. autonomic hyperactivity (e.g., sweating or pulse rate greater than 100)      2. increased hand tremor      3. insomnia      4. nausea or vomiting      5. transient visual, tactile, or auditory hallucinations or illusions      6. psychomotor agitation      7. anxiety      8. grand ma! seizures   *(continued)* |

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| * **Diagnostic criteria for 291.8 Alcohol Withdrawal** *(continued)*   C. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.  D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.  *Specify* if  **With Perceptual Disturbances** |

**Other Alcohol-Induced Disorders**

The following Alcohol-Induced Disorders are described in the sections of the manual with disorders with which they share phenomenology: **AlcohollntoxicationDelirium** (p. 129), **Alcohol Withdrawal Delirium** (p. 129), **Alcohol-Induced Persisting Dementia** (p. 152), **Alcohol-Induced Persisting Amnestic Disorder** (p. 161), **Alcohol-Induced Psychotic Disorder** (p. 310), **Alcohol-Induced Mood Disorder** (p. 370), **Alcohol-Induced Anxiety Disorder** (p. 439), **Alcohol-Induced Sexual Dysfunction** (p. 519), and **Alcohol-Induced Sleep Disorder** (p. 601). These disorders are diagnosed instead of Alcohol Intoxication or Alcohol Withdrawal only when the symptoms are in excess of those usually associated with the Alcohol Intoxication or Withdrawal syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention.

***Additional Information on Alcohol-Related Disorders***

***Associated Features and Disorders***

**Associated descriptive features and mental disorders.** Alcohol Dependence and Abuse are often associated with Dependence on, or Abuse of, other substances (e.g., cannabis; cocaine; heroin; amphetamines; the sedatives, hypnotics, and anxiolytics; and nicotine). Alcohol may be used to alleviate the unwanted effects of these other substances or to substitute for them when they are not available. Symptoms of depression, anxiety, and insomnia frequently accompany Alcohol Dependence and sometimes precede it. Alcohol Intoxication is sometimes associated with an amnesia for the events that occurred during the course of the intoxication ("blackouts"). This phenomenon may be related to the presence of a high blood alcohol level and, perhaps, to the rapidity with which this level is reached.

Alcohol-Related Disorders are associated with a significant increase in the risk of accidents, violence, and suicide. It is estimated that approximately one-half of all highway fatalities involve either a driver or a pedestrian who has been drinking. Severe Alcohol Intoxication, especially in individuals with Antisocial Personality Disorder, is

associated with the commission of criminal acts. For example, more than one-half of all murderers and their victims are believed to have been intoxicated with alcohol at the time of the murder. Severe Alcohol Intoxication also contributes to disinhibition and feelings of sadness and irritability, which contribute to suicide attempts and completed suicides. Alcohol-Related Disorders contribute to absenteeism from work, job-related accidents, and low employee productivity. Alcohol Abuse and Dependence, along with Abuse and Dependence of other substances, are prevalent among homeless individuals in the United States. Mood Disorders, Anxiety Disorders, and Schizophrenia may also be associated with Alcohol Dependence. Although antisocial behavior and Antisocial Personality Disorder are associated with Alcohol-Related Disorders, they are even more common with disorders related to illegal substances (e.g., cocaine, heroin, or amphet­ amine) whose cost commonly leads to criminal activity.

**Associated laboratory findings.** One sensitive laboratory indicator of heavy drink­ ing is an elevation(> 30 units) of gamma-glutamyltransferase (GGT). This finding may be the only laboratory abnormality. At least 70% of individuals with a high GGT level are persistent heavy drinkers. Mean corpuscular volume (MCV) may be elevated to high-normal values in individuals who drink heavily due to deficiencies of some B vitamins, as well as to the direct toxic effects of alcohol on erythropoiesis. Although the MCV can be used to help identify those who drink heavily, it is a poor method of monitoring abstinence because of the long half-life of red blood cells. Liver function tests (e.g., serum glutamic oxaloacetic transaminase [SGOT] and alkaline phosphatase) can reveal liver injury that is a consequence of heavy drinking. Elevations of lipid levels in the blood (e.g., triglycerides and lipoprotein cholesterol) can be observed, resulting from decreases in gluconeogenesis associated with heavy drinking. High fat content in the blood also contributes to the development of fatty liver. High-normal levels of uric acid can occur with heavy drinking, but are relatively nonspecific. The most direct test available to measure alcohol consumption cross-sectionally is blood alcohol concentra­ tion, which can also be used to judge tolerance to alcohol. An individual with a concentration of 100 mg of ethanol per deciliter of blood who does not show signs of intoxication can be presumed to have acquired at least some degree of tolerance to alcohol. At 200 mg/dl, most nontolerant individuals demonstrate severe intoxication.

**Associated physical examination findings and general medical conditions.** Repeated intake of high doses of alcohol can affect nearly every organ system, especially the gastrointestinal tract, cardiovascular system, and the central and peripheral nervous systems. Gastrointestinal effects include gastritis, stomach or duodenal ulcers, and, in about 15% of those who use alcohol heavily, liver cirrhosis and pancreatitis. There is also an increased rate of cancer of the esophagus, stomach, and other parts of the gastrointestinal tract. One of the most common associated general medical conditions is low-grade hypertension. Cardiomyopathy and other myopathies are less common, but occur at an increased rate among those who drink very heavily. These factors, along with marked increases in levels of triglycerides and low-density lipoprotein cholesterol, contribute to an elevated risk of heart disease. Peripheral neuropathy may be evidenced by muscular weakness, paresthesias, and decreased peripheral sensation. More persistent central nervous system effects include cognitive deficits, severe memory impairment, and degenerative changes in the cerebellum. These effects are related to vitamin deficiencies (particularly of the B vitamins, including thiamine). The most devastating central nervous system effect is the relatively rare Alcohol-Induced Persisting Amnestic

Disorder (p. 161) (Wernicke-Korsakoff syndrome), in which the ability to encode new memory is severely impaired.

Many of the symptoms and physical findings associated with the Alcohol-Related Disorders are a consequence of the disease states noted above. Examples are the dyspepsia, nausea, and bloating that accompany gastritis and the hepatomegaly, esophageal varices, and hemorrhoids that accompany alcohol-induced changes in the liver. Other physical signs include tremor, unsteady gait, insomnia, and erectile dysfunction. Individuals with chronic Alcohol Dependence may exhibit decreased testicular size and feminizing effects associated with reduced testosterone levels. Repeated heavy drinking during pregnancy is associated with spontaneous abortion and fetal alcohol syndrome. Individuals with preexisting histories of epilepsy or severe head trauma are more likely to develop alcohol-related seizures. Alcohol Withdrawal may be associated with nausea, vomiting, gastritis, hematemesis, dry mouth, puffy blotchy complexion, and mild peripheral edema. Alcohol Intoxication may result in falls and accidents that may cause fractures, subdural hematomas, and other forms of brain trauma. Severe, repeated Alcohol Intoxication may also suppress immune mechanisms and predispose individuals to infections and increase the risk for cancers. Finally, unanticipated Alcohol Withdrawal in hospitalized patients for whom a diagnosis of Alcohol Dependence has been overlooked can add to the risks and costs of hospital­ ization and to time spent in the hospital.

***Specific Culture, Age, and Gender Features***

The cultural traditions surrounding the use of alcohol in family, religious, and social settings, especially during childhood, can affect both alcohol use patterns and the likelihood that alcohol problems will develop. Marked differences characterize the quantity, frequency, and patterning of alcohol consumption in the countries of the world. In most Asian cultures, the overall prevalence of Alcohol-Related Disorders may be relatively low, and the male-to-female ratio high. These findings appear to relate to the absence, in perhaps 50% of Japanese, Chinese, and Korean individuals, of the form of aldehyde dehydrogenase that eliminates low levels of the first breakdown product of alcohol, acetaldehyde. When such individuals consume alcohol, they experience a flushed face and palpitations and are less likely to consume large amounts. In the United States, whites and African-Americans have nearly identical rates of Alcohol Abuse and Dependence. Latino males have somewhat higher rates, although prevalence is lower among Latino females than among females from other ethnic groups. Low educational level, unemployment, and lower socioeconomic status are associated with Alcohol­ Related Disorders, although it is often difficult to separate cause from effect. Years of schooling may not be as important in determining risk as completing the immediate educational goal (i.e., those who drop out of high school or college have particularly high rates of Alcohol-Related Disorders).

Among adolescents, Conduct Disorder and repeated antisocial behavior often co-occur with Alcohol Abuse or Dependence and with other Substance-Related Disor­ ders. Age-related physical changes in elderly persons result in increased brain suscep­ tibility to the depressant effects of alcohol, decreased rates of liver metabolism of a variety of substances, including alcohol, and decreased percentages of body water. These changes can cause older people to develop more severe intoxication and subsequent

problems at lower levels of consumption. Alcohol-related problems in older people are also especially likely to be associated with other medical complications.

Alcohol Abuse and Dependence are more common in males than in females, with a male-to-female ratio as high as 5:1. However, this ratio varies substantially depending on the age group. Females tend to start drinking heavily later in life than do males and may develop Alcohol-Related Disorders later. Once Alcohol Abuse or Dependence develops in females, it may progress more rapidly, so that by middle age females may have the same range of health problems and social, interpersonal, and occupational consequences as do males. Females tend to develop higher blood alcohol concentrations than males at a given dose of alcohol per kilogram because of their lower percentage of body water, higher percentage of body fat, and the fact that they tend to metabolize alcohol more slowly (in part because of lower levels of alcohol dehydrogenase in the mucosa! lining of the stomach). Because of these higher alcohol levels, they may be at greater risk than males for some of the health-related consequences of heavy alcohol intake (in particular, liver damage).

***Prevalence***

Alcohol Dependence and Abuse are among the most prevalent mental disorders in the general population. A community study conducted in the United States from 1980 to 1985 using DSM-III criteria found that about 8% of the adult population had Alcohol Dependence and about 5% had Alcohol Abuse at some time in their lives. Approximately 6% had Alcohol Dependence or Abuse during the preceding year. From data collected prospectively, about 7.5% had symptoms that met criteria for an Alcohol-Related Disorder during a 1-year period. A United States national probability sample of noninstitutional­ ized adults (ages 15-54 years) conducted in 1990-1991 using DSM-III-R criteria reported that around 14% had Alcohol Dependence at some time in their lives, with approximately 7% having had Dependence in the past year.

***Course***

The first episode of Alcohol Intoxication is likely to occur in the mid-teens, with the age at onset of Alcohol Dependence peaking in the 20s to mid-30s. The large majority of those who develop Alcohol-Related Disorders do so by their late 30s. The first evidence of Withdrawal is not likely to appear until after many other aspects of Dependence have developed. Alcohol Abuse and Dependence have a variable course that is frequently characterized by periods of remission and relapse. A decision to stop drinking, often in response to a crisis, is likely to be followed by weeks or more of abstinence, which is often followed by limited periods of controlled or nonproblematic drinking. However, once alcohol intake resumes, it is highly likely that consumption will rapidly escalate and that severe problems will once again develop. Clinicians often have the erroneous impression that Alcohol Dependence and Abuse are intractable disorders based on the fact that those who present for treatment typically have a history of many years of severe alcohol-related problems. However, these most severe cases represent only a small proportion of individuals with Alcohol Dependence or Abuse, and the typical person with an Alcohol Use Disorder has a much more promising prognosis. Follow-up studies of more highly functioning individuals show a higher than 65% 1-year abstinence rate

following treatment. Some individuals (perhaps 20% or more) with Alcohol Dependence achieve long-term sobriety even without active treatment.

During even mild Alcohol Intoxication, different symptoms are likely to be observed at different time points. Early in the drinking period, when blood alcohol levels are rising, symptoms often include talkativeness, a sensation of well-being, and a bright, expansive mood. Later, especially when blood alcohol levels are falling, the individual is likely to become progressively more depressed, withdrawn, and cognitively impaired. At very high blood alcohol levels (e.g., 200-300 mg/di), a nontolerant individual is likely to fall asleep and enter a first stage of anesthesia. Higher blood alcohol levels (e.g., in excess of 300-400 mg/di) can cause inhibition of respiration and pulse and even death in nontolerant individuals. The duration of Intoxication depends on how much alcohol was consumed over what period of time. In general, the body is able to metabolize approximately one drink per hour, so that the blood alcohol level generally decreases at a rate of 15-20 mg/di per hour. Signs and symptoms of intoxication are likely to be more intense when the blood alcohol level is rising than when it is falling.

***Familial Pattern***

Alcohol Dependence often has a familial pattern, and at least some of the transmission can be traced to genetic factors. The risk for Alcohol Dependence is three to four times higher in close relatives of people with Alcohol Dependence. Higher risk is associated with a greater number of affected relatives, closer genetic relationships, and the severity of the alcohol-related problems in the affected relative. Most studies have found a significantly higher risk for Alcohol Dependence in the monozygotic twin than in the dizygotic twin of a person with Alcohol Dependence. Adoption studies have revealed a three- to fourfold increase in risk for Alcohol Dependence in the children of individuals with Alcohol Dependence when these children were adopted away at birth and raised by adoptive parents who did not have this disorder. However, genetic factors explain only a part of the risk for Alcohol Dependence, with a significant part of the risk coming from environmental or interpersonal factors that may include cultural attitudes toward drinking and drunkenness, the availability of alcohol (including price), expectations of the effects of alcohol on mood and behavior, acquired personal experiences with alcohol, and stress.

***Di-fferential Di-agnosis***

For a general discussion of the differential diagnosis of Substance-Related Disorders, see

p. 190. Alcohol-Induced Disorders may be characterized by symptoms (e.g., depressed mood) that resemble **primary mental disorders** (e.g., Major Depressive Disorder versus Alcohol-Induced Mood Disorder, With Depressive Features, With Onset During Intoxication). See p. 193 for a discussion of this differential diagnosis.

The incoordination and impaired judgment that are associated with Alcohol Intoxication can resemble the symptoms of **certain general medical conditions** (e.g., diabetic acidosis, cerebellar ataxias, and other neurological conditions such as multiple sclerosis). Similarly, the symptoms of Alcohol Withdrawal can also be mimicked by **certain general medical conditions** (e.g., hypoglycemia and diabetic ketoacidosis). **Essential tremor,** a disorder that frequently runs in families, may suggest the tremu­ lousness associated with Alcohol Withdrawal.

Alcohol Intoxication (except for the smell of alcohol on the breath) closely resembles **Sedative, Hypnotic, or Anxiolytic Intoxication.** The presence of alcohol on the breath does not by itself exclude intoxications with other substances because multiple substances are not uncommonly used concurrently. Although intoxication at some time during their lives is likely to be a part of the history of most individuals who drink alcohol, when this phenomenon occurs regularly or causes impairment it is important to consider the possibility of a diagnosis of Alcohol Dependence or Alcohol Abuse. **Sedative, Hypnotic, or Anxiolytic Withdrawal** produces a syndrome very similar to that of Alcohol Withdrawal.

Alcohol Intoxication and Alcohol Withdrawal are distinguished from the **other**

**Alcohol-Induced Disorders** (e.g., Alcohol-Induced Anxiety Disorder, With Onset During Withdrawal) because the symptoms in these latter disorders are in excess of those usually associated with Alcohol Intoxication or Alcohol Withdrawal and are severe enough to warrant independent clinical attention. **Alcoholidiosyncratic intoxication,** defined as marked behavioral change, usually aggressiveness, following the ingestion of a relatively small of amount of alcohol, was included in DSM-III-R. Because of limited support in the literature for the validity of this condition, it is no longer included as a separate diagnosis in DSM-IV. Such presentations would most likely be diagnosed as Alcohol Intoxication or Alcohol-Related Disorder Not Otherwise Specified.

* 1. **Alcohol--Related Disorder Not Otherwise Specified**

The Alcohol-Related Disorder Not Otherwise Specified category is for disorders associ­ ated with the use of alcohol that are not classifiable as Alcohol Dependence, Alcohol Abuse, Alcohol Intoxication, Alcohol Withdrawal, Alcohol Intoxication Delirium, Alcohol Withdrawal Delirium, Alcohol-Induced Persisting Dementia, Alcohol-Induced Persisting Amnestic Disorder, Alcohol-Induced Psychotic Disorder, Alcohol-Induced Mood Disor­ der, Alcohol-Induced Anxiety Disorder, Alcohol-Induced Sexual Dysfunction, or Alco­ hol-Induced Sleep Disorder.

**Amphetamine**

**(or Amphetamine-Like)-Related Disorders**

The class of amphetamine and amphetamine-like substances includes all substances with a substituted-phenylethylamine structure, such as amphetamine, dextroamphetamine, and methamphetamine ("speed"). Also included are those substances that are structurally different but also have amphetamine-like action, such as methylphenidate and other agents used as appetite suppressants ("diet pills"). These substances are usually taken orally or intravenously, although methamphetamine is also taken by the nasal route ("snorting"). A very pure form of methamphetamine is called "ice" because of the appearance of its crystals when observed under magnification. Due to its high purity and relatively low vaporization point, ice can be smoked to produce an immediate and powerful stimulant effect (as is done with "crack" cocaine). In addition to the synthetic amphetamine-like compounds, there are naturally occurring, plant-derived stimulants

such as khat that can produce Abuse or Dependence. Unlike cocaine, which is almost always purchased on the illegal market, amphetamines and other stimulants may be obtained by prescription for the treatment of obesity, Attention-Deficit/Hyperactivity Disorder, and Narcolepsy. Prescribed stimulants have sometimes been diverted into the illegal market, often in the context of weight-control programs. Most of the effects of amphetamines and amphetamine-like drugs are similar to those of cocaine. However, unlike cocaine, these substances do not have local anesthetic (i.e., membrane ion channel) activity; therefore, their risk for inducing certain general medical conditions (e.g., cardiac arrhythmias and seizures) may be lower. The psychoactive effects of most amphetamine-like substances last longer than those of cocaine, and the peripheral sympathomimetic effects may be more potent.

This section contains discussions that are specific to the Amphetamine-Related Disorders. Texts and criteria sets have already been provided for the generic aspects of Substance Dependence (p. 176) and Substance Abuse (p. 182) that apply across all substances. Texts specific to Amphetamine Dependence and Abuse are provided below; however, there are no additional specific criteria sets for Amphetamine Dependence or Amphetamine Abuse. Specific texts and criteria sets for Amphetamine Intoxication and Amphetamine Withdrawal are also provided below. The Amphetamine-Induced Disor­ ders (other than Amphetamine Intoxication and Withdrawal) are described in the sections of the manual with disorders with which they share phenomenology (e.g., Amphetamine-Induced Mood Disorder is included in the "Mood Disorders" section). Listed below are the Amphetamine Use Disorders and the Amphetamine-Induced Disorders.

***Amphetamine Use Disorders***

**304.40 Amphetamine Dependence** (see p. 206)

**305.70 Amphetamine Abuse** (see p. 206)

***Amphetamine-Induced Disorders***

|  |  |
| --- | --- |
| **292.89** | **Amphetamine Intoxication** (see p. 207)  *Specify if* With Perceptual Disturbances |
| **292.0** | **Amphetamine Withdrawal** (see p. 208) |
| **292.81** | **Amphetamine Intoxication Delirium** (see p. 129) |
| **292.11** | **Amphetamine-Induced Psychotic Disorder, With Delusions** (see p. 310)  *Spec(fy if* With Onset During Intoxication |
| **292.12** | **Amphetamine-Induced Psychotic Disorder, With Hallucinations**  (seep. 310) *Specify if* With Onset During Intoxication |
| **292.84** | **Amphetamine-Induced Mood Disorder** (see p. 370)  *Specify if* With Onset During Intoxication/With Onset During Withdrawal |
| **292.89** | **Amphetamine-Induced Anxiety Disorder** (see p. 439)  *Specify if* With Onset During Intoxication |
| **292.89** | **Amphetamine-Induced Sexual Dysfunction** (see p. 519)  *Specify if* With Onset During Intoxication |
| **292.89** | **Amphetamine-Induced Sleep Disorder** (see p. 601)  *Specify if* With Onset During Intoxication/With Onset During Withdrawal |
| **292.9** | **Amphetamine-Related Disorder Not Otherwise Specified** (see p. 211) |

***Amphetamine Use Disorders***

**304.40 Amphetamine Dependence**

Also refer to the text and criteria for Substance Dependence (see p. 176). The patterns of use and course of Amphetamine Dependence are similar to those of Cocaine Dependence because both substances are potent central nervous system stimulants with similar psychoactive and sympathomimetic effects. However, amphetamines are longer acting than cocaine and thus are usually self-administered less frequently. As with Cocaine Dependence, usage may be chronic or episodic, with binges ("speed runs") punctuated by brief drug-free periods. Aggressive or violent behavior is associated with Amphetamine Dependence, especially when high doses are smoked (e.g., "ice") or administered intravenously. As with cocaine, intense but temporary anxiety, as well as paranoid ideation and psychotic episodes that resemble Schizophrenia, Paranoid Type, are often seen, especially in association with high-dose use. Tolerance to amphetamines develops and often leads to substantial escalation of the dose. Conversely, some individuals with Amphetamine Dependence develop reverse tolerance (sensitization). In these cases, small doses may produce marked stimulant and other adverse mental and neurological effects.

***Specifiers***

The following specifiers may be applied to a diagnosis of Amphetamine Dependence (see p. 179 for more details):

**With Physiological Dependence Without Physiological Dependence**

**Early Full Remission Early Partial Remission Sustained Full Remission**

**Sustained Partial Remission On Agonist Therapy**

**In a Controlled Environment**

**305.70 Amphetamine Abuse**

Also refer to the text and criteria for Substance Abuse (see p. 182). Legal difficulties typically arise as a result of behavior while intoxicated with amphetamines (especially aggressive behavior), as a consequence of obtaining the drug on the illegal market, or as a result of drug possession or use. Occasionally, individuals with Amphetamine Abuse will engage in illegal acts (e.g., manufacturing amphetamines, theft) to obtain the drug; however, this behavior is more common among those with Dependence. Individuals may continue to use the substance despite the knowledge that continued use results in arguments with family members while the individual is intoxicated or presents a negative example to children or other close family members. When these problems are accom­ panied by evidence of tolerance, withdrawal, or compulsive behavior, a diagnosis of Amphetamine Dependence rather than Abuse should be considered.

***Amphetamine-Induced Disorders***

**292.89 Amphetamine Intoxication**

Also refer to the text and criteria for Substance Intoxication (see p. 183). The essential feature of Amphetamine Intoxication is the presence of clinically significant maladaptive behavioral or psychological changes that develop during, or shortly after, use of amphetamine or a related substance (Criteria A and B). Amphetamine Intoxication generally begins with a "high" feeling, followed by the development of symptoms such as euphoria with enhanced vigor, gregariousness, hyperactivity, restlessness, hypervigi­ lance, interpersonal sensitivity, talkativeness, anxiety, tension, alertness, grandiosity, stereotypical and repetitive behavior, anger, fighting, and impaired judgment. In the case of chronic intoxication, there may be affective blunting with fatigue or sadness and social withdrawal. These behavioral and psychological changes are accompanied by two or more of the following signs and symptoms: tachycardia or bradycardia; pupillary dilation; elevated or lowered blood pressure; perspiration or chills; nausea or vomiting; evidence of weight loss; psychomotor agitation or retardation; muscular weakness, respiratory depression, chest pain, or cardiac arrhythmias; and confusion, seizures, dyskinesias, dystonias, or coma (Criterion C). Amphetamine Intoxication, either acute or chronic, is often associated with impaired social or occupational functioning. The symptoms must not be due to a general medical condition and are not better accounted for by another mental disorder (Criterion D). The magnitude and manifestations of the behavioral and physiological changes depend on the dose used and individual characteristics of the person using the substance (e.g., tolerance, rate of absorption, chronicity of use). The changes associated with intoxication begin no longer than 1 hour after substance use and sometimes within seconds, depending on the specific drug and method of delivery.

***Specifier***

The following specifier may be applied to a diagnosis of Amphetamine Intoxication:

**With Perceptual Disturbances.** This specifier may be noted when hallucina­ tions with intact reality testing or auditory, visual, or tactile illusions occur in the absence of a delirium. *Intact reali(y testing* means that the person knows that the hallucinations are induced by the substance and do not represent external reality. When hallucinations occur in the absence of intact reality testing, a diagnosis of Substance-Induced Psychotic Disorder, With Hallucinations, should be considered.

* **Diagnostic criteria for 292.89 Amphetamine Intoxication**
  1. Recent use of amphetamine or a related substance (e.g., methyl­ phenidate).

*(continued)*

|  |
| --- |
| * **Diagnostic criteria for 292.89 Amphetamine Intoxication**   *(continued}*   * 1. Clinically significant maladaptive behavioral or psychological changes (e.g., euphoria or affective blunting; changes in sociability; hypervigi­ lance; interpersonal sensitivity; anxiety, tension, or anger; stereotyped behaviors; impaired judgment; or impaired social or occupational functioning) that developed during, or shortly after, use of amphetamine or a related substance.   2. Two (or more) of the following, developing during, or shortly after, use of amphetamine or a related substance:      1. tachycardia or bradycardia      2. pupillary dilation      3. elevated or lowered blood pressure      4. perspiration or chills      5. nausea or vomiting      6. evidence of weight loss      7. psychomotor agitation or retardation      8. muscular weakness, respiratory depression, chest pain, or cardiac arrhythmias      9. confusion, seizures, dyskinesias, dystonias, or coma   3. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.   *Specify* if:  **With Perceptual Disturbances** |

**292.0 Amphetamine Withdrawal**

Also refer to the text and criteria for Substance Withdrawal (see p. 184). The essential feature of Amphetamine Withdrawal is the presence of a characteristic withdrawal syndrome that develops within a few hours to several days after cessation of (or reduction in) heavy and prolonged amphetamine use (Criteria A and B). The withdrawal syndrome is characterized by the development of dysphoric mood and two or more of the following physiological changes: fatigue, vivid and unpleasant dreams, insomnia or hypersomnia, increased appetite, and psychomotor retardation or agitation. Anhedonia and drug craving can also be present but are not part of the diagnostic criteria. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C). The symptoms must not be due to a general medical condition and are not better accounted for by another mental disorder.

Marked withdrawal symptoms ("crashing") often follow an episode of intense, high-dose use (a "speed run"). These periods are characterized by intense and unpleasant feelings of lassitude and depression, generally requiring several days of rest and recuperation. Weight loss commonly occurs during heavy stimulant use, whereas a

marked increase in appetite with rapid weight gain is often observed during withdrawal. Depressive symptoms may last several days and may be accompanied by suicidal ideation.

* **Diagnostic criteria for 292.0 Amphetamine Withdrawal**
  1. Cessation of (or reduction in) amphetamine (or a related substance) use that has been heavy and prolonged.
  2. Dysphoric mood and two (or more) of the following physiological changes, developing within a few hours to several days after Criterion A:
     1. fatigue
     2. vivid, unpleasant dreams
     3. insomnia or hypersomnia
     4. increased appetite
     5. psychomotor retardation or agitation
  3. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
  4. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

**Other Amphetamine--Induced Disorders**

The following Amphetamine-Induced Disorders are described in the sections of the manual with disorders with which they share phenomenology: **Amphetamine Intox­ ication Delirium** (p. 129), **Amphetamine-Induced Psychotic Disorder** (p. 310), **Amphetamine-Induced Mood Disorder** (p. 370), **Amphetamine-Induced Anxiety Disorder** (p. 439), **Amphetamine-Induced Sexual Dysfunction** (p. 519), and **Am­ phetamine-Induced Sleep Disorder** (p. 601). These disorders are diagnosed instead of Amphetamine Intoxication or Amphetamine Withdrawal only when the symptoms are in excess of those usually associated with Amphetamine Intoxication or Withdrawal and when the symptoms are sufficiently severe to warrant independent clinical attention.

***Additional Information on Amphetamine-Related Disorders***

***Associated Features and Disorders***

Acute Amphetamine Intoxication is sometimes associated with confusion, rambling speech, headache, transient ideas of reference, and tinnitus. During intense Amphet­ amine Intoxication, paranoid ideation, auditory hallucinations in a clear sensorium, and

tactile hallucinations may be experienced. Frequently, the person using the substance recognizes these symptoms as resulting from the stimulants. Extreme anger with threats or acting out of aggressive behavior may occur. Mood changes such as depression with suicidal ideation, irritability, anhedonia, emotional lability, or disturbances in attention and concentration are common, especially during withdrawal. Weight loss, anemia, and other signs of malnutrition and impaired personal hygiene are often seen with sustained Amphetamine Dependence.

Amphetamine-Related Disorders and other stimulant-related disorders are often associated with Dependence on or Abuse of other substances, especially those with sedative properties (such as alcohol or benzodiazepines), which are usually taken to reduce the unpleasant, "jittery" feelings that result from stimulant drug effects. The intravenous use of amphetamines is sometimes associated with Opioid Dependence.

The laboratory and physical examination findings and the mental disorders and general medical conditions that are associated with the Amphetamine-Related Disorders are generally similar to those that are associated with the Cocaine-Related Disorders (see

p. 226). Urine tests for substances in this class usually remain positive for only 1-3 days, even after a "binge." Adverse pulmonary effects are seen less often than with cocaine because substances in this class are inhaled much less frequently. Fewer maternal and neonatal complications have been attributed to this class of substances than to cocaine. This difference may reflect the greater prevalence of cocaine use rather than lower toxicity from amphetamines. Seizures, human immunodeficiency virus (HIV) infection, malnutrition, gunshot or knife wounds, nosebleeds, and cardiovascular problems are often seen as presenting complaints in individuals with Amphetamine-Related Disorders. A history of childhood Conduct Disorder, Antisocial Personality Disorder, and Attention­ Deficit/Hyperactivity Disorder may be associated with the later development of Amphet­ amine-Related Disorders.

***Specific Culture, Age, and Gender Features***

Amphetamine Dependence and Abuse are seen throughout all levels of society and are more common among persons between ages 18 and 30 years. Intravenous use is more common among persons from lower socioeconomic groups and has a male-to-female ratio of 3 or 4:1. The male-to-female ratio is more evenly divided among those with nonintravenous use.

***Prevalence***

A community survey conducted in the United States in 1991 reported that 7% of the population had nonmedical use of amphetamines or amphetamine-like substances one or more times in their lifetime; 1.3% had used them in the last year; and 0.3% had used them in the last month. Because the survey assessed patterns of use rather than diagnoses, it is not known how many of those in the survey who used amphetamines had symptoms that met criteria for Dependence or Abuse. A community study conducted in the United States from 1980 to 1985 that used the more narrowly defined DSM-III criteria found that about 2% of the adult population had Amphetamine Dependence or Abuse at some time in their lives.

***Course***

Some individuals who abuse or become dependent on amphetamines or amphetamine­ like substances begin use in an attempt to control their weight. Others become introduced to these substances through the illegal market. Dependence can occur rapidly when the substance is used intravenously or smoked. Oral administration usually results in a slower progression from use to Dependence. Amphetamine Dependence is associated with two patterns of administration: episodic use or daily (or almost daily) use. In the episodic pattern, substance use is separated by days of nonuse (e.g., intense use over a weekend or on one or more weekdays). These periods of intensive high-dose use (often called "speed runs" or "binges") are often associated with intravenous use. Runs tend to terminate only when drug supplies are depleted. Chronic daily use may involve high or low doses and may occur throughout the day or be restricted to only a few hours. In chronic daily use, there are generally no wide fluctuations in dose on successive days, but there is often an increase in dose over time. Chronic use of high doses often becomes unpleasant because of sensitization and the emergence of dysphoric and other negative drug effects. The few long-term data available indicate that there is a tendency for persons who have been dependent on amphetamines to decrease or stop use after 8-10 years. This appears to result from the development of adverse mental and physical effects that emerge in association with long-term depen­ dence. Little or no data are available on the long-term course of Abuse.

***m.[ferential magnosis***

For a general discussion of the differential diagnosis of Substance-Related Disorders, see

p. 190. Amphetamine-Induced Disorders may be characterized by symptoms (e.g., delusions) that resemble **pritnarymentaldisorders** (e.g., Schizophreniform Disorder versus Amphetamine-Induced Psychotic Disorder, With Delusions, With Onset During Intoxication). See p. 193 for a discussion of this differential diagnosis.

**Cocaine Intoxication, Hallucinogen Intoxication,** and **Phencyclidine Intoxi­ cation** may cause a similar clinical picture and can sometimes be distinguished from Amphetamine Intoxication only by the presence of amphetamine metabolites in a urine specimen or amphetamine in plasma. Amphetamine Dependence and Abuse should be distinguished from **Cocaine, Phencyclidine,** and **Hallucinogen Dependence** and **Abuse.** Amphetamine Intoxication and Amphetamine Withdrawal are distinguished from the **other Amphetamine-Induced Disorders** (e.g., Amphetamine-Induced Anxiety Disorder, With Onset During Intoxication) because the symptoms in these latter disorders are in excess of those usually associated with Amphetamine Intoxication or Amphet­ amine Withdrawal and are severe enough to warrant independent clinical attention.

**292.9 Amphetamine--Related Disorder Not Otherwise Specified**

The Amphetamine-Related Disorder Not Otherwise Specified category is for disorders associated with the use of amphetamine (or a related substance) that are not classifiable as Amphetamine Dependence, Amphetamine Abuse, Amphetamine Intoxication, Am­ phetamine Withdrawal, Amphetamine Intoxication Delirium, Amphetamine-Induced

Psychotic Disorder, Amphetamine-Induced Mood Disorder, Amphetamine-Induced Aruc­ iety Disorder, Amphetamine-Induced Sexual Dysfunction, or Amphetamine-Induced Sleep Disorder.

**Caffeine -Related Disorders**

Caffeine can be consumed from a number of different sources, including coffee (brewed = 100 mg/6 oz, instant = 65 mg/6 oz), tea (40 mg/6 oz), caffeinated soda (45 mg/12 oz), over-the-counter analgesics and cold remedies (25-50 mg/tablet), stimulants (100-200 mg/tablet), and weight-loss aids (75-200 mg/tablet). Chocolate and cocoa have much lower levels of caffeine (e.g., 5 mg/chocolate bar). The consumption of caffeine is ubiquitous in much of the United States, with the average caffeine intake being approximately 200 mg/day. Some individuals who drink large amounts of coffee display some aspects of dependence on caffeine and exhibit tolerance and perhaps withdrawal. However, the data are insufficient at this time to determine whether these symptoms are associated with clinically significant impairment that meets the criteria for Substance Dependence or Substance Abuse. In contrast, there is evidence that Caffeine Intoxication can be clinically significant, and specific text and criteria are provided below. Recent evidence also suggests the possible clinical relevance of caffeine withdrawal; a set of research criteria is included on p. 709. The Caffeine-Induced Disorders (other than Caffeine Intoxication) are described in the sections of the manual with disorders with which they share phenomenology (e.g., Caffeine-Induced Anxiety Disorder is included in the "Anxiety Disorders" section). Listed below are the Caffeine-Induced Disorders.

***Caffeine-Induced Disorders***

|  |  |
| --- | --- |
| **305.90** | **Caffeine Intoxication** (seep. 212) |
| **292.89** | **Caffeine-Induced Anxiety Disorder** (see p. 439)  *Specify if* With Onset During Intoxication |
| **292.89** | **Caffeine-Induced Sleep Disorder** (seep. 601)  *Specify if* With Onset During Intoxication |
| **292.9** | **Caffeine-Related Disorder Not Otherwise Specified** (seep. 215) |

***Caffeine-Induced Disorders***

**305.90 Caffeine Intoxication**

Also refer to the text and criteria for Substance Intoxication (see p. 183). The essential feature of Caffeine Intoxication is recent consumption of caffeine and five or more symptoms that develop during, or shortly after, caffeine use (Criteria A and B). Symptoms that can appear following the ingestion of as little as 100 mg of caffeine per day include restlessness, nervousness, excitement, insomnia, flushed face, diuresis, and gastrointes­ tinal complaints. Symptoms that generally appear at levels of more than 1 g/day include muscle twitching, rambling flow of thoughts and speech, tachycardia or cardiac

arrhythmia, periods of inexhaustibility, and psychomotor agitation. Caffeine Intoxication may not occur despite high caffeine intake because of the development of tolerance. The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C). The symptoms must not be due to a general medical condition and are not better accounted for by another mental disorder (e.g., an Anxiety Disorder) (Criterion D).

* **Diagnostic criteria for 305.90 Caffeine Intoxication**

1. Recent consumption of caffeine, usually in excess of 250 mg (e.g., more than 2-3 cups of brewed coffee).
2. Five (or more) of the following signs, developing during, or shortly after, caffeine use:
   1. restlessness
   2. nervousness
   3. excitement
   4. insomnia
   5. flushed face
   6. diuresis
   7. gastrointestinal disturbance
   8. muscle twitching
   9. rambling flow of thought and speech
   10. tachycardia or cardiac arrhythmia
   11. periods of inexhaustibility
   12. psychomotor agitation
3. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of func­ tioning.
4. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder (e.g., an Anxiety Disorder).

**Other Caffeine--Induced Disorders**

The following Caffeine-Induced Disorders are described in other sections of the manual with disorders with which they share phenomenology: **Caffeine-Induced Anxiety Disorder** (p. 439) and **Caffeine-InducedSleep Disorder** (p. 601). These disorders are diagnosed instead of Caffeine Intoxication only when the symptoms are in excess of those usually associated with Caffeine Intoxication and when the symptoms are sufficiently severe to warrant independent clinical attention.

***Additional Information on Caffeine-Related Disorders***

***Associated Features and Disorders***

Mild sensory disturbances (e.g., ringing in the ears and flashes of light) have been reported at higher doses. Although large doses of caffeine can increase heart rate, smaller doses can slow the pulse. Whether excess caffeine intake can cause headaches is unclear. On physical examination, agitation, restlessness, sweating, tachycardia, flushed face, and increased bowel motility may be seen. Typical patterns of caffeine intake have not been consistently associated with other medical problems. However, heavy use is associated with the development or exacerbation of anxiety and somatic symptoms such as cardiac arrhythmias and gastrointestinal pain or diarrhea. With acute doses exceeding 10 g of caffeine, grand mal seizures and respiratory failure may result in death. Excessive caffeine use is associated with Mood, Eating, Psychotic, Sleep, and Substance-Related Disorders, whereas individuals with Anxiety Disorders are likely to avoid this substance.

***Specific Culture, Age, and Gender Features***

Caffeine use and the sources from which caffeine is consumed vary widely across cultures. *The* average caffeine intake in most of the developing world is less than 50 mg/day, compared to as much as 400 mg/day or more in Sweden, the United Kingdom, and other European nations. Caffeine consumption increases during the 20s and often decreases after age 65 years. Intake is greater in males than in females.

***Course***

The half-life of caffeine is 2--6 hours, so that most symptoms of intoxication are likely to last 6-16 hours after caffeine ingestion. Because tolerance to the behavioral effects of caffeine occurs, Caffeine Intoxication is usually seen in infrequent users or in those who have recently increased their caffeine intake by a substantial amount.

***Differential Diagnosis***

For a general discussion of the differential diagnosis of Substance-Related Disorders, see

p. 190. Caffeine-Induced Disorders may be characterized by symptoms (e.g., Panic Attacks) that resemble **primary mentaldisorders** (e.g., Panic Disorder versus Caffeine­ Induced Anxiety Disorder, With Panic Attacks, With Onset During Intoxication). See

p. 193 for a discussion of this differential diagnosis.

To meet criteria for Caffeine Intoxication, the symptoms must not be due to a **general medical condition or another mental disorder,** such as an **Anxiety Disorder,** that could better explain them. **Manic Episodes, Panic Disorder, Gener­ alized Anxiety Disorder, Amphetamine Intoxication, Sedative, Hypnotic, or Anxiolytic Withdrawal or Nicotine Withdrawal, Sleep Disorders,** and **medication­ induced side effects** (e.g., akathisia) can cause a clinical picture that is similar to that of Caffeine Intoxication. The temporal relationship of the symptoms to increased caffeine use or to abstinence from caffeine helps to establish the diagnosis. Caffeine Intoxication

is differentiated from **Caffeine-Induced Anxiety Disorder, With Onset During Intoxication** (p. 439), and from **Caffeine-Induced Sleep Disorder, With Onset During Intoxication** (p. 601), by the fact that the symptoms in these latter disorders are in excess of those usually associated with Caffeine Intoxication and are severe enough to warrant independent clinical attention.

**292.9 Caffeine-Related Disorder Not Otherwise Specified**

The Caffeine-Related Disorder Not Otherwise Specified category is for disorders associated with the use of caffeine that are not classifiable as Caffeine Intoxication, Caffeine-Induced Anxiety Disorder, or Caffeine-Induced Sleep Disorder. An example is caffeine withdrawal (see p. 708 for suggested research criteria).

**Cannabis-Related Disorders**

This section includes problems that are associated with cannabinoids and chemically similar synthetic compounds. Cannabinoids are substances that are derived from the cannabis plant. When the upper leaves, tops, and stems of the plant are cut, dried, and rolled into cigarettes, the product is usually called marijuana. Hashish is the dried, resinous exudate that seeps from the tops and undersides of cannabis leaves; hashish oil is a concentrated distillate of hashish. Cannabinoids are usually smoked, but may be taken orally and are sometimes mixed with tea or food. The cannabinoid that has been identified as primarily responsible for the psychoactive effects of cannabis is delta-9- tetrahydrocannabinol (also known as THC, or delta-9-THC). This substance itself is rarely available for use in a pure form. The THC content of the marijuana that is generally available varies greatly. The THC content of illicit marijuana has increased significantly since the late 1960s from an average of approximately 1%--5% to as much as 10%-15%. Synthetic delta-9-THC has been used for certain general medical conditions (e.g., for nausea and vomiting caused by chemotherapy, for anorexia and weight loss in individuals with acquired immunodeficiency syndrome [AIDS]).

This section contains discussions specific to the Cannabis-Related Disorders. Texts

and criteria sets have already been provided to define the generic aspects of Substance Dependence (p. 176) and Substance Abuse (p. 182) that apply across all substances. Texts specific to Cannabis Dependence and Abuse are provided below; however, there are no additional specific criteria sets for Cannabis Dependence or Cannabis Abuse. A specific text and criteria set for Cannabis Intoxication is also provided below. Symptoms of possible cannabis withdrawal (e.g., irritable or anxious mood accompanied by physiological changes such as tremor, perspiration, nausea, and sleep disturbances) have been described in association with the use of very high doses, but their clinical significance is uncertain. For these reasons, the diagnosis of cannabis withdrawal is not included in this manual. The Cannabis-Induced Disorders (other than Cannabis Intoxi­ cation) are described in the sections of the manual with disorders with which they share phenomenology (e.g., Cannabis-Induced Mood Disorder is included in the "Mood Disorders" section). Listed below are the Cannabis Use Disorders and the Cannabis­ Induced Disorders.

***Cannabis Use Disorders***

**304.30 Cannabis Dependence** (seep. 216)

**305.20 Cannabis Abuse** (see p. 217)

***Cannabis-Induced Disorders***

**292.89**

**292.81**

**292.11**

**292.12**

**292.89**

**292.9**

**Cannabis Intoxication** (see p. 217)

*Specify if* With Perceptual Disturbances

**Cannabis Intoxication Delirium** (seep. 129)

**Cannabis-Induced Psychotic Disorder, With Delusions** (see p. 310)

*Specify if* With Onset During Intoxication

**Cannabis-Induced Psychotic Disorder, With Hallucinations** (see p. 310)

*Specify if:* With Onset During Intoxication **Cannabis-Induced Anxiety Disorder** (see p. 439) *Specify if* With Onset During Intoxication

**Cannabis-Related Disorder Not Otherwise Specified** (see p. 221)

***Cannabis Use Disorders***

**304.30 Cannabis Dependence**

Also refer to the text and criteria for Substance Dependence (see p. 176). Individuals with Cannabis Dependence have compulsive use and do not generally develop physiological dependence, although tolerance to most of the effects of cannabis has been reported in individuals who use cannabis chronically. There have also been some reports of withdrawal symptoms, but they have not yet been reliably shown to be clinically significant. Individuals with Cannabis Dependence may use very potent cannabis throughout the day over a period of months or years, and they may spend several hours a day acquiring and using the substance. This often interferes with family, school, work, or recreational activities. Individuals with Cannabis Dependence may also persist in their use despite knowledge of physical problems (e.g., chronic cough related to smoking) or psychological problems (e.g., excessive sedation resulting from repeated use of high doses).

***Specifiers***

The following specifiers may be applied to a diagnosis of Cannabb ucpendence (see

p. 179 for more details):

**With Physiological Dependence Without Physiological Dependence**

**Early Full Remission Early Partial Remission Sustained Full Remission**

**Sustained Partial Remission In a Controlled Environment**

**305.20 Cannabis Abuse**

Also refer to the text and criteria for Substance Abuse (see p. 182). Periodic cannabis use and intoxication can interfere with performance at work or school and may be physically hazardous in situations such as driving a car. Legal problems may occur as a consequence of arrests for cannabis possession. There may be arguments with spouses or parents over the possession of cannabis in the home or its use in the presence of children. When there are significant levels of tolerance, or when psychological or physical problems are associated with cannabis in the context of compulsive use, a diagnosis of Cannabis Dependence, rather than Cannabis Abuse, shouid be considered.

***Cannabis-Induced Disorders***

**292.89 Cannabis Intoxication**

Also refer to the text and criteria for Substance Intoxication (see p. 183). The essential feature of Cannabis Intoxication is the presence of clinically significant maladaptive behavioral or psychological changes that develop during, or shortly after, cannabis use (Criteria A and B). Intoxication typically begins with a "high" feeling followed by symptoms that include euphoria with inappropriate laughter and grandiosity, sedation, lethargy, impairment in short-term memory, difficulty carrying out complex mental processes, impaired judgment, distorted sensory perceptions, impaired motor perfor­ mance, and the sensation that time is passing slowly. Occasionally, anxiety (which can be severe), dysphoria, or social withdrawal occurs. These psychoactive effects are accompanied by two or more of the following signs, developing within 2 hours of cannabis use: conjunctiva! injection, increased appetite, dry mouth, and tachycardia (Criterion C). The symptoms must not be due to a general medical condition and are not better accounted for by another mental disorder (Criterion D).

Intoxication develops within minutes if the cannabis is smoked, but may take a few hours to develop if ingested orally. The effects usually last 3-4 hours, the duration being somewhat longer when the substance is ingested orally. The magnitude of the behavioral and physiological changes depends on the dose, the method of administration, and the individual characteristics of the person using the substance, such as rate of absorption, tolerance, and sensitivity to the effects of the substance. Because most cannabinoids, including delta-9-THC, are fat soluble, the effects of cannabis or hashish may occasionally persist or reoccur for 12-24 hours due to a slow release of psychoactive substances from fatty tissue or to enterohepatic circulation.

***Specifier***

The following specifier may be applied to a diagnosis of Cannabis Intoxication:

**With Perceptual Disturbances.** This specifier may be noted when hallucina­ tions with intact reality testing or auditory, visual, or tactile illusions occur in the absence of a delirium. *Intact reality testing* means that the person knows that the hallucinations are induced by the substance and do not represent external reality. When hallucinations occur in the absence of intact reality testing, a diagnosis of Substance-Induced Psychotic Disorder, With Hallucinations, should be considered.

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| * **Diagnostic criteria for 292.89 Cannabis Intoxication**   1. Recent use of cannabis.   2. Clinically significant maladaptive behavioral or psychological changes (e.g., impaired motor coordination, euphoria, anxiety, sensation of slowed time, impaired judgment, social withdrawal) that developed during, or shortly after, cannabis use.   3. Two (or more) of the following signs, developing within 2 hours of cannabis use:      1. conjunctival injection      2. increased appetite      3. dry mouth      4. tachycardia   4. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.   *Specify* if:  **With Perceptual Disturbances** |

**Other Cannabis--Induced Disorders**

The following Cannabis-Induced Disorders are described in other sections of the manual with disorders with which they share phenomenology: **Cannabis Intoxication Delir­ ium** (p. 129), **Cannabis-Induced Psychotic Disorder** (p. 310), and **Cannabis­ InducedAnxietyDisorder** (p. 439). These disorders are diagnosed instead of Cannabis Intoxication only when the symptoms are in excess of those usually associated with Cannabis Intoxication and when the symptoms are sufficiently severe to warrant independent clinical attention.

***Additional Information* on**

***Cannabis-Related Disorders***

***Associated Features and Disorders***

**Associated descriptive features and mental disorders.** Cannabis is often used with other substances, especially nicotine, alcohol, and cocaine. Cannabis (especially marijuana) may be mixed and smoked with opioids, phencyclidine (PCP), or other hallucinogenic drugs. Individuals who regularly use cannabis often report both physical and mental lethargy and anhedonia. Mild forms of depression, anxiety, or irritability are seen in about one-third of individuals who regularly use cannabis (daily or almost daily).

When taken in high doses, cannabinoids have psychoactive effects that can be similar to those of hallucinogens (e.g., lysergic acid diethylamide [LSD]), and individuals who use cannabinoids can experience adverse mental effects that resemble hallucinogen­ induced "bad trips." These range from mild to moderate levels of anxiety (e.g., concern that the police will discover the substance use) to severe anxiety reactions resembling Panic Attacks. There may also be paranoid ideation ranging from suspiciousness to frank delusions and hallucinations. Episodes of depersonalization and derealization have also been reported. Fatal traffic accidents have been found to occur more often in individuals who test positive for cannabinoids than in the general population. However, the significance of these findings is unclear because alcohol and other substances are often also present.

**Associated laboratory findings.** Urine tests generally identify cannabinoid metab­ olites. Because these substances are fat soluble, persist in bodily fluids for extended periods of time, and are excreted slowly, routine urine tests for cannabinoids in individuals who use cannabis casually can be positive for 7-10 days; urine of individuals with heavy use of cannabis may test positive for 2-4 weeks. A positive urine test is only consistent with past use; it does not establish Intoxication, Dependence, or Abuse. Biological alterations include temporary (and probably dose-related) suppression of immunological function and suppressed secretion of testosterone and luteinizing hormone (LH), although the clinical significance of these alterations is unclear. Acute cannabinoid use also causes diffuse slowing of background activity on EEG and rapid eye movement (REM) suppression.

**Associated physical examination findings and general medical conditions.** Cannabis smoke is highly irritating to the nasopharynx and bronchial lining and thus increases the risk for chronic cough and other signs and symptoms of nasopharyngeal pathology. Chronic cannabis use is sometimes associated with weight gain, probably resulting from overeating and reduced physical activity. Sinusitis, pharyngitis, bronchitis with persistent cough, emphysema, and pulmonary dysplasia may occur with chronic, heavy use. Marijuana smoke contains even larger amounts of known carcinogens than tobacco, and heavy use may increase the risk of developing malignant disease.

***Specific Culture, Age, and Gender Features***

Cannabis is probably the world's most commonly used illicit substance. It has been taken since ancient times for its psychoactive effects and as a remedy for a wide range of medical conditions. Cannabis is among the first drugs of experimentation (often in the teens) for all cultural groups in the United States. As with most other illicit drugs, Cannabis Use Disorders appear more often in males, and prevalence is most common in persons between ages 18 and 30 years.

***Prevalence***

Cannabinoids, especially cannabis, are also the most widely used illicit psychoactive substances in the United States, even though lifetime prevalence figures have slowly decreased from the figures obtained by surveys in the 1980s. A community survey conducted in the United States in 1991 reported that about one-third of the population

had used marijuana one or more times in their lifetime; 10% had used it in the last year; and 5% had used it in the last month. Because the survey assessed patterns of use rather than diagnoses, it is not known how many of those who used marijuana had symptoms that met criteria for Dependence or Abuse. A community study conducted in the United States from 1980 to 1985 that used the more narrowly defined DSM-III criteria found that about 4% of the adult population had Cannabis Dependence or Abuse at some time in their lives.

***Course***

Cannabis Dependence and Abuse usually develop over an extended period of time. Those who become dependent typically establish a pattern of chronic use that gradually increases in both frequency and amount. With chronic heavy use, there is sometimes a diminution or loss of the pleasurable effects of the substance. Although there may also be a corresponding increase in dysphoric effects, these are not seen as frequently as in chronic use of other substances such as alcohol, cocaine, or amphetamines. A history of Conduct Disorder in childhood or adolescence and Antisocial Personality Disorder are risk factors for the development of many Substance-Related Disorders, including Cannabis-Related Disorders. Few data are available on the long-term course of Cannabis Dependence or Abuse.

***m.[ferential magnosis***

For a general discussion of the differential diagnosis of Substance-Related Disorders, see

p. 190. Cannabis-Induced Disorders may be characterized by symptoms (e.g., anxiety) that resemble **primary mental disorders** (e.g., Generalized Anxiety Disorder versus Cannabis-Induced Anxiety Disorder, With Generalized Anxiety, With Onset During Intoxication). See p. 193 for a discussion of this differential diagnosis. Chronic intake of cannabis can produce symptoms that resemble **Dysthymic Disorder.** Acute adverse reactions to cannabis should be differentiated from the symptoms of **Panic Disorder, Major Depressive Disorder, Delusional Disorder, Bipolar Disorder, or Schizo­ phrenia, Paranoid Type.** Physical examination will usually show an increased pulse and injected conjunctivas. Urine toxicological testing can be helpful in making a diagnosis.

In contrast to Cannabis Intoxication, **Alcohol Intoxication** and **Sedative, Hyp­ notic, or Anxiolytic Intoxication** frequently decrease appetite, increase aggressive behavior, and produce nystagmus or ataxia. **Hallucinogens** in low doses may cause a clinical picture that resembles Cannabis Intoxication. Phencyclidine (PCP), like cannabis, can be smoked and also has hallucinogenic effects, but **Phencyclidine Intoxication** is much more likely to cause ataxia and aggressive behavior. Cannabis Intoxication is distinguished from the **other Cannabis-Induced Disorders** (e.g., Cannabis-Induced Anxiety Disorder, With Onset During Intoxication) because the symptoms in these latter disorders are in excess of those usually associated with Cannabis Intoxication and are severe enough to warrant independent clinical attention.

The distinction between **recreational use of cannabis** and Cannabis Dependence or Abuse can be difficult to make because social, behavioral, or psychological problems may be difficult to attribute to the substance, especially in the context of use of other substances. Denial of heavy use is common, and people appear to seek treatment for

Cannabis Dependence or Abuse less often than for other types of Substance-Related Disorders.

**292.9 Cannabis-Related Disorder Not Otherwise Specified**

The Cannabis-Related Disorder Not Otherwise Specified category is for disorders associated with the use of cannabis that are not classifiable as Cannabis Dependence, Cannabis Abuse, Cannabis Intoxication, Cannabis Intoxication Delirium, Cannabis­ Induced Psychotic Disorder, or Cannabis-Induced Anxiety Disorder.

**Cocaine-Related Disorders**

Cocaine, a naturally occurring substance produced by the coca plant, is consumed in several preparations (e.g., coca leaves, coca paste, cocaine hydrochloride, and cocaine alkaloid) that differ in potency due to varying levels of purity and speed of onset. Cocaine is the active ingredient in each preparation. Chewing coca leaves is a practice generally limited to native populations in Central and South America, where cocaine is grown. The use of coca paste, a crude extract of the coca plant, occurs almost exclusively in cocaine-producing countries in Central and South America, where its nickname is "basulca." Solvents used in the preparation of coca paste often contaminate the paste and may cause toxic effects in the central nervous system and other organ systems when the paste is smoked. Cocaine hydrochloride powder is usually "snorted" through the nostrils ("snorting") or dissolved in water and injected intravenously. It is sometimes mixed with heroin, yielding a drug combination known as a "speedball."

A commonly used form of cocaine in the United States is "crack," a cocaine alkaloid that is extracted from its powdered hydrochloride salt by mixing it with sodium bicarbonate and allowing it to dry into small "rocks." Crack differs from other forms of cocaine primarily because it is easily vaporized and inhaled and thus its effects have an extremely rapid onset. The clinical syndrome and adverse effects that are associated with crack use are identical to those produced by comparable doses of other cocaine preparations. Before the advent of crack, cocaine was separated from its hydrochloride base by heating it with ether, ammonia, or some other volatile solvent. The resulting "free base" cocaine was then smoked. This process was dangerous because of the risk that the solvents could ignite and harm the user.

This section contains discussions specific to the Cocaine-Related Disorders. Texts and criteria sets have already been provided to define the generic aspects of Substance Dependence (p. 176) and Substance Abuse (p. 182) that apply across all substances. Texts specific to Cocaine Dependence and Abuse are provided below; however, there are no additional specific criteria sets for Cocaine Dependence or Cocaine Abuse. Specific texts and criteria sets for Cocaine Intoxication and Cocaine Withdrawal are also provided below. The Cocaine-Induced Disorders (other than Cocaine Intoxication and Withdrawal) are described in the sections of the manual with disorders with which they share phenomenology (e.g., Cocaine-Induced Mood Disorder is included in the "Mood Disorders" section). Listed below are the Cocaine Use Disorders and the Cocaine­ Induced Disorders.

***Cocaine Use Disorders***

**304.20**

**305.60**

**Cocaine Dependence** (see p. 222)

**Cocaine Abuse** (see p. 223)

***Cocaine-Induced Disorders***

|  |  |
| --- | --- |
| **292.89** | **Cocaine Intoxication** (see p. 223) *Specify if* With Perceptual Disturbances |
| **292.0** | **Cocaine Withdrawal** (see p. 225) |
| **292.81** | **Cocaine Intoxication Delirium** (seep. 129) |
| **292.11** | **Cocaine-Induced Psychotic Disorder, With Delusions** (see p. 310)  *Specify if* With Onset During Intoxication |
| **292.12** | **Cocaine-Induced Psychotic Disorder, With Hallucinations** (see p. 310)  *Specify if* With Onset During Intoxication |
| **292.84** | **Cocaine-Induced Mood Disorder** (see p. 370)  *Specify if* With Onset During Intoxication/With Onset During Withdrawal |
| **292.89** | **Cocaine-InducedAnxiety Disorder** (see p. 439)  *Specify if* With Onset During Intoxication/With Onset During Withdrawal |
| **292.89** | **Cocaine-Induced Sexual Dysfunction** (see p. 519)  *Specify if* With Onset During Intoxication |
| **292.89** | **Cocaine-Induced Sleep Disorder** (seep. 601)  *Specify if* With Onset During Intoxication/With Onset During Withdrawal |
| **292.9** | **Cocaine-Related Disorder Not Otherwise Specified** (see p. 229) |

***Cocaine Use Disorders***

**304.20 Cocaine Dependence**

Also refer to the text and criteria for Substance Dependence (see p. 176). Cocaine has extremely potent euphoric effects, and individuals exposed to it can develop Depen­ dence after using cocaine for very short periods of time. An early sign of Cocaine Dependence is when the individual finds it increasingly difficult to resist using cocaine whenever it is available. Because of its short half-life, there is a need for frequent dosing to maintain a "high." Persons with Cocaine Dependence can spend extremely large amounts of money on the drug within a very short period of time. As a result, the person using the substance may become involved in theft, prostitution, or drug dealing or may request salary advances to obtain funds to purchase the drug. Individuals with Cocaine Dependence often find it necessary to discontinue use for several days to rest or to obtain additional funds. Important responsibilities such as work or child care may be grossly neglected to obtain or use cocaine. Mental or physical complications of chronic use such as paranoid ideation, aggressive behavior, anxiety, depression, and weight loss are common. Regardless of the route of administration, tolerance occurs with repeated use. Withdrawal symptoms, particularly dysphoric mood, can be seen, but are usually transitory and associated with high-dose use.

***Specifiers***

The following specifiers may be applied to a diagnosis of Cocaine Dependence (see

p. 179 for more details):

**With Physiological Dependence Without Physiological Dependence**

**Early Full Remission Early Partial Remission Sustained Full Remission**

**Sustained Partial Remission On Agonist Therapy**

**In a Controlled Environment**

**305.60 Cocaine Abuse**

Also refer to the text and criteria for Substance Abuse (see p. 182). The intensity and frequency of cocaine administration is less in Cocaine Abuse as compared with Dependence. Episodes of problematic use, neglect of responsibilities, and interpersonal conflict often occur around paydays or special occasions, resulting in a pattern of brief periods (hours to a few days) of high-dose use followed by much longer periods (weeks to months) of occasional, nonproblematic use or abstinence. Legal difficulties may result from possession or use of the drug. When the problems associated with use are accompanied by evidence of tolerance, withdrawal, or compulsive behavior related to obtaining and administering cocaine, a diagnosis of Cocaine Dependence rather than Cocaine Abuse should be considered.

***Cocaine-Induced Disorders***

**292.89 Cocaine Intoxication**

Also refer to the text and criteria for Substance Intoxication (see p. 183). The essential feature of Cocaine Intoxication is the presence of clinically significant maladaptive behavioral or psychological changes that develop during, or shortly after, use of cocaine (Criteria A and B). Cocaine Intoxication usually begins with a "high" feeling and includes one or more of the following: euphoria with enhanced vigor, gregariousness, hyper­ activity, restlessness, hypervigilance, interpersonal sensitivity, talkativeness, anxiety, tension, alertness, grandiosity, stereotyped and repetitive behavior, anger, and impaired judgment, and in the case of chronic intoxication, affective blunting with fatigue or sadness and social withdrawal. These behavioral and psychological changes are accompanied by two or more of the following signs and symptoms that develop during or shortly after cocaine use: tachycardia or bradycardia; pupillary dilation; elevated or lowered blood pressure; perspiration or chills; nausea or vomiting; evidence of weight loss; psychomotor agitation or retardation; muscular weakness, respiratory depression, chest pain, or cardiac arrhythmias; and confusion, seizures, dyskinesias, dystonias, or coma (Criterion C). Intoxication, either acute or chronic, is often associated with impaired social or occupational functioning. Severe intoxication can lead to coma. To make a

diagnosis of Cocaine Intoxication, the symptoms must not be due to a general medical condition and are not better accounted for by another mental disorder (Criterion D).

The magnitude and direction of the behavioral and physiological changes depend on many variables, including the dose used and the individual characteristics of the person using the substance (e.g., tolerance, rate of absorption, chronicity of use, context in which it is taken). Stimulant effects such as euphoria, increased pulse and blood pressure, and psychomotor activity are most commonly seen. Depressant effects such as sadness, bradycardia, decreased blood pressure, and decreased psychomotor activity are less common and generally emerge only with chronic high-dose use.

***Specifier***

The following specifier may be applied to a diagnosis of Cocaine Intoxication:

**With Perceptual Disturbances.** This specifier may be noted when hallu­ cinations with intact reality testing or auditory, visual, or tactile illusions occur in the absence of a delirium. *Intact reality testing* means that the person knows that the hallucinations are induced by the substance and do not represent external reality. When hallucinations occur in the absence of intact reality testing, a diagnosis of Substance-Induced Psychotic Disorder, With Hallucinations, should be considered.

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| * **Diagnostic criteria for 292.89 Cocaine Intoxication**   1. Recent use of cocaine.   2. Clinically significant maladaptive behavioral or psychological changes (e.g., euphoria or affective blunting; changes in sociability; hypervigi­ lance; interpersonal sensitivity; anxiety, tension, or anger; stereotyped behaviors; impaired judgment; or impaired social or occupational functioning) that developed during, or shortly after, use of cocaine.   3. Two (or more) of the following, developing during, or shortly after, cocaine use:      1. tachycardia or bradycardia      2. pupillary dilation      3. elevated or lowered blood pressure      4. perspiration or chills      5. nausea or vomiting      6. evidence of weight loss      7. psychomotor agitation or retardation      8. muscular weakness, respiratory depression, chest pain, or cardiac arrhythmias      9. confusion, seizures, dyskinesias, dystonias, or coma   *(continued)* |

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| □ **Diagnostic criteria for 292.89 Cocaine Intoxication**  (*continued)*  D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.  *Specify* if:  **With Perceptual Disturbances** |

292.0 Cocaine Withdrawal

Also refer to the text and criteria for Substance Withdrawal (see p. 184). The essential feature of Cocaine Withdrawal is the presence of a characteristic withdrawal syndrome that develops within a few hours to several days after the cessation of (or reduction in) cocaine use that has been heavy and prolonged (Criteria A and B). The withdrawal syndrome is characterized by the development of dysphoric mood accompanied by two or more of the following physiological changes: fatigue, vivid and unpleasant dreams, insomnia or hypersomnia, increased appetite, and psychomotor retardation or agitation. Anhedonia and drug craving can often be present but are not part of the diagnostic criteria. These symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C). The symptoms must not be due to a general medical condition and are not better accounted for by another mental disorder (Criterion D).

Acute withdrawal symptoms ("a crash") are often seen after periods of repetitive high-dose use ("runs" or "binges"). These periods are characterized by intense and unpleasant feelings of lassitude and depression, generally requiring several days of rest and recuperation. Depressive symptoms with suicidal ideation or behavior can occur and are generally the most serious problems seen during "crashing" or other forms of Cocaine Withdrawal. A substantial number of individuals with Cocaine Dependence have few or no clinically evident withdrawal symptoms on cessation of use.

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| * **Diagnostic criteria for 292.0 Cocaine Withdrawal**   1. Cessation of (or reduction in) cocaine use that has been heavy and prolonged.   2. Dysphoric mood and two (or more) of the following physiological changes, developing within a few hours to several days after Criterion A:      1. fatigue      2. vivid, unpleasant dreams      3. insomnia or hypersomnia   *( continued)* |

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| * **Diagnostic criteria for 292.0 Cocaine Withdrawal** *(continued)*   1. increased appetite   2. psychomotor retardation or agitation   C. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.  D. The symptoms are not clue to a general medical condition and are not better accounted for by another mental disorder. |

**Other Cocaine--Induced Disorders**

The following Cocaine-Induced Disorders are described in other sections of the manual with disorders with which they share phenomenology: **Cocaine Intoxication Delirium** (p. 129), **Cocaine-Induced Psychotic Disorder** (p. 310), **Cocaine-Induced Mood Disorder** (p. 370), **Cocaine-Induced Anxiety Disorder** (p. 439), **Cocaine-Induced Sexual Dysfunction** (p. 519), and **Cocaine-Induced Sleep Disorder** (p. 601). These disorders are diagnosed instead of Cocaine Intoxication or Cocaine Withdrawal only when the symptoms are in excess of those usually associated with the Cocaine Intoxication or Withdrawal syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention.

***Additional Information on Cocaine-Related Disorders***

***Associated Features and Disorders***

**Associated descriptive features and mental disorders.** Cocaine is a short-acting drug that produces rapid and powerful effects on the central nervous system, especially when taken intravenously or smoked as "crack." When injected or smoked, cocaine typically produces an instant feeling of well-being, confidence, and euphoria. Dramatic behavioral changes can rapidly develop, especially in association with dependence. Individuals with Cocaine Dependence have been known to spend thousands of dollars for the substance within very short periods of time, resulting in financial catastrophes in which savings or homes have been lost. Individuals may engage in criminal activities to obtain money for cocaine. Erratic behavior, social isolation, and sexual dysfunction are often seen in the context of long-term Cocaine Dependence. Aggressive behavior can result from the effects of cocaine; violence is also associated with the cocaine "trade." Promiscuous sexual behavior either as a result of increased desire or using sex for the purpose of obtaining cocaine (or for money to purchase cocaine) has become a factor in the spread of sexually transmitted diseases, including human immunodeficiency virus (HIV).

Acute Intoxication with high doses of cocaine may be associated with rambling

speech, headache, transient ideas of reference, and tinnitus. There may also be paranoid ideation, auditory hallucinations in a clear sensorium, and tactile hallucinations ("coke bugs"), which the user usually recognizes as effects of cocaine. Extreme anger with threats or acting out of aggressive behavior may occur. Mood changes such as depression, suicidal ideation, irritability, anhedonia, emotional !ability, or disturbances in attention and concentration are common, especially during Cocaine Withdrawal.

Individuals with Cocaine Dependence often have temporary depressive symptoms that meet symptomatic and duration criteria for Major Depressive Disorder (see Substance-Induced Mood Disorder, p. 370). Histories consistent with repeated Panic Attacks, social phobic-like behavior, and generalized anxiety-like syndromes are not uncommon (see Substance-Induced Anxiety Disorder, p. 439). Eating Disorders may also be associated with this substance. One of the most extreme instances of cocaine toxicity is Cocaine-Induced Psychotic Disorder (see p. 310), a disorder with delusions and hallucinations that resembles Schizophrenia, Paranoid Type. Mental disturbances that occur in association with cocaine use usually resolve within hours to days after cessation of use, although they can persist for weeks.

Individuals with Cocaine Dependence often develop conditioned responses to cocaine-related stimuli (e.g., craving on seeing any white powder-like substance). These responses probably contribute to relapse, are difficult to extinguish, and typically persist long after detoxification is completed. Cocaine Use Disorders are often associated with other Substance Dependence or Abuse, especially involving alcohol, marijuana, and benzodiazepines, which are often taken to reduce the anxiety and other unpleasant stimulant side effects of cocaine. Cocaine Dependence may be associated with Posttrau­ matic Stress Disorder, Antisocial Personality Disorder, Attention-Deficit/Hyperactivity Disorder, and Pathological Gambling.

**Associated laboratory findings.** Most laboratories test for benzoylecgonine, a me­ tabolite of cocaine that typically remains in the urine for 1-3 days after a single dose and may be present for 7-12 days in those using repeated high doses. Mildly elevated liver function tests can be seen in individuals who inject cocaine or use alcohol excessively in association with cocaine. Hepatitis, sexually transmitted diseases including HIV, and tuberculosis may be associated with cocaine use. Pneumonitis or pneumo­ thorax are occasionally observed on chest X ray. Discontinuation of chronic cocaine use is often associated with EEG changes, alterations in secretion patterns of prolactin, and down-regulation of dopamine receptors.

**Associated physical examination findings and general medical conditions.** A wide range of general medical conditions may occur that are specific to the route of administration of cocaine. Persons who use cocaine intranasally ("snort") often develop sinusitis, irritation and bleeding of the nasal mucosa, and a perforated nasal septum. Those who smoke cocaine are at increased risk for respiratory problems (e.g., coughing, bronchitis, and pneumonitis due to irritation and inflammation of the tissues lining the respiratory tract). Persons who inject cocaine have puncture marks and "tracks," most commonly on their forearms, as seen in those with Opioid Dependence. HIV infection is associated with Cocaine Dependence due to the frequent intravenous injections and the increase in promiscuous sexual behavior. Other sexually transmitted diseases, hepatitis, and tuberculosis and other lung infections are also seen. Cocaine Dependence (with any route of administration) is commonly associated with signs of weight loss and malnutrition because of its appetite-suppressing effects. Chest pain may also be a

common symptom. Pneumothorax can result from performing Valsalva-like maneuvers that are done to better absorb cocaine that has been inhaled. Myocardial infarction, sudden death from respiratory or cardiac arrest, and stroke have been associated with cocaine use among young and otherwise healthy persons. These incidents are probably caused by the ability of cocaine to increase blood pressure, cause vasoconstriction, or alter the electrical activity of the heart. Seizures have been observed in association with cocaine use, as have palpitations and arrhythmias. Traumatic injuries due to disputes resulting in violent behavior are common, especially among persons who sell cocaine. Among pregnant females, cocaine use is associated with irregularities in placental blood flow, abruptio placentae, premature labor and delivery, and an increased prevalence of infants with very low birth weights.

***Specific Culture, Age, and Gender Features***

Cocaine use and its attendant disorders affect all race, socioeconomic, age, and gender groups in the United States. Cocaine-Related Disorders are most commonly found in persons between ages 18 and 30 years. Although the current cocaine epidemic started in the 1970s among more affluent individuals, it has shifted to include lower socio­ economic groups living in large metropolitan areas. Rural areas that previously had been spared the problems associated with illicit drug use have also been affected. Unlike most other Substance-Related Disorders, with which males are more commonly affected than females, Cocaine Use Disorders are almost equally distributed between males and females.

***Prevalence***

A community survey conducted in the United States in 1991 reported that 12% of the population had used cocaine one or more times in their lifetime; 3% had used it in the last year; and less than 1% had used it in the last month. Because the survey assessed patterns of use rather than diagnoses, it is not known how many of those who used cocaine had symptoms that met criteria for Dependence or Abuse. A community study conducted in the United States from 1980 to 1985 that used the more narrowly defined DSM-III criteria that only recognized Cocaine Abuse found that about 0.2% of the adult population had Cocaine Abuse at some time in their lives. Among those who had ever had Cocaine Abuse, 17% reported use in the last month and 46% reported having had a problem with cocaine in the last year. These figures predate the increased use of cocaine experienced since the mid-1980s.

***Course***

As with amphetamines, Cocaine Dependence is associated with either of two patterns of self-administration: episodic or daily (or almost daily) use. In the episodic pattern, the cocaine use tends to be separated by 2 or more days of nonuse (e.g., intense use over a weekend or on one or more weekdays). "Binges" are a form of episodic use that typically involve continuous high-dose use over a period of hours or days and are often associated with Dependence. Binges usually terminate only when cocaine supplies are depleted. Chronic daily use may involve high or low doses and may occur throughout the day or be restricted to only a few hours. In chronic daily use, there are generally no

wide fluctuations in dose on successive days, but there is often an increase in dose over time.

Cocaine smoking and intravenous use tend to be particularly associated with a rapid progression from use to abuse or dependence, often occurring over weeks to months. Intranasal use is associated with a more gradual progression, usually occurring over months to years. Dependence is commonly associated with a progressive tolerance to the desirable effects of cocaine leading to increasing doses. With continuing use, there is a diminution of pleasurable effects due to tolerance and an increase in dysphoric effects. Few data are available on the long-term course of Cocaine Use Disorders.

***Differential magnosis***

For a general discussion of the differential diagnosis of Substance-Related Disorders, see

p. 190. Cocaine-Induced Disorders may be characterized by symptoms (e.g., depressed mood) that resemble **primary mental disorders** (e.g., Major Depressive Disorder versus Cocaine-Induced Mood Disorder, With Depressive Features, With Onset During Withdrawal). Seep. 193 for a discussion of this differential diagnosis. The marked mental disturbances that can result from the effects of cocaine should be distinguished from the symptoms of **Schizophrenia, Paranoid Type, Bipolar** and **other Mood Disorders, Generalized Anxiety Disorder,** and **Panic Disorder.**

**Amphetamine Intoxication** and **Phencyclidine Intoxication** may cause a similar clinical picture and can often only be distinguished from Cocaine Intoxication by the presence of cocaine metabolites in a urine specimen or cocaine in plasma. Cocaine Intoxication and Cocaine Withdrawal are distinguished from the other **Cocaine-Induced Disorders** (e.g., Cocaine-Induced Anxiety Disorder, With Onset During Intoxication) because the symptoms in these latter disorders are in excess of those usually associated with Cocaine Intoxication or Cocaine Withdrawal and are severe enough to warrant independent clinical attention.

**292.9 Cocaine-Related Disorder Not Otherwise Specified**

The Cocaine-Related Disorder Not Otherwise Specified category is for disorders associ­ ated with the use of cocaine that are not classifiable as Cocaine Dependence, Cocaine Abuse, Cocaine Intoxication, Cocaine Withdrawal, Cocaine Intoxication Delirium, Cocaine-Induced Psychotic Disorder, Cocaine-Induced Mood Disorder, Cocaine­ Induced Anxiety Disorder, Cocaine-Induced Sexual Dysfunction, or Cocaine-Induced Sleep Disorder.

**Hallucinogen-Related Disorders**

This diverse group of substances includes ergot and related compounds (lysergic acid diethylamide [LSD], morning glory seeds), phenylalkylamines (mescaline, "STP" [2,5- dimethoxy-4-methylamphetaminel, and MDMA [3,4-methylenedioxymethamphetamine; also called "Ecstasy"]), indole alkaloids (psilocybin, DMT [dimethyltryptamine]), and miscellaneous other compounds. Excluded from this group are phencyclidine (PCP)

(p. 255) and cannabis and its active compound, delta-9-tetrahydrocannabinol (THC) (p. 215). Although these substances can have hallucinogenic effects, they are discussed separately because of significant differences in their other psychological and behavioral effects. Hallucinogens are usually taken orally, although DMT is smoked, and use by injection does occur.

This section contains discussions specific to the Hallucinogen-Related Disorders. Texts and criteria sets have already been provided to define the generic aspects of Substance Dependence (p. 176) and Substance Abuse (p. 182) that apply across all substances. Texts specific to Hallucinogen Dependence and Abuse are provided below; however, there are no additional specific criteria sets for Hallucinogen Dependence or Hallucinogen Abuse. A specific text and criteria set for Hallucinogen Intoxication is also provided below. Tolerance develops with repeated use, but a withdrawal from these substances has not been well documented. For this reason, the diagnosis of hallucinogen withdrawal is not included in this manual. The Hallucinogen-Induced Disorders (other than Hallucinogen Intoxication) are described in the sections of the manual with disorders with which they share phenomenology (e.g., Hallucinogen-Induced Mood Disorder is included in the "Mood Disorders" section). Listed below are the Hallucinogen Use Disorders and the Hallucinogen-Induced Disorders.

***Hallucinogen Use Disorders***

**304.50 Hallucinogen Dependence** (see p. 230)

**305.30 Hallucinogen Abuse** (seep. 231)

***Hallucinogen-Induced Disorders***

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| **292.89** | **Hallucinogen Intoxication** (see p. 232) |
| **292.89** | **Hallucinogen Persisting Perception Disorder (Flashbacks)** (see p. 233) |
| **292.81** | **Hallucinogen Intoxication Delirium** (seep. 129) |
| **292.11** | **Hallucinogen-Induced Psychotic Disorder, With Delusions** (see p. 310)  *Specjfy if:* With Onset During Intoxication |
| **292.12** | **Hallucinogen-Induced Psychotic Disorder, With Hallucinations**  (seep. 310) *Specify if:* With Onset During Intoxication |
| **292.84** | **Hallucinogen-Induced Mood Disorder** (see p. 370)  *Specify if:* With Onset During Intoxication |
| **292.89** | **Hallucinogen-Induced Anxiety Disorder** (see p. 439) |
|  | *Specify if* With Onset During Intoxication |
| **292.9** | **Hallucinogen-Related Disorder Not Otherwise Specified** (see p. 236) |

***Hallucinogen Use Disorders***

**304.50 Hallucinogen Dependence**

Also refer to the text and criteria for Substance Dependence (see p. 176). Some of the generic Dependence criteria do not apply to hallucinogens and others require further explanation. Tolerance has been reported to develop rapidly to the euphoric and

psychedelic effects of hallucinogens but not to the autonomic effects such as pupillary dilation, hyperreflexia, increased blood pressure, increased body temperature, piloerec­ tion, and tachycardia. Cross-tolerance exists between LSD and other hallucinogens (e.g., psilocybin and mescaline). Hallucinogen use, even among individuals with presentations that meet full criteria for Dependence, is often limited to only a few times a week. This relatively low frequency of use (as compared with use of other substances) may be related to the desire to suppress the development of tolerance to the psychological effects of the hallucinogens. Withdrawal has not been demonstrated, but clear reports of "craving" after stopping hallucinogens are known. Due to the long half-life and extended duration of action of most hallucinogens, individuals with Hallucinogen Dependence often spend hours to days using and recovering from their effects. In contrast, some hallucinogenic "designer drngs" (e.g., DMT) are quite short acting. Hallucinogens may continue to be used despite the knowledge of adverse effects (e.g., memory impairment while intoxicated; "bad trips," which are usually panic reactions; or flashbacks). Some individuals who use MDMA (a designer drug with hallucinogenic effects) describe a "hangover" the day after use that is characterized by insomnia, fatigue, drowsiness, sore jaw muscles from teeth clenching, loss of balance, and headaches. Because adulterants or substitutes are often sold as "acid" or other hallucinogens, some of the reported adverse effects may be due to substances such as strychnine, phen­ cyclidine, or amphetamine. Some individuals can manifest dangerous behavioral reac­ tions (e.g., jumping out of a window under the belief that one can "fly'') due to lack of insight and judgment while intoxicated. These adverse effects appear to be more common among those who have preexisting mental disorders.

***Specifiers***

The following specifiers may be applied to a diagnosis of Hallucinogen Dependence (see p. 179 for more details):

**Early Full Remission Early Partial Remission Sustained Full Remission**

**Sustained Partial Remission In a Controlled Environment**

**305.30 Hallucinogen Abuse**

Also refer to the text and criteria for Substance Abuse (see p. 182). Persons who abuse hallucinogens use them much less often than do those with Dependence. However, they may repeatedly fail to fulfill major role obligations at school, work, or home due to behavioral impairment caused by Hallucinogen Intoxication. The individual may use hallucinogens in situations in which it is physically hazardous (e.g., while driving a motorcycle or a car), and legal difficulties may arise due to behaviors that result from intoxication or possession of hallucinogens. There may be recurrent social or interper­ sonal problems due to the individual's behavior while intoxicated, isolated lifestyle, or arguments with significant others.

***Hallucinogen-Induced Disorders***

**292.89 Hallucinogen Intoxication**

Also refer to the text and criteria for Substance Intoxication (see p. 183). The essential feature of Hallucinogen Intoxication is the presence of clinically significant maladaptive behavioral or psychological changes (e.g., marked anxiety or depression, ideas of reference, fear of losing one's mind, paranoid ideation, impaired judgment, or impaired social or occupational functioning) that develop during, or shortly after (within minutes to a few hours), hallucinogen use (Criteria A and B). Perceptual changes develop during or shortly after hallucinogen use and occur in a state of full wakefulness and alertness (Criterion C). These changes include subjective intensification of perceptions, deperson­ alization, derealization, illusions, hallucinations, and synesthesias. In addition, the diagnosis requires that two of the following physiological signs are also present: pupillary dilation, tachycardia, sweating, palpitations, blurring of vision, tremors, and incoordina­ tion (Criterion D). The symptoms must not be due to a general medical condition and are not better accounted for by another mental disorder (Criterion E).

Hallucinogen Intoxication usually begins with some stimulant effects such as restlessness and autonomic activation. Nausea may occur. A sequence of experiences then follows, with higher doses producing more intense symptoms. Feelings of euphoria may alternate rapidly with depression or anxiety. Initial visual illusions or enhanced sensory experience may give way to hallucinations. At low doses, the perceptual changes frequently do not include hallucinations. Synesthesias (a blending of senses) may result, for example, in sounds being "seen." The hallucinations are usually visual, often of geometric forms or figures, sometimes of persons and objects. More rarely, auditory or tactile hallucinations are experienced. In most cases, reality testing is preserved (i.e., the individual knows that the effects are substance induced).

* **Diagnostic criteria for 292.89 Hallucinogen Intoxication**
  1. Recent use of a hallucinogen.
  2. Clinically significant maladaptive behavioral or psychological changes (e.g., marked anxiety or depression, ideas of reference, fear of losing one's mind, paranoid ideation, impaired judgment, or impaired social or occupational functioning) that developed during, or shortly after, hallucinogen use.
  3. Perceptual changes occurring in a state of full wakefulness and alertness (e.g., subjective intensification of perceptions, depersonalization, de­ realization, illusions, hallucinations, synesthesias) that developed dur­ ing, or shortly after, hallucinogen use.

*(continued)*

* **Diagnostic criteria for 292.89 Hallucinogen Intoxication**

(*continued)*

D. Two (or more) of the following signs, developing during, or shortly after, hallucinogen use:

* 1. pupillary dilation
  2. tachycardia
  3. sweating
  4. palpitations
  5. blurring of vision
  6. tremors
  7. incoordination

E. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

**292.89 Hallucinogen Persisting Perception Disorder (Flashbacks)**

The essential feature of Hallucinogen Persisting Perception Disorder (Flashbacks) is the transient recurrence of disturbances in perception that are reminiscent of those experi­ enced during one or more earlier Hallucinogen Intoxications. The person must have had no recent Hallucinogen Intoxication and must show no current drug toxicity (Criterion A). This reexperiencing of perceptual symptoms causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion B). The symptoms are not due to a general medical condition (e.g., anatomical lesions and infections of the brain or visual epilepsies) and are not better accounted for by another mental disorder (e.g., delirium, dementia, or Schizophrenia) or by hypno­ pompic hallucinations (Criterion C). The perceptual disturbances may include geometric forms, peripheral-field images, flashes of color, intensified colors, trailing images (images left suspended in the path of a moving object as seen in stroboscopic photography), perceptions of entire objects, afterimages (a same-colored or complementary-colored "shadow" of an object remaining after removal of the object), halos around objects, macropsia, and micropsia. The abnormal perceptions that are associated with Halluci­ nogen Persisting Perception Disorder occur episodically and may be self-induced (e.g., by thinking about them) or triggered by entry into a dark environment, various drugs, anxiety or fatigue, or other stressors. The episodes may abate after several months, but many persons report persisting episodes for 5 years or longer. Reality testing remains intact (i.e., the person recognizes that the perception is a drug effect and does not represent external reality). In contrast, if the person has a delusional interpretation concerning the etiology of the perceptual disturbance, the appropriate diagnosis would be Psychotic Disorder Not Otherwise Specified.

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| * **Diagnostic criteria for 292.89 Hallucinogen Persisting Perception Disorder (Flashbacks)**   1. The reexperiencing, following cessation of use of a hallucinogen, of one or more of the perceptual symptoms that were experienced while intoxicated with the hallucinogen (e.g., geometric hallucinations, false perceptions of movement in the peripheral visual fields, flashes of color, intensified colors, trails of images of moving objects, positive after­ images, halos around objects, macropsia, and micropsia).   2. The symptoms in Criterion A cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.   3. The symptoms are not due to a general medical condition (e.g., anatomical lesions and infections of the brain, visual epilepsies) and are not better accounted for by another mental disorder (e.g., delirium, dementia, Schizophrenia) or hypnopompic hallucinations. |

**Other Hallucinogen--Induced Disorders**

The following Hallucinogen-Induced \_Disorders are described in other sections of the manual with disorders with which they share phenomenology: **Hallucinogen Intoxi­ cation Delirium** (p. 129), **Hallucinogen-Induced Psychotic Disorder** (p. 310), **Hallucinogen-Induced Mood Disorder** (p. 370), and **Hallucinogen-Induced Anxi­ ety Disorder** (p. 439). These disorders are diagnosed instead of Hallucinogen Intoxi­ cation only when the symptoms are in excess of those usually associated with the Hallucinogen Intoxication syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention.

***Additional Information on Hallucinogen-Related Disorders***

***Associated Features and Disorders***

When intoxicated with a hallucinogen, individuals may be voluble and discursive and show rapid alternation of moods. Fearfulness and anxiety may become intense, with dread of insanity or death. Many hallucinogenic substances have stimulant effects (e.g., tachycardia, mild hypertension, hyperthermia, and pupillary dilation) and may cause some of the features of Amphetamine Intoxication. The perceptual disturbances and impaired judgment associated with Hallucinogen Intoxication may result in injuries or fatalities from automobile accidents, physical fights, or attempts to "fly" from high places. Environmental factors and the personality and expectations of the individual using the hallucinogen may contribute to the nature and severity of Hallucinogen Intoxication.

Hallucinogen Persisting Perception Disorder may produce considerable anxiety and concern and may be more common in suggestible persons. Hallucinogen Dependence and Abuse may co-occur with chronic psychotic conditions. It remains controversial whether the chronic hallucinogen use produces a Psychotic Disorder de nova, triggers psychotic symptoms only in vulnerable persons, or is simply an early and continuing sign of an evolving psychotic process. Hallucinogen Abuse and Dependence also frequently occur in persons with preexisting adolescent Conduct Disorder or adult Antisocial Personality Disorder. LSD intoxication may be confirmed by urine toxicology.

***Specific Culture, Age, and Gender Features***

Hallucinogens may be used as part of established religious practices. Within the United States, there are regional differences in their use. Hallucinogen Intoxication usually first occurs in adolescence, and younger users may tend to experience more disruptive emotions. Hallucinogen use and Intoxication appear to be three times more common among males than among females.

***Prevalence***

A community survey conducted in the United States in 1991 reported that 8% of the population had used hallucinogens or phencyclidine (PCP) at least one or more times in their lifetime. The cohort with the highest lifetime use was persons ages 26-34 years, among whom 26% had ever tried hallucinogens. However, recent use was most common among those ages 18-25 years, with 2% of this group having used hallucinogens within the last month. A community study conducted in the United States from 1980 to 1985 that used the more narrowly defined DSM-III criteria found that about 0.3% of the adult population had Hallucinogen Abuse at some time in their lives.

***Course***

Hallucinogen Intoxication may be a brief and isolated event or may occur repeatedly. The intoxication may be prolonged if doses are frequently repeated during an episode. Frequent dosing, however, tends to reduce the intoxicating effects because of the development of tolerance. Depending on the drug and its route of administration, peak effects occur within a few minutes to a few hours, and intoxication ends within a few hours to a few days after dosing ends. The high prevalence of "ever having used" hallucinogens among those ages 26-34 years and the lower prevalence of recent use in that group suggest that many individuals may stop using hallucinogens as they get older. Some individuals who use hallucinogen report "flashbacks" that are not associated with any impairment or distress. On the other hand, flashbacks can cause impairment or distress in some individuals (Hallucinogen Persisting Perception Disorder; see above).

***m.[ferential magnosis***

For a general discussion of the differential diagnosis of Substance-Related Disorders, see

p. 190. Hallucinogen-Induced Disorders may be characterized by symptoms (e.g.,

delusions) that resemble **primary mental disorders** (e.g., Schizophreniform Disorder versus Hallucinogen-Induced Psychotic Disorder, With Delusions, With Onset During Intoxication). Seep. 193 for a discussion of this differential diagnosis.

Hallucinogen Intoxication should be differentiated from **Am.phetamine or Phen­ cyclidine Intoxication.** Toxicological tests are useful in making this distinction. **Intoxication withanticholinergics** can also produce hallucinations, but they are often associated with physical findings of fever, dry mouth and skin, flushed face, and visual disturbances. Hallucinogen Intoxication is distinguished from the **other Hallucinogen­ Induced Disorders** (e.g., Hallucinogen-Induced Anxiety Disorder, With Onset During Intoxication) because the symptoms in these latter disorders are in excess of those usually associated with Hallucinogen Intoxication and are severe enough to warrant indepen­ dent clinical attention.

Hallucinogen Intoxication is distinguished from **Hallucinogen Persisting Percep­ tion Disorder (Flashbacks)** by the fact that the latter continues episodically for weeks (or longer) after the most recent intoxication. In Hallucinogen Persisting Perception Disorder, the individual does not believe that the perception represents external reality, whereas a person with a **Psychotic Disorder** often believes that the perception is real. Hallucinogen Persisting Perception Disorder may be distinguished from **migraine, epilepsy,** or a **neurological condition** by neuro-ophthalmological history, physical examination, and appropriate laboratory evaluation.

**292.9 Hallucinogen-Related Disorder Not Otherwise Specified**

The Hallucinogen-Related Disorder Not Otherwise Specified category is for disorders associated with the use of hallucinogens that are not classifiable as Hallucinogen Dependence, Hallucinogen Abuse, Hallucinogen Intoxication, Hallucinogen Persisting Perception Disorder, Hallucinogen Intoxication Delirium, Hallucinogen-Induced Psy­ chotic Disorder, Hallucinogen-Induced Mood Disorder, or Hallucinogen-Induced Anxi­ ety Disorder.

**Inhalant -Related Disorders**

This section includes disorders induced by inhaling the aliphatic and aromatic hydro­ carbons found in substances such as gasoline, glue, paint thinners, and spray paints. Less commonly used are halogenated hydrocarbons (found in cleaners, typewriter correction fluid, spray-can propellants) and other volatile compounds containing esters, ketones, and glycols. Most compounds that are inhaled are a mixture of several substances that can produce psychoactive effects, and it is often difficult to ascertain the exact substance responsible for the disorder. Unless there is clear evidence that a single, unmixed substance has been used, the general term *inhalant* should be used in recording the diagnosis. These volatile substances are available in a wide variety of commercial products and may be used interchangeably, depending on availability and personal preference. Although there may be subtle differences in the psychoactive and physical effects of the different compounds, not enough is known about their differential

effects to distinguish among them. All are capable of producing Dependence, Abuse, and Intoxication.

Several methods are used to inhale intoxicating vapors. Most commonly, a rag soaked with the substance is applied to the mouth and nose, and the vapors are breathed in. The substance may also be placed in a paper or plastic bag and the gases in the bag inhaled. Substances may also be inhaled directly from containers or from aerosols sprayed in the mouth or nose. There are reports of individuals heating these compounds to accelerate vaporization. The inhalants reach the lungs, bloodstream, and target sites very rapidly.

This section contains discussions specific to the Inhalant-Related Disorders. Texts and criteria sets have already been provided for generic aspects of Substance Depen­ dence (p. 176) and Substance Abuse (p. 182) that apply across all substances. Texts specific to Inhalant Dependence and Abuse are provided below; however, there are no additional specific criteria sets for Inhalant Dependence or Inhalant Abuse. A specific text and criteria set for Inhalant Intoxication is also provided below. Tolerance has been reported among individuals with heavy use, but a withdrawal syndrome from these substances has not been well documented. For this reason, the diagnosis of inhalant withdrawal is not included in this manual. The Inhalant-Induced Disorders (other than Inhalant Intoxication) are described in the sections of the manual with disorders with which they share phenomenology (e.g., Inhalant-Induced Mood Disorder is included in the "Mood Disorders" section). Listed below are the Inhalant Use Disorders and the Inhalant-Induced Disorders. Reflecting their different modes of action and profiles of associated problems, disorders resulting from the use of anesthetic gases (e.g., nitrous oxide, ether) and short-acting vasodilators (e.g., amyl or butyl nitrite) are excluded from the category of Inhalant-Related Disorders and should be classified under Other Substance-Related Disorders.

***Inhalant Use Di,sorders***

**304.60**

**305.90**

**Inhalant Dependence** (see p. 238)

**Inhalant Abuse** (see p. 238)

***Inhalant-Induced msorders***

**292.89**

**292.81**

**292.82**

**292.11**

**292.12**

**292.84**

**292.89**

**292.9**

**Inhalantlntoxication** (seep. 239)

**Inhalant Intoxication Delirium** (seep. 129)

**Inhalant-Induced Persisting Dementia** (see p. 152)

**Inhalant-Induced Psychotic Disorder, With Delusions** (seep. 310)

*Specify if* With Onset During Intoxication

**Inhalant-Induced Psychotic Disorder, With Hallucinations** (see p. 310)

*Specify if* With Onset During Intoxication **Inhalant-Induced Mood Disorder** (see p. 370) *Specify if* With Onset During Intoxication **Inhalant-Induced Anxiety Disorder** (see p. 439) *Spec(fy if* With Onset During Intoxication

**Inhalant-Related Disorder Not Otherwise Specified** (see p. 242)

***Inhalant Use Disorders***

**304.60 Inhalant Dependence**

Also refer to the text and criteria for Substance Dependence (see p. 176). Some of the generic Dependence criteria do not apply to inhalants, whereas others require further explanation. Tolerance to the effects of inhalants has been reported among individuals with heavy use, although its prevalence and clinical significance are unknown. A possible withdrawal syndrome beginning 24-48 hours after cessation of use and lasting from 2 to 5 days has been described, with symptoms including sleep disturbances, tremor, irritability, diaphoresis, nausea, and fleeting illusions. However, this syndrome has not been well documented and appears not to be clinically significant. Thus, Inhalant Dependence includes neither a characteristic withdrawal syndrome nor evidence of inhalant use to relieve or avoid withdrawal symptoms. However, inhalants may be taken over longer periods of time or in larger amounts than was originally intended, and individuals who use them may find it difficult to cut down or regulate inhalant use. Because inhalants are inexpensive, legal, and easily available, spending a great deal of time attempting to procure inhalants would be rare. However, substantial amounts of time may be spent on using and recuperating from the effects of inhalant use. Recurrent inhalant use may result in the individual giving up or reducing important social, occupational, or recreational activities, and substance use may continue despite the individual's knowledge of physical problems (e.g., liver disease or central and peripheral nervous system damage) or psychological problems (e.g., severe depression) caused by the use.

***Specifiers***

The following specifiers may be applied to a diagnosis of Inhalant Dependence (see

p. 179 for more details):

**Early Full Remission Early Partial Remission Sustained Full Remission**

**Sustained Partial Remission In a Controlled Environment**

**305.90 Inhalant Abuse**

Also refer to the text and criteria for Substance Abuse (see p. 182). Individuals who abuse inhalants may use them in hazardous circumstances (e.g., driving an automobile or operating machinery when judgment and coordination are impaired by Inhalant Intoxication). Repeated intake of inhalants may be associated with family conflict and school problems (e.g., truancy, poor grades, dropping out of school).

***Inhalant-Induced Disorders***

**292.89 Inhalant Intoxication**

Also refer to the text and criteria for Substance Intoxication (see p. 183). The essential feature of Inhalant Intoxication is the presence of clinically significant maladaptive behavioral or psychological changes (e.g., belligerence, assaultiveness, apathy, impaired judgment, impaired social or occupational functioning) that develop during, or shortly after, the intentional use of, or short-term, high-dose exposure to, volatile inhalants (Criteria A and B). The maladaptive changes are accompanied by signs that include dizziness or visual disturbances (blurred vision or diplopia), nystagmus, incoordination, slurred speech, an unsteady gait, tremor, and euphoria. Higher doses of inhalants may lead to the development of lethargy and psychomotor retardation, generalized muscle weakness, depressed reflexes, stupor, or coma (Criterion C). The disturbance must not be due to a general medical condition and is not better accounted for by another mental disorder (Criterion D).

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| * **Diagnostic criteria for 292.89 Inhalant Intoxication**   1. Recent intentional use or short-term, high-dose exposure to volatile inhalants (excluding anesthetic gases and short-acting vasodilators).   2. Clinically significant maladaptive behavioral or psychological changes (e.g., belligerence, assaultiveness, apathy, impaired judgment, impaired social or occupational functioning) that developed during, or shortly after, use of or exposure to volatile inhalants.   3. Two (or more) of the following signs, developing during, or shortly after, inhalant use or exposure:      1. dizziness      2. nystagmus      3. incoordination      4. slurred speech      5. unsteady gait      6. lethargy      7. depressed reflexes      8. psychomotor retardation      9. tremor      10. generalized muscle weakness      11. blurred vision or diplopia      12. stupor or coma   03) euphoria  D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder. |

**Other Inhalant--Induced Disorders**

The following Inhalant-Induced Disorders are described in other sections of the manual with disorders with which they share phenomenology: **Inhalant Intoxication Delir­ ium** (p. 129), **Inhalant-Induced Persisting Dementia** (p. 152), **Inhalant-Induced Psychotic Disorder** (p. 310), **Inhalant-Induced Mood Disorder** (p. 370), and **Inhalant-Induced Anxiety Disorder** (p. 439). These disorders are diagnosed instead of Inhalant Intoxication only when the symptoms are in excess of those usually associated with Inhalant Intoxication and when the symptoms are sufficiently severe to warrant independent clinical attention.

***Additional Information on Inhalant-Related Disorders***

***Associated Features and Disorders***

**Associated descriptive features and mental disorders.** Individuals with Inhalant Intoxication may present with auditory, visual, or tactile hallucinations or other percep­ tual disturbances (macropsia, micropsia, illusionary misperceptions, alterations in time perception). Delusions (such as believing one can fly) may develop during periods of Inhalant Intoxication, especially those characterized by marked confusion; in some cases, these delusions may be acted on with resultant injury. Anxiety may also be present. Repeated but episodic intake of inhalants may first be associated with school problems (e.g., truancy, poor grades, dropping out of school) as well as family conflict. Use by older adolescents and young adults is often associated with social and work problems (e.g., delinquency, unemployment). Most commonly, inhalants are used by adolescents in a group setting. Solitary use tends to be more typical of those with long-term, heavy use. The use of inhalants as the predominant substance among those seeking help for Substance Dependence appears to be rare, but inhalants may be a secondary drug used by individuals with Dependence on other substances. In some individuals, there may be a progression to a stage at which inhalants become the preferred substance.

**Associated laboratory findings.** Direct assay for inhalants is rarely used clinically and is generally not part of routine screening for drugs of abuse. Damage to muscles, kidneys, liver, and other organs can result in laboratory tests being indicative of these pathological conditions.

**Associated physical examination findings and general medical conditions.** The odor of paint or solvents may be present on the breath or clothes of individuals who use inhalants, or there may be a residue of the substance on clothing or skin. A "glue sniffer's rash" may be evident around the nose and mouth, and conjunctiva! irritation may be noted. There may be evidence of trauma due to disinhibited behavior or burns due to the flammable nature of these compounds. Nonspecific respiratory findings include evidence of upper- or lower-airway irritation, including coughing, sinus discharge, dyspnea, rales, or rhonchi; rarely, cyanosis may result from pneumonitis or asphyxia. There may also be headache, generalized weakness, abdominal pain, nausea, and vomiting. Inhalants can cause both central and peripheral nervous system damage,

which may be permanent. Examination of the individual who chronically uses inhalants may reveal a number of neurological deficits, including generalized weakness and peripheral neuropathies. Cerebral atrophy, cerebellar degeneration, and white matter lesions resulting in cranial nerve or pyramidal tract signs have been reported among individuals with heavy use. Recurrent use may lead to the development of hepatitis (which may progress to cirrhosis) or metabolic acidosis consistent with distal renal tubular acidosis. Chronic renal failure, hepatorenal syndrome, and proximal renal tubular acidosis have also been reported, as has bone marrow suppression. Some inhalants (e.g., methylene chloride) may be metabolized to carbon monoxide. Death may occur from respiratory or cardiovascular depression; in particular, "sudden sniffing death" may result from acute arrhythmia, hypoxia, or electrolyte abnormalities.

***Specific Culture, Age, and Gender Features***

Because of their low cost and easy availability, inhalants are often the first drugs of experimentation for young people, and there may be a higher incidence among those living in economically depressed areas. Inhalant use may begin by ages 9-12 years, appears to peak in adolescence, and is less common after age 35 years. Males account for 70%-80% of inhalant-related emergency-room visits.

***Prevalence***

Inhalant Dependence and Abuse appear to occur in only a small proportion of individuals who use inhalants.

***Course***

It can be difficult to match inhalant dose to effect because the different methods of administration and the varying concentrations of inhalants in the products used cause highly variable concentrations in the body. The time course of Inhalant Intoxication is related to the pharmacological characteristics of the specific substance used, but it is typically brief, lasting from a few minutes to an hour. Onset is rapid, peaking within a few minutes after inhaling. Younger children diagnosed as having Inhalant Dependence may use inhalants several times a week, often on weekends and after school. Severe dependence in adults may involve varying periods of intoxication throughout each day and occasional periods of heavier use that may last several days. This pattern may persist for years, with recurrent need for treatment. Individuals who use inhalants may have a preferred level or degree of intoxication, and the method of administration (typically sniffing from a container or breathing through a rag soaked in the substance) may allow the individual to maintain that level for several hours. Cases have also been reported of the development of Dependence in industrial workers who have long-term occupational exposure and access to inhalants. A worker may begin to use the compound for its psychoactive effects and subsequently develop a pattern of Dependence. Use leading to Dependence may also occur in people who do not have access to other substances (e.g., prisoners, isolated military personnel, and adolescents or young adults in isolated rural areas).

***Dif.ferential Diagnosis***

For a general discussion of the differential diagnosis of Substance-Related Disorders, see

p. 190. Inhalant-Induced Disorders may be characterized by symptoms (e.g., depressed mood) that resemble **primary mental disorders** (e.g., Major Depressive Disorder versus Inhalant-Induced Mood Disorder, With Depressive Features, With Onset During Intoxication). Seep. 193 for a discussion of this differential diagnosis.

The symptoms of mild to moderate Inhalant Intoxication can be similar to those of **Alcohol Intoxication** and **Sedative, Hypnotic, or Anxiolytic Intoxication.** Breath odor or residues on body or clothing may be important differentiating clues, but should not be relied on exclusively. Individuals who chronically use inhalants are likely to use other substances frequently and heavily, further complicating the diagnostic picture. Concomitant use of alcohol may also make the differentiation difficult. History of the drug used and characteristic findings (including odor of solvent or paint residue) may differentiate Inhalant Intoxication from other substance intoxications; additionally, symptoms may subside faster with Inhalant Intoxication than with other substance intoxications. Rapid onset and resolution may also differentiate Inhalant Intoxication from other mental disorders and neurological conditions. Inhalant Intoxication is distinguished from the **other Inhalant-Induced Disorders** (e.g., Inhalant-Induced Mood Disorder, With Onset During Intoxication) because the symptoms in these latter disorders are in excess of those usually associated with Inhalant Intoxication and are severe enough to warrant independent clinical attention.

Industrial workers may occasionally be **accidentally exposed to volatile chemi­ cals** and suffer physiological intoxication. The category "Other Substance-Related Disorders" should be used for such toxin exposures.

**292.9 Inhalant--Related Disorder Not Otherwise Specified**

The Inhalant-Related Disorder Not Otherwise Specified category is for disorders associ­ ated with the use of inhalants that are not classifiable as Inhalant Dependence, Inhalant Abuse, Inhalant Intoxication, Inhalant Intoxication Delirium, Inhalant-Induced Persisting Dementia, Inhalant-Induced Psychotic Disorder, Inhalant-Induced Mood Disorder, or Inhalant-Induced Anxiety Disorder.

**Nicotine-Related Disorders**

Nicotine Dependence and Withdrawal can develop with use of all forms of tobacco (cigarettes, chewing tobacco, snuff, pipes, and cigars) and with prescription medications (nicotine gum and patch). The relative ability of these products to produce Dependence or to induce Withdrawal is associated with the rapidity characteristic of the route of administration (smoked over oral over transdermal) and the nicotine content of the product.

This section contains discussions specific to the Nicotine-Related Disorders. Texts and criteria sets have already been provided to define the generic aspects of Substance Dependence (p. 176) that apply across all substances. Text specific to Nicotine Dependence is provided below. Nicotine intoxication and nicotine abuse are not

included in DSM-IV; nicotine intoxication rarely occurs and has not been well studied, and nicotine abuse is not likely to be observed in the absence of Dependence. A specific text and criteria set for Nicotine Withdrawal is also provided below. Listed below are the Nicotine-Related Disorders.

***Nicotine Use Disorder***

**305.10 Nicotine Dependence** (seep. 243)

***Nicotine-Induced Disorder***

**292.0**

**292.9**

**Nicotine Withdrawal** (see p. 244)

**Nicotine-Related Disorder Not Otherwise Specified** (see p. 247)

***Nicotine Use Disorder***

**305.IO Nicotine Dependence**

Also refer to the text and criteria for Substance Dependence (see p. 176). Some of the generic Dependence criteria do not appear to apply to nicotine, whereas others require further explanation. Tolerance to nicotine is manifested by the absence of nausea, dizziness, and other characteristic symptoms despite using substantial amounts of nicotine or a diminished effect observed with continued use of the same amount of nicotine-containing products. Cessation of nicotine use produces a well-defined with­ drawal syndrome that is described below. Many individuals who use nicotine take nicotine to relieve or to avoid withdrawal symptoms when they wake up in the morning or after being in a situation where use is restricted (e.g., at work or on an airplane). Individuals who smoke and other individuals who use nicotine are likely to find that they use up their supply of cigarettes or other nicotine-containing products faster than originally intended. Although over 80% of individuals who smoke express a desire to stop smoking and 35% try to stop each year, less than 5% are successful in unaided attempts to quit. Spending a great deal of time in using the substance is best exemplified by chain-smoking. Because nicotine sources are readily and legally available, spending a great deal of time attempting to procure nicotine would be rare. Giving up important social, occupational, or recreational activities can occur when an individual forgoes an activity because it occurs in smoking-restricted areas. Continued use despite knowledge of medical problems related to smoking is a particularly important health problem (e.g., an individual who continues to smoke despite having a tobacco-induced general medical condition such as bronchitis or chronic obstructive lung disease).

***Specifiers***

The following specifiers may be applied to a diagnosis of Nicotine Dependence (see

p. 179 for more details):

**With Physiological Dependence Without Physiological Dependence**

**Early Full Remission Early Partial Remission Sustained Full Remission**

**Sustained Partial Remission On Agonist Therapy**

***Nicotine-Induced Disorder***

292.0 Nicotine Withdrawal

Also refer to the text and criteria for Substance Withdrawal (see p. 184). The essential feature of Nicotine Withdrawal is the presence of a characteristic withdrawal syndrome that develops after the abrupt cessation of, or reduction in, the use of nicotine-containing products following a prolonged period (at least several weeks) of daily use (Criteria A and B). The withdrawal syndrome includes four or more of the following: dysphoric or depressed mood; insomnia; irritability, frustration, or anger; anxiety; difficulty concen­ trating; restlessness or impatience; decreased heart rate; and increased appetite or weight gain. The withdrawal symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C). The symptoms must not be due to a general medical condition and are not better accounted for by another mental disorder (Criterion D).

These symptoms are in large part due to nicotine deprivation and are typically more intense among individuals who smoke cigarettes than among individuals who use other nicotine-containing products. The more rapid onset of nicotine effects with cigarette smoking leads to a more intensive habit pattern that is more difficult to give up because of the frequency and rapidity of reinforcement and the greater physical dependence on nicotine. In individuals who smoke cigarettes, heart rate decreases by 5 to 12 beats per minute in the first few days after stopping smoking, and weight increases an average of 2-3 kg over the first year after stopping smoking. Mild symptoms of withdrawal may occur after switching to low-tar/nicotine cigarettes and after stopping the use of smokeless (chewing) tobacco, nicotine gum, or nicotine patches.

* **Diagnostic criteria for 292.0 Nicotine Withdrawal**

A Daily use of nicotine for at least several weeks.

B. Abrupt cessation of nicotine use, or reduction in the amount of nicotine used, followed within 24 hours by four (or more) of the following signs:

1. dysphoric or depressed mood
2. insomnia
3. irritability, frustration, or anger
4. anxiety
5. difficulty concentrating

*(continued)*

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| * **Diagnostic criteria for 292.0 Nicotine Withdrawal** *(continued)*   1. restlessness   2. decreased heart rate   3. increased appetite or weight gain   C. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.  D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder. |

***Additional Information on Nicotine-Related Disorders***

***Associated Features and Di-Sorders***

**Associated descriptive features and mental disorders.** Craving is an important element in Nicotine Withdrawal and may account for the difficulty that individuals have in giving up nicotine-containing products. Other symptoms associated with Nicotine Withdrawal include a desire for sweets and impaired performance on tasks requiring vigilance. Several features associated with Nicotine Dependence appear to predict a greater level of difficulty in stopping nicotine use: smoking soon after waking, smoking when ill, difficulty refraining from smoking, reporting the first cigarette of the day to be the one most difficult to give up, and smoking more in the morning than in the afternoon. The number of cigarettes smoked per day, the nicotine yield of the cigarette, and the number of pack-years also are related to the likelihood of an individual stopping smoking. Nicotine Dependence is more common among individuals with other mental disorders. Depending on the population studied, from 55% to 90% of individuals with other mental disorders smoke, compared to 30% in the general population. Mood, Anxiety, and other Substance-Related Disorders may be more common in individuals who smoke than in those who are ex-smokers and those who have never smoked.

**Associated laboratory findings.** Withdrawal symptoms are associated with a slow­ ing on EEG, decreases in catecholamine and cortisol levels, rapid eye movement (REM) changes, impairment on neuropsychological testing, and decreased metabolic rate. Smoking increases the metabolism of many medications prescribed for the treatment of mental disorders and of other substances. Thus, cessation of smoking can increase the blood levels of these medications and other substances, sometimes to a clinically significant degree. This effect does not appear to be due to nicotine but rather to other compounds in tobacco. Nicotine and its metabolite cotinine can be measured in blood, saliva, or urine. Persons who smoke also often have diminished pulmonary function tests and increased mean corpuscular volume (MCV).

**Associated physical examination findings andgeneral medical conditions.** Nicotine Withdrawal may be associated with a dry or productive cough, decreased heart rate, increased appetite or weight gain, and a dampened orthostatic response. The most common signs of Nicotine Dependence are tobacco odor, cough, evidence of chronic obstructive pulmonary disease, and excessive skin wrinkling. Tobacco stains on the fingers can occur but are rare. Tobacco use can markedly increase the risk of lung, oral, and other cancers; cardiovascular and cerebrovascular conditions; chronic obstructive and other lung diseases; ulcers; maternal and fetal complications; and other conditions. Although most of these problems appear to be caused by the carcinogens and carbon monoxide in tobacco smoke rather than by nicotine itself, nicotine may increase the risk for cardiovascular events. Those who have never smoked but are chronically exposed to tobacco smoke appear to be at increased risk for conditions such as lung cancer and heart disease.

***Specific Culture, Age, and Gender Features***

The prevalence of smoking is decreasing in most industrialized nations, but is increasing in the developing areas. In the United States, the prevalence of smoking is slightly higher in males than in females; however, the prevalence of smoking is decreasing more rapidly in males than in females. In other countries, smoking is often much more prevalent among males.

***Prevalence***

In the United States, approximately 45% of the general population have never smoked. The remainder fall into one or more of the following categories: 25% are ex-smokers, 30% currently smoke cigarettes, 4% use pipes or cigars, and 3% use smokeless tobacco. In the United States, the prevalence of smoking has been decreasing approximately 0.7%-1.0% per year. The lifetime prevalence of Nicotine Dependence in the general population is estimated to be 20%. In the United States, between 50% and 80% of individuals who currently smoke have Nicotine Dependence. Lifetime prevalence of Nicotine Withdrawal among persons who smoke appears to be about 50%. Prospectively, it is estimated that about 50% of those who quit smoking on their own and about 75% of those in treatment programs experience Nicotine Withdrawal when they stop smoking.

***Course***

Smoking usually begins in the early teens. How quickly dependence develops is unclear. Among those who continue to smoke through age 20 years, 95% become regular, daily smokers. Of those who successfully quit, less than 25% quit on their first attempt. Most individuals who smoke have 3-4 failures before they stop smoking for good. In the United States, about 45% of those who have ever smoked eventually stop smoking. Withdrawal symptoms can begin within a few hours of cessation, typically peak in 1-4 days, and last for 3-4 weeks. Depressive symptoms postcessation may be associated with a relapse to smoking. Whether other Nicotine Withdrawal symptoms play a major role in relapse to smoking is debatable. Increased hunger and weight gain often persist for at least 6 months. Six months postcessation, 50% of individuals who have quit smoking report having had a desire for a cigarette in the last 24 hours.

***Familial Pattern***

The risk for smoking increases threefold if a first-degree biological relative smokes. Twin and adoption studies indicate that genetic factors contribute to the onset and continuation of smoking, with the degree of heritability equivalent to that observed with Alcohol Dependence.

***Differential Diagnosis***

For a general discussion of the differential diagnosis of Substance-Related Disorders, see

p. 190.

The symptoms of Nicotine Withdrawal overlap with those of **other substance withdrawal syndromes; Caffeine Intoxication; Anxiety, Mood,** and **Sleep Disor­ ders; and medication-inducedakathisia.** Admission to smoke-free inpatient units can induce withdrawal symptoms that might mimic, intensify, or disguise other diagnoses. Reduction of symptoms associated with the resumption of smoking or nicotine­ replacement therapy confirms the diagnosis.

Because regular nicotine use does not appear to impair mental functioning, Nicotine Dependence is not readily confused with other Substance-Related Disorders and mental disorders.

**292.9 Nicotine--Related Disorder Not Otherwise Specified**

The Nicotine-Related Disorder Not Otherwise Specified category is for disorders associated with the use of nicotine that are not classifiable as Nicotine Dependence or Nicotine Withdrawal.

**Opioid-Related Disorders**

The opioids include natural opioids (e.g., morphine), semisynthetics (e.g., heroin), and synthetics with morphine-like action (e.g., codeine, hydromorphone, methadone, oxycodone, meperidine, fentanyl). Medications such as pentazocine and buprenorphine that have both opiate agonist and antagonist effects are also included in this class because their agonist properties produce similar physiological and behavioral effects. Opioids are prescribed as analgesics, anesthetics, antidiarrheal agents, or cough suppressants. Heroin is one of the most commonly abused drugs of this class and is usually taken by injection, although it can be smoked or "snorted" when very pure heroin is available. Fentanyl is injected, whereas cough suppressants and antidiarrheal agents are taken orally. The other opioids are taken both by injection and orally.

This section contains discussions specific to the Opioid-Related Disorders. Texts and criteria sets have already been provided for the generic aspects of Substance Dependence (p. 176) and Substance Abuse (p. 182) that apply across all substances. Texts specific to Opioid Dependence and Abuse are provided below; however, there are no additional specific criteria sets for Opioid Dependence or Opioid Abuse. Specific text and criteria

sets for Opioid Intoxication and Opioid Withdrawal are also provided below. The Opioid-Induced Disorders (other than Opioid Intoxication and Withdrawal) are de­ scribed in the sections of the manual with disorders with which they share phenome­ nology (e.g., Opioid-Induced Mood Disorder is included in the "Mood Disorders" section). Listed below are the Opioid Use Disorders and the Opioid-Induced Disorders.

***Opioid Use Disorders***

**304.00 Opioid Dependence** (see p. 248)

**305.50 Opioid Abuse** (see p. 249)

***Opioid-Induced msorders***

|  |  |
| --- | --- |
| **292.89** | **Opioid Intoxication** (see p. 249) *Specify if* With Perceptual Disturbances |
| **292.0** | **Opioid Withdrawal** (see p. 250) |
| **292.81** | **Opioid Intoxication Delirium** (seep. 129) |
| **292.11** | **Opioid-Induced Psychotic Disorder, With Delusions** (seep. 310)  *Specify if* With Onset During Intoxication |
| **292.12** | **Opioid-Induced Psychotic Disorder, With Hallucinations** (seep. 310)  *Specify if* With Onset During Intoxication |
| **292.84** | **Opioid-Induced Mood Disorder** (see p. 370)  *Specify if* With Onset During Intoxication |
| **292.89** | **Opioid-Induced Sexual Dysfunction** (see p. 519)  *Specify if* With Onset During Intoxication |
| **292.89** | **Opioid-Induced Sleep Disorder** (seep. 601)  *Specify if* With Onset During Intoxication/With Onset During Withdrawal |
| **292.9** | **Opioid-Related Disorder Not Otherwise Specified** (see p. 255) |

***Opioid Use Disorders***

**304.00 Opioid Dependence**

Also refer to the text and criteria for Substance Dependence (seep. 176). Most individuals with Opioid Dependence have significant levels of tolerance and will experience withdrawal on abrupt discontinuation of opioid substances. Opioid Dependence includes signs and symptoms that reflect compulsive, prolonged self-administration of opioid substances that are used for no legitimate medical purpose or, if a general medical condition is present that requires opioid treatment, that are used in doses that are greatly in excess of the amount needed for pain relief. Persons with Opioid Dependence tend to develop such regular patterns of compulsive dmg use that daily activities are typically planned around obtaining and administering opioids. Opioids are usually purchased on the illegal market, but may also be obtained from physicians by faking or exaggerating general medical problems or by receiving simultaneous prescriptions from several physicians. Health care professionals with Opioid Dependence will often obtain opioids by writing prescriptions for themselves or by diverting opioids that have been prescribed for patients or from pharmacy supplies.

***Specifiers***

The following specifiers may be applied to a diagnosis of Opioid Dependence (see

p. 179 for more details):

**With Physiological Dependence Without Physiological Dependence**

**Early Full Remission Early Partial Remission Sustained Full Remission**

**Sustained Partial Remission On Agonist Therapy**

**In a Controlled Environment**

**305.50 Opioid Abuse**

Also refer to the text and criteria for Substance Abuse (seep. 182). Legal difficulties may arise as a result of behavior while intoxicated with opioids or because an individual has resorted to illegal sources of supply. Persons who abuse opioids typically use these substances much less often than do those with dependence and do not develop significant tolerance or withdrawal. When problems related to opioid use are accompa­ nied by evidence of tolerance, withdrawal, or compulsive behavior related to the use of opioids, a diagnosis of Opioid Dependence, rather than Opioid Abuse, should be considered.

***Opioid-Induced Disorders***

**292.89 Opioid Intoxication**

Also refer to the text and criteria for Substance Intoxication (see p. 183). The essential feature of Opioid Intoxication is the presence of clinically significant maladaptive behavioral or psychological changes (e.g., initial euphoria followed by apathy, dys­ phoria, psychomotor agitation or retardation, impaired judgment, or impaired social or occupational functioning) that develop during, or shortly after, opioid use (Criteria A and B). Intoxication is accompanied by pupillary constriction (unless there has been a severe overdose with consequent anoxia and pupillary dilation) and one or more of the following signs: drowsiness (described as being "on the nod") or even coma, slurred speech, and impairment in attention or memory (Criterion C). Individuals with Opioid Intoxication may demonstrate inattention to the environment, even to the point of ignoring potentially harmful events. The symptoms must not be due to a general medical condition and are not better accounted for by another mental disorder (Criterion D).

The magnitude of the behavioral and physiological changes that result from opioid use depends on the dose as well as characteristics of the individual using the substance (e.g., tolerance, rate of absorption, chronicity of use). Symptoms of Opioid Intoxication usually last for several hours, a time frame that is consistent with the half-life of most opioid drugs. Severe intoxication following an opioid overdose can lead to coma, respiratory depression, pupillary dilation, unconsciousness, and even death.

***Specifier***

The following specifier may be applied to a diagnosis of Opioid Intoxication:

**With Perceptual Disturbances.** This specifier may be noted when hallucina­ tions with intact reality testing or auditory, visual, or tactile illusions occur in the absence of a delirium. *Intact reality testing* means that the person knows that the hallucinations are induced by the substance and do not represent external reality. When hallucinations occur in the absence of intact reality testing, a diagnosis of Substance-Induced Psychotic Disorder, With Hallucinations, should be considered.

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| * **Diagnostic criteria for 292.89 Opioid Intoxication**   1. Recent use of an opioid.   2. Clinically significant maladaptive behavioral or psychological changes (e.g., initial euphoria followed by apathy, dysphoria, psychomotor agitation or retardation, impaired judgment, or impaired social or occupational functioning) that developed during, or shortly after, opioid use.   3. Pupillary constriction (or pupillary dilation due to anoxia from severe overdose) and one (or more) of the following signs, developing during, or shortly after, opioid use:      1. drowsiness or coma      2. slurred speech      3. impairment in attention or memory   4. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.   *Specify* if:  **With Perceptual Disturbances** |

292.0 Opioid Withdrawal

Also refer to the text and criteria for Substance Withdrawal (see p. 184). The essential feature of Opioid Withdrawal is the presence of a characteristic withdrawal syndrome that develops after the cessation of (or reduction in) opioid use that has been heavy and prolonged (Criterion Al). The withdrawal syndrome can be also precipitated by administration of an opioid antagonist (e.g., naloxone or naltrexone) after a period of opioid use (Criterion A2). Opioid Withdrawal is characterized by a pattern of signs and symptoms that are opposite to the acute agonist effects. The first of these are subjective and consist of complaints of anxiety, restlessness, and an "achy feeling" that is often located in the back and legs, accompanied by a wish to obtain opioids ("craving") and

drug-seeking behavior, along with irritability and increased sensitivity to pain. Three or more of the following must be present to make a diagnosis of Opioid Withdrawal: dysphoric mood; nausea or vomiting; muscle aches; lacrimation or rhinorrhea; pupillary dilation, piloerection, or increased sweating; diarrhea; yawning; fever; and insomnia (Criterion B). Piloerection and fever are associated with severe withdrawal and are not often seen in routine clinical practice because individuals with Opioid Dependence usually obtain substances before withdrawal becomes that far advanced. These symp­ toms of Opioid Withdrawal must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C). The symptoms must not be due to a general medical condition and are not better accounted for by another mental disorder (Criterion D).

In most individuals who are dependent on short-acting drugs such as heroin, withdrawal symptoms occur within 6-24 hours after the last dose. Symptoms may take 2-4 days to emerge in the case of longer-acting drugs such as methadone or LAAM (L-alphacetylmethadol). Acute withdrawal symptoms for a short-acting opioid such as heroin usually peak within 1-3 days and gradually subside over a period of 5-7 days. Less acute withdrawal symptoms can last for weeks to months. These more chronic symptoms include anxiety, dysphoria, anhedonia, insomnia, and drug craving.

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| * **Diagnostic criteria for 292.0 Opioid Withdrawal**   1. Either of the following:      1. cessation of (or reduction in) opioid use that has been heavy and prolonged (several weeks or longer)      2. administration of an opioid antagonist after a period of opioid use   2. Three (or more) of the following, developing within minutes to several days after Criterion A:      1. dysphoric mood      2. nausea or vomiting      3. muscle aches      4. lacrimation or rhinorrhea      5. pupillary dilation, piloerection, or sweating      6. diarrhea      7. yawning      8. fever      9. insomnia   3. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.   4. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder. |

**Other Opioid--Induced Disorders**

The following Opioid-Induced Disorders are described in other sections of the manual with disorders with which they share phenomenology: **Opioid Intoxication Delirium** (p. 129), **Opioid-Induced Psychotic Disorder** (p. 310), **Opioid-Induced Mood Disorder** (p. 370), **Opioid-Induced Sexual Dysfunction** (p. 519), and **Opioid­ Induced Sleep Disorder** (p. 601). These disorders are diagnosed instead of Opioid Intoxication or Opioid Withdrawal only when the symptoms are in excess of those usually associated with the Opioid Intoxication or Withdrawal syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention.

***Additional Information on Opioid-Related Disorders***

***Associated Features and Disorders***

**Associated descriptive features and mental disorders.** Opioid Dependence is commonly associated with a history of drug-related crimes (e.g., possession or distribu­ tion of drugs, forgery, burglary, robbery, larceny, or receiving stolen goods). Among health care professionals and individuals who have ready access to controlled sub­ stances, there is often a different pattern of illegal activities involving problems with state licensing boards, professional staffs of hospitals, or other administrative agencies. Divorce, unemployment, or irregular employment are often associated with Opioid Dependence at all socioeconomic levels.

For many individuals, the effect of taking an opioid for the first time is dysphoric rather than euphoric, and nausea and vomiting may result. Individuals with Opioid Dependence are especially at risk for the development of brief depressive symptoms and for episodes of mild to moderate depression that meet symptomatic and duration criteria for Major Depressive Disorder. These symptoms may represent an Opioid­ Induced Mood Disorder (seep. 370) or exacerbations of a preexisting primary depressive disorder. Periods of depression are especially common during chronic intoxication or in association with psychosocial stressors that are related to the Opioid Dependence. Insomnia is common, especially during withdrawal. Antisocial Personality Disorder is much more common in individuals with Opioid Dependence than in the general population. Posttraumatic Stress Disorder is also seen with increased frequency. A history of Conduct Disorder in childhood or adolescence has been identified as a significant risk factor for Substance-Related Disorders, especially Opioid Dependence.

**Associated laboratory findings.** Routine urine toxicology tests are often positive for opioid drugs in individuals with Opioid Dependence. Urine tests remain positive for most opioids for 12-36 hours after administration. Longer-acting opioids (e.g., methadone and LAAM) can be identified in urine for several days. Fentanyl is not detected by standard urine tests but can be identified by more specialized procedures. Laboratory evidence of the presence of other substances (e.g., cocaine, marijuana, alcohol, amphetamines, benzodiazepines) is common. Hepatitis screening tests are often positive, either for hepatitis antigen (signifying active infection) or hepatitis antibody

(signifying past infection). Mildly elevated liver function tests are common, either as a result of resolving hepatitis or from toxic injury to the liver due to contaminants that have been mixed with the injected opioid. Subtle changes in cortisol secretion patterns and body temperature regulation have been observed for up to 6 months following opioid detoxification.

**Associated physical examination findings and general medical conditions.** Acute and chronic opioid use are associated with a lack of secretions, causing dry mouth and nose, slowing of gastrointestinal activity, and constipation. Visual acuity may be impaired as a result of pupillary constriction. In individuals who use opioids intrave­ nously, sclerosed veins ("tracks") and puncture marks on the lower portions of the upper extremities are common. Veins sometimes become so badly sclerosed that peripheral edema develops and individuals switch to veins in the legs, neck, or groin. When these veins become unusable or otherwise unavailable, individuals often inject directly into their subcutaneous tissue ("skin-popping"), resulting in cellulitis, abscesses, and circu­ lar-appearing scars from healed skin lesions. Tetanus is a relatively rare but extremely serious consequence of injecting opioids. Infections may also occur in other organs and include bacterial endocarditis, hepatitis, and human immunodeficiency virus (HIV) infection. Tuberculosis is a particularly serious problem among individuals who use drugs intravenously, especially those dependent on heroin. Infection with the tubercle bacillus is usually asymptomatic and evident only by the presence of a positive tuberculin skin test. However, many cases of active tuberculosis have been found, especially among those who are infected with HIV. These individuals often have a newly acquired infection, but also are likely to experience reactivation of a prior infection due to impaired immune function. Persons who sniff heroin or other opioids ("snorting") often develop irritation of the nasal mucosa, sometimes accompanied by perforation of the nasal septum. Difficulties in sexual functioning are common. Males often experience erectile dysfunction during intoxication or chronic use. Females commonly have disturbances of reproductive function and irregular menses.

The incidence of HIV infection is high among individuals who use intravenous drugs,

a large proportion of whom are individuals with Opioid Dependence. HIV infection rates have been reported to be as high as 60% among persons dependent on heroin in some areas of the United States.

In addition to infections such as cellulitis, hepatitis, HIV, tuberculosis, and endocar­ ditis, Opioid Dependence is associated with a very high death rate-at the level of approximately 10 per 1,000 per year among untreated persons. Death most often results from overdose, accidents, injuries, or other general medical complications. Accidents and injuries due to violence that is associated with buying or selling drugs are common. In some areas, violence accounts for more opioid-related deaths than overdose or HIV infection. Physiological dependence on opioids may occur in about half of the infants born to females with Opioid Dependence; this can produce a severe withdrawal syndrome requiring medical treatment. Although low birth weight is also seen in children of mothers with Opioid Dependence, it is usually not marked and is generally not associated with serious adverse consequences.

***Specific Culture, Age, and Gender Features***

Since the 1920s, in the United States, members of minority groups living in economically deprived areas have been overrepresented among persons with Opioid Dependence.

However, in the late 1800s and early 1900s, Opioid Dependence was seen more often among white middle-class individuals, suggesting that differences in use reflect the availability of opioid drugs and other social factors. Medical personnel who have ready access to opioids may have an increased risk for Opioid Abuse and Dependence.

Increasing age appears to be associated with a decrease in prevalence. This tendency for Dependence to remit generally begins after age 40 years and has been called "maturing out." However, many persons have remained opioid dependent for 50 years or longer. Males are more commonly affected, with the male-to-female ratio typically being 3 or 4:1.

***Prevalence***

A community survey conducted in the United States in 1991 reported that 6% of the population sampled ever used analgesics for nonmedical purposes; 2.5% had used them within the past year; and 0.7% has used them in the last month. The survey also showed that 1.3% had used heroin in their lifetime, and 0.2% had used it in the last year (use in the last month was not reported). Because the survey assessed patterns of use rather than diagnoses, it is not known how many of those who used analgesics or heroin had symptoms that met criteria for Dependence or Abuse. A community study conducted in the United States from 1980 to 1985 that used the more narrowly defined DSM-III criteria found that 0.7% of the adult population had Opioid Dependence or Abuse at some time in their lives. Among those with Dependence or Abuse, 18% reported use in the last month and 42% reported having had a problem with opioids in the last year.

***Course***

Opioid Dependence can begin at any age, but problems associated with opioid use are most commonly first observed in the late teens or early 20s. Once Dependence develops, it is usually continuous over a period of many years, even though brief periods of abstinence are frequent. Relapse following abstinence is common, even after many years of incarceration. One exception to the typical chronic course of Opioid Dependence was observed in service personnel who became dependent on opioids in Vietnam. On their return to the United States, less than 10% of those who had been dependent on opioids relapsed, although they experienced increased rates of Alcohol or Amphetamine Dependence. Few data are available on the course of Opioid Abuse.

***Familial Pattern***

The family members of individuals with Opioid Dependence are likely to have higher levels of psychopathology, especially an increased incidence of other Substance-Related Disorders and Antisocial Personality Disorder.

***Di,fferential magnosis***

For a general discussion of the differential diagnosis of Substance-Related Disorders, see

p. 190. Opioid-Induced Disorders may be characterized by symptoms (e.g., depressed mood) that resemble **primary mental disorders** (e.g., Dysthymia versus Opioid­ Induced Mood Disorder, With Depressive Features, With Onset During Intoxication).

Seep. 193 for a discussion of this differential diagnosis. Opioids are less likely to produce symptoms of mental disturbance than are most other drugs of abuse and, in some instances, will even reduce such symptoms. In these cases, mental symptoms or disorders may emerge after opioid use is discontinued.

**Alcohol Intoxication** and **Sedative, Hypnotic, or Anxiolytic Intoxication** can cause a clinical picture that resembles Opioid Intoxication. A diagnosis of Alcohol or Sedative, Hypnotic, or Anxiolytic Intoxication can usually be made based on the absence of pupillary constriction or the lack of a response to a naloxone challenge. In some cases, intoxication may be due both to opioids and to alcohol or other sedatives. In these cases, the naloxone challenge will not reverse all of the sedative effects. The anxiety and restlessness associated with Opioid Withdrawal resemble symptoms seen in **Sedative, Hypnotic, or Anxiolytic Withdrawal.** However, Opioid Withdrawal is also accompanied by rhinorrhea, lacrimation, and pupillary dilation, which are not seen in sedative-type withdrawal. Dilated pupils are also seen in **Hallucinogen Intoxica­ tion, Amphetamine Intoxication,** and **Cocaine Intoxication.** However, others signs or symptoms of Opioid Withdrawal such as nausea, vomiting, diarrhea, abdominal cramps, rhinorrhea, or lacrimation are not present. Opioid Intoxication and Opioid Withdrawal are distinguished from the **other Opioid-Induced Disorders** (e.g., Opioid­ Induced Mood Disorder, With Onset During Intoxication) because the symptoms in these latter disorders are in excess of those usually associated with Opioid Intoxication or Opioid Withdrawal and are severe enough to warrant independent clinical attention.

**292.9 Opioid-Related Disorder Not Otherwise Specified**

The Opioid-Related Disorder Not Otherwise Specified category is for disorders associated with the use of opioids that are not classifiable as Opioid Dependence, Opioid Abuse, Opioid Intoxication, Opioid Withdrawal, Opioid Intoxication Delirium, Opioid-Induced Psychotic Disorder, Opioid-Induced Mood Disorder, Opioid-Induced Sexual Dysfunc­ tion, or Opioid-Induced Sleep Disorder.

**Phencyclidine**

**(or Phencyclidine-Like)-Related Disorders**

The phencyclidines (or phencyclidine-like) substances include phencyclidine (PCP, Sernylan) and similarly acting compounds such as ketamine (Ketalar, Ketaject) and the thiophene analogue of phencyclidine (TCP; 1-[1-2-thienyl-cyclohexyllpiperidine). These substances were first developed as dissociative anesthetics in the 1950s and became street drugs in the 1960s. They can be taken orally or intravenously or can be smoked. Phencyclidine (sold illicitly under a variety of names such as PCP, Hog, Tranq, Angel Dust, and Peace Pill) is the most commonly abused substance in this class.

This section contains discussions specific to the Phencyclidine-Related Disorders. Texts and criteria sets have already been provided for the generic aspects of Substance Dependence (p. 176) and Substance Abuse (p. 182) that apply across all substances. Texts specific to Phencyclidine Dependence and Abuse are provided below; however, there are no additional specific criteria sets for Phencyclidine Dependence or Phency­ clidine Abuse. A specific text and criteria set for Phencyclidine Intoxication is also

provided below. Although symptoms of phencyclidine withdrawal may occur, their clinical significance is uncertain, and a diagnosis of phencyclidine withdrawal is not included in this manual. The Phencyclidine-Induced Disorders (other than Phencyclidine Intoxication) are described in the sections of the manual with disorders with which they share phenomenology (e.g., Phencyclidine-Induced Psychotic Disorder is included in the "Schizophrenia and Other Psychotic Disorders" section). Listed below are the Phencyclidine Use Disorders and the Phencyclidine-Induced Disorders.

***Phencyclidine Use Disorders***

**304.90 Phencyclidine Dependence** (see p. 256)

**305.90 Phencyclidine Abuse** (see p. 257)

***Phencyclidine-Induced Disorders***

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| **292.89** | **Phencyclidine Intoxication** (see p. 257)  *Specify if* With Perceptual Disturbances |
| **292.81** | **Phencyclidine Intoxication Delirium** (seep. 129) |
| **292.11** | **Phencyclidine-Induced Psychotic Disorder, With Delusions** (see p. 310)  *Specify tf* With Onset During Intoxication |
| **292.12** | **Phencyclidine-Induced Psychotic Disorder, With Hallucinations**  (seep. 310) *Specify if* With Onset During Intoxication |
| **292.84** | **Phencyclidine-Induced Mood Disorder** (see p. 370)  *Specify if* With Onset During Intoxication |
| **292.89** | **Phencyclidine-Induced Anxiety Disorder** (see p. 439)  *Specify if* With Onset During Intoxication |
| **292.9** | **Phencyclidine-Related Disorder Not Otherwise Specified** (see p. 261) |

***Pbencyclidine Use Disorders***

**304.90 Phencyclidine Dependence**

Also refer to the text and criteria for Substance Dependence (see p. 176). Some of the generic criteria for Substance Dependence do not apply to phencyclidine. Although "craving" has been reported by individuals with heavy use, neither tolerance nor withdrawal symptoms have been clearly demonstrated in humans (although both have been shown to occur in animal studies). Phencyclidine is usually not difficult to obtain, and individuals with Phencyclidine Dependence often smoke it at least 2-3 times per day, thus spending a significant proportion of their time using the substance and experiencing its effects. Phencyclidine use may continue despite the presence of psychological problems (e.g., disinhibition, anxiety, rage, aggression, panic, flashbacks) or medical problems (e.g., hyperthermia, hypertension, seizures) that the individual knows are caused by the substance. Individuals with Phencyclidine Dependence can manifest dangerous behavioral reactions due to lack of insight and judgment while intoxicated. Aggressive behavior involving fighting has been identified as an especially problematic adverse effect of phencyclidine. As with hallucinogens, adverse reactions

to phencyclidine may be more common among individuals with preexisting mental disorders.

***Specifiers***

The following specifiers may be applied to a diagnosis of Phencyclidine Dependence (see p. 179 for more details):

**Early Full Remission Early Partial Remission Sustained Full Remission**

**Sustained Partial Remission In a Controlled Environment**

**305.90 Phencyclidine Abuse**

Also refer to the text and criteria for Substance Abuse (seep. 182). Although individuals who abuse phencyclidine use the substance much less often than those with Depen­ dence, they may repeatedly fail to fulfill major role obligations at school, work, or home because of Phencyclidine Intoxication. Individuals may use phencyclidine in situations where it is physically hazardous (such as while operating heavy machinery or driving a motorcycle or car). Legal difficulties may arise due to possession of phencyclidine or to behaviors resulting from Intoxication (e.g., fighting). There may be recurrent social or interpersonal problems due to the individual's behavior while intoxicated or to the chaotic lifestyle, multiple legal problems, or arguments with significant others.

***Phencyclidine-Induced Disorders***

**292.89 Phencyclidine Intoxication**

Also refer to the text and criteria for Substance Intoxication (see p. 183). The essential feature of Phencyclidine Intoxication is the presence of clinically significant maladaptive behavioral changes (e.g., belligerence, assaultiveness, impulsiveness, unpredictability, psychomotor agitation, impaired judgment, or impaired social or occupational function­ ing) that develop during, or shortly after, use of phencyclidine (or a related substance) (Criteria A and B). These changes are accompanied by two or more of the following signs that develop within an hour of using the substance (or less when it is smoked, "snorted," or used intravenously): vertical or horizontal nystagmus, hypertension or tachycardia, numbness or diminished responsiveness to pain, ataxia, dysarthria, muscle rigidity, seizures or coma, and hyperacusis (Criterion C). The symptoms must not be due to a general medical condition and are not better accounted for by another mental disorder (Criterion D).

Specific signs and symptoms are dose related. Lower doses of phencyclidine produce vertigo, ataxia, nystagmus, mild hypertension, abnormal involuntary movements, slurred speech, nausea, weakness, slowed reaction times, euphoria or affective dulling, loquac­ ity, and lack of concern. Disorganized thinking, changed body image and sensory perception, depersonalization, and feelings of unreality occur at intermediate doses.

Higher doses produce amnesia and coma, with analgesia sufficient for surgery, and seizures with respiratory depression occur at the highest doses. Effects begin almost immediately after an intravenous or transpulmonary dose, reaching a peak within minutes. Peak effects occur about 2 hours after oral doses. In milder intoxications, the effects resolve after 8-20 hours, whereas signs and symptoms of severe intoxications may persist for several days. Phencyclidine-Induced Psychotic Disorder (p. 310) may persist for weeks.

***Specifier***

The following specifier may be applied to a diagnosis of Phencyclidine Intoxication:

**With Perceptual Disturbances.** This specifier may be noted when hallucina­ tions with intact reality testing or auditory, visual, or tactile illusions occur in the absence of a delirium. *Intact reality testing* means that the person knows that the hallucinations are induced by the substance and do not represent external reality. When hallucinations occur in the absence of intact reality testing, a diagnosis of Substance-Induced Psychotic Disorder, With Hallucinations, should he considered.

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| * **Diagnostic criteria for 292.89 Phencyclidine Intoxication**   1. Recent use of phencyclidine (or a related substance).   2. Clinically significant maladaptive behavioral changes (e.g., belligerence, assaultiveness, impulsiveness, unpredictability, psychomotor agitation, impaired judgment, or impaired social or occupational functioning) that developed during, or shortly after, phencyclidine use.   3. Within an hour (less when smoked, "snorted," or used intravenously), two (or more) of the following signs:      1. vertical or horizontal nystagmus      2. hypertension or tachycardia      3. numbness or diminished responsiveness to pain      4. ataxia      5. dysarthria      6. muscle rigidity      7. seizures or coma      8. hyperacusis   4. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.   *Specify* if:  **With Perceptual Disturbances** |

**Other Phencyclidine-Induced Disorders**

The following Phencyclidine-Induced Disorders are described in other sections of the manual with disorders with which they share phenomenology: **Phencyclidine Intox­ ication Delirium** (p. 129), **Phencyclidine-Induced Psychotic Disorder** (p. 310), **Phencyclidine-InducedMoodDisorder** (p. 370), and **Phencyclidine-InducedAnx­ iety Disorder** (p. 439). These disorders are diagnosed instead of Phencyclidine Intoxication only when the symptoms are in excess of those usually associated with the Phencyclidine Intoxication syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention.

***Additional Information on Phencyclidine-Related Disorders***

***Associated Features and Disorders***

**Associated descriptive features and mental disorders.** Although individuals with Phencyclidine Intoxication may remain alert and oriented, they may show delirium, coma, psychotic symptoms, or catatonic mutism with posturing. Repeated intoxications may lead to job, family, social, or legal problems. Violence, agitation, and bizarre behavior (e.g., confused wandering) may occur. Individuals with Phencyclidine Depen­ dence or Abuse may report repeated intoxication-induced hospitalizations, emergency­ room visits, and arrests for confused or bizarre behavior or for fighting. Conduct Disorder in adolescents and Antisocial Personality Disorder in adults may be associated with phencyclidine use. Dependence on other substances (especially cocaine, alcohol, and amphetamines) is common among those who have Phencyclidine Dependence.

**Associated laboratory findings.** Phencyclidine (or a related substance) is present in the urine of individuals who are acutely intoxicated with one of these substances. The substance may be detectable in urine for several weeks after the end of prolonged or very high dose use. Phencyclidine may be detected more readily in acidic urine. Creatine phosphokinase (CPK) and serum glutamic-oxaloacetic transaminase (SGOT) are often elevated.

**Associated physical examination findings and general medical conditions.** Phencyclidine Intoxication produces extensive cardiovascular and neurological (e.g., seizures, dystonias, dyskinesias, catalepsy, and hypothermia or hyperthermia) toxicity. In those with Phencyclidine Dependence or Abuse, there may be physical evidence of injuries from accidents, fights, and falls. Needle tracks, hepatitis, human immunodefici­ ency virus (HIV) disease, and bacterial endocarditis may be found among the relatively few individuals who take phencyclidine intravenously. Drowning, even in small volumes of water, has been reported. Respiratory problems arise with apnea, bronchospasm, bronchorrhea, aspiration during coma, and hypersalivation. Rhabdomyolysis with renal impairment is seen in about 2% of individuals who seek emergency care. Cardiac arrest is a rare outcome.

***Specific Culture, Age, and Gender Features***

The prevalence of phencyclidine-related problems appears to be higher among males (about twofold), among those between ages 20 and 40 years, and among ethnic minorities (about twofold). Males compose about three-quarters of those with phen­ cyclidine-related emergency-room visits.

***Prevalence***

Medical examiners nationally report that phencyclidine is involved in about 3% of deaths associated with substance use. It is mentioned as a problem in about 3% of substance­ related emergency-room visits. The percentage of high-school seniors who report ever having used phencyclidine fell from about 13% in 1980 to about 3% in 1990.

***Differential Diagnosis***

For a general discussion of the differential diagnosis of Substance-Related Disorders, see

p. 190. Phencyclidine-Induced Disorders may be characterized by symptoms (e.g., depressed mood) that resemble **primary mental disorders** (e.g., Major Depressive Disorder versus Phencyclidine-Induced Mood Disorder, With Depressive Features, With Onset During Intoxication). See p. 193 for a discussion of this differential diagnosis. Recurring episodes of psychotic or mood symptoms due to Phencyclidine Intoxication may mimic **Schizophrenia or Mood Disorders.** History or laboratory evidence of phencyclidine use establishes a role for the substance, but does not rule out the co-occurrence of other primary mental disorders. Rapid onset of symptoms also suggests Phencyclidine Intoxication rather than Schizophrenia, but phencyclidine use may induce acute psychotic episodes in individuals with preexisting Schizophrenia. Rapid resolution of symptoms and the absence of a history of Schizophrenia may aid in this differentiation. Drug-related violence or impaired judgment may co-occur with, or may mimic aspects of, **Conduct Disorder or Antisocial Personality Disorder.** Absence of behavioral problems before the onset of substance use, or during abstinence, may help to clarify this differentiation.

Phencyclidine and related substances may produce perceptual disturbances (e.g., scintillating lights, perception of sounds, illusions, or formed visual images) that the person usually recognizes as resulting from the drug use. If reality testing remains intact and the person neither believes that the perceptions are real nor acts on them, the specifier With Perceptual Disturbances is noted for Phencyclidine Intoxication. If reality testing is impaired, the diagnosis of **Phencyclidine-Induced Psychotic Disorder** should be considered.

Differentiating Phencyclidine Intoxication from **other Substance Intoxications** (with which it often coexists) depends on a history of having taken the substance, the presence of characteristic findings (e.g., nystagmus and mild hypertension), and positive urine toxicological tests. Individuals who use phencyclidine often use other drugs as well, and comorbid Abuse or Dependence on other drugs must be considered. Phencyclidine Intoxication is distinguished from the **other Phencyclidine-Induced Disorders** (e.g., Phencyclidine-Induced Mood Disorder, With Onset During Intoxica­ tion) because the symptoms in these latter disorders are in excess of those usually associated with Phencyclidine Intoxication and are severe enough to warrant indepen­ dent clinical attention.

**292.9 Phencyclidine-Related Disorder Not Otherwise Specified**

The Phencyclidine-Related Disorder Not Otherwise Specified category is for disorders associated with the use of phencyclidine that are not classifiable as Phencyclidine Dependence, Phencyclidine Abuse, Phencyclidine Intoxication, Phencyclidine Intoxica­ tion Delirium, Phencyclidine-Induced Psychotic Disorder, Phencyclidine-Induced Mood Disorder, or Phencyclidine-Induced Anxiety Disorder.

**Sedative-, Hypnotic-, or Anxiolytic-Related Disorders**

The sedative, hypnotic, and anxiolytic (antianxiety) substances include the benzodiaze­ pines, the carbamates (e.g., glutethimide, meprobamate), the barbiturates (e.g., secobar­ bital), and the barbiturate-like hypnotics (e.g., glutethimide, methaqualone). This class of substances includes all prescription sleeping medications and almost all prescription antianxiety medications. The nonbenzodiazepine antianxiety agents (e.g., buspirone, gepirone) are not included in this class. Some medications in this class have other important clinical uses (e.g., as anticonvulsants). Like alcohol, these agents are brain depressants and can produce similar Substance-Induced and Substance Use Disorders. At high doses, sedatives, hypnotics, and anxiolytics can be lethal, particularly when mixed with alcohol. Sedatives, hypnotics, and anxiolytics are available both by prescrip­ tion and from illegal sources. Occasionally, individuals who obtain these substances by prescription will abuse them; conversely, some of those who purchase substances from this class "on the street" do not develop Dependence or Abuse. Medications with rapid onset and/or short to intermediate lengths of action may be especially vulnerable to being abused.

This section contains discussions specific to the Sedative-, Hypnotic-, or Anxiolytic­ Related Disorders. Texts and criteria sets have already been provided to define the generic aspects of Substance Dependence (p. 176) and Substance Abuse (p. 182) that apply across all substances. Texts specific to Sedative, Hypnotic, or Anxiolytic Depen­ dence and Abuse are provided below; however, there are no additional specific criteria sets for Sedative, Hypnotic, or Anxiolytic Dependence or Sedative, Hypnotic, or Anxiolytic Abuse. Specific texts and criteria sets for Sedative, Hypnotic, or Anxiolytic Intoxication and Sedative, Hypnotic, or Anxiolytic Withdrawal are also provided below. The Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders (other than Sedative, Hyp­ notic, or Anxiolytic Intoxication and Withdrawal) are described in the sections of the manual with disorders with which they share phenomenology (e.g., Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder is included in the "Anxiety Disorders" section). Listed below are the Sedative, Hypnotic, or Anxiolytic Use Disorders and the Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders.

***Sedative, Hypnotic, or Anxiolytic Use Di,Sorders***

**304.10 Sedative, Hypnotic, or Anxiolytic Dependence** (seep. 262)

**305.40 Sedative, Hypnotic, or Anxiolytic Abuse** (see p. 263)

***Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders***

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| **292.89** | **Sedative, Hypnotic, or Anxiolytic Intoxication** (see p. 263) |
| **292.0** | **Sedative, Hypnotic, or Anxiolytic Withdrawal** (see p. 264) |
| **292.81** | *Specify if:* With Perceptual Disturbances  **Sedative, Hypnotic, or Anxiolytic Intoxication Delirium** (seep. 129) |
| **292.81** | **Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium** (see p. 129) |
| **292.82** | **Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Dementia** |
|  | (seep. 152) |
| **292.83** | **Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Amnestic** |
|  | **Disorder** (see p. 161) |
| **292.11** | **Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder,** |
|  | **With Delusions** (see p. 310)  *Specify if:* With Onset During Intoxication/With Onset During Withdrawal |
| **292.12** | **Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder,** |
|  | **With Hallucinations** (seep. 310)  *Specify if:* With Onset During Intoxication/With Onset During Withdrawal |
| **292.84** | **Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder** (see p. 370)  *Specify if:* With Onset During Intoxication/With Onset During Withdrawal |
| **292.89** | **Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder**  (see p. 439) *Specify if:* With Onset During Withdrawal |
| **292.89** | **Sedative-, Hypnotic-, or Anxiolytic-Induced Sexual Dysfunction**  (see p. 519) *Specify if:* With Onset During Intoxication |
| **292.89** | **Sedative-, Hypnotic-, or Anxiolytic-Induced Sleep Disorder** (seep. 601)  *Specify if:* With Onset During Intoxication/With Onset During Withdrawal |
| **292.9** | **Sedative-, Hypnotic-, or Anxiolytic-Related Disorder** |
|  | **Not Otherwise Specified** (see p. 269) |

***Sedative, Hypnotic, or Anxiolytic Use Disorders***

**304.10 Sedative, Hypnotic, or Anxiolytic Dependence**

Also refer to the text and criteria for Substance Dependence (seep. 176). Very significant levels of physiological dependence, marked by both tolerance and withdrawal, can develop to the sedatives, hypnotics, and anxiolytics. The timing and severity of the withdrawal syndrome will differ depending on the specific substance and its pharma­ cokinetics and pharmacodynamics. For example, withdrawal from shorter-acting sub­ stances that are rapidly absorbed and that have no active metabolites (e.g., triazolam) can begin within hours after the substance is stopped; withdrawal from substances with long-acting metabolites (e.g., diazepam) may not begin for 1-2 days or longer. The withdrawal syndrome produced by substances in this class may be characterized by the development of a delirium that can be life threatening. There may be evidence of tolerance and withdrawal in the absence of a diagnosis of Substance Dependence in an individual who has abruptly discontinued benzodiazepines that were taken for long

periods of time at prescribed and therapeutic doses. A diagnosis of Substance Depen­ dence should be considered only when, in addition to having physiological dependence, the individual using the substance shows evidence of a range of problems (e.g., an individual who has developed drug-seeking behavior to the extent that important activities are given up or reduced to obtain the substance).

***Specifiers***

The following specifiers may be applied to a diagnosis of Sedative, Hypnotic, or Anxiolytic Dependence (see p. 179 for more details):

**With Physiological Dependence Without Physiological Dependence**

**Early Full Remission Early Partial Remission Sustained Full Remission**

**Sustained Partial Remission On Agonist Therapy**

**In a Controlled Environment**

**305.40 Sedative, Hypnotic, or Anxiolytic Abuse**

Also refer to the text and criteria for Substance Abuse (seep. 182). Abuse of substances from this class may occur on its own or in conjunction with use of other substances. For example, individuals may use intoxicating doses of sedatives or benzodiazepines to "come down" from cocaine or amphetamines or use high doses of benzodiazepines in combination with methadone to "boost" its effects. Abuse of substances from this class may result in use in hazardous situations, such as getting "high" and then driving. The individual may miss work or school or neglect home duties as a result of intoxication or get into arguments with spouses or parents about episodes of substance use. When these problems are accompanied by evidence of tolerance, withdrawal, or compulsive behavior related to the use of sedatives, hypnotics, or anxiolytics, a diagnosis of Sedative, Hypnotic, or Anxiolytic Dependence should be considered.

***Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders***

**292.89 Sedative, Hypnotic, or Anxiolytic Intoxication**

Also refer to the text and criteria for Substance Intoxication (see p. 183). The essential feature of Sedative, Hypnotic, or Anxiolytic Intoxication is the presence of clinically significant maladaptive behavioral or psychological changes (e.g., inappropriate sexual or aggressive behavior, mood !ability, impaired judgment, impaired social or occupa­ tional functioning) that develop during, or shortly after, use of a sedative, hypnotic, or anxiolytic substance (Criteria A and B). As with other brain depressants, these behaviors

may be accompanied by slurred speech, an unsteady gait, nystagmus, memory or attentional problems, levels of incoordination that can interfere with driving abilities and with performing usual activities to the point of causing accidents, and stupor or coma (Criterion C). Memory impairment is a prominent feature of Sedative, Hypnotic, or Anxiolytic Intoxication and is most often characterized by an anterograde amnesia that resembles "alcoholic blackouts," which can be quite disturbing to the individual. The symptoms must not be due to a general medical condition and are not better accounted for by another mental disorder (Criterion D). Intoxication may occur in individuals who are receiving these substances by prescription, are borrowing the medication from friends or relatives, or are deliberately taking the substance to achieve intoxication.

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| * **Diagnostic criteria for 292.89 Sedative, Hypnotic, or Anxiolytic Intoxication**   1. Recent use of a sedative, hypnotic, or anxiolytic.   2. Clinically significant maladaptive behavioral or psychological changes (e.g., inappropriate sexual or aggressive behavior, mood lability, im­ paired judgment, impaired social or occupational functioning) that developed during, or shortly after, sedative, hypnotic, or anxiolytic use.   3. One (or more) of the following signs, developing during, or shortly after, sedative, hypnotic, or anxiolytic use:      1. slurred speech      2. incoordination      3. unsteady gait      4. nystagmus      5. impairment in attention or memory      6. stupor or coma   4. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder. |

**292.0 Sedative, Hypnotic, or Anxiolytic Withdrawal**

Also refer to the text and criteria for Substance Withdrawal (see p. 184). The essential feature of Sedative, Hypnotic, or Anxiolytic Withdrawal is the presence of a characteristic syndrome that develops after a marked decrease in or cessation of intake after several weeks or more of regular use (Criteria A and B). This withdrawal syndrome is characterized by two or more symptoms (similar to Alcohol Withdrawal) that include autonomic hyperactivity (e.g., increases in heart rate, respiratory rate, blood pressure, or body temperature, along with sweating); a tremor of the hands; insomnia, anxiety,

and nausea sometimes accompanied by vomiting; and psychomotor agitation. A grand mal seizure may occur in perhaps as many as 20%-30% of individuals undergoing untreated withdrawal from these substances. In severe Withdrawal, visual, tactile, or auditory hallucinations or illusions can occur. If the person's reality testing is intact (i.e., he or she knows the substance is causing the hallucinations) and the illusions occur in a clear sensorium, the specifier With Perceptual Disturbances can be noted (see below). The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C). The symptoms must not be due to a general medical condition and are not better accounted for by another mental disorder (e.g., Alcohol Withdrawal or Generalized Anxiety Disorder) (Criterion D). Relief of withdrawal symptoms with administration of any sedative-hypnotic agent would support a diagnosis of Sedative, Hypnotic, or Anxiolytic Withdrawal.

The withdrawal syndrome is characterized by signs and symptoms that are generally the opposite of the acute effects that are likely to be observed in a first-time user of these agents. The time course of the withdrawal syndrome is generally predicted by the half-life of the substance. Medications whose actions typically last about 10 hours or less (e.g., lorazepam, oxazepam, and temazepam) produce withdrawal symptoms within 6-8 hours of decreasing blood levels that peak in intensity on the second day and improve markedly by the fourth or fifth day. For substances with longer half-lives (e.g., diazepam), symptoms may not develop for more than a week, peak in intensity during the second week, and decrease markedly during the third or fourth week. There may be additional longer-term symptoms at a much lower level of intensity that persist for several months. As with alcohol, these lingering withdrawal symptoms (e.g., anxiety, moodiness, and trouble sleeping) can be mistaken for non-substance-induced Anxiety or Depressive Disorders (e.g., Generalized Anxiety Disorder).

The longer the substance has been taken and the higher the dosages used, the more likely it is that there will be severe Withdrawal. However, Withdrawal has been reported with as little as 15 mg of diazepam (or its equivalent in other benzodiazepines) when taken daily for several months. Dosages of approximately 40 mg of diazepam (or its equivalent) daily are more likely to produce clinically relevant withdrawal symptoms, and even higher doses (e.g., 100 mg of diazepam) are more likely to be followed by withdrawal seizures or delirium. Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium (seep. 129) is characterized by disturbances in consciousness and cognition, with visual, tactile, or auditory hallucinations. When present, Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium should be diagnosed instead of Withdrawal.

***Specifier***

The following specifier may be applied to a diagnosis of Sedative, Hypnotic, or Anxiolytic Withdrawal:

**With Perceptual Disturbances.** This specifier may be noted when hallucin­ ations with intact reality testing or auditory, visual, or tactile illusions occur in the absence of a delirium. *Intact reality testing* means that the person knows that the hallucinations are induced by the substance and do not represent external reality. When hallucinations occur in the absence of intact reality testing, a diagnosis of Substance-Induced Psychotic Disorder, With Hallucinations, should be con­ sidered.

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| * **Diagnostic criteria for 292.0 Sedative, Hypnotic, or Anxiolytic Withdrawal**   1. Cessation of (or reduction in) sedative, hypnotic, or anxiolytic use that has been heavy and prolonged.   2. Two (or more) of the following, developing within several hours to a few days after Criterion A:      1. autonomic hyperactivity (e.g., sweating or pulse rate greater than 100)      2. increased hand tremor      3. insomnia      4. nausea or vomiting      5. transient visual, tactile, or auditory hallucinations or illusions      6. psychomotor agitation      7. anxiety      8. grand mal seizures   3. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of func­ tioning.   4. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.   *Specify* if:  **With Perceptual Disturbances** |

**Other Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders**

The following Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders are described in other sections of the manual with disorders with which they share phenomenology: **Sedative, Hypnotic, or Anxiolytic Intoxication Delirium** (p. 129), **Sedative, Hyp­ notic, or Anxiolytic Withdrawal Delirium** (p. 129), **Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Dementia** (p. 152), **Sedative-, Hypnotic-, or An­ xiolytic-Induced Persisting Amnestic Disorder** (p. 161), **Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder** (p. 310), **Sedative-, Hypnotic-, or An­ xiolytic-Induced Mood Disorder** (p. 370), **Sedative-, Hypnotic-, or Anxiolytic­ Induced Anxiety Disorder** (p. 439), **Sedative-, Hypnotic-, or Anxiolytic-Induced Sexual Dysfunction** (p. 519), and **Sedative-, Hypnotic-, or Anxiolytic-Induced Sleep Disorder** (p. 601). These disorders are diagnosed instead of Sedative, Hypnotic, or Anxiolytic Intoxication or Sedative, Hypnotic, or Anxiolytic Withdrawal only when the symptoms are in excess of those usually associated with the Sedative, Hypnotic, or Anxiolytic Intoxication or Withdrawal syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention.

***Additional Information on***

***Sedative-, Hypnotic-, or Anxiolytic-Related Di,Sorders***

***Associated Features and Disorders***

**Associated descriptive features and mental disorders.** Sedative, Hypnotic, or Anxiolytic Dependence and Abuse may often be associated with Dependence on, or Abuse of, other substances (e.g., alcohol, cannabis, cocaine, heroin, amphetamines). Sedatives are often used to alleviate the unwanted effects of these other substances. Acute Intoxication can result in accidental injury through falls and automobile accidents. For elderly individuals, even short-term use of these sedating medications at prescribed doses can be associated with an increased risk for cognitive problems and falls. Some data indicate that the disinhibiting effects of these agents can, like alcohol, actually contribute to overly aggressive behavior, with subsequent interpersonal and legal problems. Intense or repeated Sedative, Hypnotic, or Anxiolytic Intoxication may be associated with severe depressions that, although temporary, can be intense enough to lead to suicide attempts and completed suicides. Accidental or deliberate overdoses, similar to those observed for Alcohol Abuse or Dependence or repeated Alcohol Intoxication, can occur. In contrast to their wide margin of safety when used alone, benzodiazepines taken in combination with alcohol appear to be particularly dangerous, and accidental overdoses have been reported. Accidental overdoses have also been reported in individuals who deliberately abuse barbiturates and other nonbenzodiaze­ pine sedatives (e.g., methaqualone). With repeated use in search of euphoria, tolerance develops to the sedative effects, and a progressively higher dose is used. However, tolerance to brain stem depressant effects develops much more slowly, and as the person takes more substance to achieve euphoria, there may be a sudden onset of respiratory depression and hypotension, which may result in death. Antisocial behavior and Antisocial Personality Disorder are associated with Sedative, Hypnotic, or Anxiolytic Dependence and Abuse, especially when the substances are obtained illegally.

**Associated laboratory f'tndings.** Almost all of these substances can be identified through laboratory evaluations of urine or blood (which can quantify the amounts of these agents in the body). Urine tests are likely to remain positive for up to a week or so after the use of long-acting substances (e.g., flurazepam).

**Associated physical examination findings andgeneral medical conditions.** Physical examination is likely to reveal evidence of a mild decrease in most aspects of autonomic nervous system functioning, including a slower pulse, a slightly decreased respiratory rate, and a slight drop in blood pressure (most likely to occur with postural changes). Overdoses of sedatives, hypnotics, and anxiolytics may be associated with a deterioration in vital signs that may signal an impending medical emergency (e.g., respiratory arrest from barbiturates). There may be consequences of trauma (e.g., internal bleeding or a subdural hematoma) from accidents that occur while intoxicated. Intravenous use of these substances can result in medical complications related to the use of contaminated needles (e.g., hepatitis and human immunodeficiency virus [HIV] infection).

***Specific Culture, Age, and Gender Features***

There are marked variations in prescription patterns (and availability) of this class of substances in different countries, which may lead to variations in prevalence of Sedative-, Hypnotic-, or Anxiolytic-Related Disorders. Deliberate Intoxication to achieve a "high" is most likely to be observed in teenagers and individuals in their 20s. Withdrawal, Dependence, and Abuse are also seen in individuals in their 40s and older who escalate the dose of prescribed medications. Both acute and chronic toxic effects of these substances, especially effects on cognition, memory, and motor coordination, are likely to increase with age as a consequence of pharmacodynamic and pharmacokinetic age-related changes. Individuals with dementia are more likely to develop Intoxication and impaired physiological functioning at lower doses. Women may be at higher risk for prescription drug abuse of substances of this class.

***Prevalence***

In the United States, up to 90% of individuals hospitalized for medical care or surgery receive orders for sedative, hypnotic, or anxiolytic medications during their hospital stay, and more than 15% of American adults use these medications (usually by prescription) during any 1 year. Most of these individuals take the medication as directed, without evidence of misuse. Among the medications in this class, the benzodiazepines are the most widely used, with perhaps 10% of adults having taken a benzodiazepine for at least 1 month during the prior year. A community survey conducted in the United States in 1991 reported that about 4% of the population sampled had ever used sedatives for nonmedical purposes; approximately 1% had such use in the last year; and 0.4% in the last month. For antianxiety agents, around 6% of the population had ever used them for nonmedical purposes; almost 2% had such use in the last year; and 0.5% in the last month. Because the survey assessed patterns of use rather than diagnoses, it is not known how many of those who used substances from this class had symptoms that met criteria for Dependence or Abuse. A community study conducted in the United States from 1980 to 1985 that used the more narrowly defined DSM-III criteria found that 1.1% of the population surveyed had met criteria for Sedative, Hypnotic, or Anxiolytic Abuse or Dependence at some time in their lives.

***Course***

The more usual course involves young people in their teens or 20s who may escalate their "recreational" use of sedatives, hypnotics, and anxiolytics to the point at which they develop problems that might qualify for a diagnosis of Dependence or Abuse. This pattern may be especially likely among individuals who have other Substance Use Disorders (e.g., related to alcohol, opioids, cocaine, amphetamine). An initial pattern of intermittent use at parties can lead to daily use and high levels of tolerance. Once this occurs, an increasing level of interpersonal, work, and legal difficulties, as well as increasingly severe episodes of memory impairment and physiological withdrawal, can be expected to ensue.

The second and less frequently observed clinical course begins with an individual who originally obtained the medication by prescription from a physician, usually for the treatment of anxiety, insomnia, or somatic complaints. Although the great majority of those who are prescribed a medication from this class do not develop problems, a small

proportion do. In these individuals, as either tolerance or a need for higher doses of the medication develops, there is a gradual increase in the dose and frequency of self-administration. The person is likely to continue to justify use on the basis of the original symptoms of anxiety or insomnia, but substance-seeking behavior becomes more prominent and the person may seek out multiple physicians to obtain sufficient supplies of the medication. Tolerance can reach high levels, and Withdrawal (including seizures and Withdrawal Delirium) may occur. Other individuals at heightened risk might include those with Alcohol Dependence who may receive repeated prescriptions in response to their complaints of alcohol-related anxiety or insomnia.

***m.[ferential magnosis***

For a general discussion of the differential diagnosis of Substance-Related Disorders, see

p. 190. Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders may present with symp­ toms (e.g., anxiety) that resemble **primary mentaldisorders** (e.g., Generalized Anxiety Disorder versus Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder, With Onset During Withdrawal). See p. 193 for a discussion of this differential diagnosis.

Sedative, Hypnotic, or Anxiolytic Intoxication closely resembles **Alcohol Intoxica­ tion,** except for the smell of alcohol on the breath. In older persons, the clinical picture of intoxication can resemble a **progressive dementia.** In addition, the slurred speech, incoordination, and other associated features characteristic of Sedative, Hypnotic, or Anxiolytic Intoxication could be the result of a **general medical condition** (e.g., multiple sclerosis) or of a **prior head trauma** (e.g., a subdural hematoma).

**Alcohol Withdrawal** produces a syndrome very similar to that of Sedative, Hypnotic, or Anxiolytic Withdrawal. The anxiety, insomnia, and autonomic nervous system hyperactivity that is a consequence of **intoxication with other drugs** (e.g., stimulants such as amphetamines or cocaine), that are **consequences of physiological conditions** (e.g., hyperthyroidism), or that are related to **primary Anxiety Disorders** (e.g., Panic Disorder or Generalized Anxiety Disorder) can resemble some aspects of Sedative, Hypnotic, or Anxiolytic Withdrawal.

Sedative, Hypnotic, or Anxiolytic Intoxication and Withdrawal are distinguished from the **other Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders** (e.g., Seda­ tive-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder, With Onset During With­ drawal) because the symptoms in these latter disorders are in excess of those usually associated with Sedative, Hypnotic, or Anxiolytic Intoxication or Withdrawal and are severe enough to warrant independent clinical attention.

It should be noted that there are individuals who continue to take benzodiazepine medication according to a physician's direction for a legitimate medical indication over extended periods of time. Even if physiologically dependent on the medication, many of these individuals do not develop symptoms that meet the criteria for Dependence because they are not preoccupied with obtaining the substance and its use does not interfere with their performance of usual social or occupational roles.

**292.9 Sedative.-, Hypnotic.-, or Anxiolytic.-Related Disorder Not Otherwise Specified**

The Sedative-, Hypnotic-, or Anxiolytic-Related Disorder Not Otherwise Specified category is for disorders associated with the use of sedatives, hypnotics, or anxiolytics

that are not classifiable as Sedative, Hypnotic, or Anxiolytic Dependence; Sedative, Hypnotic, or Anxiolytic Abuse; Sedative, Hypnotic, or Anxiolytic Intoxication; Sedative, Hypnotic, or Anxiolytic Withdrawal; Sedative, Hypnotic, or Anxiolytic Intoxication Delirium; Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium; Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Dementia; Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Amnestic Disorder; Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder; Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder; Sedative-, Hyp­ notic-, or Anxiolytic-Induced Anxiety Disorder; Sedative-, Hypnotic-, or Anxiolytic­ Induced Sexual Dysfunction; or Sedative-, Hypnotic-, or Anxiolytic-Induced Sleep Disorder.

**Polysubstance-Related Disorder**

**304.80 Polysubstance Dependence**

This diagnosis is reserved for behavior during the same 12-month period in which the person was repeatedly using at least three groups of substances (not including caffeine and nicotine), but no single substance predominated. Further, during this period, the Dependence criteria were met for substances as a group but not for any specific substance.

**Other (or Unknown) Substance-Related Disorders**

The Other (or Unknown) Substance-Related Disorders category is for classifying Substance-Related Disorders associated with substances not listed above. Examples of these substances, which are described in more detail below, include anabolic steroids, nitrite inhalants ("poppers"), nitrous oxide, over-the-counter and prescription medica­ tions not otherwise covered by the 11 categories (e.g., cortisol, antihistamines, benztro­ pine), and other substances that have psychoactive effects. In addition, this category may be used when the specific substance is unknown (e.g., an intoxication after taking a bottle of unlabeled pills).

**Anabolic steroids** sometimes produce an initial sense of enhanced well-being (or even euphoria), which is replaced after repeated use by lack of energy, irritability, and other forms of dysphoria. Continued use of these substances may lead to more severe symptoms (e.g., depressive symptomatology) and general medical conditions (liver disease).

**Nitrite inhalants** ("poppers"-forms of amyl, butyl, and isobutyl nitrite) produce an intoxication that is characterized by a feeling of fullness in the head, mild euphoria, a change in the perception of time, relaxation of smooth muscles, and a possible increase in sexual feelings. In addition to possible compulsive use, these substances carry dangers of potential impairment of immune functioning, irritation of the respiratory system, a decrease in the oxygen-carrying capacity of the blood, and a toxic reaction that can include vomiting, severe headache, hypotension, and dizziness.

**Nitrous oxide** ("laughing gas") causes rapid onset of an intoxication that is characterized by light-headedness and a floating sensation that clears in a matter of minutes after administration is stopped. There are reports of temporary but clinically relevant confusion and reversible paranoid states when nitrous oxide is used regularly. Other substances that are capable of producing mild intoxications include **catnip,** which can produce states similar to those observed with marijuana and which in high doses is reported to result in LSD-type perceptions; **betel nut,** which is chewed in many cultures to produce a mild euphoria and floating sensation; and **kava** (a substance derived from the South Pacific pepper plant), which produces sedation, incoordination, weight loss, mild forms of hepatitis, and lung abnormalities. In addition, individuals can develop dependence and impairment through repeated self-administration of **over-the­ counter** and **prescription drugs,** including **cortisol, antiparkinsonian agents** that have anticholinergic properties, and **antihistamines.** A discussion of how to code

medication-related disorders is found on p. 188.

Texts and criteria sets have already been provided to define the generic aspects of Substance Dependence (p. 176), Substance Abuse (p. 182), Substance Intoxication (p. 183), and Substance Withdrawal (p. 184) that are applicable across classes of substances. The Other (or Unknown) Substance-Induced Disorders are described in the sections of the manual with disorders with which they share phenomenology (e.g., Other (or Unknown) Substance-Induced Mood Disorder is included in the "Mood Disorders" section). Listed below are the Other (or Unknown) Substance Use Disorders and the Other (or Unknown) Substance-Induced Disorders.

***Other (or Unknown) Substance Use Disorders***

**304.90 Other (or Unknown) Substance Dependence** (see p. 176)

**305.90 Other (or Unknown) Substance Abuse** (see p. 182)

***Other ( or Unknown) Substance-Induced Disorders***

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| --- | --- |
| **292.89** | **Other (or Unknown) Substance Intoxication** (see p. 183) |
| **292.0** | *Specify if* With Perceptual Disturbances  **Other (or Unknown) Substance Withdrawal** (see p. 184) |
| **292.81** | *Specify if* With Perceptual Disturbances  **Other (or Unknown) Substance-Induced Delirium** (see p. 129) |
| **292.82** | **Other (or Unknown) Substance-Induced Persisting Dementia** |
|  | (seep. 152) |
| **292.83** | **Other (or Unknown) Substance-Induced Persisting Amnestic** |
|  | **Disorder** (see p. 161) |
| **292.11** | **Other (or Unknown) Substance-Induced Psychotic Disorder,**  **With Delusions** (seep. 310) *Specify if* With Onset During Intoxication/ |
|  | With Onset During Withdrawal |
| **292.12** | **Other (or Unknown) Substance-Induced Psychotic Disorder,** |
|  | **With Hallucinations** (seep. 310)  *Specify if* With Onset During Intoxication/With Onset During Withdrawal |
| **292.84** | **Other (or Unknown) Substance-Induced Mood Disorder** (see p. 370) |

*Specify if* With Onset During Intoxication/With Onset During Withdrawal

|  |  |
| --- | --- |
| **292.89** | **Other (or Unknown) Substance-Induced Anxiety Disorder** (see p. 439)  *Specify if* With Onset During Intoxication/With Onset During Withdrawal |
| **292.89** | **Other (or Unknown) Substance-Induced Sexual Dysfunction**  (seep. 519) *Specify if* With Onset During Intoxication |
| **292.89** | **Other (or Unknown) Substance-Induced Sleep Disorder** (see p. 601)  *Specify if* With Onset During Intoxication/With Onset During Withdrawal |
| **292.9** | **Other (or Unknown) Substance-Related Disorder** |
|  | **Not Otherwise Specified** |

## [Schizophrenia and Other Psychotic Disorders](#_bookmark0)

he disorders included in this section are all characterized by having psychotic symptoms as the defining feature. Other disorders that may present with psychotic symptoms (but not as defining features) are included elsewhere in the manual (e.g., Dementia of the Alzheimer's Type and Substance-Induced Delirium in the "Delirium, Dementia, and Amnestic and Other Cognitive Disorders" section; Major Depressive

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Disorder, With Psychotic Features, in the "Mood Disorders" section).

The term *psychotic* has historically received a number of different definitions, none of which has achieved universal acceptance. The narrowest definition of *psychotic* is restricted to delusions or prominent hallucinations, with the hallucinations occurring in the absence of insight into their pathological nature. A slightly less restrictive definition would also include prominent hallucinations that the individual realizes are hallucinatory experiences. Broader still is a definition that also includes other positive symptoms of Schizophrenia (i.e., disorganized speech, grossly disorganized or catatonic behavior). Unlike these definitions based on symptoms, the definition used in earlier classifications (e.g., DSM-II and ICD-9) was probably far too inclusive and focused on the severity of functional impairment, so that a mental disorder was termed "psychotic" if it resulted in "impairment that grossly interferes with the capacity to meet ordinary demands of life." Finally, the term has been defined conceptually as a loss of ego boundaries or a gross impairment in reality testing. The different disorders in this section emphasize different aspects of the various definitions of *psychotic.* In Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, and Brief Psychotic Disorder, the term *psychotic* refers to delusions, any prominent hallucinations, disorganized speech, or disorganized or catatonic behavior. In Psychotic Disorder Due to a General Medical Condition and in Substance-Induced Psychotic Disorder, *psychotic* refers to delusions or only those hallucinations that are not accompanied by insight. Finally, in Delusional Disorder and Shared Psychotic Disorder, *psychotic* is equivalent to delusional.

The following disorders are included in this section:

**Schizophrenia** is a disturbance that lasts for at least 6 months and includes at least 1 month of active-phase symptoms (i.e., two [or more] of the following: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms). Definitions for the Schizophrenia subtypes (Paranoid, Disorganized, Cata­ tonic, Undifferentiated, and Residual) are also included in this section.

**Schizophreniform Disorder** is characterized by a symptomatic presentation that

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is equivalent to Schizophrenia except for its duration (i.e., the disturbance lasts from 1 to 6 months) and the absence of a requirement that there be a decline in functioning. **Schizoaffective Disorder** is a disturbance in which a mood episode and the active-phase symptoms of Schizophrenia occur together and were preceded or are followed by at least 2 weeks of delusions or hallucinations without prominent mood

symptoms.

**Delusional Disorder** is characterized by at least 1 month of nonbizarre delusions without other active-phase symptoms of Schizophrenia.

**Brief Psychotic Disorder** is a psychotic disturbance that lasts more than 1 day and remits by 1 month.

**Shared Psychotic Disorder** is a disturbance that develops in an individual who is influenced by someone else who has an established delusion with similar content.

In **Psychotic Disorder Due to a General Medical Condition,** the psychotic symptoms are judged to be a direct physiological consequence of a general medical condition.

In **Substance-Induced Psychotic Disorder,** the psychotic symptoms are judged to be a direct physiological consequence of a drug of abuse, a medication, or toxin exposure.

**Psychotic Disorder Not Otherwise Specified** is included for classifying psychotic presentations that do not meet the criteria for any of the specific Psychotic Disorders defined in this section or psychotic symptomatology about which there is inadequate or contradictory information.

**Schizophrenia**

The essential features of Schizophrenia are a mixture of characteristic signs and symptoms (both positive and negative) that have been present for a significant portion of time during a 1-month period (or for a shorter time if successfully treated), with some signs of the disorder persisting for at least 6 months (Criteria A and C). These signs and symptoms are associated with marked social or occupational dysfunction (Criterion B). The disturbance is not better accounted for by Schizoaffective Disorder or a Mood Disorder With Psychotic Features and is not due to the direct physiological effects of a substance or a general medical condition (Criteria D and E). In individuals with a previous diagnosis of Autistic Disorder (or another Pervasive Developmental Disorder), the additional diagnosis of Schizophrenia is warranted only if prominent delusions or hallucinations are present for at least a month (Criterion F). The characteristic symptoms of Schizophrenia involve a range of cognitive and emotional dysfunctions that include perception, inferential thinking, language and communication, behavioral monitoring, affect, fluency and productivity of thought and speech, hedonic capacity, volition and drive, and attention. No single symptom is pathognomonic of Schizophrenia; the diagnosis involves the recognition of a constellation of signs and symptoms associated with impaired occupational or social functioning.

Characteristic symptoms (Criterion A) may be conceptualized as falling into two broad categories--positive and negative. The positive symptoms appear to reflect an excess or distortion of normal functions, whereas the negative symptoms appear to reflect a diminution or loss of normal functions. The positive symptoms (Criteria Al-A4) include distortions or exaggerations of inferential thinking (delusions), perception

(hallucinations), language and communication (disorganized speech), and behavioral monitoring (grossly disorganized or catatonic behavior). These positive symptoms may comprise two distinct dimensions, which may in turn be related to different underlying neural mechanisms and clinical correlations: the "psychotic dimension" includes delu­ sions and hallucinations, whereas the "disorganization dimension" includes disorga­ nized speech and behavior. Negative symptoms (Criterion AS) include restrictions in the range and intensity of emotional expression (affective flattening), in the fluency and productivity of thought and speech (alogia), and in the initiation of goal-directed behavior (avolition).

Delusions (Criterion Al) are erroneous beliefs that usually involve a misinterpreta­ tion of perceptions or experiences. Their content may include a variety of themes (e.g., persecutory, referential, somatic, religious, or grandiose). Persecutory delusions are most common; the person believes he or she is being tormented, followed, tricked, spied on, or subjected to ridicule. Referential delusions are also common; the person believes that certain gestures, comments, passages from books, newspapers, song lyrics, or other environmental cues are specifically directed at him or her. The distinction between a delusion and a strongly held idea is sometimes difficult to make and depends on the degree of conviction with which the belief is held despite clear contradictory evidence. Although bizarre delusions are considered to be especially characteristic of Schizo­ phrenia, "bizarreness" may be difficult to judge, especially across different cultures. Delusions are deemed bizarre if they are clearly implausible and not understandable and do not derive from ordinary life experiences. An example of a bizarre delusion is a person's belief that a stranger has removed his or her internal organs and has replaced them with someone else's organs without leaving any wounds or scars. An example of a nonbizarre delusion is a person's false belief that he or she is under surveillance by the police. Delusions that express a loss of control over mind or body (i.e., those included among Schneider's list of "first-rank symptoms") are generally considered to be bizarre; these include a person's belief that his or her thoughts have been taken away by some outside force ("thought withdrawal"), that alien thoughts have been put into his or her mind ("thought insertion"), or that his or her body or actions are being acted on or manipulated by some outside force ("delusions of control"). If the delusions are judged to be bizarre, only this single symptom is needed to satisfy Criterion A for Schizophrenia. Hallucinations (Criterion A2) may occur in any sensory modality (e.g., auditory, visual, olfactory, gustatory, and tactile), but auditory hallucinations are by far the most common and characteristic of Schizophrenia. Auditory hallucinations are usually expe­ rienced as voices, whether familiar or unfamiliar, that are perceived as distinct from the person's own thoughts. The content may be quite variable, although pejorative or threatening voices are especially common. Certain types of auditory hallucinations (i.e., two or more voices conversing with one another or voices maintaining a running commentary on the person's thoughts or behavior) have been considered to be particularly characteristic of Schizophrenia and were included among Schneider's list of first-rank symptoms. If these types of hallucinations are present, then only this single symptom is needed to satisfy Criterion A. The hallucinations must occur in the context of a clear sensorium; those that occur while falling asleep (hypnagogic) or waking up (hypnopompic) are considered to be within the range of normal experience. Isolated experiences of hearing one's name called or experiences that lack the quality of an external percept (e.g., a humming in one's head) are also not considered to be hallucinations characteristic of Schizophrenia. Hallucinations may also be a normal part

of religious experience in certain cultural contexts.

Disorganized thinking ("formal thought disorder," "loosening of associations") has been argued by some (Bleuler, in particular) to be the single most important feature of Schizophrenia. Because of the difficulty inherent in developing an objective definition of "thought disorder," and because in a clinical setting inferences about thought are based primarily on the individual's speech, the concept of disorganized speech (Criterion A3) has been emphasized in the definition for Schizophrenia used in this manual. The speech of individuals with Schizophrenia may be disorganized in a variety of ways. The person may "slip off the track" from one topic to another ("derailment" or "loose associations"); answers to questions may be obliquely related or completely unrelated ("tangentiality"); and, rarely, speech may be so severely disorganized that it is nearly incomprehensible and resembles receptive aphasia in its linguistic disorganization ("incoherence" or "word salad"). Because mildly disorganized speech is common and nonspecific, the symptom must be severe enough to substantially impair effective communication. Less severe disorganized thinking or speech may occur during the prodromal and residual periods of Schizophrenia (see Criterion C).

Grossly disorganized behavior (Criterion A4) may manifest itself in a variety of ways, ranging from childlike silliness to unpredictable agitation. Problems may be noted in any form of goal-directed behavior, leading to difficulties in performing activities of daily living such as organizing meals or maintaining hygiene. The person may appear markedly disheveled, may dress in an unusual manner (e.g., wearing multiple overcoats, scarves, and gloves on a hot day), or may display clearly inappropriate sexual behavior (e.g., public masturbation) or unpredictable and untriggered agitation (e.g., shouting or swearing). Care should be taken not to apply this criterion too broadly. Grossly disorganized behavior must be distinguished from behavior that is merely aimless or generally unpurposeful and from organized behavior that is motivated by delusional beliefs. Similarly, a few instances of restless, angry, or agitated behavior should not be considered to be evidence of Schizophrenia, especially if the motivation is understandable.

Catatonic motor behaviors (Criterion A4) include a marked decrease in reactivity to

the environment, sometimes reaching an extreme degree of complete unawareness (catatonic stupor), maintaining a rigid posture and resisting efforts to be moved (catatonic rigidity), active resistance to instructions or attempts to be moved (catatonic negativism), the assumption of inappropriate or bizarre postures (catatonic posturing), or purposeless and unstimulated excessive motor activity (catatonic excitement). Although catatonia has historically been associated with Schizophrenia, the clinician should keep in mind that catatonic symptoms are nonspecific and may occur in other mental disorders (see Mood Disorders With Catatonic Features, p. 382), in general medical conditions (see Catatonic Disorder Due to a General Medical Condition, p. 169), and Medication-Induced Movement Disorders (see Neuroleptic-Induced Parkinsonism, p. 736).

The negative symptoms of Schizophrenia (Criterion AS) account for a substantial degree of the morbidity associated with the disorder. Three negative symptoms­ affective flattening, alogia, and avolition-are included in the definition of Schizophrenia; other negative symptoms (e.g., anhedonia) are noted in the "Associated Features and Disorders" section below. Affective flattening is especially common and is characterized by the person's face appearing immobile and unresponsive, with poor eye contact and

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appears to have a diminution of thoughts that is reflected in decreased fluency and productivity of speech. This must be differentiated from an unwillingness to speak, a clinical judgment that may require observation over time and in a variety of situations. Avolition is characterized by an inability to initiate and persist in goal-directed activities. The person may sit for long periods of time and show little interest in participating in work or social activities.

Although quite ubiquitous in Schizophrenia, negative symptoms are difficult to evaluate because they occur on a continuum with normality, are nonspecific, and may be due to a variety of other factors (e.g., as a consequence of positive symptoms, medication side effects, a Mood Disorder, environmental understimulation, or demoral­ ization). Social isolation or impoverished speech may not be best conceived of as negative symptoms if they occur as a consequence of a positive symptom (e.g., a paranoid delusion or a prominent hallucination). For example, the behavior of an individual who has the delusional belief that he will be in danger if he leaves his room or talks to anyone may mimic alogia and avolition. Neuroleptic medications often produce extrapyramidal side effects that closely resemble affective flattening or avolition. The distinction between true negative symptoms and medication side effects depends on clinical judgment concerning the severity of negative symptoms, the nature and type of neuroleptic medication, the effects of dosage adjustment, and the effects of anticho­ linergic medications. The difficult distinction between negative symptoms and depressive symptoms may be informed by the other accompanying symptoms that are present and the fact that individuals with symptoms of depression typically experience an intense painful affect, whereas those with Schizophrenia have a diminution or emptiness of affect. Finally, chronic environmental understimulation or demoralization may result in learned apathy and avolition. In establishing the presence of negative symptoms, perhaps the best test is their persistence for a considerable period of time despite efforts directed at resolving each of the potential causes described above. It has been suggested that enduring negative symptoms be referred to as "deficit" symptoms.

Criterion A for Schizophrenia requires that at least two of the five items be present concurrently for much of at least 1 month. However, if delusions are bizarre or hallucinations involve "voices commenting" or "voices conversing," then the presence of only one item is required. The presence of this relatively severe constellation of signs and symptoms is referred to as the "active phase." In those situations in which the active-phase symptoms remit within a month in response to treatment, Criterion A can still be considered to have been met if the clinician judges that the symptoms would have persisted for a month in the absence of effective treatment. In children, evaluation of the characteristic symptoms should include due consideration of the presence of other disorders or developmental difficulties. For example, the disorganized speech in a child with a Communication Disorder should not count toward a diagnosis of Schizophrenia unless the degree of disorganization is significantly greater than would be expected on the basis of the Communication Disorder alone.

Schizophrenia involves dysfunction in one or more major areas of functioning (e.g., interpersonal relations, work or education, or self-care) (Criterion B). Typically, func­ tioning is clearly below that which had been achieved before the onset of symptoms. If the disturbance begins in childhood or adolescence, however, there may be a failure to achieve what would have been expected for the individual rather than a deterioration in functioning. Comparing the individual with unaffected siblings may be helpful in making this determination. Educational progress is frequently disrupted, and the individual may be unable to finish school. Many individuals are unable to hold a job for

sustained periods of time and are employed at a lower level than their parents ("downward drift"). The majority (60%-70%) of individuals with Schizophrenia do not marry, and most have relatively limited social contacts. The dysfunction persists for a substantial period during the course of the disorder and does not appear to be a direct result of any single feature. For example, if a woman quits her job because of the circumscribed delusion that her boss is trying to kill her, this alone is not sufficient evidence for this criterion unless there is a more pervasive pattern of difficulties (usually in multiple domains of functioning).

Some signs of the disturbance must persist for a continuous period of at least 6 months (Criterion C). During that time period, there must be at least 1 month of symptoms (or less than 1 month if symptoms are successfully treated) that meet Criterion A of Schizophrenia (the active phase). Prodromal symptoms are often present prior to the active phase, and residual symptoms may follow it. Some prodromal and residual symptoms are relatively mild or subthreshold forms of the positive symptoms specified in Criterion A. Individuals may express a variety of unusual or odd beliefs that are not of delusional proportions (e.g., ideas of reference or magical thinking); they may have unusual perceptual experiences (e.g., sensing the presence of an unseen person or force in the absence of formed hallucinations); their speech may be generally understandable but digressive, vague, or overly abstract or concrete; and their behavior may be peculiar but not grossly disorganized (e.g., mumbling to themselves, collecting odd and apparently worthless objects). In addition to these positive-like symptoms, negative symptoms are particularly common in the prodromal and residual phases and can often be quite severe. Individuals who had been socially active may become withdrawn; they lose interest in previously pleasurable activities; they may become less talkative and inquisitive; and they may spend the bulk of their time in bed. Such negative symptoms are often the first sign to the family that something is wrong; family members may ultimately report that they experienced the individual as "gradually slipping away."

***Subtypes and Course Specifiers***

The diagnosis of a particular subtype is based on the clinical picture that occasioned the most recent evaluation or admission to clinical care and may therefore change over time. Separate text and criteria are provided for each of the following subtypes:

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| **295.30** | **Paranoid Type** (see p. 287) |
| **295.10** | **Disorganized Type** (see p. 287) |
| **295.20** | **Catatonic Type** (see p. 288) |
| **295.90** | **Undifferentiated Type** (see p. 289) |
| **295.60** | **Residual Type** (see p. 289) |

The following specifiers may be used to indicate the characteristic course of symptoms of Schizophrenia over time. These specifiers can be applied only after at least 1 year has elapsed since the initial onset of active-phase symptoms. During this initial I-year period, no course specifiers can be given.

**Episodic WithlnterepisodeResidual Symptoms.** This specifier applies when the course is characterized by episodes in which Criterion A for Schizophrenia is met and there are clinically significant residual symptoms between the episodes. **With Prominent Negative Symptoms** can be added if prominent negative symptoms are present during these residual periods.

**Episodic With No Interepisode Residual Symptoms.** This specifier applies when the course is characterized by episodes in which Criterion A for Schizo­ phrenia is met and there are no clinically significant residual symptoms between the episodes.

**Continuous.** This specifier applies when characteristic symptoms of Criterion A are met throughout all (or most) of the course. **With Prominent Negative Symptoms** can be added if prominent negative symptoms are also present.

**Single Episode In Partial Remission.** This specifier applies when there has been a single episode in which Criterion A for Schizophrenia is met and some clinically significant residual symptoms remain. **With Prominent Negative Symptoms** can be added if these residual symptoms include prominent negative symptoms.

**Single Episode In Full Remission.** This specifier applies when there has been a single episode in which Criterion A for Schizophrenia has been met and no clinically significant residual symptoms remain.

**Other or Unspecified Pattern.** This specifier is used if another or an unspec­ ified course pattern has been present.

***Recording Procedures***

The diagnostic code for Schizophrenia is selected based on the appropriate subtype:

295.30 for Paranoid Type, 295.10 for Disorganized Type, 295.20 for Catatonic Type,

295.90 for Undifferentiated Type, and 295.60 for Residual Type. There are no fifth-digit codes available for the course specifiers. In recording the name of the disorder, the course specifiers are noted after the appropriate subtype (e.g., 295.30 Schizophrenia, Paranoid Type, Episodic With Interepisode Residual Symptoms, With Prominent Nega­ tive Symptoms).

***Associated Features and Disorders***

**Associated descriptive features and mental disorders.** The individual with Schizophrenia may display inappropriate affect (e.g., smiling, laughing, or a silly facial expression in the absence of an appropriate stimulus), which is one of the defining features of the Disorganized Type. Anhedonia is common and is manifested by a loss of interest or pleasure. Dysphoric mood may take the form of depression, anxiety, or anger. There may be disturbances in sleep pattern (e.g., sleeping during the day and nighttime activity or restlessness). The individual may show a lack of interest in eating or may refuse food as a consequence of delusional beliefs. Often there are abnormalities of psychomotor activity (e.g., pacing, rocking, or apathetic immobility). Difficulty concentrating is frequently evident and may reflect problems with focusing attention or distractibility due to preoccupation with internal stimuli. Although basic intellectual functions are classically considered to be intact in Schizophrenia, some indications of cognitive dysfunction are often present. The individual may be confused or disoriented or may have memory impairment during a period of exacerbation of active symptoms or in the presence of very severe negative symptoms. Lack of insight is common and may be one of the best predictors of poor outcome, perhaps because it predisposes the individual to noncompliance with treatment. Depersonalization, derealization, and somatic concerns may occur and sometimes reach delusional proportions. Motor

abnormalities (e.g., grimacing, posturing, odd mannerisms, ritualistic or stereotyped behavior) are sometimes present. The life expectancy of individuals with Schizophrenia is shorter than that of the general population for a variety of reasons. Suicide is an important factor, because approximately 10% of individuals with Schizophrenia commit suicide. Risk factors for suicide include being male, age under 30 years, depressive symptoms, unemployment, and recent hospital discharge. There is conflicting evidence with regard to whether the frequency of violent acts is greater than in the general population. Comorbidity with Substance-Related Disorders (including Nicotine Depen­ dence) is common. Schizotypal, Schizoid, or Paranoid Personality Disorder may some­ times precede the onset of Schizophrenia. Whether these Personality Disorders are simply prodromal to Schizophrenia or whether they constitute a separate earlier disorder is not clear.

**Associated laboratory findings.** No laboratory findings have been identified that are diagnostic of Schizophrenia. However, a variety of laboratory findings have been noted to be abnormal in groups of individuals with Schizophrenia relative to control subjects. Structural abnormalities in the brain have consistently been demonstrated in individuals with Schizophrenia as a group; the most common structural abnormalities include enlargement of the ventricular system and prominent sulci in the cortex. A variety of other abnormalities have also been noted using structural imaging techniques (e.g., decreased temporal and hippocampal size, increased size of the basal ganglia, decreased cerebral size). Functional imaging techniques have indicated that some individuals may have abnormal cerebral blood flow or glucose utilization in specific brain regions (e.g., prefrontal cortex). Neuropsychological assessments may show a broad range of dysfunc­ tions (e.g., difficulty in changing response set, focusing attention, formulating abstract concepts). Neurophysiological findings include a slowing in reaction times, abnormalities in eye tracking, or impairments in sensory gating. Abnormal laboratory findings may also be noted as either a complication of Schizophrenia or of its treatment. Some individuals with Schizophrenia drink excessive amounts of fluid ("water intoxication") and develop abnormalities in urine specific gravity or electrolyte imbalances. Elevated creatine phosphokinase (CPK) may result from Neuroleptic Malignant Syndrome (see p. 739).

**Associated physical examination findings andgeneral medical conditions.** Individuals with Schizophrenia are sometimes physically awkward and may display neurological "soft signs," such as left/right confusion, poor coordination, or mirroring. Some minor physical anomalies (e.g., highly arched palate, narrow- or wide-set eyes or subtle malformations of the ears) may be more common among individuals with Schizophrenia. Perhaps the most common associated physical findings are motor abnormalities. Most of these are likely to be related to side effects from treatment with antipsychotic medications. Motor abnormalities that are secondary to neuroleptic treatment include Neuroleptic-Induced Tardive Dyskinesia (see p. 747), Neuroleptic­ Induced Parkinsonism (seep. 736), Neuroleptic-Induced Acute Akathisia (seep. 744), Neuroleptic-Induced Acute Dystonia (see p. 742), and Neuroleptic Malignant Syndrome (see p. 739). Spontaneous motor abnormalities resembling those that may be induced by neuroleptics (e.g., sniffing, tongue clucking, grunting) had been described in the preneuroleptic era and are also still observed, although they may be difficult to distinguish from neuroleptic effects. Other physical findings may be related to frequently associated disorders. For example, because Nicotine Dependence is so common in

Schizophrenia, these individuals are more likely to develop cigarette-related pathology (e.g., emphysema and other pulmonary and cardiac problems).

***Specific Culture, Age, and Gender Features***

Clinicians assessing the symptoms of Schizophrenia in socioeconomic or cultural situations that are different from their own must take cultural differences into account. Ideas that may appear to be delusional in one culture (e.g., sorcery and witchcraft) may be commonly held in another. In some cultures, visual or auditory hallucinations with a religious content may be a normal part of religious experience (e.g., seeing the Virgin Mary or hearing God's voice). In addition, the assessment of disorganized speech may be made difficult by linguistic variation in narrative styles across cultures that affects the logical form of verbal presentation. The assessment of affect requires sensitivity to differences in styles of emotional expression, eye contact, and body language, which vary across cultures. If the assessment is conducted in a language that is different from the individual's primary language, care must be taken to ensure that alogia is not related to linguistic barriers. Because the cultural meaning of self-initiated, goal-directed activity can be expected to vary across diverse settings, disturbances of volition must also be carefully assessed. There is some evidence that clinicians may have a tendency to overdiagnose Schizophrenia (instead of Bipolar Disorder) in some ethnic groups.

Cultural differences have been noted in the presentation, course, and outcome of

"-'riave aouunuarten::urnl-oluo(n1Jw ,/r g1uL=e7.Itnr'Lauvn 'n( peunc Ula1rr rt:gRJ115 ,e.g., prefrontal cortex). Neuropsychological assessments may show a broad range of dysfunc­ tions (e.g., difficulty in changing response set, focusing attention, formulating abstract concepts). Neurophysiological findings include a slowing in reaction times, abnormalities in eye tracking, or impairments in sensory gating. Abnormal laboratory findings may also be noted as either a complication of Schizophrenia or of its treatment. Some individuals with Schizophrenia drink excessive amounts of fluid ("water intoxication") and develop abnormalities in urine specific gravity or electrolyte imbalances. Elevated creatine phosphokinase (CPK) may result from Neuroleptic Malignant Syndrome (see p. 739).

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and definition. Hospital-based studies suggest a higher rate of Schizophrenia in males, whereas community-based surveys have mostly suggested an equal sex ratio. Broader definitions of Schizophrenia with respect to the boundary with Mood Disorders will yield a higher female-to-male ratio than the relatively narrow construct of Schizophrenia used in this manual.

***Prevalence***

There is variability in the reported prevalence of Schizophrenia because different studies have used different methods of ascertainment (e.g., rural versus urban, community versus clinic or hospital) and different definitions of Schizophrenia (narrow versus broad, criterion-based versus clinical). Estimates of prevalence have ranged from 0.2% to 2.0% across many large studies. Prevalence rates are similar throughout the world, but pockets of high prevalence have been reported in some specific areas. Taking all these sources of information into account, the lifetime prevalence of Schizophrenia is usually estimated to be between 0.5% and 1%. Because Schizophrenia tends to be chronic, incidence rates are considerably lower than prevalence rates and are estimated to be approximately 1 per 10,000 per year.

***Course***

The median age at onset for the first psychotic episode of Schizophrenia is in the early to mid-20s for men and in the late 20s for women. The onset may be abrupt or insidious, but the majority of individuals display some type of prodromal phase manifested by the slow and gradual development of a variety of signs and symptoms (e.g., social withdrawal, loss of interest in school or work, deterioration in hygiene and grooming, unusual behavior, outbursts of anger). Family members may find this behavior difficult to interpret and assume that the person is "going through a phase." Eventually, however, the appearance of some active-phase symptom marks the disturbance as Schizophrenia. The age at onset may have both pathophysiological and prognostic significance. Individuals with an early age at onset are more often male and have a poorer premorbid adjustment, lower educational achievement, more evidence of structural brain abnor­ malities, more prominent negative signs and symptoms, more evidence of cognitive impairment as assessed with neuropsychological testing, and a worse outcome. Con­ versely, individuals with a later onset are more often female, have less evidence of structural brain abnormalities or cognitive impairment, and display a better outcome.

Most studies of course and outcome in Schizophrenia suggest that the course may be variable, with some individuals displaying exacerbations and remissions, whereas others remain chronically ill. Because of variability in definition and ascertainment, an accurate summary of the long-term outcome of Schizophrenia is not possible. Complete remission (i.e., a return to full premorbid functioning) is probably not common in this disorder. Of those who remain ill, some appear to have a relatively stable course, whereas others show a progressive worsening associated with severe disability. Early in the illness, negative symptoms may be prominent, appearing primarily as prodromal features. Subsequently, positive symptoms appear. Because these positive symptoms are partic­ ularly responsive to treatment, they typically diminish, but in many individuals, negative symptoms persist between episodes of positive symptoms. There is some suggestion that negative symptoms may become steadily more prominent in some individuals during

the course of the illness. Numerous studies have indicated a group of factors that are associated with a better prognosis. These include good premorbid adjustment, acute onset, later age at onset, being female, precipitating events, associated mood disturbance, brief duration of active-phase symptoms, good interepisode functioning, minimal residual symptoms, absence of structural brain abnormalities, normal neurological functioning, a family history of Mood Disorder, and no family history of Schizophrenia.

***Familial Pattern***

The first-degree biological relatives of individuals with Schizophrenia have a risk for Schizophrenia that is about 10 times greater than that of the general population. Concordance rates for Schizophrenia are higher in monozygotic twins than in dizygotic twins. Adoption studies have shown that biological relatives of individuals with Schizophrenia have a substantially increased risk for Schizophrenia, whereas adoptive relatives have no increased risk. Although much evidence suggests the importance of genetic factors in the etiology of Schizophrenia, the existence of a substantial discordance rate in monozygotic twins also indicates the importance of environmental factors.

***Differential Diagnosis***

A wide variety of general medical conditions can present with psychotic symptoms. **Psychotic Disorder Due to a General Medical Condition, delirium, or dementia** is diagnosed when there is evidence from the history, physical examination, or laboratory tests that indicates that the delusions or hallucinations are the direct physiological consequence of a general medical condition (e.g., Cushing's syndrome, brain tumor) (see p. 306). **Substance-InducedPsychotic Disorder, Substance-InducedDelirium,** and **Substance-Induced Persisting Dementia** are distinguished from Schizophrenia by the fact that a substance (e.g., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the delusions or hallucinations (seep. 310). Many different types of **Substance-Related Disorders** may produce symptoms similar to those of Schizophrenia (e.g., sustained amphetamine or cocaine use may produce delusions or hallucinations; phencyclidine use may produce a mixture of positive and negative symptoms). Based on a variety of features that characterize the course of Schizophrenia and Substance-Related Disorders, the clinician must determine whether the psychotic symptoms have been initiated and maintained by the substance use. Ideally, the clinician should attempt to observe the individual during a sustained period (e.g., 4 weeks) of abstinence. However, because such prolonged periods of abstinence are often difficult to achieve, the clinician may need to consider other evidence, such as whether the psychotic symptoms appear to be exacerbated by the substance and to diminish when it has been discontinued, the relative severity of psychotic symptoms in relation to the amount and duration of substance use, and knowledge of the characteristic symptoms produced by a particular substance (e.g., amphetamines typically produce delusions and stereotypies, but not affective blunting or prominent negative symptoms). Distinguishing Schizophrenia from **Mood Disorder With Psychotic Features** and **SchizoaffectiveDisorder** is made difficult by the fact that mood disturbance is common during the prodromal, active, and residual phases of Schizophrenia. If psychotic symptoms occur exclusively during periods of mood disturbance, the diagnosis is Mood Disorder With Psychotic Features. In Schizoaffective Disorder, there must be a mood

episode that is concurrent with the active-phase symptoms of Schizophrenia, mood symptoms must be present for a substantial portion of the total duration of the disturbance, and delusions or hallucinations must be present for at least 2 weeks in the absence of prominent mood symptoms. In contrast, mood symptoms in Schizophrenia either have a duration that is brief in relation to the total duration of the disturbance, occur only during the prodromal or residual phases, or do not meet full criteria for a mood episode. When mood symptoms that meet full criteria for a mood episode are superimposed on Schizophrenia and are of particular clinical significance, an additional diagnosis of **Depressive Disorder Not Otherwise Specified or Bipolar Disorder Not Otherwise Specified** may be given. Schizophrenia, Catatonic Type, may be difficult to distinguish from a **Mood Disorder With Catatonic Features.**

By definition, Schizophrenia differs from **SchizophreniformDisorder** on the basis of duration. Schizophrenia involves the presence of symptoms (including prodromal or residual symptoms) for at least 6 months, whereas the total duration of symptoms in Schizophreniform Disorder must be at least 1 month but less than 6 months. Schizophreniform Disorder also does not require a decline in functioning. **Brief Psychotic Disorder** is defined by the presence of delusions, hallucinations, disorga­ nized speech, or grossly disorganized or catatonic behavior lasting for at least 1 day but for less than 1 month.

The differential diagnosis between Schizophrenia and **Delusional Disorder** rests on the nature of the delusions (nonbizarre in Delusional Disorder) and the absence of other characteristic symptoms of Schizophrenia (e.g., hallucinations, disorganized speech or behavior, or prominent negative symptoms). Delusional Disorder is particu­ larly difficult to differentiate from the Paranoid Type of Schizophrenia, because this subtype does not include prominent disorganized speech, disorganized behavior, or flat or inappropriate affect and is often associated with less decline in functioning than is characteristic of the other subtypes of Schizophrenia. When poor psychosocial function­ ing is present in Delusional Disorder, it arises directly from the delusional beliefs themselves.

A diagnosis of **Psychotic Disorder Not Otherwise Specified** may be made if insufficient information is available to choose between Schizophrenia and other Psy­ chotic Disorders (e.g., Schizoaffective Disorder) or to determine whether the presenting symptoms are substance induced or are the result of a general medical condition. Such uncertainty is particularly likely to occur early in the course of the disorder.

Although Schizophrenia and **Pervasive Developmental Disorders** (e.g., Autistic Disorder) share disturbances in language, affect, and interpersonal relatedness, they can be distinguished in a number of ways. Pervasive Developmental Disorders are charac­ teristically recognized during infancy or early childhood (usually before age 3 years), whereas such early onset is rare in Schizophrenia. Moreover, in Pervasive Developmental Disorders, there is an absence of prominent delusions and hallucinations; more pronounced abnormalities in affect; and speech that is absent or minimal and charac­ terized by stereotypies and abnormalities in prosody. Schizophrenia may occasionally develop in individuals with a Pervasive Developmental Disorder; a diagnosis of Schizophrenia is warranted in individuals with a preexisting diagnosis of Autistic Disorder or another Pervasive Developmental Disorder only if prominent hallucinations or delusions have been present for at least a month. Childhood-onset Schizophrenia must be distinguished from **childhood presentations combining disorganized speech** (from a **Communication Disorder)** and disorganized behavior (from **Attention-Deficit/ Hyperactivity Disorder).**

Schizophrenia shares features (e.g., paranoid ideation, magical thinking, social avoidance, and vague and digressive speech) with and may be preceded by **Schizotypal, Schizoid, or Paranoid Personality Disorder.** An additional diagnosis of Schizophrenia is appropriate when the symptoms are severe enough to satisfy Criterion A of Schizophrenia. The preexisting Personality Disorder may be noted on Axis II followed by "Premorbid" in parentheses [e.g., Schizotypal Personality Disorder (Premorbid)].

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| * **Diagnostic criteria for Schizophrenia**   1. *Characteristicsymptoms:* Two (or more) of the following, each present for a significant portion of time during a I-month period (or less if successfully treated):      1. delusions      2. hallucinations      3. disorganized speech (e.g., frequent derailment or incoherence)      4. grossly disorganized or catatonic behavior      5. negative symptoms, i.e., affective flattening, alogia, or avolition   **Note:** Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.   * 1. *Social/occupational dyifunction:* For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).   2. *Duration:* Continuous signs of the disturbance persist for at least   6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).  D. *Schizoaffectiveand Mood Disorder exclusion:* Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total  *(continued)* |

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| * **Diagnostic criteria for Schizophrenia** *(continued)*   duration has been brief relative to the duration of the active and residual periods.   * 1. *Substance/general medical condition exclusion:* The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.   2. *Relationship to a Pervasive Developmental Disorder:* If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delu­ sions or hallucinations are also present for at least a month (or less if successfully treated).   *Classification of longitudinal course* (can be applied only after at least 1 year has elapsed since the initial onset of active-phase symptoms):  **Episodic With Interepisode Residual Symptoms** (episodes are defined by the reemergence of prominent psychotic symptoms); *also specify if* **With Prominent Negative Symptoms**  **Episodic With No Interepisode Residual Symptoms**  **Continuous** (prominent psychotic symptoms are present throughout the period of observation); *also specify if* **With Prominent Negative Symptoms**  **Single Episode In Partial Remission;** *also specify if* **With Prominent Negative Symptoms**  **Single Episode In Full Remission Other or Unspecified Pattern** |

***Schizophrenia Subtypes***

The subtypes of Schizophrenia are defined by the predominant symptomatology at the time of evaluation. Although the prognostic and treatment implications of the subtypes are variable, the Paranoid and Disorganized Types tend to be the least and most severe, respectively. The diagnosis of a particular subtype is based on the clinical picture that occasioned the most recent evaluation or admission to clinical care and may therefore change over time. Not infrequently, the presentation may include symptoms that are characteristic of more than one subtype. The choice among subtypes depends on the following algorithm: Catatonic Type is assigned whenever prominent catatonic symp­ toms are present (regardless of the presence of other symptoms); Disorganized Type is assigned whenever disorganized speech and behavior and flat or inappropriate affect are prominent (unless Catatonic Type is also present); Paranoid Type is assigned whenever there is a preoccupation with delusions or frequent hallucinations are prominent (unless the Catatonic or Disorganized Type is present). Undifferentiated Type is a residual category describing presentations that include prominent active-phase

symptoms not meeting criteria for the Catatonic, Disorganized, or Paranoid Type; and Residual Type is for presentations in which there is continuing evidence of the disturbance, but the criteria for the active-phase symptoms are no longer met.

A dimensional alternative to the traditional Schizophrenia subtypes is described in Appendix B (seep. 710). The suggested dimensions are the psychotic dimension, the disorganized dimension, and the negative dimension.

**295.30 Paranoid Type**

The essential feature of the Paranoid Type of Schizophrenia is the presence of prominent delusions or auditory hallucinations in the context of a relative preservation of cognitive functioning and affect. Symptoms characteristic of the Disorganized and Catatonic Types (e.g., disorganized speech, flat or inappropriate affect, catatonic or disorganized behavior) are not prominent. Delusions are typically persecutory or grandiose, or both, but delusions with other themes (e.g., jealousy, religiosity, or somatization) may also occur. The delusions may be multiple, but are usually organized around a coherent theme. Hallucinations are also typically related to the content of the delusional theme. Associated features include anxiety, anger, aloofness, and argumentativeness. The individual may have a superior and patronizing manner and either a stilted, formal quality or extreme intensity in interpersonal interactions. The persecutory themes may predis­ pose the individual to suicidal behavior, and the combination of persecutory and grandiose delusions with anger may predispose the individual to violence. Onset tends to be later in life than the other types of Schizophrenia, and the distinguishing characteristics may be more stable over time. These individuals usually show little or no impairment on neuropsychological or other cognitive testing. Some evidence suggests that the prognosis for the Paranoid Type may be considerably better than for the other types of Schizophrenia, particularly with regard to occupational functioning and capacity for independent living.

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| * **Diagnostic criteria for 295.30 Paranoid Type**   A type of Schizophrenia in which the following criteria are met:   * 1. Preoccupation with one or more delusions or frequent auditory hallucinations.   2. None of the following is prominent: disorganized speech, disorganized or catatonic behavior, or flat or inappropriate affect. |

**295.10 Disorganized Type**

The essential features of the Disorganized Type of Schizophrenia are disorganized speech, disorganized behavior, and flat or inappropriate affect. The disorganized speech

may be accompanied by silliness and laughter that are not closely related to the content of the speech. The behavioral disorganization (i.e., lack of goal orientation) may lead to severe disruption in the ability to perform activities of daily living (e.g., showering, dressing, or preparing meals). Criteria for the Catatonic Type of Schizophrenia are not met, and delusions or hallucinations, if present, are fragmentary and not organized into a coherent theme. Associated features include grimacing, mannerisms, and other oddities of behavior. Impaired performance may be noted on a variety of neuropsychological and cognitive tests. This subtype is also usually associated with poor premorbid personality, early and insidious onset, and a continuous course without significant remissions. Historically, and in other classification systems, this type is termed *hebephrenic.*

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| * **Diagnostic criteria for 295. IO Disorganized Type**   A type of Schizophrenia in which the following criteria are met:   * 1. All of the following are prominent:      1. disorganized speech      2. disorganized behavior      3. flat or inappropriate affect   2. The criteria are not met for Catatonic Type. |

**295.20 Catatonic Type**

The essential feature of the Catatonic Type of Schizophrenia is a marked psychomotor disturbance that may involve motoric immobility, excessive motor activity, extreme negativism, mutism, peculiarities of voluntary movement, echolalia, or echopraxia. Motoric immobility may be manifested by catalepsy (waxy flexibility) or stupor. The excessive motor activity is apparently purposeless and is not influenced by external stimuli. There may be extreme negativism that is manifested by the maintenance of a rigid posture against attempts to be moved or resistance to all instructions. Peculiarities of voluntary movement are manifested by the voluntary assumption of inappropriate or bizarre postures or by prominent grimacing. Echolalia is the pathological, parrotlike, and apparently senseless repetition of a word or phrase just spoken by another person. Echopraxia is the repetitive imitation of the movements of another person. Additional features include stereotypies, mannerisms, and automatic obedience or mimicry. During severe catatonic stupor or excitement, the person may need careful supervision to avoid self-harm or harming others. There are potential risks from malnutrition, exhaustion, hyperpyrexia, or self-inflicted injury. To diagnose this subtype, the individual's presen­ tation must first meet the full criteria for Schizophrenia and not be better accounted for by another etiology: substance induced (e.g., Neuroleptic-Induced Parkinsonism, see

p. 736), a general medical condition (seep. 169), or a Manic or Major Depressive Episode (seep. 382).

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| * **Diagnostic criteria for 295.20 Catatonic Type**   A type of Schizophrenia in which the clinical picture is dominated by at least two of the following:   * 1. motoric immobility as evidenced by catalepsy (including waxy flexibility) or stupor   2. excessive motor activity (that is apparently purposeless and not influenced by external stimuli)   3. extreme negativism (an apparently motiveless resistance to all instructions or maintenance of a rigid posture against attempts to be moved) or mutism   4. peculiarities of voluntary movement as evidenced by posturing (voluntary assumption of inappropriate or bizarre postures), ste­ reotyped movements, prominent mannerisms, or prominent gri­ macing   5. echolalia or echopraxia |

**295.90 Undifferentiated Type**

The essential feature of the Undifferentiated Type of Schizophrenia is the presence of symptoms that meet Criterion A of Schizophrenia but that do not meet criteria for the Paranoid, Disorganized, or Catatonic Type.

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| * **Diagnostic criteria for 295.90 Undifferentiated Type**   A type of Schizophrenia in which symptoms that meet Criterion A are present, but the criteria are not met for the Paranoid, Disorganized, or Catatonic Type. |

**295.60 Residual Type**

The Residual Type of Schizophrenia should be used when there has been at least one episode of Schizophrenia, but the current clinical picture is without prominent positive psychotic symptoms (e.g., delusions, hallucinations, disorganized speech or behavior). There is continuing evidence of the disturbance as indicated by the presence of negative symptoms (e.g., flat affect, poverty of speech, or avolition) or two or more attenuated positive symptoms (e.g., eccentric behavior, mildly disorganized speech, or odd beliefs). If delusions or hallucinations are present, they are not prominent and are not accompa­ nied by strong affect. The course of the Residual Type may be time limited and represent a transition between a full-blown episode and complete remission. However, it may also be continuously present for many years, with or without acute exacerbations.

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| * **Diagnostic criteria for 295.60 Residual Type**   A type of Schizophrenia in which the following criteria are met:   * 1. Absence of prominent delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior.   2. There is continuing evidence of the disturbance, as indicated by the presence of negative symptoms or two or more symptoms listed in Criterion A for Schizophrenia, present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences). |

**295.40 Schizophreniform Disorder**

***Diagnostic Features***

The essential features of Schizophreniform Disorder are identical to those of Schizophre­ nia (Criterion A) except for two differences: the total duration of the illness (including prodromal, active, and residual phases) is at least 1 month but less than 6 months (Criterion B) and impaired social or occupational functioning during some part of the illness is not required (although it may occur). The duration requirement for Schizophreniform Disorder is intermediate between that for Brief Psychotic Disorder (in which symptoms last for at least 1 day but for less than 1 month) and Schizophrenia (in which the symptoms persist for at least 6 months). The diagnosis of Schizophreniform Disorder is made under two conditions. In the first, the diagnosis is applied without qualification to an episode of illness of between 1 and 6 months' duration from which the individual has already recovered. In the second instance, the diagnosis is applied when a person who, although symptomatic, has been so for less than the 6 months required for a diagnosis of Schizophrenia. In this case, the diagnosis of Schizophreniform Disorder should be qualified as "Provisional" because there is no certainty that the individual will actually recover from the disturbance within the 6-month period. If the disturbance persists beyond 6 months, the diagnosis would be changed to Schizophrenia.

***Specifiers***

The following specifiers for Schizophreniform Disorder may be used to indicate the presence or absence of features that may be associated with a better prognosis:

**With Good Prognostic Features.** This specifier is used if at least two of the following features are present: onset of prominent psychotic symptoms within 4 weeks of the first noticeable change in usual behavior or functioning, confusion or perplexity at the height of the psychotic episode, good premorbid social and occupational functioning, and absence of blunted or flat affect.

**Without Good Prognostic Features.** This specifier is used if two or more of the above features have not been present.

***Associated Features and Disorders***

Also see the discussion in the "Associated Features and Disorders" section for Schizo­ phrenia, p. 279. Unlike Schizophrenia, impairment in social or occupational functioning is not required for a diagnosis of Schizophreniform Disorder. However, most individuals do experience dysfunction in various areas of daily functioning (e.g., work or school, interpersonal relationships, and self-care).

***Specific Culture, Age, and Gender Features***

For additional discussion of culture, age, and gender factors relevant to the diagnosis of Schizophreniform Disorder, see the "Specific Culture, Age, and Gender Features" section for Schizophrenia (p. 281). There are suggestions that in developing countries, recovery from Psychotic Disorders may be more rapid, which would result in higher rates of Schizophreniform Disorder than of Schizophrenia.

***Prevalence***

Community studies have reported a lifetime prevalence of Schizophreniform Disorder of around 0.2%, with a 1-year prevalence of 0.1%.

***Course***

There is little available information on the course of Schizophreniform Disorder. Approximately one-third of individuals with an initial diagnosis of Schizophreniform Disorder (Provisional) recover within the 6-month period and receive Schizophreniform Disorder as their final diagnosis. The remaining two-thirds will progress to the diagnosis of Schizophrenia or Schizoaffective Disorder.

***Differential Diagnosis***

Because the diagnostic criteria for Schizophrenia and Schizophreniform Disorder differ primarily in terms of duration of illness, the discussion of the differential diagnosis of Schizophrenia (p. 283) also applies to Schizophreniform Disorder. Schizophreniform Disorder differs from **Brief Psychotic Disorder,** which has a duration of less than 1 month.

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| * **Diagnostic criteria for 295.40 Schizophreniform Disorder**   1. Criteria A, D, and E of Schizophrenia are met.   2. An episode of the disorder (including prodromal, active, and residual phases) lasts at least 1 month but less than 6 months. (When the diagnosis must be made without waiting for recovery, it should be qualified as "Provisional.")   *(continued)* |

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| * **Criteria for 295.40 Schizophreniform Disorder** *(continued)*   *Specify* if:  **Without Good Prognostic Features**  **With Good Prognostic Features:** as evidenced by two (or more) of the following:   * 1. onset of prominent psychotic symptoms within 4 weeks of the first noticeable change in usual behavior or functioning   2. confusion or perplexity at the height of the psychotic episode   3. good premorbid social and occupational functioning   4. absence of blunted or flat affect |

**295.70 Schizoaffective Disorder**

***Diagnostic Features***

The essential feature of Schizoaffective Disorder is an uninterrupted period of illness during which, at some time, there is a Major Depressive, Manic, or Mixed Episode concurrent with symptoms that meet Criterion A for Schizophrenia (Criterion A). In addition, during the same period of illness, there have been delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms (Criterion B). Finally, the mood symptoms are present for a substantial portion of the total duration of the illness (Criterion C). The symptoms must not be due to the direct physiological effects of a substance (e.g., cocaine) or a general medical condition (e.g., hyperthyroidism or temporal lobe epilepsy) (Criterion D). To meet criteria for Schizoaffective Disorder, the essential features must occur within a single uninterrupted period of illness. The phrase "period of illness" as used here refers to a time period during which the individual continues to display active or residual symptoms of psychotic illness. For some individuals, this period of illness may last for years or even decades. A period of illness is considered to have ended when the individual has completely recovered for a significant interval of time and no longer demonstrates any significant symptoms of the disorder.

The phase of the illness with concurrent mood and psychotic symptoms is characterized by the full criteria being met for both the active phase of Schizophrenia (i.e., Criterion A) (see p. 274) and for a Major Depressive Episode (p. 320), a Manic Episode (p. 328), or a Mixed Episode (p. 333). The duration of the Major Depressive Episode must be at least 2 weeks; the duration of the Manic or Mixed Episode must be at least 1 week. Because the psychotic symptoms must have a total duration of at least 1 month to meet Criterion A for Schizophrenia, the minimum duration of a schizoaffective episode is also 1 month. An essential feature of a Major Depressive Episode is the presence of either depressed mood or markedly diminished interest or pleasure. Because loss of interest or pleasure is so common in nonaffective Psychotic Disorders, to meet Criterion A for Schizoaffective Disorder the Major Depressive Episode must include pervasive depressed mood (i.e., the presence of markedly diminished interest or pleasure is not sufficient). The phase of the illness with psychotic symptoms alone is characterized by delusions or hallucinations that last at least 2 weeks. Although some mood symptoms

may be present during this phase, they are not prominent. This determination can be difficult and may require longitudinal observation and multiple sources of information. The symptoms of Schizoaffective Disorder may occur in a variety of temporal patterns. The following is a typical pattern: An individual may have pronounced auditory hallucinations and persecutory delusions for 2 months before the onset of a prominent Major Depressive Episode. The psychotic symptoms and the full Major Depressive Episode are then present for 3 months. Then, the person recovers completely from the Major Depressive Episode, but the psychotic symptoms persist for another month before they too disappear. During this period of illness, the individual's symptoms concurrently met criteria for a Major Depressive Episode and Criterion A for Schizophrenia, and, during this same period of illness, auditory hallucinations and delusions were present both before and after the depressive phase. The total period of illness lasted for about 6 months, with psychotic symptoms alone present during the initial 2 months, both depressive and psychotic symptoms present during the next 3 months, and psychotic symptoms alone present during the last month. In this instance, the duration of the depressive episode was not brief relative to the total duration of the psychotic disturbance, and thus the presentation qualifies for a diagnosis of Schizoaffective

Disorder.

Criterion C for Schizoaffective Disorder specifies that mood symptoms that meet criteria for a mood episode must be present for a substantial portion of the entire period of illness. If the mood symptoms are present for only a relatively brief period of time, the diagnosis is Schizophrenia, not Schizoaffective Disorder. In evaluating this criterion, the clinician should determine the proportion of time during the continuous period of psychotic illness (i.e., both active and residual symptoms) in which there were significant mood symptoms accompanying the psychotic symptoms. The operationalization of what is meant by "a substantial portion of time" requires clinical judgment. For example, an individual with a 4-year history of active and residual symptoms of Schizophrenia develops a superimposed Major Depressive Episode that lasts for 5 weeks during which the psychotic symptoms persist. This presentation would not meet the criterion for "a substantial portion of the total duration" because the symptoms that meet criteria for a mood episode occurred for only 5 weeks out of a total of 4 years of disturbance. The diagnosis in this example remains Schizophrenia with the additional diagnosis of Depressive Disorder Not Otherwise Specified to indicate the superimposed Major Depressive Episode.

***Subtypes***

Two subtypes of Schizoaffective Disorder may be noted based on the mood component of the disorder:

**BipolarType.** This subtype applies if a Manic Episode or Mixed Episode is part of the presentation. Major Depressive Episodes may also occur.

**Depressive Type.** This subtype applies if only Major Depressive Episodes are part of the presentation.

***Associated Features and Disorders***

There may be poor occupational functioning, a restricted range of social contact, difficulties with self-care, and increased risk of suicide associated with Schizoaffective Disorder. Residual and negative symptoms are usually less severe and less chronic than

those seen in Schizophrenia. Individuals with Schizoaffective Disorder may be at increased risk for later developing episodes of pure Mood Disorder (e.g., Major Depressive or Bipolar Disorder) or of Schizophrenia or Schizophreniform Disorder. There may be associated Alcohol and other Substance-Related Disorders. Limited clinical evidence suggests that Schizoaffective Disorder may be preceded by Schizoid, Schizotypal, Borderline, or Paranoid Personality Disorder.

***Specific Culture, Age, and Gender Features***

For additional discussion of culture, age, and gender factors relevant to evaluating psychotic symptoms, see the text for Schizophrenia (p. 281), and for a discussion of such factors relevant to diagnosing Mood Disorders, seep. 341 and p. 352. Schizoaffective Disorder, Bipolar Type, may be more common in young adults, whereas Schizoaffective Disorder, Depressive Type, may be more common in older adults. Compared with Schizophrenia, Schizoaffective Disorder probably occurs more often in women.

***Prevalence***

Detailed information is lacking, but Schizoaffective Disorder appears to be less common than Schizophrenia.

***Course***

The typical age at onset of Schizoaffective Disorder is probably in early adulthood, although onset can occur anywhere from adolescence to late in life. The prognosis for Schizoaffective Disorder is somewhat better than the prognosis for Schizophrenia, but considerably worse than the prognosis for Mood Disorders. Substantial occupational and social dysfunction are not uncommon. The outcome for Schizoaffective Disorder, Bipolar Type, may be better than that for Schizoaffective Disorder, Depressive Type.

***Familial Pattern***

There is substantial evidence that there is an increased risk for Schizophrenia in first-degree biological relatives of individuals with Schizoaffective Disorder. Most studies also show that relatives of individuals with Schizoaffective Disorder are at increased risk for Mood Disorders.

***Differential Diagnosis***

General medical conditions and substance use can present with a combination of psychotic and mood symptoms. **Psychotic Disorder Due to a General Medical Condition, a delirium,** or a **dementia** is diagnosed when there is evidence from the history, physical examination, or laboratory tests indicating that the symptoms are the direct physiological consequence of a specific general medical condition (see p. 306). **Substance-Induced Psychotic Disorder** and **Substance-Induced Delirium** are dis­ tinguished from Schizoaffective Disorder by the fact that a substance (e.g., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the symptoms (seep. 310).

Distinguishing Schizoaffective Disorder from Schizophrenia and from Mood Disorder

With Psychotic Features is often difficult. In Schizoaffective Disorder, there must be a mood episode that is concurrent with the active-phase symptoms of Schizophrenia, mood symptoms must be present for a substantial portion of the total duration of the disturbance, and delusions or hallucinations must be present for at least 2 weeks in the absence of prominent mood symptoms. In contrast, mood symptoms in Schizophrenia either have a duration that is brief relative to the total duration of the disturbance, occur only during the prodromal or residual phases, or do not meet full criteria for a mood episode. If psychotic symptoms occur exclusively during periods of mood disturbance, the diagnosis is Mood Disorder With Psychotic Features. In Schizoaffective Disorder, symptoms should not be counted toward a mood episode if they are clearly the result of symptoms of Schizophrenia (e.g., difficulty sleeping because of disturbing auditory hallucinations, weight loss because food is considered poisoned, difficulty concentrating because of psychotic disorganization). Loss of interest or pleasure is common in nonaffective Psychotic Disorders; therefore, to meet Criterion A for Schizoaffective Disorder, the Major Depressive Episode must include pervasive depressed mood.

Because the relative proportion of mood to psychotic symptoms may change over the course of the disturbance, the appropriate diagnosis for an individual episode of illness may change from Schizoaffective Disorder to Schizophrenia (e.g., a diagnosis of Schizoaffective Disorder for a severe and prominent Major Depressive Episode lasting 3 months during the first 6 months of a chronic psychotic illness would be changed to Schizophrenia if active psychotic or prominent residual symptoms persist over several years without a recurrence of another mood episode). The diagnosis may also change for different episodes of illness separated by a period of recovery. For example, an individual may have an episode of psychotic symptoms that meet Criterion A for Schizophrenia during a Major Depressive Episode, recover fully from this episode, and then later develop 6 weeks of delusions and hallucinations without prominent mood symptoms. The diagnosis in this instance would not be Schizoaffective Disorder because the period of delusions and hallucinations was not continuous with the initial period of disturbance. Instead, the appropriate diagnoses for the first episode would be Mood Disorder With Psychotic Features, In Full Remission, and Schizophreniform Disorder (Provisional) for the current episode.

Mood disturbances, especially depression, commonly develop during the course of **DelusionalDisorder.** However, such presentations do not meet criteria for Schizoaffec­ tive Disorder because the psychotic symptoms in Delusional Disorder are restricted to nonbizarre delusions and therefore do not meet Criterion A for Schizoaffective Disorder. If there is insufficient information concerning the relationship between psychotic and mood symptoms, **Psychotic Disorder Not Otherwise Specified** may be the most

appropriate diagnosis.

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| * **Diagnostic criteria for 295.70 Schizoaffective Disorder**   A. An uninterrupted period of illness during which, at some time, there is either a Major Depressive Episode, a Manic Episode, or a Mixed Episode concurrent with symptoms that meet Criterion A for Schizophrenia.  **Note:** The Major Depressive Episode must include Criterion Al: depressed mood.  *(continued)* |