Adjustment Disorders

Diagnostic Features

The essential feature of an Adjustment Disorder is the development of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor or stressors. The symptoms must develop within 3 months after the onset of the stressor(s) (Criterion A). The clinical significance of the reaction is indicated either by marked distress that is in excess of what would be expected given the nature of the stressor, or by significant impairment in social or occupational (academic) functioning (Criterion B). This category should not be used if the disturbance meets the criteria for another specific Axis I disorder (e.g., a specific Anxiety or Mood Disorder) or is merely an exacerbation of a preexisting Axis I or II disorder (Criterion C). However, an Adjustment Disorder may be diagnosed in the presence of another Axis I or Axis II disorder if the latter does not account for the pattern of symptoms that have occurred in response to the stressor. The diagnosis of an Adjustment Disorder also does not apply when the symptoms represent Bereavement (Criterion D). By definition, an Adjustment Disorder must resolve within 6 months of the termination of the stressor (or its consequences) (Criterion E). However, the symptoms may persist for a prolonged period (i.e., longerthan 6 months) if they occur in response to a chronic stressor (e.g., a chronic, disabling general medical condition) or to a stressor that has enduring consequences (e.g., the financial and emotional difficulties resulting from a divorce).

The stressor may be a single event (e.g., termination of a romantic relationship), or there may be multiple stressors (e.g., marked business difficulties and marital problems). Stressors may be recurrent (e.g., associated with seasonal business crises) or continuous (e.g., living in a crime-ridden neighborhood). Stressors may affect a single individual, an entire family, or a larger group or community (e.g., as in a natural disaster). Some stressors may accompany specific developmental events (e.g., going to school, leaving the parental home, getting married, becoming a parent, failing to attain occupational goals, retirement).

Subtypes and Specifiers

Adjustment Disorders are coded according to the subtype that best characterizes the predominant symptoms:

309.0 With Depressed Mood. This subtype should be used when the pre- dominant manifestations are symptoms such as depressed mood, tearfulness, or feelings of

hopelessness.

309.24 With Anxiety. This subtype should be used when the predominant manifestations are symptoms such as nervousness, worry, or jitteriness or, in children, fears of separation from major attachment figures.

309.28 With Mixed Anxiety and Depressed Mood. This subtype should be used when the predominant manifestation is a combination of depression and anxiety.

309.3 With Disturbance of Conduct. This subtype should be used when the predominant manifestation is a disturbance in conduct in which there is violation of the rights of others or of major age-appropriate societal norms and rules (e.g., truancy, vandalism, reckless driving, fighting, defaulting on legal responsibilities).

309.4 With Mixed Disturbance of Emotions and Conduct. This subtype should be used when the predominant manifestations are both emotional symptoms (e.g., depression, anxiety) and a disturbance of conduct (see above subtype).

309.9 Unspecified. This subtype should be used for maladaptive reactions (e.g., physical complaints, social withdrawal, or work or academic inhibition) to psychosocial stressors that are not classifiable as one of the specific subtypes of Adjustment Disorder.

The duration of the symptoms of an Adjustment Disorder can be indicated by choosing one of the following specifiers:

Acute. This specifier can be used to indicate persistence of symptoms for less than 6 months.

Chronic. This specifier can be used to indicate persistence of symptoms for 6 months or longer. By definition, symptoms cannot persist for more than 6 months after the termination of the stressor or its consequences. The Chronic specifier therefore applies when the duration of the disturbance is longer than 6 months in response to a chronic stressor or to a stressor that has enduring consequences.

Reporting Procedures

The predominant symptom presentation for an Adjustment Disorder should be indicated by choosing the diagnostic code and term from the list above, followed, if desired, by the Acute or Chronic specifier (e.g., 309.0 Adjustment Disorder With Depressed Mood, Acute). In a multiaxial assessment, the nature of the stressor can be indicated by listing it on Axis IV (e.g., Divorce).

Associated Features and Disorders

The subjective distress or impairment in functioning associated with Adjustment Disorders is frequently manifested as decreased performance at work or school and temporary changes in social relationships. Adjustment Disorders are associated with an increased risk of suicide attempts and suicide. The presence of an Adjustment Disorder may complicate the course of illness in individuals who have a general medical condition (e.g., decreased compliance with the recommended medical regimen or increased length of hospital stay).

Specific Culture, Age, and Gender Features

The context of the individual's cultural setting should be taken into account in making the clinical judgment of whether the individual's response to the stressor is maladaptive or whether the associated distress is in excess of what would be expected. The nature, meaning, and experience of the stressors and the evaluation of the response to the stressors may vary across cultures. Adjustment Disorders may occur in any age group, and males and females are equally affected.

Prevalence

Adjustment Disorders are apparently common, although epidemiological figures vary widely as a function of the population studied and the assessment methods used. The percentage of individuals in outpatient mental health treatment with a principal diagnosis of Adjustment Disorder ranges from approximately 5% to 20%. Individuals from disadvantaged life circumstances experience a high rate of stressors and may be at increased risk for the disorder.

Course

By definition, the disturbance in Adjustment Disorder begins within 3 months of onset of a stressor and lasts no longer than 6 months after the stressor or its consequences have ceased. If the stressor is an acute event (e.g., being fired from a job), the onset of the disturbance is usually immediate (or.within a few days) and the duration is relatively brief (e.g., no more than a few months). If the stressor or its consequences persist, the Adjustment Disorder may also persist.

Di,fferential magnosis

Adjustment Disorder is a residual category used to describe presentations that are a response to an identifiable stressor and that do not meet the criteria for another specific Axis I disorder. For example, if an individual has symptoms that meet criteria for a Major Depressive Episode in response to a stressor, the diagnosis of Adjustment Disorder is not applicable. Adjustment Disorder can be diagnosed in addition to another Axis I disorder only if the latter does not account for the particular symptoms that occur in reaction to the stressor. For example, an individual may develop Adjustment Disorder With Depressed Mood after losing a job and at the same time have a diagnosis of Obsessive-Compulsive Disorder.

Because **PersonalityDisorders** are frequently exacerbated by stress, the additional diagnosis of Adjustment Disorder is usually not made. However, if symptoms that are not characteristic of the Personality Disorder appear in response to a stressor (e.g., a person with Paranoid Personality Disorder develops depressed mood in response to job loss), the additional diagnosis of Adjustment Disorder may be appropriate.

The diagnosis of Adjustment Disorder requires the presence of an identifiable stressor, in contrast to the atypical or subthreshold presentations that would be diagnosed as a **Not Otherwise Specified disorder** (e.g., Anxiety Disorder Not Otherwise Specified). If the symptoms of Adjustment Disorder persist for more than 6 months after the stressor or its consequences have ceased, the diagnosis should be changed to another

mental disorder, usually in the appropriate Not Otherwise Specified category.

Adjustment Disorder, **Posttraumatic Stress Disorder,** and **Acute Stress Disorder** all require the presence of a psychosocial stressor. Posttraumatic Stress Disorder and Acute Stress Disorder are characterized by the presence of an extreme stressor and a specific constellation of symptoms. In contrast, Adjustment Disorder can be triggered by a stressor of any severity and may involve a wide range of possible symptoms.

In **Psychological Factors Affecting Medical Condition,** specific psychological symptoms, behaviors, or other factors exacerbate a general medical condition, complicate treatment for a general medical condition, or otherwise increase the risks of developing a general medical condition. In Adjustment Disorder, the relationship is the reverse (i.e., the psychological symptoms develop in response to the stress of having or being diagnosed with a general medical condition). Both conditions may be present in some individuals.

Bereavement is generally diagnosed instead of Adjustment Disorder when the reaction is an expectable response to the death of a loved one. The diagnosis of Adjustment Disorder may be appropriate when the reaction is in excess of, or more prolonged than, what would be expected. Adjustment Disorder should also be distin- guished from other **nonpathological reactions to stress** that do not lead to marked distress in excess of what is expected and that do not cause significant impairment in social or occupational functioning.

Diagnostic criteria for Adjustment Disorders

A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).

B. These symptoms or behaviors are clinically significant as evidenced by either of the following:
   (1) marked distress that is in excess of what would be expected from exposure to the stressor
   (2) significant impairment in social or occupational (academic) functioning

C. The stress-related disturbance does not meet the criteria for another specific Axis I disorder and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

D. The symptoms do not represent Bereavement.

E. Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional 6 months.

Specify if:

Acute: if the disturbance lasts less than 6 months

Chronic: if the disturbance lasts for 6 months or longer

(continued)

☐ **Diagnostic criteria for Adjustment Disorders** *(continued)*

Adjustment Disorders are coded based on the subtype, which is selected according to the predominant symptoms. The specific stressor(s) can be specified on Axis IV.

309.0 With Depressed Mood
309.24 With Anxiety
309.28 With Mixed Anxiety and Depressed Mood
309.3 With Disturbance of Conduct
309.4 With Mixed Disturbance of Emotions and Conduct
309.9 Unspecified

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Personality Disorders

This section begins with a general definition of Personality Disorder that applies to each of the 10 specific Personality Disorders. A Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment. The Personality Disorders included in this section are listed below.

Paranoid Personality Disorder is a pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent.

Schizoid Personality Disorder is a pattern of detachment from social relationships and a restricted range of emotional expression.

Schizotypal Personality Disorder is a pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behavior.

Antisocial Personality Disorder is a pattern of disregard for, and violation of, the rights of others.

Borderline Personality Disorder is a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity.

Histrionic Personality Disorder is a pattern of excessive emotionality and attention seeking.

Narcissistic Personality Disorder is a pattern of grandiosity, need for admiration, and lack of empathy.

Avoidant Personality Disorder is a pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.

Dependent Personality Disorder is a pattern of submissive and clinging behavior related to an excessive need to be taken care of.

Obsessive-Compulsive Personality Disorder is a pattern of preoccupation with orderliness, perfectionism, and control.

Personality Disorder Not Otherwise Specified is a category provided for two situations: 1) the individual's personality pattern meets the general criteria for a Personality Disorder and traits of several different Personality Disorders are present, but the criteria for any specific Personality Disorder are not met; or 2) the individual's personality pattern meets the general criteria for a Personality Disorder, but the individual is considered to have a Personality Disorder that is not included in the Classification (e.g., passive-aggressive personality disorder).

The Personality Disorders are grouped into three clusters based on descriptive similarities. Cluster A includes the Paranoid, Schizoid, and Schizotypal Personality Disorders. Individuals with these disorders often appear odd or eccentric. Cluster B

includes the Antisocial, Borderline, Histrionic, and Narcissistic Personality Disorders. Individuals with these disorders often appear dramatic, emotional, or erratic. Cluster C includes the Avoidant, Dependent, and Obsessive-Compulsive Personality Disorders. Individuals with these disorders often appear anxious or fearful. It should be noted that this clustering system, although useful in some research and educational situations, has serious limitations and has not been consistently validated. Moreover, individuals frequently present with co-occurring Personality Disorders from different clusters.

Diagnostic Features

Personality traits are enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts. Only when personality traits are inflexible and maladaptive and cause significant functional impairment or subjective distress do they constitute Personality Disorders. The essential feature of a Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture and is manifested in at least two of the following areas: cognition, affectivity, interpersonal functioning, or impulse control (Criterion A). This enduring pattern is inflexible and pervasive across a broad range of personal and social situations (Criterion B) and leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C). The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood (Criterion D). The pattern is not better accounted for as a manifestation or consequence of another mental disorder (Criterion E) and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, exposure to a toxin) or a general medical condition (e.g., head trauma) (Criterion F). Specific diagnostic criteria are also provided for each of the Personality Disorders included in this section. The items in the criteria sets for each of the specific Personality Disorders are listed in order of decreasing diagnostic importance as measured by relevant data on diagnostic efficiency (when available).

The diagnosis of Personality Disorders requires an evaluation of the individual's long-term patterns of functioning, and the particular personality features must be evident by early adulthood. The personality traits that define these disorders must also be distinguished from characteristics that emerge in response to specific situational stressors or more transient mental states (e.g., Mood or Anxiety Disorders, Substance Intoxication). The clinician should assess the stability of personality traits over time and across different situations. Although a single interview with the person is sometimes sufficient for making the diagnosis, it is often necessary to conduct more than one interview and to space these over time. Assessment can also be complicated by the fact that the characteristics that define a Personality Disorder may not be considered problematic by the individual (i.e., the traits are often ego-syntonic). To help overcome this difficulty, supplementary information from other informants may be helpful.

Recording Procedures

Personality Disorders are coded on Axis II. When (as is often the case) an individual's pattern of behavior meets criteria for more than one Personality Disorder, the clinician should list all relevant Personality Disorder diagnoses in order of importance. When an

Axis I disorder is not the principal diagnosis or the reason for visit, the clinician is encouraged to indicate which Personality Disorder is the principal diagnosis or the reason for visit by noting "Principal Diagnosis" or "Reason for Visit" in parentheses. In most cases, the principal diagnosis or the reason for visit is also the main focus of attention or treatment. Personality Disorder Not Otherwise Specified is the appropriate diagnosis for a "mixed" presentation in which criteria are not met for any single Personality Disorder but features of several Personality Disorders are present and involve clinically significant impairment.

Specific maladaptive personality traits that do not meet the threshold for a Personality Disorder may also be listed on Axis II. In such instances, no specific code should be used; for example, the clinician might record "Axis II: V71.09 No diagnosis on Axis II, histrionic personality traits." The use of particular defense mechanisms may also be indicated on Axis II. For example, a clinician might record "Axis II: 301.6 Dependent Personality Disorder; Frequent use of denial." Glossary definitions for specific defense mechanisms and the Defensive Functioning Scale appear in Appendix B (p. 751).

When an individual has a chronic Axis I Psychotic Disorder (e.g., Schizophrenia) that was preceded by a preexisting Personality Disorder (e.g., Schizotypal, Schizoid, Paranoid), the Personality Disorder should be recorded on Axis II, followed by "Premorbid" in parentheses. For example: Axis I: 295.30 Schizophrenia, Paranoid Type; Axis II: 301.20 Schizoid Personality Disorder (Premorbid).

Specific Culture, Age, and Gender Features

Judgments about personality functioning must take into account the individual's ethnic, cultural, and social background. Personality Disorders should not be confused with problems associated with acculturation following immigration or with the expression of habits, customs, or religious and political values professed by the individual's culture of origin. Especially when evaluating someone from a different background, it is useful for the clinician to obtain additional information from informants who are familiar with the person's cultural background.

Personality Disorder categories may be applied to children or adolescents in those relatively unusual instances in which the individual's particular maladaptive personality traits appear to be pervasive, persistent, and unlikely to be limited to a particular developmental stage or an episode of an Axis I disorder. It should be recognized that the traits of a Personality Disorder that appear in childhood will often not persist unchanged into adult life. To diagnose a Personality Disorder in an individual under age 18 years, the features must have been present for at least 1 year. The one exception to this is Antisocial Personality Disorder, which cannot be diagnosed in individuals under age 18 years (see p. 645). Although, by definition, a Personality Disorder requires an onset no later than early adulthood, individuals may not come to clinical attention until relatively late in life. A Personality Disorder may be exacerbated following the loss of significant supporting persons (e.g., a spouse) or previously stabilizing social situations (e.g., a job). However, the development of a change in personality in middle adulthood or later life warrants a thorough evaluation to determine the possible presence of a Personality Change Due to a General Medical Condition or an unrecognized Substance- Related Disorder.

Certain Personality Disorders (e.g., Antisocial Personality Disorder) are diagnosed more frequently in men. Others (e.g., Borderline, Histrionic, and Dependent Personality

Disorders) are diagnosed more frequently in women. Although these differences **in** prevalence probably reflect real gender differences in the presence of such patterns, clinicians must be cautious not to overdiagnose or underdiagnose certain Personality Disorders in females or in males because of social stereotypes about typical gender roles and behaviors.

Course

The features of a Personality Disorder usually become recognizable during adolescence or early adult life. By definition, a Personality Disorder is an enduring pattern of thinking, feeling, and behaving that is relatively stable over time. Some types of Personality Disorder (notably, Antisocial and Borderline Personality Disorders) tend to become less evident or to remit with age, whereas this appears to be less true for some other types (e.g., Obsessive-Compulsive and Schizotypal Personality Disorders).

Differential Diagnosis

Many of the specific criteria for the Personality Disorders describe features (e.g., suspiciousness, dependency, or insensitivity) that are also characteristic of episodes of **Axis I mental disorders.** A Personality Disorder should be diagnosed only when the defining characteristics appeared before early adulthood, are typical of the individual's long-term functioning, and do not occur exclusively during an episode of an Axis I disorder. It may be particularly difficult (and not particularly useful) to distinguish Personality Disorders from those Axis I disorders (e.g., Dysthymic Disorder) that have an early onset and a chronic, relatively stable course. Some Personality Disorders may have a "spectrum" relationship to particular Axis I conditions (e.g., Schizotypal Personality Disorder with Schizophrenia; Avoidant Personality Disorder with Social Phobia) based on phenomenological or biological similarities or familial aggregation.

For the three Personality Disorders that may be related to the **Psychotic Disorders** (i.e., Paranoid, Schizoid, and Schizotypal), there is an exclusion criterion stating that the pattern of behavior must not have occurred exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, or another Psychotic Disorder. When an individual has a chronic Axis I Psychotic Disorder (e.g., Schizophrenia) that was preceded by a preexisting Personality Disorder, the Personality Disorder should also be recorded, on Axis II, followed by "Premorbid" in parentheses.

The clinician must be cautious in diagnosing Personality Disorders during an episode of a **Mood Disorder** or an **Anxiety Disorder** because these conditions may have cross-sectional symptom features that mimic personality traits and may make it more difficult to evaluate retrospectively the individual's long-term patterns of functioning. When personality changes emerge and persist after an individual has been exposed to extreme stress, a diagnosis of **Posttraumatic Stress Disorder** should be considered (seep. 424). When a person has a **Substance-Related Disorder,** it is important not to make a Personality Disorder diagnosis based solely on behaviors that are consequences of Substance Intoxication or Withdrawal or that are associated with activities in the service of sustaining a dependency (e.g., antisocial behavior). When enduring changes in personality arise as a result of the direct physiological effects of a general medical condition (e.g., brain tumor), a diagnosis of **Personality Change Due to a General Medical Condition** (p. 171) should be considered.

Personality Disorders must be distinguished from **personality traits that do not reach the threshold for a Personality Disorder.** Personality traits are diagnosed as a Personality Disorder only when they are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress.

General diagnostic criteria for a Personality Disorder

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:
   (1) cognition (i.e., ways of perceiving and interpreting self, other people, and events)
   (2) affectivity (i.e., the range, intensity, !ability, and appropriateness of emotional response)
   (3) interpersonal functioning
   (4) impulse control

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood.

E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.

F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma).

mmensional Models for Personality msorders

The diagnostic approach used in this manual represents the categorical perspective that Personality Disorders represent qualitatively distinct clinical syndromes. An alternative to the categorical approach is the dimensional perspective that Personality Disorders represent maladaptive variants of personality traits that merge imperceptibly into normality and into one another. There have been many different attempts to identify the most fundamental dimensions that underlie the entire domain of normal and pathological personality functioning. One model consists of the following five dimensions: neuroticism, introversion versus extroversion, closedness versus openness to experience, antagonism versus agreeableness, and conscientiousness. Another approach is to describe more specific areas of personality dysfunction, including as many as 15-40 dimensions (e.g., affective reactivity, social apprehensiveness, cognitive distortion,

impulsivity, insincerity, self-centeredness). Other dimensions that have been studied include novelty seeking, reward dependence, harm avoidance, dominance, affiliation, constraint, persistence, positive emotionality versus negative emotionality, pleasure seeking versus pain avoidance, passive accommodation versus active modification, and self-propagation versus other nurturance. The DSM-IV Personality Disorder clusters (i.e., odd-eccentric, dramatic-emotional, and anxious-fearful) may also be viewed as dimensions representing spectra of personality dysfunction on a continuum with Axis I mental disorders. The relationship of the various dimensional models to the Personality Disorder diagnostic categories and to various aspects of personality dysfunction remains under active investigation.

Cluster A Personality Disorders

301.0 Paranoid Personality Disorder

Di-agnostic Features

The essential feature of Paranoid Personality Disorder is a pattern of pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent. This pattern begins by early adulthood and is present in a variety of contexts.

Individuals with this disorder assume that other people will exploit, harm, or deceive them, even if no evidence exists to support this expectation (Criterion Al). They suspect on the basis of little or no evidence that others are plotting against them and may attack them suddenly, at any time and without reason. They often feel that they have been deeply and irreversibly injured by another person or persons even when there is no objective evidence for this. They are preoccupied with unjustified doubts about the loyalty or trustworthiness of their friends and associates, whose actions are minutely scrutinized for evidence of hostile intentions (Criterion A2). Any perceived deviation from trustworthiness or loyalty serves to support their underlying assumptions. They are so amazed when a friend or associate shows loyalty that they cannot trust or believe it. It they get into trouble, they expect that friends and associates will either attack or ignore them.

Individuals with this disorder are reluctant to confide in or become close to others because they fear that the information they share will be used against them (Criterion A3). They may refuse to answer personal questions, saying that the information is "nobody's business." They read hidden meanings that are demeaning and threatening into benign remarks or events (Criterion A4). For example, an individual with this disorder may misinterpret an honest mistake by a store clerk as a deliberate attempt to shortchange or may view a casual humorous remark by a co-worker as a serious character attack. Compliments are often misinterpreted (e.g., a compliment on a new acquisition is misinterpreted as a criticism for selfishness; a compliment on an accomplishment is misinterpreted as an attempt to coerce more and better performance). They may view an offer of help as a criticism that they are not doing well enough on their own.

Individuals with this disorder persistently bear grudges and are unwilling to forgive the insults, injuries, or slights that they think they have received (Criterion AS). Minor slights arouse major hostility, and the hostile feelings persist for a long time. Because

they are constantly vigilant to the harmful intentions of others, they very often feel that their character or reputation has been attacked or that they have been slighted in some other way. They are quick to counterattack and react with anger to perceived insults (Criterion A6). Individuals with this disorder may be pathologically jealous, often suspecting that their spouse or sexual partner is unfaithful without any adequate justification (Criterion A7). They may gather trivial and circumstantial "evidence" to support their jealous beliefs. They want to maintain complete control of intimate relationships to avoid being betrayed and may constantly question and challenge the whereabouts, actions, intentions, and fidelity of their spouse or partner.

Paranoid Personality Disorder should not be diagnosed if the pattern of behavior occurs exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, or another Psychotic Disorder or if it is due to the direct physiological effects of a neurological (e.g., temporal lobe epilepsy) or other general medical condition (Criterion B).

Associated Features and Disorders

Individuals with Paranoid Personality Disorder are generally difficult to get along with and often have problems with close relationships. Their excessive suspiciousness and hostility may be expressed in overt argumentativeness, in recurrent complaining, or by quiet, apparently hostile aloofness. Because they are hypervigilant for potential threats, they may act in a guarded, secretive, or devious manner and appear to be "cold" and lacking in tender feelings. Although they may appear to be objective, rational, and unemotional, they more often display a labile range of affect, with hostile, stubborn, and sarcastic expressions predominating. Their combative and suspicious nature may elicit a hostile response in others, which then serves to confirm their original ex- pectations.

Because individuals with Paranoid Personality Disorder lack trust in others, they have an excessive need to be self-sufficient and a strong sense of autonomy. They also need to have a high degree of control over those around them. They are often rigid, critical of others, and unable to collaborate, although they have great difficulty accepting criticism themselves. They may blame others for their own shortcomings. Because of their quickness to counterattack in response to the threats they perceive around them, they may be litigious and frequently become involved in legal disputes. Individuals with this disorder seek to confirm their preconceived negative notions regarding people or situations they encounter, attributing malevolent motivations to others that are projections of their own fears. They may exhibit thinly hidden, unrealistic grandiose fantasies, are often attuned to issues of power and rank, and tend to develop negative stereotypes of others, particularly those from population groups distinct from their own. Attracted by simplistic formulations of the world, they are often wary of ambiguous situations. They may be perceived as "fanatics" and form tightly knit "cults" or groups with others who share their paranoid belief systems.

Particularly in response to stress, individuals with this disorder may experience very brief psychotic episodes (lasting minutes to hours). In some instances, Paranoid Personality Disorder may appear as the premorbid antecedent of Delusional Disorder or Schizophrenia. Individuals with this disorder may develop Major Depressive Disorder and may be at increased risk for Agoraphobia and Obsessive-Compulsive Disorder. Alcohol and otherSubstance Abuse or Dependence frequently occur. The most common

co-occurring Personality Disorders appear to be Schizotypal, Schizoid, Narcissistic, Avoidant, and Borderline.

Specific Culture, Age, and Gender Features

Some behaviors that are influenced by sociocultural contexts or specific life circumstances may be erroneously labeled paranoid and may even be reinforced by the process of clinical evaluation. Members of minority groups, immigrants, political and economic refugees, or individuals of different ethnic backgrounds may display guarded or defensive behaviors due to unfamiliarity (e.g., language barriers or lack of knowledge of rules and regulations) or in response to the perceived neglect or indifference of the majority society. These behaviors can, in turn, generate anger and frustration in those who deal with these individuals, thus setting up a vicious cycle of mutual mistrust, which should not be confused with Paranoid Personality Disorder. Some ethnic groups also display culturally related behaviors that can be misinterpreted as paranoid.

Paranoid Personality Disorder may be first apparent in childhood and adolescence with solitariness, poor peer relationships, social anxiety, underachievement in school, hypersensitivity, peculiar thoughts and language, and idiosyncratic fantasies. These children may appear to be "odd" or "eccentric" and attract teasing. In clinical samples, this disorder appears to be more commonly diagnosed in males.

Prevalence

The prevalence of Paranoid Personality Disorder has been reported to be 0.5%-2.5% in the general population, 10%-30% among those in inpatient psychiatric settings, and 2%-10% among those in outpatient mental health clinics.

Familial Pattern

There is some evidence for an increased prevalence of Paranoid Personality Disorder in relatives of probands with chronic Schizophrenia and for a more specific familial relationship with Delusional Disorder, Persecutory Type.

Differential Diagnosis

Paranoid Personality Disorder can be distinguished from **Delusional Disorder, Persecutory Type, Schizophrenia, Paranoid Type,** and **Mood Disorder With Psychotic Features** because these disorders are all characterized by a period of persistent psychotic symptoms (e.g., delusions and hallucinations). To give an additional diagnosis of Paranoid Personality Disorder, the Personality Disorder must have been present before the onset of psychotic symptoms and must persist when the psychotic symptoms are in remission. When an individual has a chronic Axis I Psychotic Disorder (e.g., Schizophre- nia) that was preceded by Paranoid Personality Disorder, Paranoid Personality Disorder should be recorded on Axis II, followed by "Premorbid" in parentheses.

Paranoid Personality Disorder must be distinguished from **Personality Change Due to a General Medical Condition,** in which the traits emerge due to the direct effects of a general medical condition on the central nervous system. It must also be distinguished from **symptoms that may develop in association with chronic**

substance use (e.g., Cocaine-Related Disorder Not Otherwise Specified). Finally, it must also be distinguished from **paranoid traits associated with the development of physical handicaps** (e.g., a hearing impairment).

Other Personality Disorders may be confused with Paranoid Personality Disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more Personality Disorders in addition to Paranoid Personality Disorder, all can be diagnosed. Paranoid Personality Disorder and **Schizotypal Personality Disorder** share the traits of suspiciousness, interpersonal aloofness, and paranoid ideation, but Schizotypal Personality Disorder also includes symptoms such as magical thinking, unusual perceptual experiences, and odd thinking and speech. Individuals with behaviors that meet criteria for **Schizoid Personality Disorder** are often perceived as strange, eccentric, cold, and aloof, but they do not usually have prominent paranoid ideation. The tendency of individuals with Paranoid Personality Disorder to react to minor stimuli with anger is also seen in **Borderline** and **Histrionic Personality Disorders.** However, these disorders are not necessarily associated with pervasive suspiciousness. People with **Avoidant Personality Disorder** may also be reluctant to confide in others, but more because of a fear of being embarrassed or found inadequate than from fear of others' malicious intent. Although antisocial behavior may be present in some individuals with Paranoid Personality Disorder, it is not usually motivated by a desire for personal gain or to exploit others as in **Antisocial Personality Disorder,** but rather is more often due to a desire for revenge. Individuals with **Narcissistic Personality Disorder** may occasionally display suspiciousness, social withdrawal, or alienation, but this derives primarily from fears of having their imperfections or flaws revealed.

Paranoid traits may be adaptive, particularly in threatening environments. Paranoid Personality Disorder should be diagnosed only when these traits are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress.

Diagnostic criteria for 301.0 Paranoid Personality Disorder

A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

(1) suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her

(2) is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates

(3) is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her

(4) reads hidden demeaning or threatening meanings into benign remarks or events

(5) persistently bears grudges, i.e., is unforgiving of insults, injuries, or slights

(continued)

☐ **Diagnostic criteria for 301.0 Paranoid Personality Disorder** *(continued)*

(6) perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack
(7) has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner

B. Does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, or another Psychotic Disorder and is not due to the direct physiological effects of a general medical condition.

Note: If criteria are met prior to the onset of Schizophrenia, add "Premorbid," e.g., "Paranoid Personality Disorder (Premorbid)."

301.20 Schizoid Personality Disorder

magnostic Features

The essential feature of Schizoid Personality Disorder is a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings. This pattern begins by early adulthood and is present in a variety of contexts.

Individuals with Schizoid Personality Disorder appear to lack a desire for intimacy, seem indifferent to opportunities to develop close relationships, and do not seem to derive much satisfaction from being part of a family or other social group (Criterion Al). They prefer spending time by themselves, rather than being with other people. They often appear to be socially isolated or "loners" and almost always choose solitary activities or hobbies that do not include interaction with others (Criterion A2). They prefer mechanical or abstract tasks, such as computer or mathematical games. They may have very little interest in having sexual experiences with another person (Criterion A3) and take pleasure in few, if any, activities (Criterion A4). There is usually a reduced experience of pleasure from sensory, bodily, or interpersonal experiences, such as walking on a beach at sunset or having sex. These individuals have no close friends or confidants, except possibly a first-degree relative (Criterion AS).

Individuals with Schizoid Personality Disorder often seem indifferent to the approval or criticism of others and do not appear to be bothered by what others may think of them (Criterion A6). They may be oblivious to the normal subtleties of social interaction and often do not respond appropriately to social cues so that they seem socially inept or superficial and self-absorbed. They usually display a "bland" exterior without visible emotional reactivity and rarely reciprocate gestures or facial expressions, such as smiles or nods (Criterion A7). They claim that they rarely experience strong emotions such as anger and joy. They often display a constricted affect and appear cold and aloof. However, in those very unusual circumstances in which these individuals become at least temporarily comfortable in revealing themselves, they may acknowledge having painful feelings, particularly related to social interactions.

Schizoid Personality Disorder should not be diagnosed if the pattern of behavior occurs exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, another Psychotic Disorder, or a Pervasive Developmental Disorder or if it is due to the direct physiological effects of a neurological (e.g., temporal lobe epilepsy) or other general medical condition (Criterion B).

Associated Features and Disorders

Individuals with Schizoid Personality Disorder may have particular difficulty expressing anger, even in response to direct provocation, which contributes to the impression that they lack emotion. Their lives sometimes seem directionless, and they may appear to "drift" in their goals. Such individuals often react passively to adverse circumstances and have difficulty responding appropriately to important life events. Because of their lack of social skills and lack of desire for sexual experiences, individuals with this disorder have few friendships, date infrequently, and often do not marry. Occupational function- ing may be impaired, particularly if interpersonal involvement is required, but individuals with this disorder may do well when they work under conditions of social isolation. Particularly in response to stress, individuals with this disorder may experience very brief psychotic episodes (lasting minutes to hours). In some instances, Schizoid Personality Disorder may appear as the premorbid antecedent of Delusional Disorder or Schizophrenia. Individuals with this disorder may sometimes develop Major Depres- sive Disorder. Schizoid Personality Disorder most often co-occurs with Schizotypal, Paranoid, and Avoidant Personality Disorders.

Specific CuUure, Age, and Gender Features

Individuals from a variety of cultural backgrounds sometimes exhibit defensive behaviors and interpersonal styles that may be erroneously labeled as schizoid. For example, those who have moved from rural to metropolitan environments may react with "emotional freezing" that may last for several months and be manifested by solitary activities, constricted affect, and other deficits in communication. Immigrants from other countries are sometimes mistakenly perceived as cold, hostile, or indifferent.

Schizoid Personality Disorder may be first apparent in childhood and adolescence with solitariness, poor peer relationships, and underachievement in school, which mark these children or adolescents as different and make them subject to teasing.

Schizoid Personality Disorder is diagnosed slightly more often in males and may cause more impairment in them.

Prevalence

Schizoid Personality Disorder is uncommon in clinical settings.

Familial Pattern

Schizoid Personality Disorder may have increased prevalence in the relatives of individuals with Schizophrenia or Schizotypal Personality Disorder.

Differential Diagnosis

Schizoid Personality Disorder can be distinguished from **Delusional Disorder, Schizophrenia,** and **Mood Disorder With Psychotic Features** because these disorders are all characterized by a period of persistent psychotic symptoms (e.g., delusions and hallucinations). To give an additional diagnosis of Schizoid Personality Disorder, the Personality Disorder must have been present before the onset of psychotic symptoms and must persist when the psychotic symptoms are in remission. When an individual has a chronic Axis I Psychotic Disorder (e.g., Schizophrenia) that was preceded by Schizoid Personality Disorder, Schizoid Personality Disorder should be recorded on Axis II followed by "Premorbid" in parentheses.

There may be great difficulty differentiating individuals with Schizoid Personality Disorder from those with milder forms of **Autistic Disorder** and from those with **Asperger's Disorder.** Milder forms of Autistic Disorder and Asperger's Disorder are differentiated by more severely impaired social interaction and stereotyped behaviors and interests.

Schizoid Personality Disorder must be distinguished from **Personality Change Due to a General Medical Condition,** in which the traits emerge due to the direct effects of a general medical condition on the central nervous system. It must also be distinguished from **symptoms that may develop in association with chronic substance use** (e.g., Cocaine-Related Disorder Not Otherwise Specified).

Other Personality Disorders may be confused with Schizoid Personality Disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more Personality Disorders in addition to Schizoid Personality Disorder, all can be diagnosed. Although characteristics of social isolation and restricted affectivity are common to Schizoid, Schizotypal, and Paranoid Personality Disorders, Schizoid Personality Disorder can be distinguished from **Schizotypal Personality Disorder** by the lack of cognitive and perceptual distortions and from **Paranoid Personality Disorder** by the lack of suspiciousness and paranoid ideation. The social isolation of Schizoid Personality Disorder can be distinguished from that of **Avoidant Personality Disorder,** which is due to fear of being embarrassed or found inadequate and excessive anticipation of rejection. In contrast, people with Schizoid Personality Disorder have a more pervasive detachment and limited desire for social intimacy. Individuals with **Obsessive- Compulsive Personality Disorder** may also show an apparent social detachment stemming from devotion to work and discomfort with emotions, but they do have an underlying capacity for intimacy.

Individuals who are "loners" may display personality traits that might be considered schizoid. Only when these traits are inflexible and maladaptive and cause significant functional impairment or subjective distress do they constitute Schizoid Personality Disorder.

Diagnostic criteria for 301.20 Schizoid Personality Disorder

A. A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

(1) neither desires nor enjoys close relationships, including being part of a family
(2) almost always chooses solitary activities
(3) has little, if any, interest in having sexual experiences with another person
(4) takes pleasure in few, if any, activities
(5) lacks close friends or confidants other than first-degree relatives
(6) appears indifferent to the praise or criticism of others
(7) shows emotional coldness, detachment, or flattened affectivity

B. Does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, another Psychotic Disorder, or a Pervasive Developmental Disorder and is not due to the direct physiological effects of a general medical condition.

Note: If criteria are met prior to the onset of Schizophrenia, add "Premorbid," e.g., "Schizoid Personality Disorder (Premorbid)."

301.22 Schizotypal Personality Disorder

Diagnostic Features

The essential feature of Schizotypal Personality Disorder is a pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior. This pattern begins by early adulthood and is present in a variety of contexts.

Individuals with Schizotypal Personality Disorder often have ideas of reference (i.e., incorrect interpretations of casual incidents and external events as having a particular and unusual meaning specifically for the person) (Criterion A1). These should be distinguished from delusions of reference, in which the beliefs are held with delusional conviction. These individuals may be superstitious or preoccupied with paranormal phenomena that are outside the norms of their subculture (Criterion A2). They may feel that they have special powers to sense events before they happen or to read others' thoughts. They may believe that they have magical control over others, which can be implemented directly (e.g., believing that their spouse taking the dog out for a walk is the direct result of thinking it should be done an hour earlier) or indirectly through compliance with magical rituals (e.g., walking past a specific object three times to avoid a certain harmful outcome). Perceptual alterations may be present (e.g., sensing that

another person is present or hearing a voice murmuring his or her name) (Criterion A3). Their speech may include unusual or idiosyncratic phrasing and construction. It is often loose, digressive, or vague, but without actual derailment or incoherence (Criterion A4). Responses can be either overly concrete or overly abstract, and words or concepts are sometimes applied in unusual ways (e.g., the person may state that he or she was not "talkable" at work).

Individuals with this disorder are often suspicious and may have paranoid ideation (e.g., believing their colleagues at work are intent on undermining their reputation with the boss) (Criterion AS). They are usually not able to negotiate the full range of affects and interpersonal cuing required for successful relationships and thus often appear to interact with others in an inappropriate, stiff, or constricted fashion (Criterion A6). These individuals are often considered to be odd or eccentric because of unusual mannerisms, an often unkempt manner of dress that does not quite "fit together," and inattention to the usual social conventions (e.g., the person may avoid eye contact, wear clothes that are ink stained and ill-fitting, and be unable to join in the give-and-take banter of co-workers) (Criterion A7).

Individuals with Schizotypal Personality Disorder experience interpersonal relatedness as problematic and are uncomfortable relating to other people. Although they may express unhappiness about their lack of relationships, their behavior suggests a decreased desire for intimate contacts. As a result, they usually have no or few close friends or confidants other than a first-degree relative (Criterion AS). They are anxious in social situations, particularly those involving unfamiliar people (Criterion A9). They will interact with other people when they have to, but prefer to keep to themselves because they feel that they are different and just do not "fit in." Their social anxiety does not easily abate, even when they spend more time in the setting or become more familiar with the other people, because their anxiety tends to be associated with suspiciousness regarding others' motivations. For example, when attending a dinner party, the individual with Schizotypal Personality Disorder will not become more relaxed as time goes on, but rather may become increasingly tense and suspicious.

Schizotypal Personality Disorder should not be diagnosed if the pattern of behavior occurs exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, another Psychotic Disorder, or a Pervasive Developmental Disorder (Crite- rion B).

Associated Features and Disorders

Individuals with Schizotypal Personality Disorder often seek treatment for the associated symptoms of anxiety, depression, or other dysphoric affects rather than for the personality disorder features per se. Particularly in response to stress, individuals with this disorder may experience transient psychotic episodes (lasting minutes to hours), although they usually are insufficient in duration to warrant an additional diagnosis such as Brief Psychotic Disorder or Schizophreniform Disorder. In some cases, clinically significant psychotic symptoms may develop that meet criteria for Brief Psychotic Disorder, Schizophreniform Disorder, Delusional Disorder, or Schizophrenia. Over half may have a history of at least one Major Depressive Episode. From 30% to 50% of individuals diagnosed with this disorder have a concurrent diagnosis of Major Depressive Disorder when admitted to a clinical setting. There is considerable co-occurrence with Schizoid, Paranoid, Avoidant, and Borderline Personality Disorders.

Specific Culture, Age, and Gender Features

Cognitive and perceptual distortions must be evaluated in the context of the individual's cultural milieu. Pervasive culturally determined characteristics, particularly those regarding religious beliefs and rituals, can appear to be schizotypal to the uninformed outsider (e.g., voodoo, speaking in tongues, life beyond death, shamanism, mind reading, sixth sense, evil eye, and magical beliefs related to health and illness).

Schizotypal Personality Disorder may be first apparent in childhood and adolescence with solitariness, poor peer relationships, social anxiety, underachievement in school, hypersensitivity, peculiar thoughts and language, and bizarre fantasies. These children may appear "odd" or "eccentric" and attract teasing. Schizotypal Personality Disorder may be slightly more common in males.

Prevalence

Schizotypal Personality Disorder has been reported to occur in approximately 3% of the general population.

Course

Schizotypal Personality Disorder has a relatively stable course, with only a small proportion of individuals going on to develop Schizophrenia or another Psychotic Disorder.

Familial Pattern

Schizotypal Personality Disorder appears to aggregate familially and is more prevalent among the first-degree biological relatives of individuals with Schizophrenia than among the general population. There may also be a modest increase in Schizophrenia and other Psychotic Disorders in the relatives of probands with Schizotypal Personality Disorder.

Di,fferential magnosis

Schizotypal Personality Disorder can be distinguished from **Delusional Disorder, Schizophrenia,** and **Mood Disorder With Psychotic Features** because these disor- ders are all characterized by a period of persistent psychotic symptoms (e.g., delusions and hallucinations). To give an additional diagnosis of Schizotypal Personality Disorder, the Personality Disorder must have been present before the onset of psychotic symptoms and persist when the psychotic symptoms are in remission. When an individual has a chronic Axis I Psychotic Disorder (e.g., Schizophrenia) that was preceded by Schizotypal Personality Disorder, Schizotypal Personality Disorder should be recorded on Axis II followed by "Premorbid" in parentheses.

There may be great difficulty differentiating children with Schizotypal Personality Disorder from the heterogeneous group of solitary, odd children whose behavior is characterized by marked social isolation, eccentricity, or peculiarities of language and whose diagnoses would probably include milder forms of **Autistic Disorder, Asperger's Disorder,** and **Expressive** and **Mixed Receptive-ExpressiveLanguage**

Disorders. Communication Disorders may be differentiated by the primacy and severity of the disorder in language accompanied by compensatory efforts by the child to communicate by other means (e.g., gestures) and by the characteristic features of impaired language found in a specialized language assessment. Milder forms of Autistic Disorder and Asperger's Disorder are differentiated by the even greater lack of social awareness and emotional reciprocity and stereotyped behaviors and interests.

Schizotypal Personality Disorder must be distinguished from **Personality Change Due to a General Medical Condition,** in which the traits emerge due to the direct effects of a general medical condition on the central nervous system. It must also be distinguished from **symptoms that may develop in association with chronic substance use** (e.g., Cocaine-Related Disorder Not Otherwise Specified).

Other Personality Disorders may be confused with Schizotypal Personality Disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more Personality Disorders in addition to Schizotypal Personality Disorder, all can be diagnosed. Although **Paranoid** and **Schizoid Personality Disorders** may also be characterized by social detachment and restricted affect, Schizotypal Personality Disorder can be distinguished from these two diagnoses by the presence of cognitive or perceptual distortions and marked eccentricity or oddness. Close relationships are limited in both Schizotypal Personality Disorder and **Avoidant Personality Disorder;** however, in Avoidant Personality Disorder an active desire for relationships is constrained by a fear of rejection, whereas in Schizotypal Personality Disorder there is a lack of desire for relationships and persistent detachment. Individuals with **Narcissistic Personality Disorder** may also display suspiciousness, social withdrawal, or alienation, but in Narcissistic Personality Disorder these qualities derive primarily from fears of having imperfections or flaws revealed. Individuals with **Borderline Personality Disorder** may also have transient, psychotic-like symptoms, but these are usually more closely related to affective shifts in response to stress (e.g., intense anger, anxiety, or disappointment) and are usually more dissociative (e.g., derealization or depersonalization). In contrast, individuals with Schizotypal Personality Disorder are more likely to have enduring psychotic-like symptoms that may worsen under stress but are less likely to be invariably associated with pronounced affective symptoms. Although social isolation may occur in Borderline Personality Disorder, this is usually secondary to repeated interpersonal failures due to angry outbursts and frequent mood shifts, rather than a result of a persistent lack of social contacts and desire for intimacy. Furthermore, individuals with Schizotypal Personality Disorder do not usually demonstrate the impulsive or manipulative behaviors of the individual with Borderline Personality Disorder. However, there is a high rate of co-occurrence between the two disorders, so that making such distinctions is not always feasible. **Schizotypal features during adolescence** may be reflective of transient emotional turmoil, rather than an enduring personality disorder.

Diagnostic criteria for 30 I .22 Schizotypal Personality Disorder

A. A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) ideas of reference (excluding delusions of reference)
(2) odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations)
(3) unusual perceptual experiences, including bodily illusions
(4) odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped)
(5) suspiciousness or paranoid ideation
(6) inappropriate or constricted affect
(7) behavior or appearance that is odd, eccentric, or peculiar
(8) lack of close friends or confidants other than first-degree relatives
(9) excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self

B. Does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, another Psychotic Disorder, or a Pervasive Developmental Disorder.

Note: If criteria are met prior to the onset of Schizophrenia, add "Premorbid," e.g., "Schizotypal Personality Disorder (Premorbid)."

Cluster B Personality Disorders

30I.7 Antisocial Personality Disorder

magnostic Features

The essential feature of Antisocial Personality Disorder is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood.

This pattern has also been referred to as psychopathy, sociopathy, or dyssocial personality disorder. Because deceit and manipulation are central features of Antisocial Personality Disorder, it may be especially helpful to integrate information acquired from

systematic clinical assessment with information collected from collateral sources.

For this diagnosis to be given, the individual must be at least age 18 years (Criterion B) and must have had a history of some symptoms of Conduct Disorder before age 15 years (Criterion C). Conduct Disorder involves a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. The specific behaviors characteristic of Conduct Disorder fall into one of four categories: aggression to people and animals, destruction of property, deceitfulness or theft, or serious violation of rules. These are described in more detail on p. 85.

The pattern of antisocial behavior continues into adulthood. Individuals with Antisocial Personality Disorder fail to conform to social norms with respect to lawful behavior (Criterion A1). They may repeatedly perform acts that are grounds for arrest (whether they are arrested or not), such as destroying property, harassing others, stealing, or pursuing illegal occupations. Persons with this disorder disregard the wishes, rights, or feelings of others. They are frequently deceitful and manipulative in order to gain personal profit or pleasure (e.g., to obtain money, sex, or power) (Criterion A2). They may repeatedly lie, use an alias, con others, or malinger. A pattern of impulsivity may be manifested by a failure to plan ahead (Criterion A3). Decisions are made on the spur of the moment, without forethought, and without consideration for the consequences to self or others; this may lead to sudden changes of jobs, residences, or relationships. Individuals with Antisocial Personality Disorder tend to be irritable and aggressive and may repeatedly get into physical fights or commit acts of physical assault (including spouse beating or child beating) (Criterion A4). Aggressive acts that are required to defend oneself or someone else are not considered to be evidence for this item. These individuals also display a reckless disregard for the safety of themselves or others (Criterion A5). This may be evidenced in their driving behavior (recurrent speeding, driving while intoxicated, multiple accidents). They may engage in sexual behavior or substance use that has a high risk for harmful consequences. They may neglect or fail to care for a child in a way that puts the child in danger.

Individuals with Antisocial Personality Disorder also tend to be consistently and extremely irresponsible (Criterion A6). Irresponsible work behavior may be indicated by significant periods of unemployment despite available job opportunities, or by abandonment of several jobs without a realistic plan for getting another job. There may also be a pattern of repeated absences from work that are not explained by illness either in themselves or in their family. Financial irresponsibility is indicated by acts such as defaulting on debts, failing to provide child support, or failing to support other dependents on a regular basis. Individuals with Antisocial Personality Disorder show little remorse for the consequences of their acts (Criterion A7). They may be indifferent to, or provide a superficial rationalization for, having hurt, mistreated, or stolen from someone (e.g., "life's unfair," "losers deserve to lose," or "he had it coming anyway"). These individuals may blame the victims for being foolish, helpless, or deserving their fate; they may minimize the harmful consequences of their actions; or they may simply indicate complete indifference. They generally fail to compensate or make amends for their behavior. They may believe that everyone is out to "help number one" and that one should stop at nothing to avoid being pushed around.

The antisocial behavior must not occur exclusively during the course of Schizophrenia or a Manic Episode (Criterion D).

Associated Features and Disorders

Individuals with Antisocial Personality Disorder frequently lack empathy and tend to be callous, cynical, and contemptuous of the feelings, rights, and sufferings of others. They may have an inflated and arrogant self-appraisal (e.g., feel that ordinary work is beneath them or lack a realistic concern about their current problems or their future) and may be excessively opinionated, self-assured, or cocky. They may display a glib, superficial charm and can be quite voluble and verbally facile (e.g., using technical terms or jargon that might impress someone who is unfamiliar with the topic). Lack of empathy, inflated self-appraisal, and superficial charm are features that have been commonly included in traditional conceptions of psychopathy and may be particularly distinguishing of Antisocial Personality Disorder in prison or forensic settings where criminal, delinquent, or aggressive acts are likely to be nonspecific. These individuals may also be irresponsible and exploitative in their sexual relationships. They may have a history of many sexual partners and may never have sustained a monogamous relationship. They may be irresponsible as parents, as evidenced by malnutrition of a child, an illness in the child resulting from a lack of minimal hygiene, a child's dependence on neighbors or nonresident relatives for food or shelter, a failure to arrange for a caretaker for a young child when the individual is away from home, or repeated squandering of money required for household necessities. These individuals may receive dishonorable discharges from the armed services, may fail to be self-supporting, may become impoverished or even homeless, or may spend many years in penal institutions. Individuals with Antisocial Personality Disorder are more likely than people in the general population to die prematurely by violent means (e.g., suicide, accidents, and homicides).

Individuals with this disorder may also experience dysphoria, including complaints of tension, inability to tolerate boredom, and depressed mood. They may have associated Anxiety Disorders, Depressive Disorders, Substance-Related Disorders, Somatization Disorder, Pathological Gambling, and other disorders of impulse control. Individuals with Antisocial Personality Disorder also often have personality features that meet criteria for other Personality Disorders, particularly Borderline, Histrionic, and Narcissistic Personality Disorders. The likelihood of developing Antisocial Personality Disorder in adult life is increased if the individual experienced an early onset of Conduct Disorder (before age 10 years) and accompanying Attention-Deficit/Hyperactivity Disorder. Child abuse or neglect, unstable or erratic parenting, or inconsistent parental discipline may increase the likelihood that Conduct Disorder will evolve into Antisocial Personality Disorder.

Specific CuUure, Age, and Gender Features

Antisocial Personality Disorder appears to be associated with low socioeconomic status and urban settings. Concerns have been raised that the diagnosis may at times be misapplied to individuals in settings in which seemingly antisocial behavior may be part of a protective survival strategy. In assessing antisocial traits, it is helpful for the clinician to consider the social and economic context in which the behaviors occur.

By definition, Antisocial Personality cannot be diagnosed before age 18 years. Antisocial Personality Disorder is much more common in males than in females. There has been some concern that Antisocial Personality Disorder may be underdiagnosed in females, particularly because of the emphasis on aggressive items in the definition of Conduct Disorder.

Prevalence

The overall prevalence of Antisocial Personality Disorder in community samples is about 3% in males and about 1% in females. Prevalence estimates within clinical settings have varied from 3% to 30%, depending on the predominant characteristics of the populations being sampled. Even higher prevalence rates are associated with substance abuse treatment settings and prison or forensic settings.

Course

Antisocial Personality Disorder has a chronic course but may become less evident or remit as the individual grows older, particularly by the fourth decade of life. Although this remission tends to be particularly evident with respect to engaging in criminal behavior, there is likely to be a decrease in the full spectrum of antisocial behaviors and substance use.

Familial Pattern

Antisocial Personality Disorder is more common among the first-degree biological relatives of those with the disorder than among the general population. The risk to biological relatives of females with the disorder tends to be higher than the risk to biological relatives of males with the disorder. Biological relatives of persons with this disorder are also at increased risk for Somatization Disorder and Substance-Related Disorders. Within a family that has a member with Antisocial Personality Disorder, males more often have Antisocial Personality Disorder and Substance-Related Disorders, whereas females more often have Somatization Disorder. However, in such families, there is an increase in prevalence of all of these disorders in both males and females compared with the general population. Adoption studies indicate that both genetic and environmental factors contribute to the risk of this group of disorders. Both adopted and biological children of parents with Antisocial Personality Disorder have an increased risk of developing Antisocial Personality Disorder, Somatization Disorder, and Substance-Related Disorders. Adopted-away children resemble their biological parents more than their adoptive parents, but the adoptive family environment influences the risk of developing a Personality Disorder and related psychopathology.

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The diagnosis of Antisocial Personality Disorder is not given to individuals under age 18 years and is given only if there is a history of some symptoms of Conduct Disorder before age 15 years. For individuals over age 18 years, a diagnosis of Conduct Disorder is given only if the criteria for Antisocial Personality Disorder are not met.

When antisocial behavior in an adult is associated with a **Substance-Related Disorder,** the diagnosis of Antisocial Personality Disorder is not made unless the signs of Antisocial Personality Disorder were also present in childhood and have continued into adulthood. When substance use and antisocial behavior both began in childhood and continued into adulthood, both a Substance-Related Disorder and Antisocial Personality Disorder should be diagnosed if the criteria for both are met, even though some antisocial acts may be a consequence of the Substance-Related Disorder (e.g.,

illegal selling of drugs or thefts to obtain money for drugs). Antisocial behavior that occurs exclusively during the course of **Schizophrenia** or a **Manic Episode** should not be diagnosed as Antisocial Personality Disorder.

Other Personality Disorders may be confused with Antisocial Personality Disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more Personality Disorders in addition to Antisocial Personality Disorder, all can be diagnosed. Individuals with Antisocial Personality Disorder and **Narcissistic Personality Disorder** share a tendency to be tough-minded, glib, superficial, exploitative, and unempathic. However, Narcissistic Personality Disorder does not include characteristics of impulsivity, aggres- sion, and deceit. In addition, individuals with Antisocial Personality Disorder may not be as needy of the admiration and envy of others, and persons with Narcissistic Personality Disorder usually lack the history of Conduct Disorder in childhood or criminal behavior in adulthood. Individuals with Antisocial Personality Disorder and **Histrionic Personality Disorder** share a tendency to be impulsive, superficial, excitement seeking, reckless, seductive, and manipulative, but persons with Histrionic Personality Disorder tend to be more exaggerated in their emotions and do not characteristically engage in antisocial behaviors. Individuals with Histrionic and **Borderline Personality Disorders** are manipulative to gain nurturance, whereas those with Antisocial Personality Disorder are manipulative to gain profit, power, or some other material gratification. Individuals with Antisocial Personality Disorder tend to be less emotionally unstable and more aggressive than those with Borderline Personality Disorder. Although antisocial behavior may be present in some individuals with **Paranoid Personality Disorder,** it is not usually motivated by a desire for personal gain or to exploit others as in Antisocial Personality Disorder, but rather is more often due to a desire for revenge.

Antisocial Personality Disorder must *be* distinguished from criminal behavior undertaken for gain that is not accompanied by the personality features characteristic of this disorder. **Adult Antisocial Behavior** (listed in the "Other Conditions That May Be a Focus of Clinical Attention" section, p. 683) can be used to describe criminal, aggressive, or other antisocial behavior that comes to clinical attention but that does not meet the full criteria for Antisocial Personality Disorder. Only when antisocial personality traits are inflexible, maladaptive, and persistent and cause significant functional impair- ment or subjective distress do they constitute Antisocial Personality Disorder.

Diagnostic criteria for 30l. 7 Antisocial Personality Disorder

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:

(1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest

(continued)

☐ **Diagnostic criteria for 30 l. 7 Antisocial Personality Disorder** *(continued)*

(2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
(3) impulsivity or failure to plan ahead
(4) irritability and aggressiveness, as indicated by repeated physical fights or assaults
(5) reckless disregard for safety of self or others
(6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
(7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

B. The individual is at least age 18 years.

C. There is evidence of Conduct Disorder (see p. 90) with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.

301.83 Borderline Personality Disorder

Di-agnostic Features

The essential feature of Borderline Personality Disorder is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts.

Individuals with Borderline Personality Disorder make frantic efforts to avoid real or imagined abandonment (Criterion 1). The perception of impending separation or rejection, or the loss of external structure, can lead to profound changes in self-image, affect, cognition, and behavior. These individuals are very sensitive to environmental circumstances. They experience intense abandonment fears and inappropriate anger even when faced with a realistic time-limited separation or when there are unavoidable changes in plans (e.g., sudden despair in reaction to a clinician's announcing the end of the hour; panic or fury when someone important to them is just a few minutes late or must cancel an appointment). They may believe that this "abandonment" implies they are "bad." These abandonment fears are related to an intolerance of being alone and a need to have other people with them. Their frantic efforts to avoid abandonment may include impulsive actions such as self-mutilating or suicidal behaviors, which are described separately in Criterion 5.

Individuals with Borderline Personality Disorder have a pattern of unstable and intense relationships (Criterion 2). They may idealize potential caregivers or lovers at the first or second meeting, demand to spend a lot of time together, and share the most

intimate details early in a relationship. However, they may switch quickly from idealizing other people to devaluing them, feeling that the other person does not care enough, does not give enough, is not "there" enough. These individuals can empathize with and nurture other people, but only with the expectation that the other person will "be there" in return to meet their own needs on demand. These individuals are prone to sudden and dramatic shifts in their view of others, who may alternately be seen as beneficent supports or as cruelly punitive. Such shifts often reflect disillusionment with a caregiver whose nurturing qualities had been idealized or whose rejection or abandonment is expected.

There may be an identity disturbance characterized by markedly and persistently unstable self-image or sense of self (Criterion 3). There are sudden and dramatic shifts in self-image, characterized by shifting goals, values, and vocational aspirations. There may be sudden changes in opinions and plans about career, sexual identity, values, and types of friends. These individuals may suddenly change from the role of a needy supplicant for help to a righteous avenger of past mistreatment. Although they usually have a self-image that is based on being bad or evil, individuals with this disorder may at times have feelings that they do not exist at all. Such experiences usually occur in situations in which the individual feels a lack of a meaningful relationship, nurturing, and support. These individuals may show worse performance in unstructured work or school situations.

Individuals with this disorder display impulsivity in at least two areas that are potentially self-damaging (Criterion 4). They may gamble, spend money irresponsibly, binge eat, abuse substances, engage in unsafe sex, or drive recklessly. Individuals with Borderline Personality Disorder display recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior (Criterion 5). Completed suicide occurs in 8%-10% of such individuals, and self-mutilative acts (e.g., cutting or burning) and suicide threats and attempts are very common. Recurrent suicidality is often the reason that these individuals present for help. These self-destructive acts are usually precipitated by threats of separation or rejection or by expectations that they assume increased responsibility. Self-mutilation may occur during dissociative experiences and often brings relief by reaffirming the ability to feel or by expiating the individual's sense of being evil.

Individuals with Borderline Personality Disorder may display affective instability that is due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days) (Criterion 6). The basic dysphoric mood of those with Borderline Personality Disorder is often disrupted by periods of anger, panic, or despair and is rarely relieved by periods of well-being or satisfaction. These episodes may reflect the individual's extreme reactivity to interpersonal stresses. Individuals with Borderline Personality Disorder may be troubled by chronic feelings of emptiness (Criterion 7). Easily bored, they may constantly seek something to do. Individuals with Borderline Personality Disorder frequently express inappropriate, intense anger or have difficulty controlling their anger (Criterion 8). They may display extreme sarcasm, enduring bitterness, or verbal outbursts. The anger is often elicited when a caregiver or lover is seen as neglectful, withholding, uncaring, or abandoning. Such expressions of anger are often followed by shame and guilt and contribute to the feeling they have of being evil. During periods of extreme stress, transient paranoid ideation or dissociative symptoms (e.g., depersonalization) may occur (Criterion 9), but these are generally of insufficient severity or duration to warrant an additional diagnosis. These episodes occur most frequently in response to a real or imagined abandonment. Symptoms tend to be transient, lasting minutes or hours.

The real or perceived return of the caregiver's nurturance may result in a remission of symptoms.

Associated Features and Disorders

Individuals with Borderline Personality Disorder may have a pattern of undermining themselves at the moment a goal is about to be realized (e.g., dropping out of school just before graduation; regressing severely after a discussion of how well therapy is going; destroying a good relationship just when it is clear that the relationship could last). Some individuals develop psychotic-like symptoms (e.g., hallucinations, body- image distortions, ideas of reference, and hypnagogic phenomena) during times of stress. Individuals with this disorder may feel more secure with transitional objects (i.e., a pet or inanimate possession) than in interpersonal relationships. Premature death from suicide may occur in individuals with this disorder, especially in those with co-occurring Mood Disorders or Substance-Related Disorders. Physical handicaps may result from self-inflicted abuse behaviors or failed suicide attempts. Recurrent job losses, interrupted education, and broken marriages are common. Physical and sexual abuse, neglect, hostile conflict, and early parental loss or separation are more common in the childhood histories of those with Borderline Personality Disorder. Common co-occurring Axis I disorders include Mood Disorders, Substance-Related Disorders, Eating Disorders (no- tably Bulimia), Posttraumatic Stress Disorder, and Attention-Deficit/Hyperactivity Disor- der. Borderline Personality Disorder also frequently co-occurs with the other Personality Disorders.

Specific Culture, Age, and Gender Features

The pattern of behavior seen in Borderline Personality Disorder has been identified in many settings around the world. Adolescents and young adults with identity problems (especially when accompanied by substance use) may transiently display behaviors that misleadingly give the impression of Borderline Personality Disorder. Such situations are characterized by emotional instability, "existential" dilemmas, uncertainty, anxiety-provoking choices, conflicts about sexual orientation, and competing social pressures to decide on careers. Borderline Personality Disorder is diagnosed predominantly (about 75%) in females.

Prevalence

The prevalence of Borderline Personality Disorder is estimated to be about 2% of the general population, about 10% among individuals seen in outpatient mental health clinics, and about 20% among psychiatric inpatients. It ranges from 30% to 60% among clinical populations with Personality Disorders.

Course

There is considerable variability in the course of Borderline Personality Disorder. The most common pattern is one of chronic instability in early adulthood, with episodes of serious affective and impulsive dyscontrol and high levels of use of health and mental health resources. The impairment from the disorder and the risk of suicide are greatest

in the young-adult years and gradually wane with advancing age. During their 30s and 40s, the majority of individuals with this disorder attain greater stability in their relationships and vocational functioning.

Familial Pattern

Borderline Personality Disorder is about five times more common among first-degree biological relatives of those with the disorder than in the general population. There is also an increased familial risk for Substance-Related Disorders, Antisocial Personality Disorder, and Mood Disorders.

Differential Diagnosis

Borderline Personality Disorder often co-occurs with **Mood Disorders,** and when criteria for both are met, both may be diagnosed. Because the cross-sectional presenta- tion of Borderline Personality Disorder can be mimicked by an episode of Mood Disorder, the clinician should avoid giving an additional diagnosis of Borderline Personality Disorder based only on cross-sectional presentation without having docu- mented that the pattern of behavior has an early onset and a long-standing course.

Other Personality Disorders may be confused with Borderline Personality Disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more Personality Disorders in addition to Borderline Personality Disorder, all can be diagnosed. Although **Histrionic Personality Disorder** can also be characterized by attention seeking, manipulative behavior, and rapidly shifting emotions, Borderline Personality Disorder is distinguished by self-destructiveness, angry disruptions in close relationships, and chronic feelings of deep emptiness and loneliness. Paranoid ideas or illusions may be present in both Borderline Personality Disorder and **SchizotypalPersonalityDisorder,** but these symptoms are more transient, interpersonally reactive, and responsive to external structuring in Borderline Personality Disorder. Although **Paranoid Personality Disorder** and **Narcissistic Personality Disorder** may also be characterized by an angry reaction to minor stimuli, the relative stability of self-image as well as the relative lack of self-destructiveness, impulsivity, and abandonment concerns distinguish these disorders from Borderline Personality Disorder. Although **Antisocial Personality Disorder** and Borderline Personality Disorder are both characterized by manipulative behavior, individuals with Antisocial Personality Disorder are manipulative to gain profit, power, or some other material gratification, whereas the goal in Borderline Personality Disorder is directed more toward gaining the concern of caretakers. Both **Dependent Personality Disorder** and Borderline Personality Disorder are characterized by fear of abandonment; however, the individual with Borderline Personality Disorder reacts to abandonment with feelings of emotional emptiness, rage, and demands, whereas the individual with Dependent Personality Disorder reacts with increasing appeasement and submissiveness and urgently seeks a replacement relationship to provide caregiving and support. Borderline Personality Disorder can further be distinguished from Dependent Personality Disorder by the typical pattern of unstable and intense relationships.

Borderline Personality Disorder must be distinguished from **Personality Change Due to a General Medical Condition,** in which the traits emerge due to the direct

effects of a general medical condition on the central nervous system. It must also be distinguished from **symptoms that may develop in association with chronic substance use** (e.g., Cocaine-Related Disorder Not Otherwise Specified).

Borderline Personality Disorder should be distinguished from **Identity Problem** (see p. 685), which is reserved for identity concerns related to a developmental phase (e.g., adolescence) and does not qualify as a mental disorder.

Diagnostic criteria for 301.83 Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) frantic efforts to avoid real or imagined abandonment. **Note:** Do not include suicidal or self-mutilating behavior covered in Crite- rion 5.
(2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
(3) identity disturbance: markedly and persistently unstable self-image or sense of self
(4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). **Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.
(5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
(6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
(7) chronic feelings of emptiness
(8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
(9) transient, stress-related paranoid ideation or severe dissociative symptoms

30I. 50 Histrionic Personality Disorder

magnostic Features

The essential feature of Histrionic Personality Disorder is pervasive and excessive emotionality and attention-seeking behavior. This pattern begins by early adulthood and is present in a variety of contexts.

Individuals with Histrionic Personality Disorder are uncomfortable or feel unappreciated when they are not the center of attention (Criterion 1). Often lively and dramatic, they tend to draw attention to themselves and may initially charm new acquaintances by their enthusiasm, apparent openness, or flirtatiousness. These qualities wear thin, however, as these individuals continually demand to be the center of attention. They commandeer the role of "the life of the party." If they are not the center of attention, they may do something dramatic (e.g., make up stories, create a scene) to draw the focus of attention to themselves. This need is often apparent in their behavior with a clinician (e.g., flattery, bringing gifts, providing dramatic descriptions of physical and psychological symptoms that are replaced by new symptoms each visit).

The appearance and behavior of individuals with this disorder are often inappropriately sexually provocative or seductive (Criterion 2). This behavior is directed not only toward persons in whom the individual has a sexual or romantic interest, but occurs in a wide variety of social, occupational, and professional relationships beyond what is appropriate for the social context. Emotional expression may be shallow and rapidly shifting (Criterion 3). Individuals with this disorder consistently use physical appearance to draw attention to themselves (Criterion 4). They are overly concerned with impressing others by their appearance and expend an excessive amount of time, energy, and money on clothes and grooming. They may "fish for compliments" regarding appearance and be easily and excessively upset by a critical comment about how they look or by a photograph that they regard as unflattering.

These individuals have a style of speech that is excessively impressionistic and lacking in detail (Criterion 5). Strong opinions are expressed with dramatic flair, but underlying reasons are usually vague and diffuse, without supporting facts and details. For example, an individual with Histrionic Personality Disorder may comment that a certain individual is a wonderful human being, yet be unable to provide any specific examples of good qualities to support this opinion. Individuals with this disorder are characterized by self-dramatization, theatricality, and an exaggerated expression of emotion (Criterion 6). They may embarrass friends and acquaintances by an excessive public display of emotions (e.g., embracing casual acquaintances with excessive ardor, sobbing uncontrollably on minor sentimental occasions, or having temper tantrums). However, their emotions often seem to be turned on and off too quickly to be deeply felt, which may lead others to accuse the individual of faking these feelings.

Individuals with Histrionic Personality Disorder have a high degree of suggestibility (Criterion 7). Their opinions and feelings are easily influenced by others and by current fads. They may be overly trusting, especially of strong authority figures whom they see as magically solving their problems. They have a tendency to play hunches and to adopt convictions quickly. Individuals with this disorder often consider relationships more intimate than they actually are, describing almost every acquaintance as "my dear, dear friend" or referring to physicians met only once or twice under professional circumstances by their first names (Criterion 8). Flights into romantic fantasy are common.

Associated Features and Disorders

Individuals with Histrionic Personality Disorder may have difficulty achieving emotional intimacy in romantic or sexual relationships. Without being aware of it, they often act out a role (e.g., "victim" or "princess") in their relationships to others. They may seek to control their partner through emotional manipulation or seductiveness on one level, whereas displaying a marked dependency on them at another level. Individuals with this disorder often have impaired relationships with same-sex friends because their sexually provocative interpersonal style may seem a threat to their friends' relationships. These individuals may also alienate friends with demands for constant attention. They often become depressed and upset when they are not the center of attention. They may crave novelty, stimulation, and excitement and have a tendency to become bored with their usual routine. These individuals are often intolerant of, or frustrated by, situations that involve delayed gratification, and their actions are often directed at obtaining immediate satisfaction. Although they often initiate a job or project with great enthusiasm, their interest may lag quickly. Longer-term relationships may be neglected to make way for the excitement of new relationships.

The actual risk of suicide is not known, but clinical experience suggests that individuals with this disorder are at increased risk for suicidal gestures and threats to get attention and coerce better caregiving. Histrionic Personality Disorder has been associated with higher rates of Somatization Disorder, Conversion Disorder, and Major Depressive Disorder. Borderline, Narcissistic, Antisocial, and Dependent Personality Disorders often co-occur.

Specific Culture, Age, and Gender Features

Norms for interpersonal behavior, personal appearance, and emotional expressiveness vary widely across cultures, genders, and age groups. Before considering the various traits (e.g., emotionality, seductiveness, dramatic interpersonal style, novelty seeking, sociability, charm, impressionability, and a tendency to somatization) to be evidence of Histrionic Personality Disorder, it is important to evaluate whether they cause clinically significant impairment or distress. In clinical settings, this disorder has been diagnosed more frequently in females; however, the sex ratio is not significantly different than the sex ratio of females within the respective clinical setting. In contrast, some studies using structured assessments report similar prevalence rates among males and females. The behavioral expression of Histrionic Personality Disorder may be influenced by sex role stereotypes. For example, a man with this disorder may dress and behave in a manner often identified as "macho" and may seek to be the center of attention by bragging about athletic skills, whereas a woman, for example, may choose very feminine clothes and talk about how much she impressed her dance instructor.

Prevalence

Limited data from general population studies suggest a prevalence of Histrionic Personality Disorder of about 2%-3%. Rates of about 10%-15% have been reported in inpatient and outpatient mental health settings when structured assessment is used.

Differential Diagnosis

Other Personality Disorders may be confused with Histrionic Personality Disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more Personality Disorders in addition to Histrionic Personality Disorder, all can be diagnosed. Although **Borderline Personality Disorder** can also be characterized by attention seeking, manipulative behavior, and rapidly shifting emotions, it is distinguished by self-destruc- tiveness, angry disruptions in close relationships, and chronic feelings of deep emptiness and identity disturbance. Individuals with **Antisocial Personality Disorder** and Histrionic Personality Disorder share a tendency to be impulsive, superficial, excitement seeking, reckless, seductive, and manipulative, but persons with Histrionic Personality Disorder tend to be more exaggerated in their emotions and do not characteristically engage in antisocial behaviors. Individuals with Histrionic Personality Disorder are manipulative to gain nurturance, whereas those with Antisocial Personality Disorder are manipulative to gain profit, power, or some other material gratification. Although individuals with **Narcissistic Personality Disorder** also crave attention from others, they usually want praise for their "superiority," whereas the individual with Histrionic Personality Disorder is willing to be viewed as fragile or dependent if this is instrumental in getting attention. Individuals with Narcissistic Personality Disorder may exaggerate the intimacy of their relationships with other people, but they are more apt to emphasize the "VIP" status or wealth of their friends. In **Dependent Personality Disorder,** the person is excessively dependent on others for praise and guidance, but is without the flamboyant, exaggerated, emotional features of Histrionic Personality Disorder.

Histrionic Personality Disorder must be distinguished from **Personality Change Due to a General Medical Condition,** in which the traits emerge due to the direct effects of a general medical condition on the central nervous system. It must also be distinguished from **symptoms that may develop in association with chronic substance use** (e.g., Cocaine-Related Disorder Not Otherwise Specified).

Many individuals may display histrionic personality traits. Only when these traits are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress do they constitute Histrionic Personality Disorder.

Diagnostic criteria for 301.50 Histrionic Personality Disorder

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) is uncomfortable in situations in which he or she is not the center of attention
(2) interaction with others is often characterized by inappropriate sexually seductive or provocative behavior

(continued)

☐ **Diagnostic criteria for 301.50 Histrionic Personality Disorder** *(continued)*

(3) displays rapidly shifting and shallow expression of emotions
(4) consistently uses physical appearance to draw attention to self
(5) has a style of speech that is excessively impressionistic and lacking in detail
(6) shows self-dramatization, theatricality, and exaggerated expression of emotion
(7) is suggestible, i.e., easily influenced by others or circumstances
(8) considers relationships to be more intimate than they actually are

301.81 Narcissistic Personality Disorder

Diagnostic Features

The essential feature of Narcissistic Personality Disorder is a pervasive pattern of grandiosity, need for admiration, and lack of empathy that begins by early adulthood and is present in a variety of contexts.

Individuals with this disorder have a grandiose sense of self-importance (Crite- rion 1). They routinely overestimate their abilities and inflate their accomplishments, often appearing boastful and pretentious. They may blithely assume that others attribute the same value to their efforts and may be surprised when the praise they expect and feel they deserve is not forthcoming. Often implicit in the inflated judgments of their own accomplishments is an underestimation (devaluation) of the contributions of others. They are often preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love (Criterion 2). They may ruminate about "long overdue" admiration and privilege and compare themselves favorably with famous or privileged people.

Individuals with Narcissistic Personality Disorder believe that they are superior, special, or unique and expect others to recognize them as such (Criterion 3). They may feel that they can only be understood by, and should only associate with, other people who are special or of high status and may attribute "unique," "perfect," or "gifted" qualities to those with whom they associate. Individuals with this disorder believe that their needs are special and beyond the ken of ordinary people. Their own self-esteem is enhanced (i.e., "mirrored") by the idealized value that they assign to those with whom they associate. They are likely to insist on having only the "top" person (doctor, lawyer, hairdresser, instructor) or being affiliated with the "best" institutions, but may devalue the credentials of those who disappoint them.

Individuals with this disorder generally require excessive admiration (Criterion 4). Their self-esteem is almost invariably very fragile. They may be preoccupied with how well they are doing and how favorably they are regarded by others. This often takes the form of a need for constant attention and admiration. They may expect their arrival to be greeted with great fanfare and are astonished if others do not covet their possessions. They may constantly fish for compliments, often with great charm. A sense of entitlement is evident in these individuals' unreasonable expectation of especially favorable treat-

ment (Criterion 5). They expect to be catered to and are puzzled or furious when this does not happen. For example, they may assume that they do not have to wait in line and that their priorities are so important that others should defer to them, and then get irritated when others fail to assist "in their very important work." This sense of entitlement combined with a lack of sensitivity to the wants and needs of others may result in the conscious or unwitting exploitation of others (Criterion 6). They expect to be given whatever they want or feel they need, no matter what it might mean to others. For example, these individuals may expect great dedication from others and may overwork them without regard for the impact on their lives. They tend to form friendships or romantic relationships only if the other person seems likely to advance their purposes or otherwise enhance their self-esteem. They often usurp special privileges and extra resources that they believe they deserve because they are so special.

Individuals with Narcissistic Personality Disorder generally have a lack of empathy and have difficulty recognizing the desires, subjective experiences, and feelings of others (Criterion 7). They may assume that others are totally concerned about their welfare. They tend to discuss their own concerns in inappropriate and lengthy detail, while failing to recognize that others also have feelings and needs. They are often contemptuous and impatient with others who talk about their own problems and concerns. These individuals may be oblivious to the hurt their remarks may inflict (e.g., exuberantly telling a former lover that "I am now in the relationship of a lifetime!"; boasting of health in front of someone who is sick). When recognized, the needs, desires, or feelings of others are likely to be viewed disparagingly as signs of weakness or vulnerability. Those who relate to individuals with Narcissistic Personality Disorder typically find an emotional coldness and lack of reciprocal interest.

These individuals are often envious of others or believe that others are envious of them (Criterion 8). They may begrudge others their successes or possessions, feeling that they better deserve those achievements, admiration, or privileges. They may harshly devalue the contributions of others, particularly when those individuals have received acknowledgment or praise for their accomplishments. Arrogant, haughty behaviors characterize these individuals. They often display snobbish, disdainful, or patronizing attitudes (Criterion 9). For example, an individual with this disorder may complain about a clumsy waiter's "rudeness" or "stupidity" or conclude a medical evaluation with a condescending evaluation of the physician.

Associated Features and Disorders

Vulnerability in self-esteem makes individuals with Narcissistic Personality Disorder very sensitive to "injury" from criticism or defeat. Although they may not show it outwardly, criticism may haunt these individuals and may leave them feeling humiliated, degraded, hollow, and empty. They may react with disdain, rage, or defiant counterattack. Such experiences often lead to social withdrawal or an appearance of humility that may mask and protect the grandiosity. Interpersonal relations are typically impaired due to problems derived from entitlement, the need for admiration, and the relative disregard for the sensitivities of others. Though overweening ambition and confidence may lead to high achievement, performance may be disrupted due to intolerance of criticism or

social withdrawal, depressed mood, and Dysthymic or Major Depressive Disorder. In contrast, sustained periods of grandiosity may be associated with a hypomanic mood. Narcissistic Personality Disorder is also associated with Anorexia Nervosa and Substance-Related Disorders (especially related to cocaine). Histrionic, Borderline, Antisocial, and Paranoid Personality Disorders may be associated with Narcissistic Personality Disorder.

Specific Age and Gender Features

Narcissistic traits may be particularly common in adolescents and do not necessarily indicate that the individual will go on to have Narcissistic Personality Disorder. Individuals with Narcissistic Personality Disorder may have special difficulties adjusting to the onset of physical and occupational limitations that are inherent in the aging process. Of those diagnosed with Narcissistic Personality Disorder, 50%--75% are male.

Prevalence

Estimates of prevalence of Narcissistic Personality Disorder range from 2% to 16% in the clinical population and are less than 1% in the general population.

Differential Diagnosis

Other Personality Disorders may be confused with Narcissistic Personality Disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more Personality Disorders in addition to Narcissistic Personality Disorder, all can be diagnosed. The most useful feature in discriminating Narcissistic Personality Disorder from **Histrionic, Antisocial,** and **Borderline Personality Disorders,** whose interactive styles are respectively coquettish, callous, and needy, is the grandiosity characteristic of Narcissistic Personality Disorder. The relative stability of self-image as well as the relative lack of self-destructiveness, impulsivity, and abandonment concerns also help distinguish Narcissistic Personality Disorder from Borderline Personality Disorder. Excessive pride in achievements, a relative lack of emotional display, and disdain for others' sensitivities help distinguish Narcissistic Personality Disorder from Histrionic Personality Disorder. Although individuals with Borderline, Histrionic, and Narcissistic Personality Disorders may require much attention, those with Narcissistic Personality Disorder specifically need that attention to be admiring. Individuals with Antisocial and Narcissistic Personality Disorders will share a tendency to be tough-minded, glib, superficial, exploitative, and unempathic. However, Narcissistic Personality Disorder does not necessarily include characteristics of impulsivity, aggression, and deceit. In addition, individuals with Antisocial Personality Disorder may not be as needy of the admiration and envy of others, and persons with Narcissistic Personality Disorder usually lack the history of Conduct Disorder in childhood or criminal behavior in adulthood. In both Narcissistic Personality Disorder and **Obsessive-Compulsive Personality Disorder,** the individual may profess a commitment to perfectionism and believe that others cannot do things as well. In contrast to the accompanying self-criticism of those with Obsessive-Compulsive Personality Disorder, individuals with Narcissistic Personality Disorder are more likely to believe that they have achieved perfection. Suspiciousness and social withdrawal

usually distinguish those with **Schizotypal or Paranoid Personality Disorder** from those with Narcissistic Personality Disorder. When these qualities are present in individuals with Narcissistic Personality Disorder, they derive primarily from fears of having imperfections or flaws revealed. Grandiosity may emerge as part of **Manic** or **Hypomanic Episodes,** but the association with mood change or functional impairments helps distinguish these episodes from Narcissistic Personality Disorder.

Narcissistic Personality Disorder must be distinguished from **Personality Change Due to a General Medical Condition,** in which the traits emerge due to the direct effects of a general medical condition on the central nervous system. It must also be distinguished from **symptoms that may develop in association with chronic substance use** (e.g., Cocaine-Related Disorder Not Otherwise Specified).

Many highly successful individuals display personality traits that might be considered narcissistic. Only when these traits are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress do they constitute Narcissistic Personality Disorder.

Diagnostic criteria for 301.81 Narcissistic Personality Disorder

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
(2) is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
(3) believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high- status people (or institutions)
(4) requires excessive admiration
(5) has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations
(6) is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends
(7) lacks empathy: is unwilling to recognize or identify with the feelings and needs of others
(8) is often envious of others or believes that others are envious of him or her
(9) shows arrogant, haughty behaviors or attitudes

Cluster C Personality Disorders

301.82 Avoidant Personality Disorder

Diagnostic Features

The essential feature of Avoidant Personality Disorder is a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation that begins by early adulthood and is present in a variety of contexts.

Individuals with Avoidant Personality Disorder avoid work or school activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection (Criterion 1). Offers of job promotions may be declined because the new responsibilities might result in criticism from co-workers. These individuals avoid making new friends unless they are certain they will be liked and accepted without criticism (Criterion 2). Until they pass stringent tests proving the contrary, other people are assumed to be critical and disapproving. Individuals with this disorder will not join in group activities unless there are repeated and generous offers of support and nurturance. Interpersonal intimacy is often difficult for these individuals, although they are able to establish intimate relationships when there is assurance of uncritical acceptance. They may act with restraint, have difficulty talking about themselves, and withhold intimate feelings for fear of being exposed, ridiculed, or shamed (Criterion 3).

Because individuals with this disorder are preoccupied with being criticized or rejected in social situations, they may have a markedly low threshold for detecting such reactions (Criterion 4). If someone is even slightly disapproving or critical, they may feel extremely hurt. They tend to be shy, quiet, inhibited, and "invisible" because of the fear that any attention would be degrading or rejecting. They expect that no matter what they say, others will see it as "wrong," and so they may say nothing at all. They react strongly to subtle cues that are suggestive of mockery or derision. Despite their longing to be active participants in social life, they fear placing their welfare in the hands of others. Individuals with Avoidant Personality Disorder are inhibited in new interpersonal situations because they feel inadequate and have low self-esteem (Criterion 5). Doubts concerning social competence and personal appeal become especially manifest in settings involving interactions with strangers. These individuals believe themselves to be socially inept, personally unappealing, or inferior to others (Criterion 6). They are unusually reluctant to take personal risks or to engage in any new activities because these may prove embarrassing (Criterion 7). They are prone to exaggerate the potential dangers of ordinary situations, and a restricted lifestyle may result from their need for certainty and security. Someone with this disorder may cancel a job interview for fear of being embarrassed by not dressing appropriately. Marginal somatic symptoms or other problems may become the reason for avoiding new activities.

Associated Features and Disorders

Individuals with Avoidant Personality Disorder often vigilantly appraise the movements and expressions of those with whom they come into contact. Their fearful and tense demeanor may elicit ridicule and derision from others, which in turn confirms their self-doubts. They are very anxious about the possibility that they will react to criticism

with blushing or ctying. They are described by others as being "shy," "timid," "lonely," and "isolated." The major problems associated with this disorder occur in social and occupational functioning. The low self-esteem and hypersensitivity to rejection are associated with restricted interpersonal contacts. These individuals may become relatively isolated and usually do not have a large social support network that can help them weather crises. They desire affection and acceptance and may fantasize about idealized relationships with others. The avoidant behaviors can also adversely affect occupational functioning because these individuals tty to avoid the types of social situations that may be important for meeting the basic demands of the job or for advancement.

Other disorders that are commonly diagnosed with Avoidant Personality Disorder include Mood and Anxiety Disorders (especially Social Phobia of the Generalized Type). Avoidant Personality Disorder is often diagnosed with Dependent Personality Disorder, because individuals with Avoidant Personality Disorder become vety attached to and dependent on those few other people with whom they are friends. Avoidant Personality Disorder also tends to be diagnosed with Borderline Personality Disorder and with the Cluster A Personality Disorders (i.e., Paranoid, Schizoid, or Schizotypal Personality Disorders).

Specific Culture, Age, and Gender Features

There may be variation in the degree to which different cultural and ethnic groups regard diffidence and avoidance as appropriate. Moreover, avoidant behavior may be the result of problems in acculturation following immigration. This diagnosis should be used with great caution in children and adolescents for whom shy and avoidant behavior may be developmentally appropriate. Avoidant Personality Disorder appears to be equally frequent in males and females.

Prevalence

The prevalence of Avoidant Personality Disorder in the general population is between 0.5% and 1.0%. Avoidant Personality Disorder has been reported to be present in about 10% of outpatients seen in mental health clinics.

Course

The avoidant behavior often starts in infancy or childhood with shyness, isolation, and fear of strangers and new situations. Although shyness in childhood is a common precursor of Avoidant Personality Disorder, in most individuals it tends to gradually dissipate as they get older. In contrast, individuals who go on to develop Avoidant Personality Disorder may become increasingly shy and avoidant during adolescence and early adulthood, when social relationships with new people become especially important. There is some evidence that in adults Avoidant Personality Disorder tends to become less evident or to remit with age.

Di,fferential magnosis

There appears to be a great deal of overlap between Avoidant Personality Disorder and **Social Phobia, Generalized Type,** so much so that they may be alternative conceptu-

alizations of the same or similar conditions. Avoidance also characterizes both Avoidant Personality Disorder and **Panic Disorder With Agoraphobia,** and they often co-occur. The avoidance in Panic Disorder With Agoraphobia typically starts after the onset of Panic Attacks and may vary based on their frequency and intensity. In contrast, the avoidance in Avoidant Personality Disorder tends to have an early onset, an absence of clear precipitants, and a stable course.

Other Personality Disorders may be confused with Avoidant Personality Disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more Personality Disorders in addition to Avoidant Personality Disorder, all can be diagnosed. Both Avoidant Personality Disorder and **Dependent Personality Disorder** are characterized by feelings of inadequacy, hypersensitivity to criticism, and a need for reassurance. Although the primary focus of concern in Avoidant Personality Disorder is avoidance of humiliation and rejection, in Dependent Personality Disorder the focus is on being taken care of. However, Avoidant Personality Disorder and Dependent Personality Disorder are particularly likely to co-occur. Like Avoidant Personality Disorder, **Schizoid Personality Disorder** and **Schizotypal Personality Disorder** are characterized by social isolation. However, individuals with Avoidant Personality Disorder want to have relationships with others and feel their loneliness deeply, whereas those with Schizoid or Schizotypal Personality Disorder may be content with and even prefer their social isolation. **Paranoid Personality Disorder** and Avoidant Personality Disorder are both characterized by a reluctance to confide in others. However, in Avoidant Personality Disorder, this reluctance is due more to a fear of being embarrassed or being found inadequate than to a fear of others' malicious intent.

Avoidant Personality Disorder must be distinguished from **Personality Change Due to a General Medical Condition,** in which the traits emerge due to the direct effects of a general medical condition on the central nervous system. It must also be distinguished from **symptoms that may develop in association with chronic substance use** (e.g., Cocaine-Related Disorder Not Otherwise Specified).

Many individuals display avoidant personality traits. Only when these traits are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress do they constitute Avoidant Personality Disorder.

Diagnostic criteria for 30 I .82 Avoidant Personality Disorder

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

(1) avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection

(continued)

☐ **Diagnostic criteria for 301.82 Avoidant Personality Disorder** *(continued)*

(2) is unwilling to get involved with people unless certain of being liked
(3) shows restraint within intimate relationships because of the fear of being shamed or ridiculed
(4) is preoccupied with being criticized or rejected in social situations
(5) is inhibited in new interpersonal situations because of feelings of inadequacy
(6) views self as socially inept, personally unappealing, or inferior to others
(7) is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

301.6 Dependent Personality Disorder

magnostic Features

The essential feature of Dependent Personality Disorder is a pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation. This pattern begins by early adulthood and is present in a variety of contexts. The dependent and submissive behaviors are designed to elicit caregiving and arise from a self-perception of being unable to function adequately without the help of others.

Individuals with Dependent Personality Disorder have great difficulty making everyday decisions (e.g., what color shirt to wear to work or whether to carry an umbrella) without an excessive amount of advice and reassurance from others (Criterion 1). These individuals tend to be passive and to allow other people (often a single other person) to take the initiative and assume responsibility for most major areas of their lives (Criterion 2). Adults with this disorder typically depend on a parent or spouse to decide where they should live, what kind of job they should have, and which neighbors to befriend. Adolescents with this disorder may allow their parent(s) to decide what they should wear, with whom they should associate, how they should spend their free time, and what school or college they should attend. This need for others to assume responsibility goes beyond age-appropriate and situation-appropriate requests for assistance from others (e.g., the specific needs of children, elderly persons, and handicapped persons). Dependent Personality Disorder may occur in an individual who has a serious general medical condition or disability, but in such cases the difficulty in taking responsibility must go beyond what would normally be associated with that condition or disability.

Because they fear losing support or approval, individuals with Dependent Personality Disorder often have difficulty expressing disagreement with other people, especially those on whom they are dependent (Criterion 3). These individuals feel so unable to function alone that they will agree with things that they feel are wrong rather than risk losing the help of those to whom they look for guidance. They do not get appropriately

angry at others whose support and nurturance they need for fear of alienating them. If the individual's concerns regarding the consequences of expressing disagreement are realistic (e.g., realistic fears of retribution from an abusive spouse), the behavior should not be considered to be evidence of Dependent Personality Disorder.

Individuals with this disorder have difficulty initiating projects or doing things independently (Criterion 4). They lack self-confidence and believe that they need help to begin and carry through tasks. They will wait for others to start things because they believe that as a rule others can do them better. These individuals are convinced that they are incapable of functioning independently and present themselves as inept and requiring constant assistance. They are, however, likely to function adequately if given the assurance that someone else is supervising and approving. There may be a fear of becoming or appearing to be more competent, because they may believe that this will lead to abandonment. Because they rely on others to handle their problems, they often do not learn the skills of independent living, thus perpetuating dependency.

Individuals with Dependent Personality Disorder may go to excessive lengths to obtain nurturance and support from others, even to the point of volunteering for unpleasant tasks if such behavior will bring the care they need (Criterion 5). They are willing to submit to what others want, even if the demands are unreasonable. Their need to maintain an important bond will often result in imbalanced or distorted relationships. They may make extraordinary self-sacrifices or tolerate verbal, physical, or sexual abuse. (It should be noted that this behavior should be considered evidence of Dependent Personality Disorder only when it can clearly be established that other options are available to the individual). Individuals with this disorder feel uncomfortable or helpless when alone, because of their exaggerated fears of being unable to care for themselves (Criterion 6). They will "tag along" with important others just to avoid being alone, even if they are not interested or involved in what is happening.

When a dose relationship ends (e.g., a breakup with a lover; the death of a caregiver), individuals with Dependent Personality Disorder may urgently seek another relationship to provide the care and support they need (Criterion 7). Their belief that they are unable to function in the absence of a dose relationship motivates these individuals to become quickly and indiscriminately attached to another person. Individ- uals with this disorder are often preoccupied with fears of being left to care for themselves (Criterion 8). They see themselves as so totally dependent on the advice and help of an important other person that they worry about being abandoned by that person when there are no grounds to justify such fears. To be considered as evidence of this criterion, the fears must be excessive and unrealistic. For example, an elderly man with cancer who moves into his son's household for care is exhibiting dependent behavior that is appropriate given this person's life circumstances.

Associated Features and Disorders

Individuals with Dependent Personality Disorder are often characterized by pessimism and self-doubt, tend to belittle their abilities and assets, and may constantly refer to themselves as "stupid." They take criticism and disapproval as proof of their worthlessness and lose faith in themselves. They may seek overprotection and dominance from others. Occupational functioning may be impaired if independent initiative is required. They may avoid positions of responsibility and become anxious when faced with decisions. Social relations tend to be limited to those few people on whom the individual

is dependent. There may be an increased risk of Mood Disorders, Anxiety Disorders, and Adjustment Disorder. Dependent Personality Disorder often co-occurs with other Personality Disorders, especially Borderline, Avoidant, and Histrionic Personality Disorders. Chronic physical illness or Separation Anxiety Disorder in childhood or adolescence may predispose the individual to the development of this disorder.

Specific Culture, Age, and Gender Features

The degree to which dependent behaviors are considered to be appropriate varies substantially across different age and sociocultural groups. Age and cultural factors need to be considered in evaluating the diagnostic threshold of each criterion. Dependent behavior should be considered characteristic of the disorder only when it is clearly in excess of the individual's cultural norms or reflects unrealistic concerns. An emphasis on passivity, politeness, and deferential treatment is characteristic of some societies and may be misinterpreted as traits of Dependent Personality Disorder. Similarly, societies may differentially foster and discourage dependent behavior in males and females. This diagnosis should be used with great caution, if at all, in children and adolescents, for whom dependent behavior may be developmentally appropriate. In clinical settings, this disorder has been diagnosed more frequently in females; however, the sex ratio of this disorder is not significantly different than the sex ratio of females within the respective clinical setting. Moreover, some studies using structured assessments report similar prevalence rates among males and females.

Prevalence

Dependent Personality Disorder is among the most frequently reported Personality Disorders encountered in mental health clinics.

Differential Diagnosis

Dependent Personality Disorder must be distinguished from dependency arising as a consequence of Axis I disorders (e.g., **Mood Disorders, Panic Disorder,** and **Agoraphobia)** and as a result of **general medical conditions.** Dependent Personality Disorder has an early onset, chronic course, and a pattern of behavior that does not occur exclusively during an Axis I or Axis III disorder.

Other Personality Disorders may be confused with Dependent Personality Disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more Personality Disorders in addition to Dependent Personality Disorder, all can be diagnosed. Although many Personality Disorders are characterized by dependent features, Dependent Per- sonality Disorder can be distinguished by its predominantly submissive, reactive, and clinging behavior. Both Dependent Personality Disorder and **Borderline Personality Disorder** are characterized by fear of abandonment; however, the individual with Borderline Personality Disorder reacts to abandonment with feelings of emotional emptiness, rage, and demands, whereas the individual with Dependent Personality Disorder reacts with increasing appeasement and submissiveness and urgently seeks a replacement relationship to provide caregiving and support. Borderline Personality

Disorder can further be distinguished from Dependent Personality Disorder by a typical pattern of unstable and intense relationships. Individuals with **Histrionic Personality Disorder,** like those with Dependent Personality Disorder, have a strong need for reassurance and approval and may appear childlike and clinging. However, unlike Dependent Personality Disorder, which is characterized by self-effacing and docile behavior, Histrionic Personality Disorder is characterized by gregarious flamboyance with active demands for attention. Both Dependent Personality Disorder and **Avoidant Personality Disorder** are characterized by feelings of inadequacy, hypersensitivity to criticism, and a need for reassurance; however, individuals with Avoidant Personality Disorder have such a strong fear of humiliation and rejection that they withdraw until they are certain they will be accepted. In contrast, individuals with Dependent Personality Disorder have a pattern of seeking and maintaining connections to important others, rather than avoiding and withdrawing from relationships.

Dependent Personality Disorder must be distinguished from **Personality Change Due to a General Medical Condition,** in which the traits emerge due to the direct effects of a general medical condition on the central nervous system. It must also be distinguished from **symptoms that may develop in association with chronic substance use** (e.g., Cocaine-Related Disorder Not Otherwise Specified).

Many individuals display dependent personality traits. Only when these traits are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress do they constitute Dependent Personality Disorder.

Diagnostic criteria for 30l .6 Dependent Personality Disorder

A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) has difficulty making everyday decisions without an excessive amount of advice and reassurance from others
(2) needs others to assume responsibility for most major areas of his or her life
(3) has difficulty expressing disagreement with others because of fear of loss of support or approval. **Note:** Do not include realistic fears of retribution.
(4) has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)
(5) goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant
(6) feels uncomfortable or helpless when alone because of exagger- ated fears of being unable to care for himself or herself

(continued)

☐ **Diagnostic criteria for 301.6 Dependent Personality Disorder** *(continued)*

(7) urgently seeks another relationship as a source of care and support when a close relationship ends
(8) is unrealistically preoccupied with fears of being left to take care of himself or herself

301.4 Obsessive-Compulsive Personality Disorder

Diagnostic Features

The essential feature of Obsessive-Compulsive Personality Disorder is a preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency. This pattern begins by early adulthood and is present in a variety of contexts.

Individuals with Obsessive-Compulsive Personality Disorder attempt to maintain a sense of control through painstaking attention to rules, trivial details, procedures, lists, schedules, or form to the extent that the major point of the activity is lost (Criterion 1). They are excessively careful and prone to repetition, paying extraordinary attention to detail and repeatedly checking for possible mistakes. They are oblivious to the fact that other people tend to become very annoyed at the delays and inconveniences that result from this behavior. For example, when such individuals misplace a list of things to be done, they will spend an inordinate amount of time looking for the list rather than spending a few moments re-creating it from memory and proceeding to accomplish the tasks. Time is poorly allocated, the most important tasks being left to the last moment. The perfectionism and self-imposed high standards of performance cause significant dysfunction and distress in these individuals. They may become so involved in making every detail of a project absolutely perfect that the project is never finished (Criterion 2). For example, the completion of a written report is delayed by numerous time-consuming rewrites that all come up short of "perfection." Deadlines are missed, and aspects of the individual's life that are not the current focus of activity may fall into disarray.

Individuals with Obsessive-Compulsive Personality Disorder display excessive devotion to work and productivity to the exclusion of leisure activities and friendships (Criterion 3). This behavior is not accounted for by economic necessity. They often feel that they do not have time to take an evening or a weekend day off to go on an outing or to just relax. They may keep postponing a pleasurable activity, such as a vacation, so that it may never occur. When they do take time for leisure activities or vacations, they are very uncomfortable unless they have taken along something to work on so they do not "waste time." There may be a great concentration on household chores (e.g., repeated excessive cleaning so that "one could eat off the floor"). If they spend time with friends, it is likely to be in some kind of formally organized activity (e.g., sports). Hobbies or recreational activities are approached as serious tasks requiring careful organization and hard work to master. The emphasis is on perfect performance. These individuals turn play into a structured task (e.g., correcting an infant for not putting rings

on the post in the right order; telling a toddler to ride his or her tricycle in a straight line; turning a baseball game into a harsh "lesson").

Individuals with Obsessive-Compulsive Personality Disorder may be excessively conscientious, scrupulous, and inflexible about matters of morality, ethics, or values (Criterion 4). They may force themselves and others to follow rigid moral principles and very strict standards of performance. They may also be mercilessly self-critical about their own mistakes. Individuals with this disorder are rigidly deferential to authority and rules and insist on quite literal compliance, with no rule bending for extenuating circumstances. For example, the individual will not lend a quarter to a friend who needs one to make a telephone call, because "neither a borrower or lender be" or because it would be "bad" for the person's character. These qualities should not be accounted for by the individual's cultural or religious identification.

Individuals with this disorder may be unable to discard worn-out or worthless objects, even when they have no sentimental value (Criterion 5). Often these individuals will admit to being "pack rats." They regard discarding objects as wasteful because "you never know when you might need something" and will become upset if someone tries to get rid of the things they have saved. Their spouses or roommates may complain about the amount of space taken up by old parts, magazines, broken appliances, and so on.

Individuals with Obsessive-Compulsive Personality Disorder are reluctant to delegate tasks or to work with others (Criterion 6). They stubbornly and unreasonably insist that everything be done their way and that people conform to their way of doing things. They often give very detailed instructions about how things should be done (e.g., there is one and only one way to mow the lawn, wash the dishes, build a doghouse) and are surprised and irritated if others suggest creative alternatives. At other times they may reject offers of help even when behind schedule because they believe no one else can do it right.

Individuals with this disorder may be miserly and stingy and maintain a standard of living far below what they can afford, believing that spending must be tightly controlled to provide for future catastrophes (Criterion 7). Individuals with Obsessive-Compulsive Personality Disorder are characterized by rigidity and stubbornness (Criterion 8). They are so concerned about having things done the one "correct" way that they have trouble going along with anyone else's ideas. These individuals plan ahead in meticulous detail and are unwilling to consider changes. Totally wrapped up in their own perspective, they have difficulty acknowledging the viewpoints of others. Friends and colleagues may become frustrated by this constant rigidity. Even when individuals with Obsessive- Compulsive Personality Disorder recognize that it may be in their interest to compromise, they may stubbornly refuse to do so, arguing that it is "the principle of the thing."

Associated Features and Disorders

When rules and established procedures do not dictate the correct answer, decision making may become a time-consuming, often painful process. Individuals with Obses- sive-Compulsive Personality Disorder may have such difficulty deciding which tasks take priority or what is the best way of doing some particular task that they may never get started on anything. They are prone to become upset or angry in situations in which they are not able to maintain control of their physical or interpersonal environment, although the anger is typically not expressed directly. For example, a person may be

angry when service in a restaurant is poor, but instead of complaining to the management, the individual ruminates about how much to leave as a tip. On other occasions, anger may be expressed with righteous indignation over a seemingly minor matter. People with this disorder may be especially attentive to their relative status in dominance-submission relationships and may display excessive deference to an author- ity they respect and excessive resistance to authority that they do not respect.

Individuals with this disorder usually express affection in a highly controlled or stilted fashion and may be very uncomfortable in the presence of others who are emotionally expressive. Their everyday relationships have a formal and serious quality, and they may be stiff in situations in which others would smile and be happy (e.g., greeting a lover at the airport). They carefully hold themselves back until they are sure that whatever they say will be perfect. They may be preoccupied with logic and intellect, and intolerant of affective behavior in others. They often have difficulty expressing tender feelings, rarely paying compliments. Individuals with this disorder may experience occupational difficulties and distress, particularly when confronted with new situations that demand flexibility and compromise.

Although some studies suggest an association with Obsessive-Compulsive Disorder (included in the "Anxiety Disorders" section, p. 417), it appears that the majority of individuals with Obsessive-Compulsive Disorder do not have a pattern of behavior that meets criteria for Obsessive-Compulsive Personality Disorder. Many of the features of Obsessive-Compulsive Personality Disorder overlap with "type A" personality character- istics (e.g., hostility, competitiveness, and **time** urgency), and these features may be present in people at risk for myocardial infarction. There may be an association between Obsessive-Compulsive Personality Disorder and Mood and Anxiety Disorders.

Specific Culture and Gender Features

In assessing an individual for Obsessive-Compulsive Personality Disorder, the clinician should not include those behaviors that reflect habits, customs, or interpersonal styles that are culturally sanctioned by the individual's reference group. Certain cultures place substantial emphasis on work and productivity; the resulting behaviors in members of those societies need not be considered indications of Obsessive-Compulsive Personality Disorder. In systematic studies, the disorder appears to be diagnosed about twice as often among males.

Prevalence

Studies that have used systematic assessment suggest prevalence estimates of Obses- sive-Compulsive Personality Disorder of about 1% in community samples and about 3%-10% in individuals presenting to mental health clinics.

Di,fferential magnosis

Despite the similarity in names, **Obsessive-Compulsive Disorder** is usually easily distinguished from Obsessive-Compulsive Personality Disorder by the presence of true obsessions and compulsions. A diagnosis of Obsessive-Compulsive Disorder should be considered especially when hoarding is extreme (e.g., accumulated stacks of worthless objects present a fire hazard and make it difficult for others to walk through the house).

When criteria for both disorders are met, both diagnoses should be recorded.

Other Personality Disorders may be confused with Obsessive-Compulsive Personality Disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more Personality Disorders in addition to Obsessive-Compulsive Personality Disorder, all can be diagnosed. Individuals with **Narcissistic Personality Disorder** may also profess a commitment to perfectionism and believe that others cannot do things as well, but these individuals are more likely to believe that they have achieved perfection, whereas those with Obsessive-Compulsive Personality Disorder are usually self-critical. Individuals with Narcissistic or **Antisocial Personality Disorder** lack generosity but will indulge themselves, whereas those with Obsessive-Compulsive Personality Disorder adopt a miserly spending style toward both self and others. Both **Schizoid Personality Disorder** and Obsessive-Compulsive Personality Disorder may be characterized by an apparent formality and social detachment. In Obsessive-Compulsive Personality Disor- der, this stems from discomfort with emotions and excessive devotion to work, whereas in Schizoid Personality Disorder there is a fundamental lack of capacity for intimacy.

Obsessive-Compulsive Personality Disorder must be distinguished from **Personality Change Due to a General Medical Condition,** in which the traits emerge due to the direct effects of a general medical condition on the central nervous system. It must also be distinguished from **symptoms that may develop in association with chronic substance use** (e.g., Cocaine-Related Disorder Not Otherwise Specified).

Obsessive-compulsive personality traits in moderation may be especially adaptive, particularly in situations that reward high performance. Only when these traits are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress do they constitute Obsessive-Compulsive Personality Disorder.

Diagnostic criteria for 301.4 Obsessive–compulsive Personality Disorder

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

(1) is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost
(2) shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met)
(3) is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)
(4) is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)

(continued)

☐ **Diagnostic criteria for 301.4 Obsessive Compulsive Personality Disorder** *(continued)*

(5) is unable to discard worn-out or worthless objects even when they have no sentimental value
(6) is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things
(7) adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes
(8) shows rigidity and stubbornness

301.9 Personality Disorder Not Otherwise Specified

This category is for disorders of personality functioning that do not meet criteria for any specific Personality Disorder. An example is the presence of features of more than one specific Personality Disorder that do not meet the full criteria for any one Personality Disorder ("mixed personality"), but that together cause clinically significant distress or impairment in one or more important areas of functioning (e.g., social or occupational). This category can also be used when the clinician judges that a specific Personality Disorder that is not included in the Classification is appropriate. Examples include depressive personality disorder and passive-aggressive personality disorder (seep. 732 and p. 733, respectively, for suggested research criteria).

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Other Conditions That May Be a Focus of Clinical Attention

This section covers other conditions or problems that may be a focus of clinical attention. These are related to the mental disorders described previously in this manual in one of the following ways: 1) the problem is the focus of diagnosis or treatment and the individual has no mental disorder (e.g., a Partner Relational Problem in which neither partner has symptoms that meet criteria for a mental disorder, in which case only the Partner Relational Problem is coded); 2) the individual has a mental disorder but it is unrelated to the problem (e.g., a Partner Relational Problem in which one of the partners has an incidental Specific Phobia, in which case both can be coded); 3) the individual has a mental disorder that is related to the problem, but the problem is sufficiently severe to warrant independent clinical attention (e.g., a Partner Relational Problem sufficiently problematic to be a focus of treatment that is also associated with Major Depressive Disorder in one of the partners, in which case both can be coded). The conditions and problems in this section are coded on Axis I.

Psychological Factors Affecting Medical Condition

316 Psychological Factor Affecting Medical Condition

magnostic Features

The essential feature of Psychological Factors Affecting Medical Condition is the presence of one or more specific psychological or behavioral factors that adversely affect a general medical condition. There are several different ways in which these factors can adversely affect the general medical condition. The factors can influence the course of the general medical condition (which can be inferred by a close temporal association between the factors and the development or exacerbation of, or delayed recovery from, the medical condition). The factors may interfere with treatment of the general medical condition.

The factors may constitute an additional health risk for the individual (e.g., continued overeating in an individual with weight-related diabetes). They may precipitate or exacerbate symptoms of a general medical condition by eliciting stress-related physiological responses (e.g., causing chest pain in individuals with coronary artery disease, or bronchospasm in individuals with asthma).

The psychological or behavioral factors that influence general medical conditions include Axis I disorders, Axis II disorders, psychological symptoms or personality traits that do not meet the full criteria for a specific mental disorder, maladaptive health behaviors, or physiological responses to environmental or social stressors.

Psychological or behavioral factors play a potential role in the presentation or treatment of almost every general medical condition. This category should be reserved for those situations in which the psychological factors have a clinically significant effect on the course or outcome of the general medical condition or place the individual at a significantly higher risk for an adverse outcome. There must be reasonable evidence to suggest an association between the psychological factors and the medical condition, although it may often not be possible to demonstrate direct causality or the mechanisms underlying the relationship. Psychological and behavioral factors may affect the course of almost every major category of disease, including cardiovascular conditions, dermatological conditions, endocrinological conditions, gastrointestinal conditions, neoplastic conditions, neurological conditions, pulmonary conditions, renal conditions, and rheumatological conditions.

The Psychological Factors Affecting Medical Condition diagnosis is coded on Axis I, and the accompanying general medical condition is coded on Axis III. (See Appendix G for a list of diagnostic codes for general medical conditions.) To provide greater specificity regarding the type of psychological factor, the name is chosen from the list below. When more than one type of factor is present, the most prominent should be specified.

Mental Disorder Affecting ... ***[Indicate the General Medical Condition].*** A specific Axis I or Axis II disorder significantly affects the course or treatment of a general medical condition (e.g., Major Depressive Disorder adversely affecting the prognosis of myocardial infarction, renal failure, or hemodialysis; Schizophrenia complicating the treatment of diabetes mellitus). In addition to coding this condition on Axis I, the specific mental disorder is also coded on Axis I or Axis II.

Psychological Symptoms Affecting ... ***[Indicate the General Medical Condition].*** Symptoms that do not meet full criteria for an Axis I disorder significantly affect the course or treatment of a general medical condition (e.g., symptoms of anxiety or depression affecting the course and severity of irritable bowel syndrome or peptic ulcer disease, or complicating recovery from surgery).

Personality Traits or Coping Style Affecting ... ***[Indicate the General Medical Condition].*** A personality trait or a maladaptive coping style significantly affects the course or treatment of a general medical condition. Personality traits can be subthreshold for an Axis II disorder or represent another pattern that has been demonstrated to be a risk factor for certain illnesses (e.g., "type A," pressured, hostile behavior for coronary artery disease). Problematic personality traits and maladaptive coping styles can impede the working relationship with health care personnel.

Maladaptive Health Behaviors Affecting ... ***{Indicate the General Medical Condition].*** Maladaptive health behaviors (e.g., sedentary lifestyle, unsafe sexual prac- tices, overeating, excessive alcohol and drug use) significantly affect the course or treatment of a general medical condition. If the maladaptive behaviors are better accounted for by an Axis I disorder (e.g., overeating as part of Bulimia Nervosa, alcohol use as part of Alcohol Dependence), the name "Mental Disorder Affecting Medical Condition" should be used instead.

Stress-Related Physiological Response Affecting . . . ***[Indicate the General Medi- cal Condition].*** Stress-related physiological responses significantly affect the course or treatment of a general medical condition (e.g., precipitate chest pain or arrhythmia in a patient with coronary artery disease).

Other or Unspecified Factors Affecting ... ***{Indicate the General Medical Condi- tion].*** A factor not included in the subtypes specified above or an unspecified psychological or behavioral factor significantly affects the course or treatment of a general medical condition.

Differential Diagnosis

A temporal association between symptoms of a mental disorder and a general medical condition is also characteristic of a **Mental Disorder Due to a General Medical Condition,** but the presumed causality is in the opposite direction. In a Mental Disorder Due to a General Medical Condition, the general medical condition is judged to be causing the mental disorder through a direct physiological mechanism. In Psychological Factors Affecting Medical Condition, the psychological or behavioral factors are judged to affect the course of the general medical condition.

Substance Use Disorders (e.g., Alcohol Dependence, Nicotine Dependence) adversely affect the prognosis of many general medical conditions. If an individual has a coexisting Substance Use Disorder that adversely affects or causes a general medical condition, Mental Disorder Affecting General Medical Condition can be coded on Axis I in addition to the Substance Use Disorder. For substance use patterns affecting a general medical condition that do not meet the criteria for a Substance Use Disorder, Maladaptive Health Behaviors Affecting Medical Condition can he specified.

Somatofonn Disorders are characterized by the presence of both psychological factors and physical symptoms, but there is no general medical condition that can completely account for the physical symptoms. In contrast, in Psychological Factors Affecting Medical Condition, the psychological factors adversely affect a diagnosable general medical condition. Psychological factors affecting pain syndromes are not diagnosed as Psychological Factors Affecting Medical Condition hut rather as **Pain Disorder Associated With Psychological Factors or Pain Disorder Associated With Both Psychological Factors and a General Medical Condition.**

When noncompliance with treatment for a general medical condition results from psychological factors but becomes the major focus of clinical attention, **Noncompliance With Treatment** (seep. 683) should be coded.

316 ... *[Specified Psychological Factor)* Affecting ... *[Indicate tlie General Medical Condition)*

A. A general medical condition (coded on Axis III) is present.

B. Psychological factors adversely affect the general medical condition in one of the following ways:

(1) the factors have influenced the course of the general medical condition as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the general medical condition
(2) the factors interfere with the treatment of the general medical condition
(3) the factors constitute additional health risks for the individual
(4) stress-related physiological responses precipitate or exacerbate symptoms of the general medical condition

Choose name based on the nature of the psychological factors (if more than one factor is present. indicate the most prominent):

Mental Disorder Affecting ... ***[Indicate the General Medical Condition]*** (e.g., an Axis I disorder such as Major Depressive Disorder delaying recovery from a myocardial infarction)

Psychological Symptoms Affecting . . . ***[Indicate the Genera/Medical Condition]*** (e.g., depressive symptoms delaying recovery from surgery; anxiety exacerbating asthma)

Personality Traits or Coping Style Affecting ... ***{Indicate the General Medical Condition]*** (e.g., pathological denial of the need for surgery in a patient with cancer; hostile, pressured behavior contributing to cardiovascular disease)

Maladaptive Health Behaviors Affecting ... ***{Indicate the General Medical Condition]*** (e.g., overeating; lack of exercise; unsafe sex)

Stress-Related Physiological Response Affecting ... ***{Indicate the General Medical Condition]*** (e.g., stress-related exacerbations of ulcer, hypertension, arrhythmia, or tension headache)

Other or Unspecified Psychological Factors Affecting ... ***{Indicate the General Medical Condition]*** (e.g., interpersonal, cultural, or religious factors)

Medication Induced Movement Disorders

The following Medication-Induced Movement Disorders are included because of their frequent importance in 1) the management by medication of mental disorders or general medical conditions; and 2) the differential diagnosis with Axis I disorders (e.g., Anxiety Disorder versus Neuroleptic-Induced Akathisia; catatonia versus Neuroleptic Malignant Syndrome). Although these disorders are labeled "medication induced," it is often

difficult to establish the causal relationship between medication exposure and the development of the movement disorder, especially because some of these movement disorders also occur in the absence of medication exposure. The term *neuroleptic* is used broadly in this manual to refer to medications with dopamine-antagonist properties. These include so-called "typical" antipsychotic agents (e.g., chlorpromazine, haloperidol, fluphenazine), "atypical" antipsychotic agents (e.g., clozapine), certain dopamine receptor blocking drugs used in the treatment of symptoms such as nausea and gastroparesis (e.g., prochlorperazine, promethazine, trimethobenzamide, thiethylperazine, and metoclopramide), and amoxapine, which is marketed as an antidepressant. Medication-Induced Movement Disorders should be coded on Axis I.

332.1 Neuroleptic--Induced Parkinsonism

Parkinsonian tremor, muscular rigidity, or akinesia developing within a few weeks of starting or raising the dose of a neuroleptic medication (or after reducing a medication used to treat extrapyramidal symptoms). (Seep. 736 for suggested research criteria.)

333.92 Neuroleptic Malignant Syndrome

Severe muscle rigidity, elevated temperature, and other related findings (e.g., diaphoresis, dysphagia, incontinence, changes in level of consciousness ranging from confusion to coma, mutism, elevated or labile blood pressure, elevated creatine phosphokinase [CPK]) developing in association with the use of neuroleptic medication. (See p. 739 for suggested research criteria.)

333.7 Neuroleptic--Induced Acute Dystonia

Abnormal positioning or spasm of the muscles of the head, neck, limbs, or trunk developing within a few days of starting or raising the dose of a neuroleptic medication (or after reducing a medication used to treat extrapyramidal symptoms). (Seep. 742 for suggested research criteria.)

333.99 Neuroleptic--Induced Acute Akathisia

Subjective complaints of restlessness accompanied by observed movements (e.g., fidgety movements of the legs, rocking from foot to foot, pacing, or inability to sit or stand still) developing within a few weeks of starting or raising the dose of a neuroleptic medication (or after reducing a medication used to treat extrapyramidal symptoms). (Seep. 744 for suggested research criteria.)

333.82 Neuroleptic--Induced Tardive Dyskinesia

Involuntary choreiform, athetoid, or rhythmic movements (lasting at least a few weeks) of the tongue, jaw, or extremities developing in association with the use of neuroleptic

medication for at least a few months (may be for a shorter period of time in elderly persons). (Seep. 747 for suggested research criteria.)

333.1 Medication--Induced Postural Tremor

Fine tremor occurring during attempts to maintain a posture that develops in association with the use of medication (e.g., lithium, antidepressants, valproate). (See p. 749 for suggested research criteria.)

333.90 Medication--Induced Movement Disorder Not Otherwise Specified

This category is for Medication-Induced Movement Disorders not classified by any of the specific disorders listed above. Examples include 1) parkinsonism, acute akathisia, acute dystonia, or dyskinetic movement that is associated with a medication other than a neuroleptic; 2) a presentation that resembles neuroleptic malignant syndrome that is associated with a medication other than a neuroleptic; or 3) tardive dystonia.

Other Medication Induced Disorder

995.2 Adverse Effects of Medication Not Otherwise Specified

This category is available for optional use by clinicians to code side effects of medication (other than movement symptoms) when these adverse effects become a main focus of clinical attention. Examples include severe hypotension, cardiac arrhythmias, and priapism.

Relational Problems

Relational problems include patterns of interaction between or among members of a relational unit that are associated with clinically significant impairment in functioning, or symptoms among one or more members of the relational unit, or impairment in the functioning of the relational unit itself. The following relational problems are included because they are frequently a focus of clinical attention among individuals seen by health professionals. These problems may exacerbate or complicate the management of a mental disorder or general medical condition in one or more members of the relational unit, may be a result of a mental disorder or a general medical condition, may be independent of other conditions that are present, or can occur in the absence of any other condition. When these problems are the principal focus of clinical attention, they should be listed on Axis I. Otherwise, if they are present but not the principal focus of

clinical attention, they may be listed on Axis IV. The relevant category is generally applied to all members of a relational unit who are being treated for the problem.

V61.9 Relational Problem Related to a Mental Disorder or General Medical Condition

This category should be used when the focus of clinical attention is a pattern of impaired interaction that is associated with a mental disorder or a general medical condition in a family member.

V61.20 Parent--Child Relational Problem

This category should be used when the focus of clinical attention is a pattern of interaction between parent and child (e.g., impaired communication, overprotection, inadequate discipline) that is associated with clinically significant impairment in individ- ual or family functioning or the development of clinically significant symptoms in parent or child.

V61.1 Partner Relational Problem

This category should be used when the focus of clinical attention is a pattern of interaction between spouses or partners characterized by negative communication (e.g., criticisms), distorted communication (e.g., unrealistic expectations), or noncommunica- tion (e.g., withdrawal) that is associated with clinically significant impairment in individual or family functioning or the development of symptoms in one or both partners.

V61.8 Sibling Relational Problem

This category should be used when the focus of clinical attention is a pattern of interaction among siblings that is associated with clinically significant impairment in individual or family functioning or the development of symptoms in one or more of the siblings.

V62.81 Relational Problem Not Otherwise Specified

This category should be used when the focus of clinical attention is on relational problems that are not classifiable by any of the specific problems listed above (e.g., difficulties with co-workers).

Problems Related to Abuse or Neglect

This section includes categories that should be used when the focus of clinical attention is severe mistreatment of one individual by another through physical abuse, sexual abuse, or child neglect. These problems are included because they are frequently a focus of clinical attention among individuals seen by health professionals. The appropriate V code applies if the focus of attention is on the perpetrator of the abuse or neglect or on the relational unit in which it occurs. If the individual being evaluated or treated is the victim of the abuse or neglect, code 995.5 for a child or 995.81 for an adult.

V61.21 Physical Abuse of Child

This category should be used when the focus of clinical attention is physical abuse of a child.
Coding note: *Specify* **995.5** *if focus of clinical attention is on the victim.*

V61.21 Sexual Abuse of Child

This category should be used when the focus of clinical attention is sexual abuse of a child.
Coding note: *Specify* **995.5** *if focus of clinical attention is on the victim.*

V61.21 Neglect of Child

This category should be used when the focus of clinical attention is child neglect.
Coding note: *Specify* **995.5** *if focus of clinical attention is on the victim.*

V61.11 Physical Abuse of Adult

This category should be used when the focus of clinical attention is physical abuse of an adult (e.g., spouse beating, abuse of elderly parent).
Coding note: *Specify* **995.81** *if focus of clinical attention is on the victim.*

V61.11 Sexual Abuse of Adult

This category should be used when the focus of clinical attention is sexual abuse of an adult (e.g., sexual coercion, rape).
Coding note: *Specify* **995.81** *if focus of clinical attention is on the victim.*

Additional Conditions That May Be a Focus of Clinical Attention

VI 5.81 Noncompliance With Treatment

This category can be used when the focus of clinical attention is noncompliance with an important aspect of the treatment for a mental disorder or a general medical condition. The reasons for noncompliance may include discomfort resulting from treatment (e.g., medication side effects), expense of treatment, decisions based on personal value judgments or religious or cultural beliefs about the advantages and disadvantages of the proposed treatment, maladaptive personality traits or coping styles (e.g., denial of illness), or the presence of a mental disorder (e.g., Schizophrenia, Avoidant Personality Disorder). This category should be used only when the problem is sufficiently severe to warrant independent clinical attention.

V65.2 Malingering

The essential feature of Malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs. Under some circumstances, Malingering may represent adaptive behavior-for example, feigning illness while a captive of the enemy during wartime.

Malingering should be strongly suspected if any combination of the following is noted:

1. Medicolegal context of presentation (e.g., the person is referred by an attorney to the clinician for examination)
2. Marked discrepancy between the person's claimed stress or disability and the objective findings
3. Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen
4. The presence of Antisocial Personality Disorder

Malingering differs from Factitious Disorder in that the motivation for the symptom production in Malingering is an external incentive, whereas in Factitious Disorder external incentives are absent. Evidence of an intrapsychic need to maintain the sick role suggests Factitious Disorder. Malingering is differentiated from Conversion Disorder and other Somatoform Disorders by the intentional production of symptoms and by the obvious, external incentives associated with it. In Malingering (in contrast to Conversion Disorder), symptom relief is not often obtained by suggestion or hypnosis.

V71.01 Adult Antisocial Behavior

This category can be used when the focus of clinical attention is adult antisocial behavior that is not due to a mental disorder (e.g., Conduct Disorder, Antisocial Personality

Disorder, or an Impulse-Control Disorder). Examples include the behavior of some professional thieves, racketeers, or dealers in illegal substances.

V7I .02 Child or Adolescent Antisocial Behavior

This category can be used when the focus of clinical attention is antisocial behavior in a child or adolescent that is not due to a mental disorder (e.g., Conduct Disorder or an Impulse-Control Disorder). Examples include isolated antisocial acts of children or adolescents (not a pattern of antisocial behavior).

V62.89 Borderline Intellectual Functioning

This category can be used when the focus of clinical attention is associated with borderline intellectual functioning, that is, an IQ in the 71-84 range. Differential diagnosis between Borderline Intellectual Functioning and Mental Retardation (an IQ of 70 or below) is especially difficult when the coexistence of certain mental disorders (e.g., Schizophrenia) is involved.
Coding note: *This is coded on Axis II.*

780.9 Age--Related Cognitive Decline

This category can be used when the focus of clinical attention is an objectively identified decline in cognitive functioning consequent to the aging process that is within normal limits given the person's age. Individuals with this condition may report problems remembering names or appointments or may experience difficulty in solving complex problems. This category should be considered only after it has been determined that the cognitive impairment is not attributable to a specific mental disorder or neurological condition.

V62.82 Bereavement

This category can be used when the focus of clinical attention is a reaction to the death of a loved one. As part of their reaction to the loss, some grieving individuals present with symptoms characteristic of a Major Depressive Episode (e.g., feelings of sadness and associated symptoms such as insomnia, poor appetite, and weight loss). The bereaved individual typically regards the depressed mood as "normal," although the person may seek professional help for relief of associated symptoms such as insomnia or anorexia. The duration and expression of "normal" bereavement vary considerably among different cultural groups. The diagnosis of Major Depressive Disorder is generally not given unless the symptoms are still present 2 months after the loss. However, the presence of certain symptoms that are not characteristic of a "normal" grief reaction may be helpful in differentiating bereavement from a Major Depressive Episode. These include 1) guilt about things other than actions taken or not taken by the survivor at the time of the death; 2) thoughts of death other than the survivor feeling that he or she

would be better off dead or should have died with the deceased person; 3) morbid preoccupation with worthlessness; 4) marked psychomotor retardation; 5) prolonged and marked functional impairment; and 6) hallucinatory experiences other than thinking that he or she hears the voice of, or transiently sees the image of, the deceased person.

V62.3 Academic Problem

This category can be used when the focus of clinical attention is an academic problem that is not due to a mental disorder or, if due to a mental disorder, is sufficiently severe to warrant independent clinical attention. An example is a pattern of failing grades or of significant underachievement in a person with adequate intellectual capacity in the absence of a Learning or Communication Disorder or any other mental disorder that would account for the problem.

V62.2 Occupational Problem

This category can be used when the focus of clinical attention is an occupational problem that is not due to a mental disorder or, if it is due to a mental disorder, is sufficiently severe to warrant independent clinical attention. Examples include job dissatisfaction and uncertainty about career choices.

31 3.82 Identity Problem

This category can be used when the focus of clinical attention is uncertainty about multiple issues relating to identity such as long-term goals, career choice, friendship patterns, sexual orientation and behavior, moral values, and group loyalties.

V62.89 Religious or Spiritual Problem

This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution.

V62.4 Acculturation Problem

This category can be used when the focus of clinical attention is a problem involving adjustment to a different culture (e.g., following migration).

V62.89 Phase of Life Problem

This category can be used when the focus of clinical attention is a problem associated with a particular developmental phase or some other life circumstance that is not due

to a mental disorder or, if it is due to a mental disorder, is sufficiently severe to warrant independent clinical attention. Examples include problems associated with entering school, leaving parental control, starting a new career, and changes involved in marriage, divorce, and retirement.

Additional Codes

300.9 Unspecified Mental Disorder (nonpsychotic)

There are several circumstances in which it may be appropriate to assign this code: 1) for a specific mental disorder not included in the DSM-IV Classification, 2) when none of the available Not Otherwise Specified categories is appropriate, or 3) when it is judged that a nonpsychotic mental disorder is present but there is not enough information available to diagnose one of the categories provided in the Classification. In some cases, the diagnosis can be changed to a specific disorder after more information is obtained.

V71.09 No Diagnosis or Condition on Axis I

When no Axis I diagnosis or condition is present, this should be indicated. There may or may not be an Axis II diagnosis.

799.9 Diagnosis or Condition Deferred on Axis I

When there is insufficient information to make any diagnostic judgment about an Axis I diagnosis or condition, this should be noted as Diagnosis or Condition Deferred on Axis I.

V71.09 No Diagnosis on Axis II

When no Axis II diagnosis (e.g., no Personality Disorder) is present, this should be indicated. There may or may not be an Axis I diagnosis or condition.

799.9 Diagnosis Deferred on Axis II

When there is insufficient information to make any diagnostic judgment about an Axis II diagnosis, this should be noted as Diagnosis Deferred on Axis II.

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Appendix A

Decision Trees for Differential Diagnosis

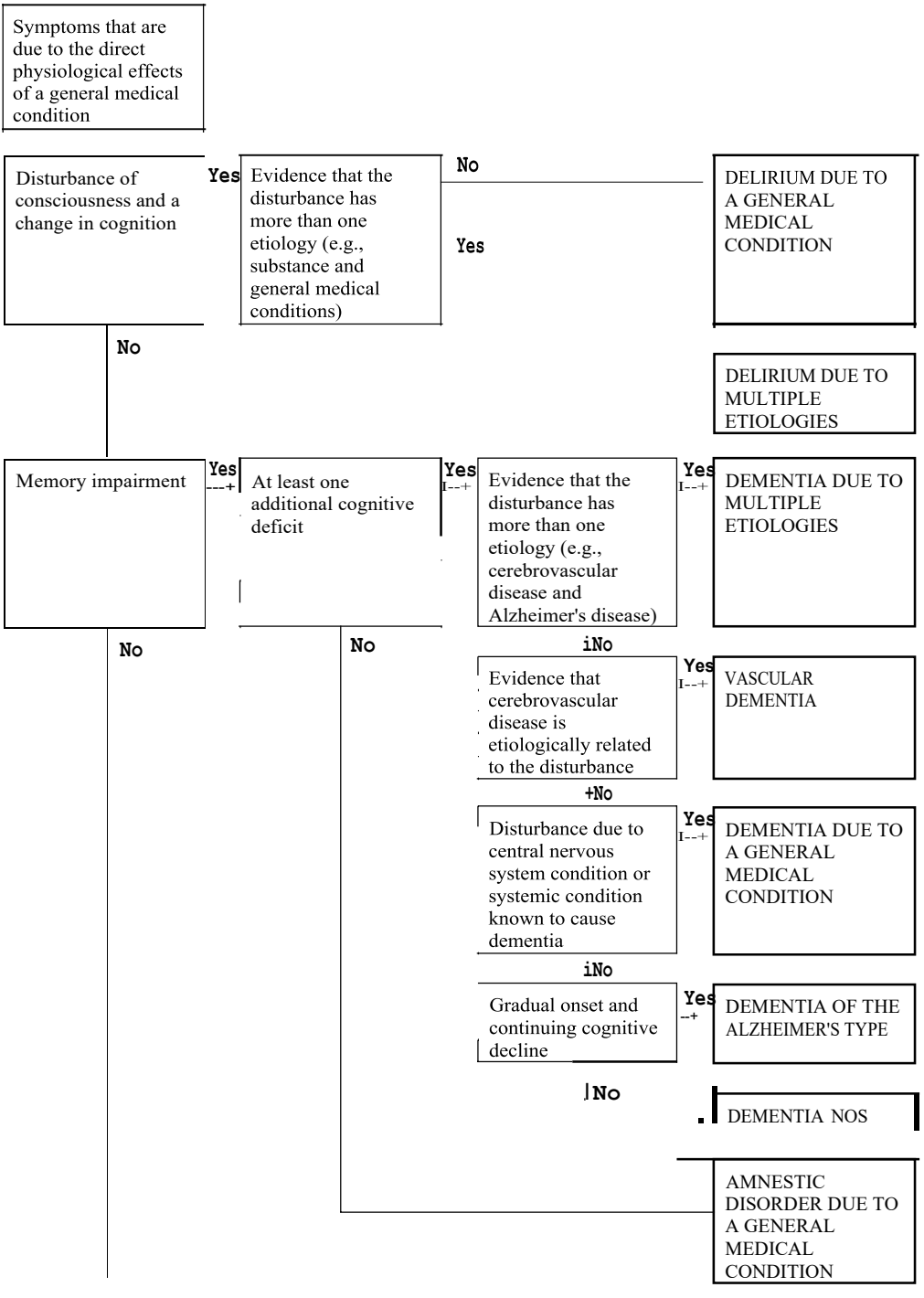
The purpose of these decision trees is to aid the clinician in understanding the organization and hierarchical structure of the DSM-IV Classification. Each decision tree starts with a set of clinical features. When one of these features is a prominent part of the presenting clinical picture, the clinician can follow the series of questions to rule in or rule out various disorders. Note that the questions are only approximations of the diagnostic criteria and are not meant to replace them.

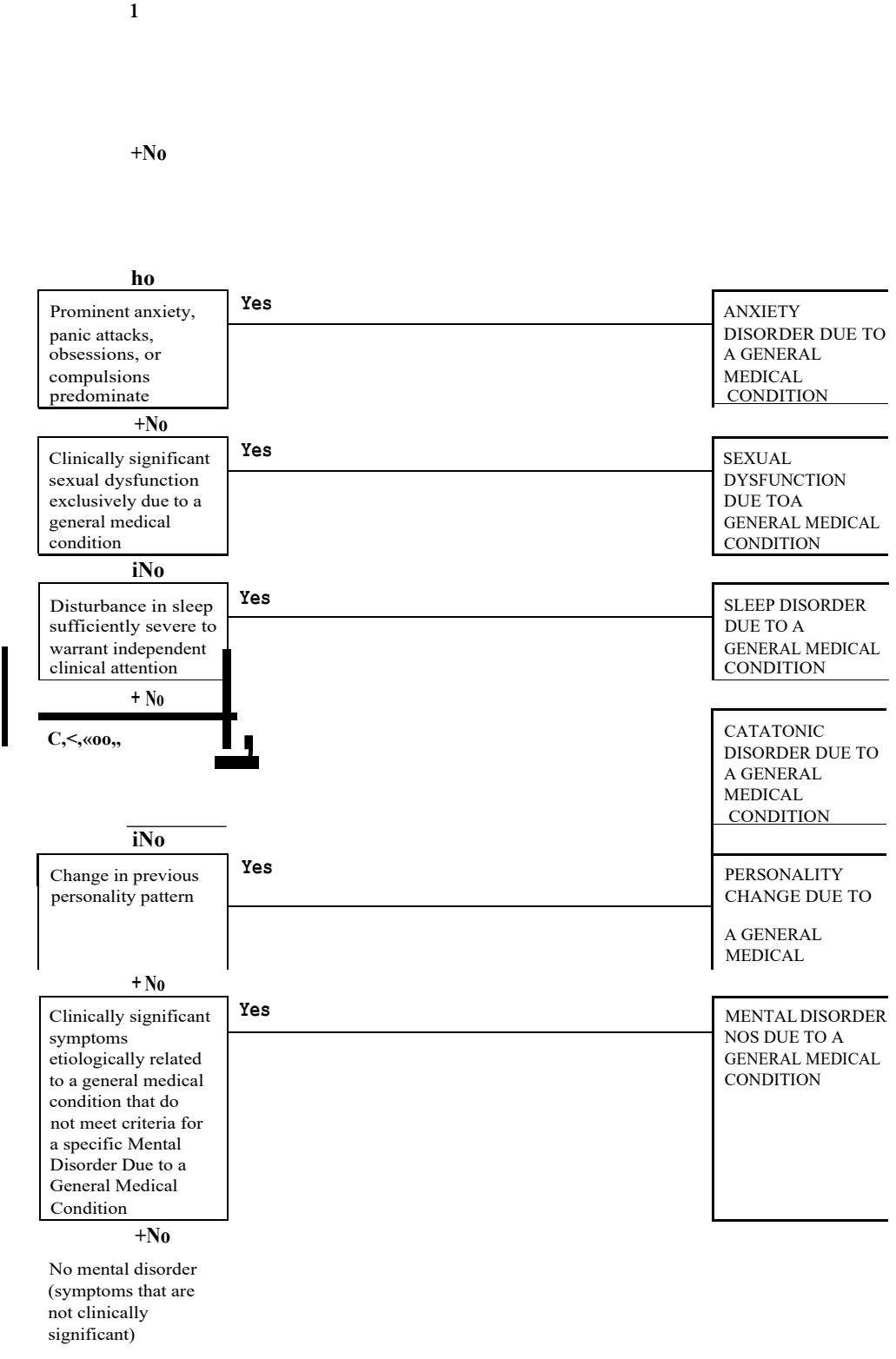
The Psychotic Disorders decision tree is the only one that contains disorders that are mutually exclusive (i.e., only one disorder from that section can be diagnosed in a given individual for a particular episode). For the other decision trees, it is important to refer to the individual criteria sets to determine when more than one diagnosis may apply.

Contents

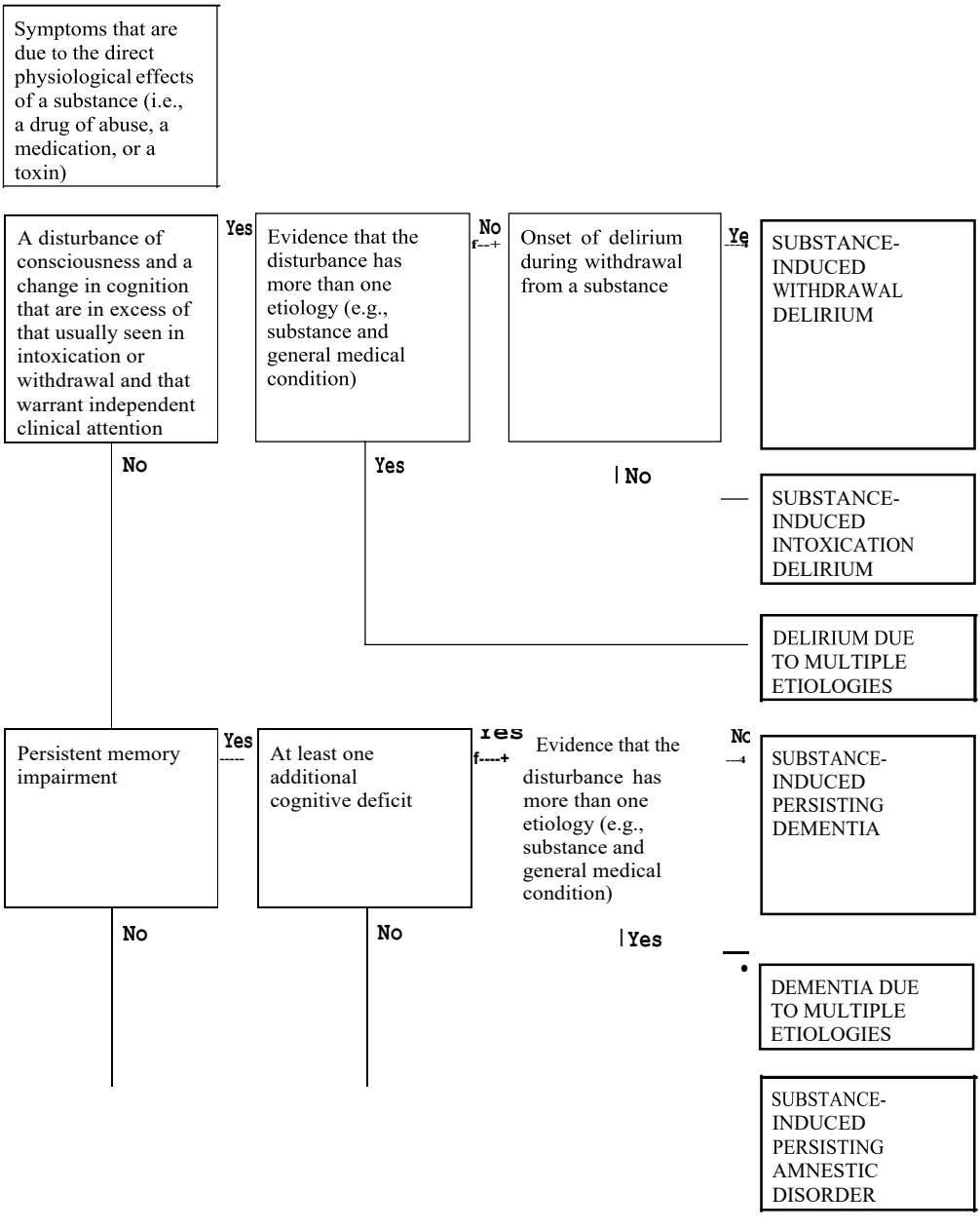
Note: Prepared by Michael B. First, M.D., Allen Frances, M.D., and Harold Alan Pincus, M.D.

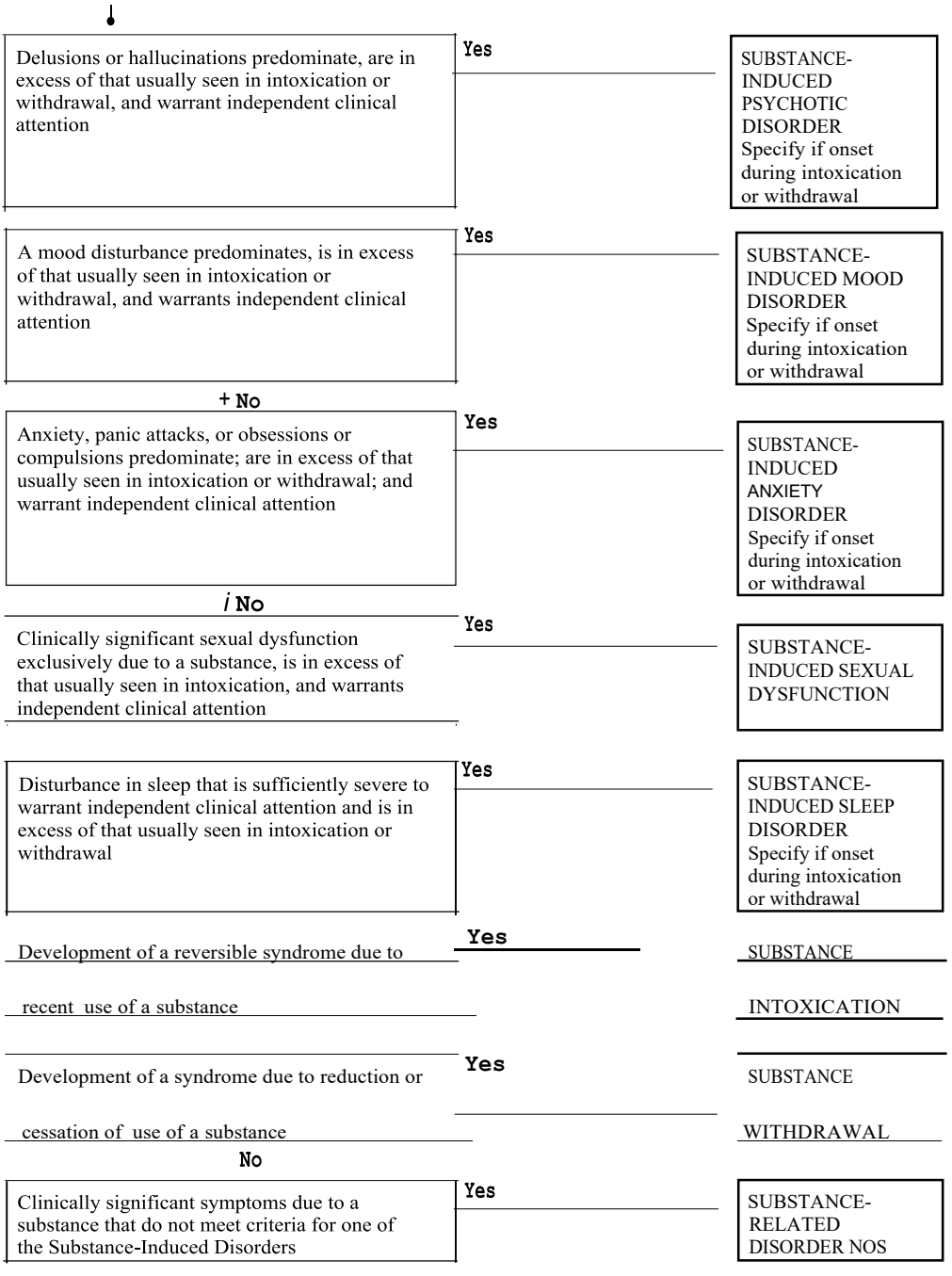
Differential Diagnosis of Mental Disorders Due to a General Medical Condition



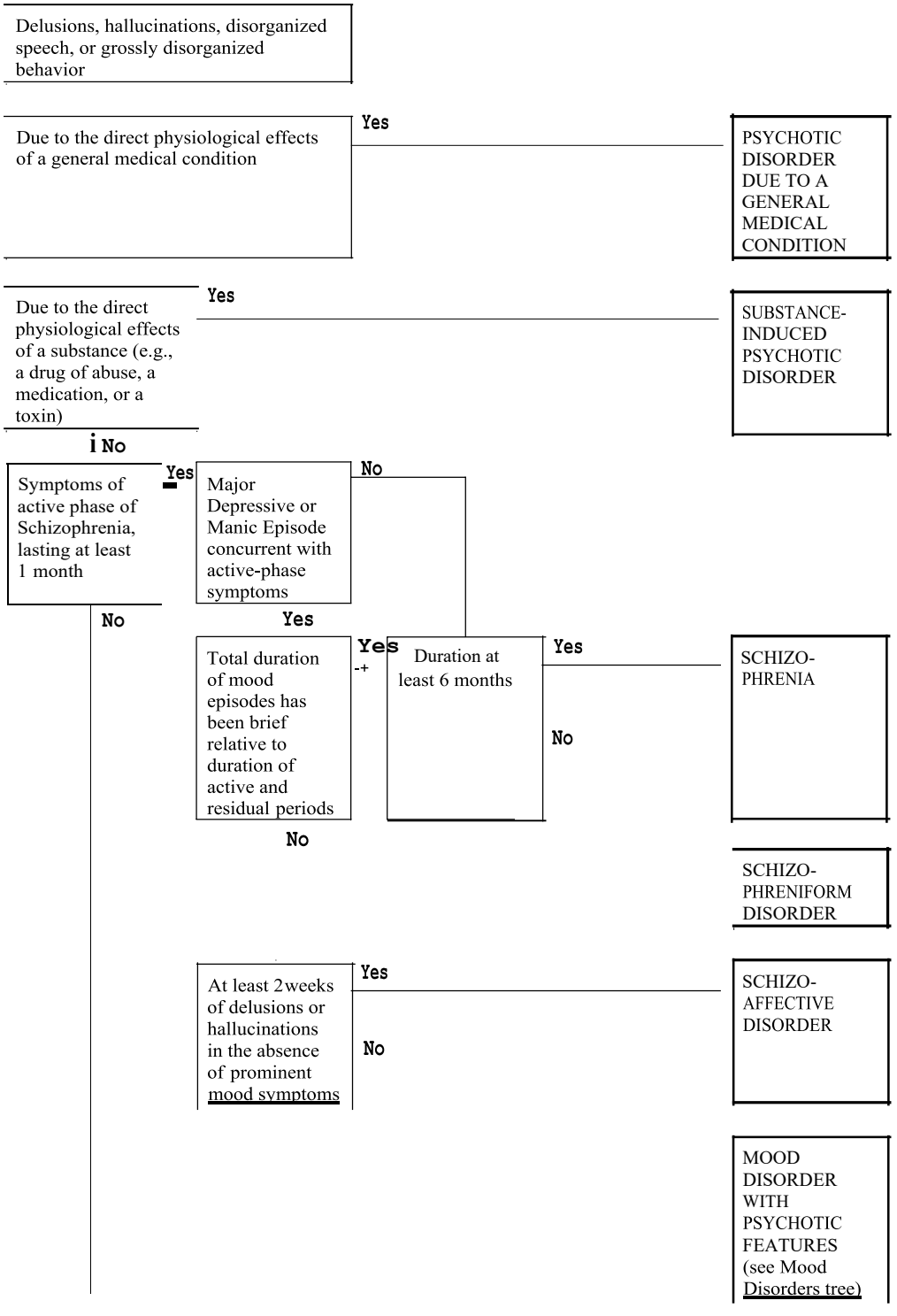

i
+No
ho
Prominent anxiety, panic attacks, obsessions, or compulsions predominate
Yes
ANXIETY DISORDER DUE TO A GENERAL MEDICAL CONDITION
+No
Clinically significant sexual dysfunction exclusively due to a general medical condition
Yes
SEXUAL DYSFUNCTION DUE TOA GENERAL MEDICAL CONDITION
iNo
Disturbance in sleep sufficiently severe to warrant independent clinical attention
Yes
SLEEP DISORDER DUE TO A GENERAL MEDICAL CONDITION
+ No
C,<,«oo,,
CATATONIC DISORDER DUE TO A GENERAL MEDICAL CONDITION
iNo
Change in previous personality pattern
Yes
PERSONALITY CHANGE DUE TO
A GENERAL MEDICAL
+ No
Clinically significant symptoms etiologically related to a general medical condition that do not meet criteria for a specific Mental Disorder Due to a General Medical Condition
Yes
MENTAL DISORDER NOS DUE TO A GENERAL MEDICAL CONDITION
+No
No mental disorder (symptoms that are not clinically significant)

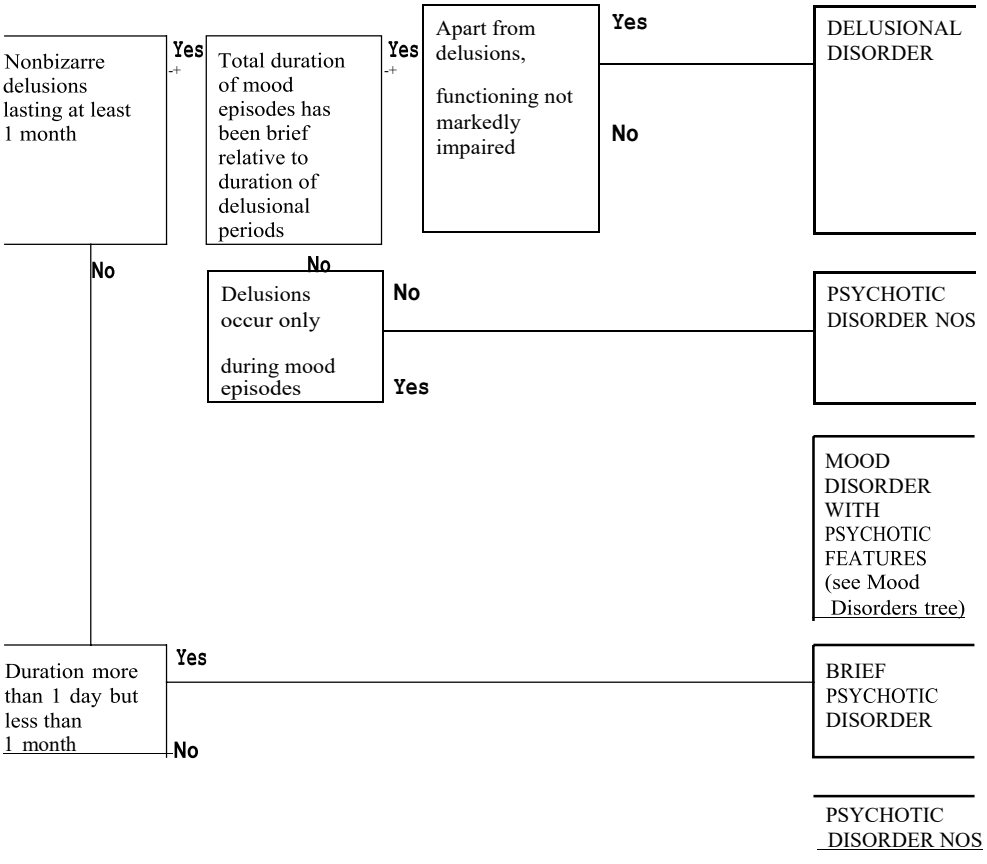
Differential Diagnosis of Substance--Induced Disorders (Not Including Dependence and Abuse)



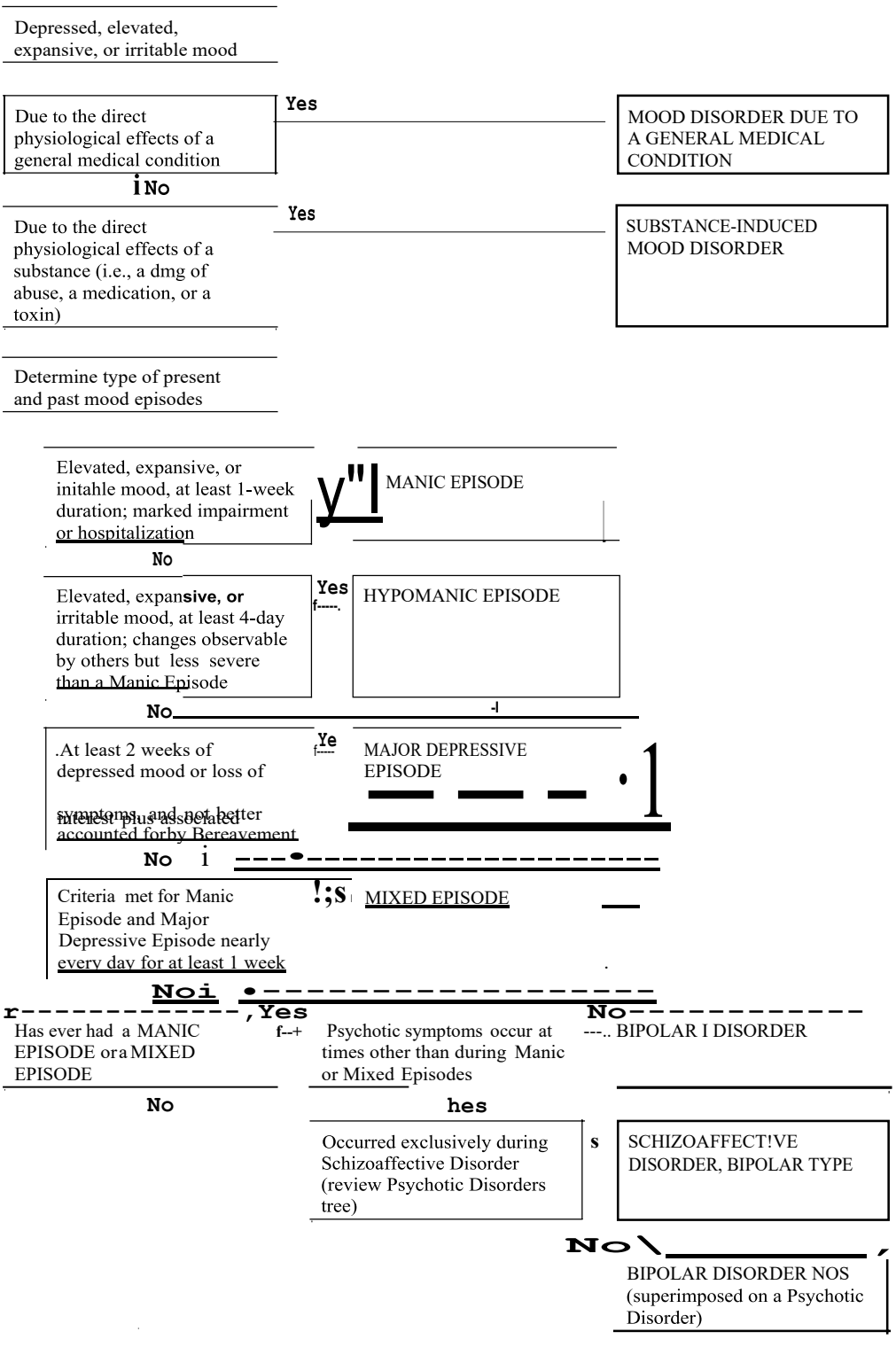

Delusions or hallucinations predominate, are in excess of that usually seen in intoxication or withdrawal, and warrant independent clinical attention
Yes
SUBSTANCE-INDUCED PSYCHOTIC DISORDER Specify if onset during intoxication or withdrawal
A mood disturbance predominates, is in excess of that usually seen in intoxication or withdrawal, and warrants independent clinical attention
Yes
SUBSTANCE-INDUCED MOOD DISORDER Specify if onset during intoxication or withdrawal
+ No
Anxiety, panic attacks, or obsessions or compulsions predominate; are in excess of that usually seen in intoxication or withdrawal; and warrant independent clinical attention
Yes
SUBSTANCE-INDUCED ANXIETY DISORDER Specify if onset during intoxication or withdrawal
/ No
Clinically significant sexual dysfunction exclusively due to a substance, is in excess of that usually seen in intoxication, and warrants independent clinical attention
Yes
SUBSTANCE-INDUCED SEXUAL DYSFUNCTION
Disturbance in sleep that is sufficiently severe to warrant independent clinical attention and is in excess of that usually seen in intoxication or withdrawal
Yes
SUBSTANCE-INDUCED SLEEP DISORDER Specify if onset during intoxication or withdrawal
Development of a reversible syndrome due to recent use of a substance
Yes
SUBSTANCE INTOXICATION
Development of a syndrome due to reduction or cessation of use of a substance
Yes
SUBSTANCE WITHDRAWAL
No
Clinically significant symptoms due to a substance that do not meet criteria for one of the Substance-Induced Disorders
Yes
SUBSTANCE-RELATED DISORDER NOS
No Substance-Induced Disorder (substance-induced symptoms that are not clinically significant)

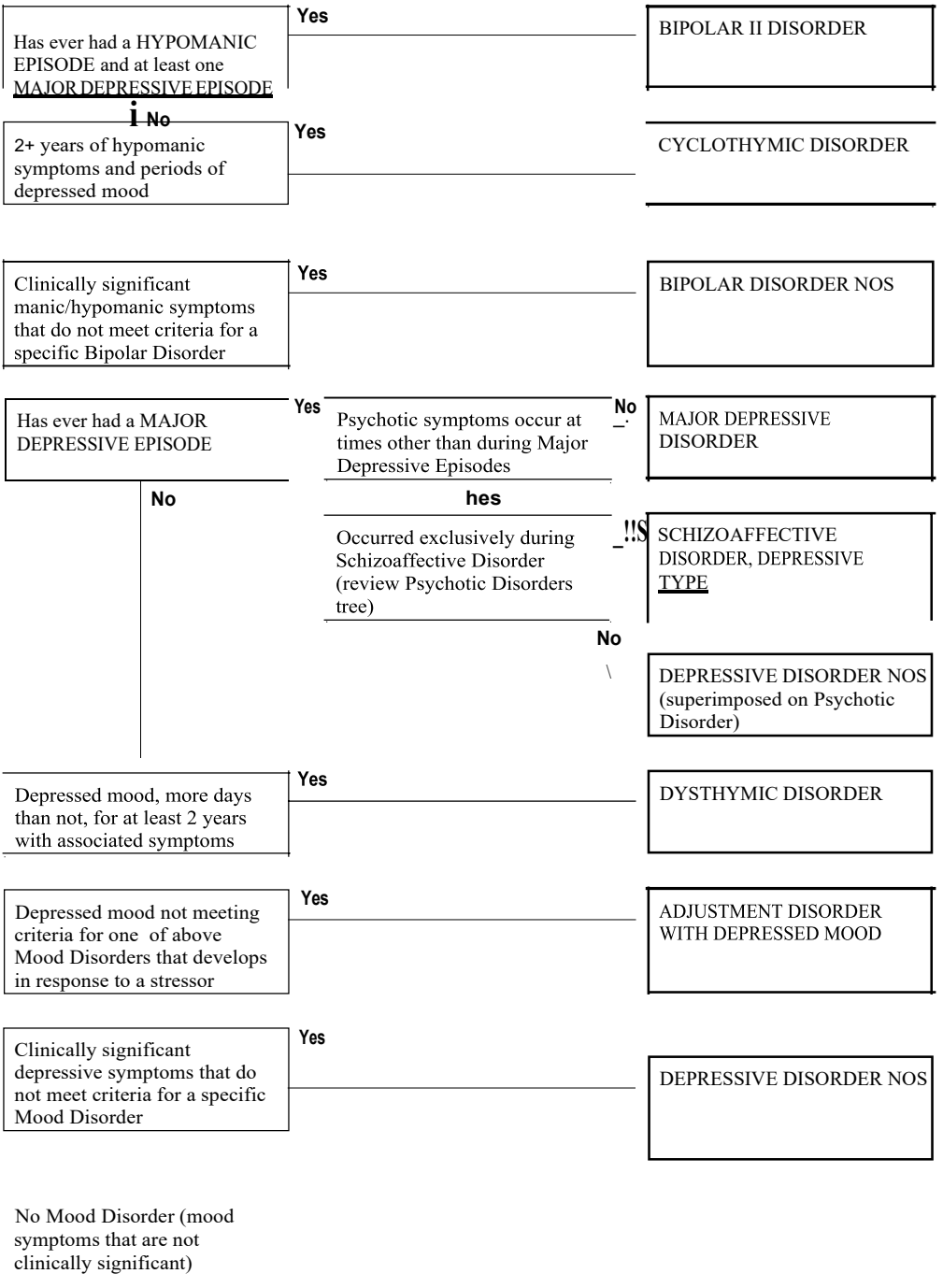
Differential Diagnosis of Psychotic Disorders



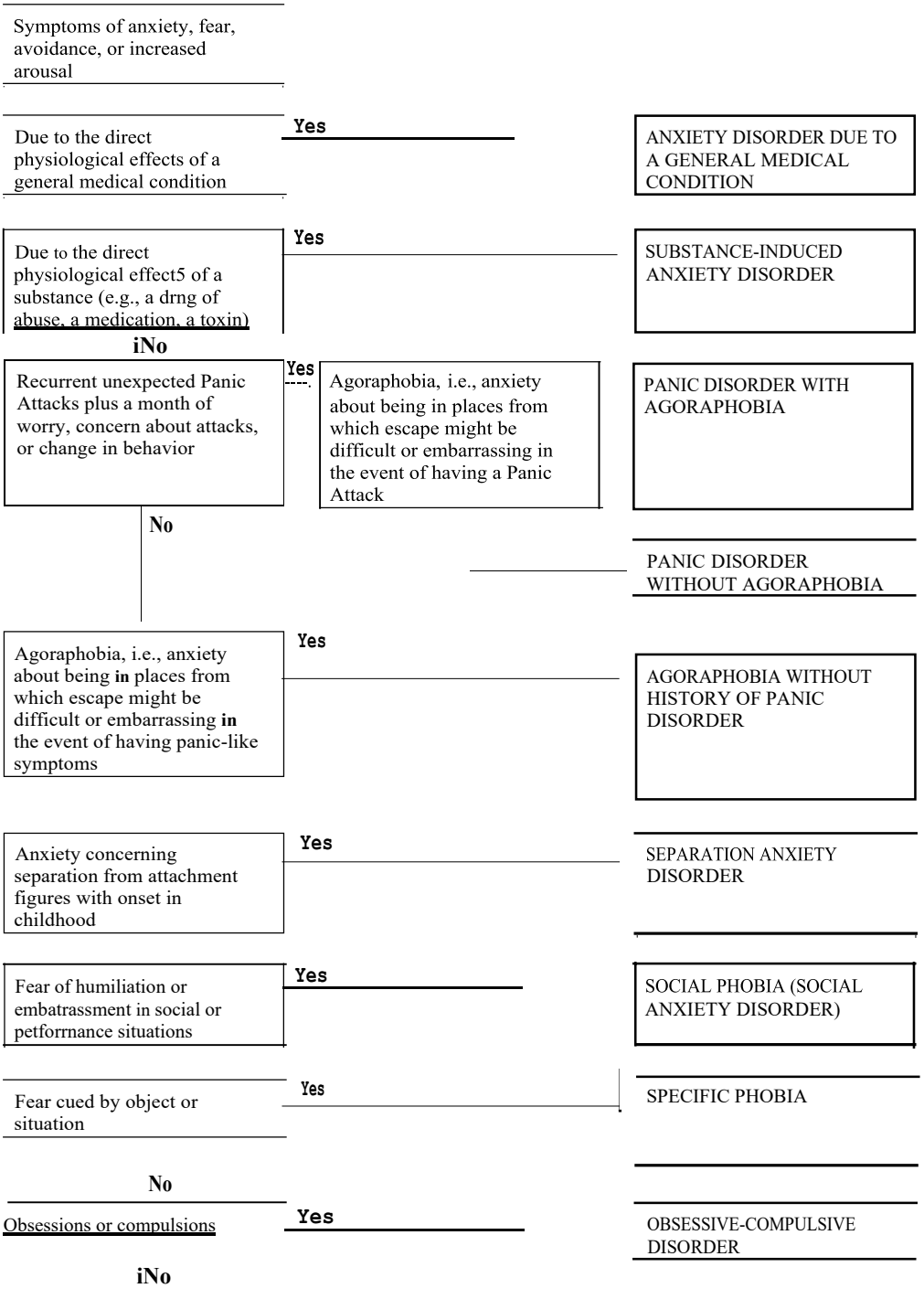

Nonbizarre delusions lasting at least 1 month
Yes
Total duration of mood episodes has been brief relative to duration of delusional periods
Yes
Apart from delusions,
functioning not markedly impaired
Yes
No
DELUSIONAL DISORDER
No
No
Delusions occur only
during mood episodes
No
Yes
PSYCHOTIC DISORDER NOS
MOOD DISORDER WITH PSYCHOTIC FEATURES (see Mood Disorders tree)
Duration more than 1 day but less than 1 month
Yes
No
BRIEF PSYCHOTIC DISORDER
PSYCHOTIC DISORDER NOS

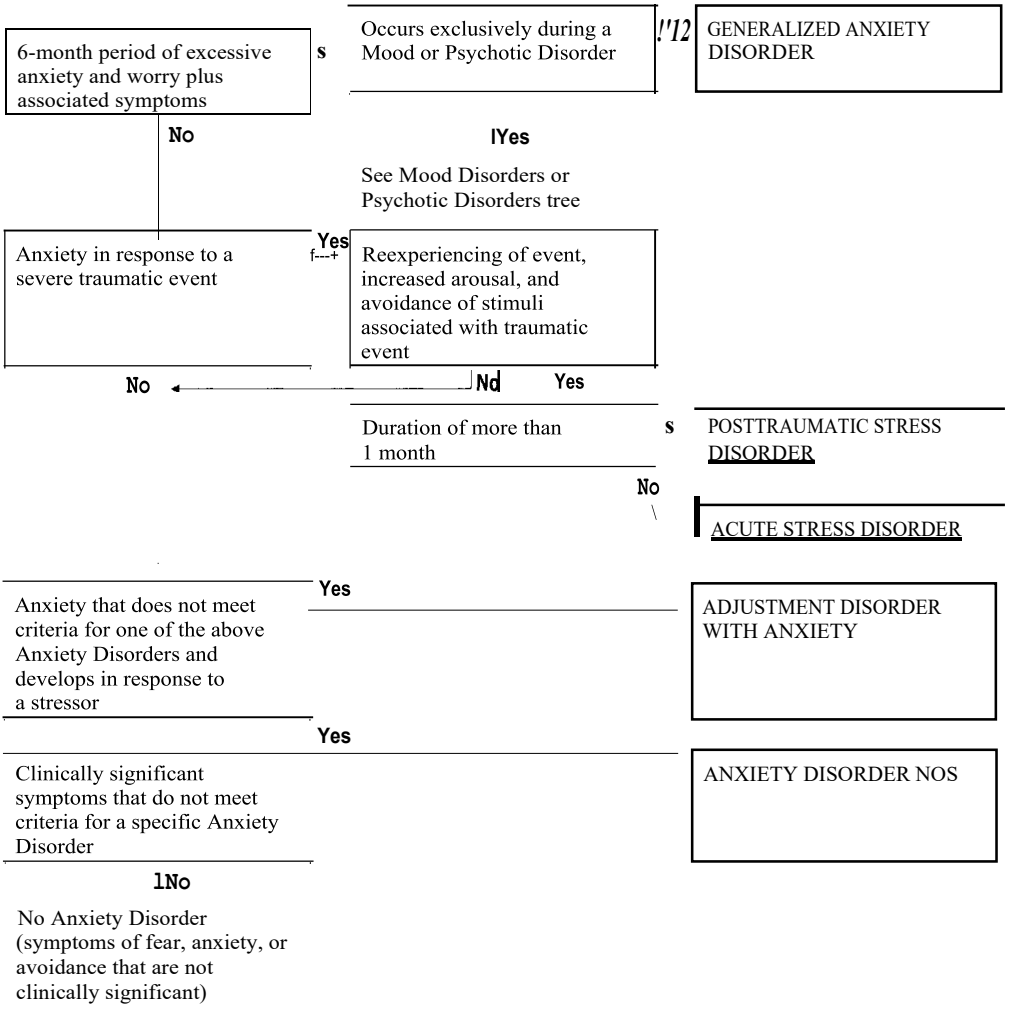
Differential Diagnosis of Mood Disorders



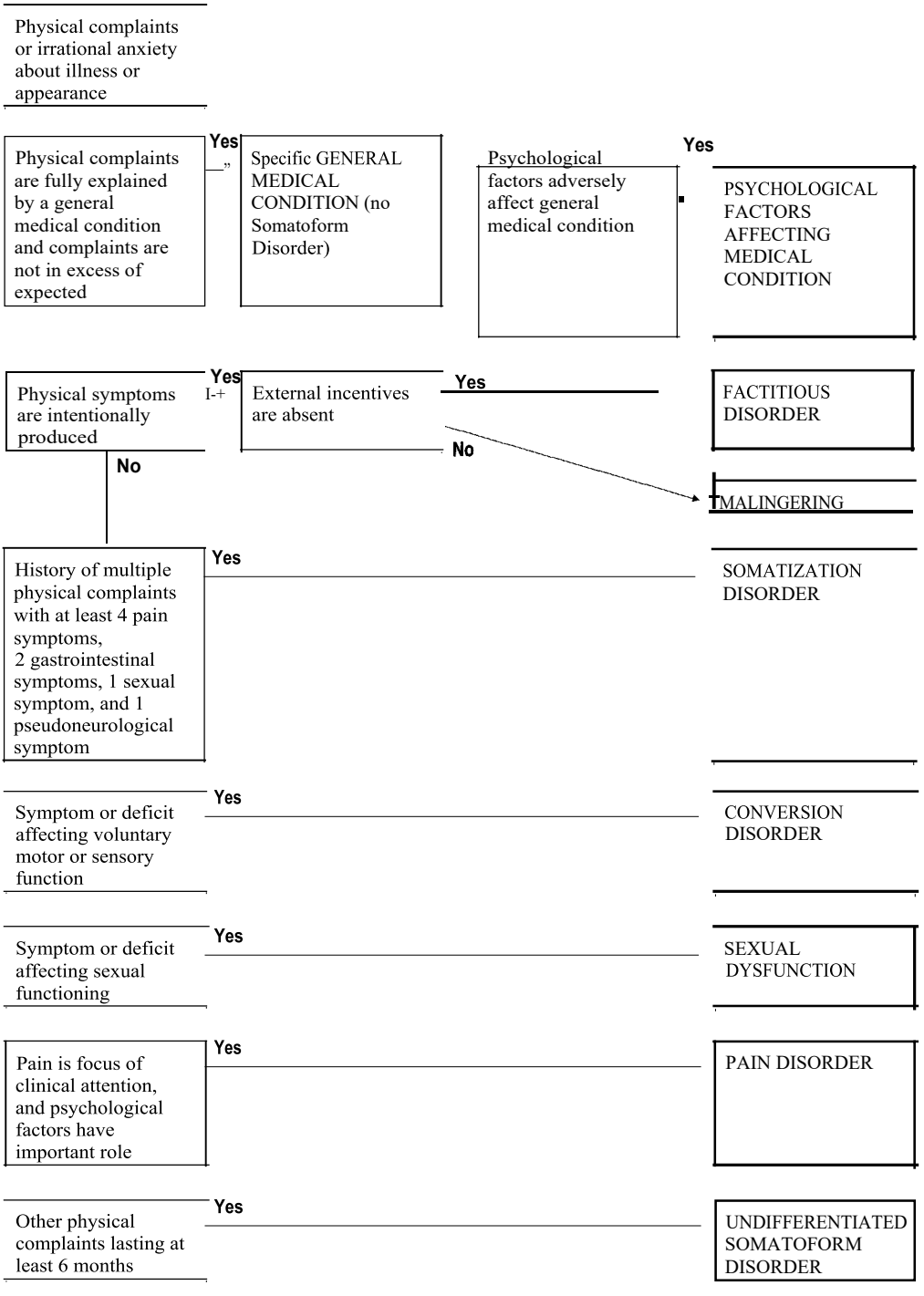

Has ever had a HYPOMANIC EPISODE and at least one MAJOR DEPRESSIVE EPISODE
Yes
BIPOLAR II DISORDER
No
2+ years of hypomanic symptoms and periods of depressed mood
Yes
CYCLOTHYMIC DISORDER
Clinically significant manic/hypomanic symptoms that do not meet criteria for a specific Bipolar Disorder
Yes
BIPOLAR DISORDER NOS
Has ever had a MAJOR DEPRESSIVE EPISODE
Yes
Psychotic symptoms occur at times other than during Major Depressive Episodes
No
MAJOR DEPRESSIVE DISORDER
hes
Occurred exclusively during Schizoaffective Disorder (review Psychotic Disorders tree)
SCHIZOAFFECTIVE DISORDER, DEPRESSIVE TYPE
No
DEPRESSIVE DISORDER NOS (superimposed on Psychotic Disorder)
No
Depressed mood, more days than not, for at least 2 years with associated symptoms
Yes
DYSTHYMIC DISORDER
Depressed mood not meeting criteria for one of above Mood Disorders that develops in response to a stressor
Yes
ADJUSTMENT DISORDER WITH DEPRESSED MOOD
Clinically significant depressive symptoms that do not meet criteria for a specific Mood Disorder
Yes
DEPRESSIVE DISORDER NOS
No Mood Disorder (mood symptoms that are not clinically significant)

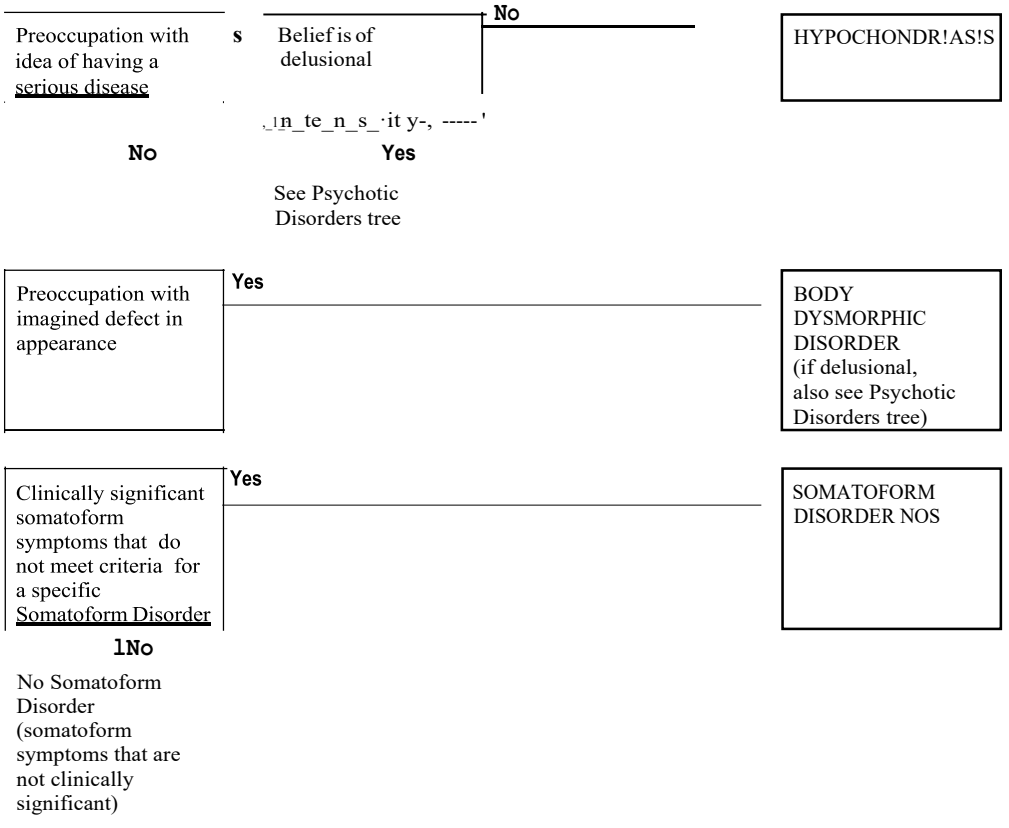
Differential Diagnosis of Anxiety Disorders




6-month period of excessive anxiety and worry plus associated symptoms
s
Occurs exclusively during a Mood or Psychotic Disorder
!"12
GENERALIZED ANXIETY DISORDER
No
lYes
See Mood Disorders or Psychotic Disorders tree
Anxiety in response to a severe traumatic event
Yes
Reexperiencing of event, increased arousal, and avoidance of stimuli associated with traumatic event
No
Nd
Yes
Duration of more than 1 month
s
POSTTRAUMATIC STRESS DISORDER
No
ACUTE STRESS DISORDER
Anxiety that does not meet criteria for one of the above Anxiety Disorders and develops in response to a stressor
Yes
ADJUSTMENT DISORDER WITH ANXIETY
Yes
Clinically significant symptoms that do not meet criteria for a specific Anxiety Disorder
ANXIETY DISORDER NOS
lNo
No Anxiety Disorder (symptoms of fear, anxiety, or avoidance that are not clinically significant)

Differential Diagnosis of Somatoform Disorders




Preoccupation with idea of having a serious disease
s
Belief is of delusional
No
HYPOCHONDRIASIS
Intensity
No
Yes
See Psychotic Disorders tree
Preoccupation with imagined defect in appearance
Yes
BODY DYSMORPHIC DISORDER (if delusional, also see Psychotic Disorders tree)
Clinically significant somatoform symptoms that do not meet criteria for a specific Somatoform Disorder
Yes
SOMATOFORM DISORDER NOS
No
No Somatoform Disorder (somatoform symptoms that are not clinically significant)

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Appendix B

Criteria Sets and Axes Provided for Further Study

This appendix contains a number of proposals for new categories and axes that were suggested for possible inclusion in DSM-IV. The DSM-IV Task Force and Work Groups subjected each of these proposals to a careful empirical review and invited wide commentary from the field. The Task Force determined that there was insufficient information to warrant inclusion of these proposals as official categories or axes in DSM-IV.

The items, thresholds, and durations contained in the research criteria sets are intended to provide a common language for researchers and clinicians who are interested in studying these disorders. It is hoped that such research will help to determine the possible utility of these proposed categories and will result in refinement of the criteria sets. The specific thresholds and durations were set by expert consensus (informed by literature review, data reanalysis, and field-trial results when such information was available) and, as such, should be considered tentative. It would be highly desirable for researchers to study alternative items, thresholds, or durations whenever this is possible.

The following proposals are included in this appendix:

Postconcussional disorder
Mild neurocognitive disorder
Caffeine withdrawal
Alternative dimensional descriptors for Schizophrenia
Postpsychotic depressive disorder of Schizophrenia
Simple deteriorative disorder (simple Schizophrenia)
Premenstrual dysphoric disorder
Alternative Criterion B for Dysthymic Disorder
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 (negativistic personality disorder)
Medication-Induced Movement Disorders
Neuroleptic-Induced Parkinsonism
Neuroleptic Malignant Syndrome
Neuroleptic-Induced Acute Dystonia
Neuroleptic-Induced Acute Akathisia
Neuroleptic-Induced Tardive Dyskinesia
Medication-Induced Postural Tremor
Medication-Induced Movement Disorder Not Otherwise Specified

(Note: These categories are included in the "Other Conditions That May Be a Focus of Clinical Attention" section. Text and research criteria sets for these conditions are included here.)

Defensive Functioning Scale
Global Assessment of Relational Functioning (GARF) Scale
Social and Occupational Functioning Assessment Scale (SOFAS)

Postconcussional Disorder

Features

The essential feature is an acquired impairment in cognitive functioning, accompanied by specific neurobehavioral symptoms, that occurs as a consequence of closed head injury of sufficient severity to produce a significant cerebral concussion. The manifestations of concussion include loss of consciousness, posttraumatic amnesia, and less commonly, posttraumatic onset of seizures. Specific approaches for defining this criterion need to be refined by further research. Although there is insufficient evidence to establish a definite threshold for the severity of the closed head injury, specific criteria have been suggested, for example, two of the following: 1) a period of unconsciousness lasting more than 5 minutes, 2) a period of posttraumatic amnesia that lasts more than 12 hours after the closed head injury, or 3) a new onset of seizures (or marked worsening of a preexisting seizure disorder) that occurs within the first 6 months after the closed head injury. There must also be documented cognitive deficits in either attention (concentration, shifting focus of attention, performing simultaneous cognitive tasks) or memory (learning or recalling information). Accompanying the cognitive disturbances, there must be three (or more) symptoms that are present for at least 3 months following the closed head injury. These include becoming fatigued easily; disordered sleep; headache; vertigo or dizziness; irritability or aggression on little or no provocation; anxiety, depression, or affective !ability; apathy or lack of spontaneity; and other changes in personality (e.g., social or sexual inappropriateness). The cognitive disturbances and the somatic and behavioral symptoms develop after the head trauma has occurred or represent a significant worsening of preexisting symptoms. The cognitive and neurobehavioral sequelae are accompanied by significant impairment in social or occupational functioning and represent a significant decline from a previous level of functioning. In the case of school-age children, there may be significant worsening in academic achievement dating from the trauma. This proposed disorder should not be considered if the individual's symptoms meet the criteria for Dementia Due to Head Trauma or if the symptoms are better accounted for by another mental disorder.

Associated Features

Additional features that may be sequelae of closed head injury include visual or hearing impairments and anosmia (loss of sense of smell). The latter may be related to a lack of interest in food. Specific orthopedic and neurological complications may be present, depending on the cause, nature, and extent of the trauma. Substance-Related Disorders are frequently associated with closed head injury. Closed head injury occurs more often in young males and has been associated with risk-taking behaviors.

Differential Diagnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Cognitive Disorder Not Otherwise Specified.**

If the head trauma results in a **dementia** (e.g., memory impairment and at least one other cognitive impairment), postconcussional disorder should not be considered. **Mild neurocognitive disorder,** like postconcussional disorder, is included in this appendix (see p. 706). Postconcussional disorder can be differentiated from mild neurocognitive disorder by the specific pattern of cognitive, somatic, and behavioral symptoms and the presence of a specific etiology (i.e., closed head injury). Individuals with **Somatization Disorder** and **Undifferentiated Somatoform Disorder** may manifest similar behavioral or somatic symptoms; however, these disorders do not have a specific etiology (i.e., closed head injury) or measurable impairment in cognitive functioning. Postconcussional disorder must be distinguished from **Factitious Disorder** (the need to assume the sick role) and **Malingering** (in which the desire for compensation may lead to the production or prolongation of symptoms due to closed head injury).

Research criteria for postconcussional disorder

A. A history of head trauma that has caused significant cerebral concussion.

Note: The manifestations of concussion include loss of consciousness, posttraumatic amnesia, and, less commonly, posttraumatic onset of seizures. The specific method of defining this criterion needs to be established by further research.

B. Evidence from neuropsychological testing or quantified cognitive assessment of difficulty in attention (concentrating, shifting focus of attention, performing simultaneous cognitive tasks) or memory (learning or recalling information).

C. Three (or more) of the following occur shortly after the trauma and last at least 3 months:

(1) becoming fatigued easily
(2) disordered sleep
(3) headache

(continued)

☐ **Research criteria for postconcussional disorder** *(continued)*

(4) vertigo or dizziness
(5) irritability or aggression on little or no provocation
(6) anxiety, depression, or affective !ability
(7) changes in personality (e.g., social or sexual inappropriateness)
(8) apathy or lack of spontaneity

D. The symptoms in Criteria B and C have their onset following head trauma or else represent a substantial worsening of preexisting symp- toms.

E. The disturbance causes significant impairment in social or occupational functioning and represents a significant decline from a previous level of functioning. In school-age children, the impairment may be manifested by a significant worsening in school or academic performance dating from the trauma.

F. The symptoms do not meet criteria for Dementia Due to Head Trauma and are not better accounted for by another mental disorder (e.g., Amnestic Disorder Due to Head Trauma, Personality Change Due to Head Trauma).

Mild Neurocognitive Disorder

Features

The essential feature is the development of impairment in neurocognitive functioning that is due to a general medical condition. By definition, the level of cognitive impairment and the impact on everyday functioning is **mild** (e.g., the individual is able to partially compensate for cognitive impairment with additional effort). Individuals with this condition have a new onset of deficits in at least two areas of cognitive functioning. These may include disturbances in memory (learning or recalling new information), executive functioning (e.g., planning, reasoning), attention or speed of information processing (e.g., concentration, rapidity of assimilating or analyzing information), perceptual motor abilities (e.g., integrating visual, tactile, or auditory information with motor activities), or language (e.g., word-finding difficulties, reduced fluency). The report of cognitive impairment must be corroborated by the results of neuropsychological testing or bedside standardized cognitive assessment techniques. Furthermore, the cognitive deficits cause marked distress or interfere with the individual's social, occupa- tional, or other important areas of functioning and represent a decline from a previous level of functioning. The cognitive disturbance does not meet criteria for a delirium, a dementia, or an amnestic disorder and is not better accounted for by another mental disorder (e.g., a Substance-Related Disorder, Major Depressive Disorder).

Associated Features

The associated features depend on the underlying general medical condition. In the case of certain chronic disorders (e.g., hypoxemia, electrolyte imbalances), the cognitive profile is usually one of a generalized reduction in all cognitive functions. Some neurological and other general medical conditions produce patterns of cognitive impairment that suggest more "subcortical" brain involvement (i.e., disproportionate impairment in the ability to concentrate and learn new facts and in the speed and efficiency of processing information). These include the early phases of Huntington's disease, HIV-associated neurocognitive disorder, and Parkinson's disease. Other condi- tions (e.g., systemic lupus erythematosus) are more frequently associated with a multifocal or patchy pattern of cognitive loss. The EEG may show mild slowing of background activity or disturbance in evoked potentials. Mild cognitive impairment, even in cases of early Alzheimer's disease, is frequently present without specific changes on neuroanatomical studies using magnetic resonance imaging (MRI) or computed tomography (CD. Abnormalities are more likely to be present in functional brain imaging studies (single photon emission computer tomography [SPECT], positron-emission tomography [PET], functional MRI). The course depends on the underlying etiology. In some instances, the cognitive impairment slowly worsens so that ultimately a diagnosis of dementia becomes appropriate (e.g., early phases of Alzheimer's disease, Huntington's disease, and other slowly progressive neurodegenerative conditions). In other instances, the disturbance may improve slowly, as in gradual recovery from hypothyroidism. In some instances, cognitive disturbances due to severe metabolic derangements or infectious diseases may resolve partially but be characterized by a residual impairment that is permanent.

Di,fferential magnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Cognitive Disorder Not Otherwise Specified.**

Although there is no clear boundary between mild neurocognitive disorder and **dementia,** mild neurocognitive disorder has less cognitive impairment and less impact on daily activities, and memory impairment is not a requirement. Mild neurocognitive disorder may be confused with a slowly evolving **delirium,** especially early in its course. Mild neurocognitive disorder can be distinguished from an **amnestic disorder** by the requirement that there be cognitive impairment in at least two areas. Mild neurocognitive disorder should not be considered if an individual's symptoms meet criteria for a **Substance-Related Disorder** (including medication side effects). In such cases, the appropriate Substance-Related Disorder Not Otherwise Specified should be diagnosed.

Postconcussionaldisorder, another category listed in this appendix (see p. 704), is distinguished from mild neurocognitive disorder by the presence of a specific pattern of symptoms and a specific etiology (i.e., closed head injury).

Mild neurocognitive disturbances are a common associated feature of a number of **mental disorders** (e.g., Major Depressive Disorder). Mild neurocognitive disorder should only be considered if the cognitive impairment is better accounted for by the direct effects of a general medical condition than by a mental disorder. Individuals with **Age-Related Cognitive Decline** may have similar levels of cognitive impairment, but the decline is considered to be part of the normative aging process rather than attributable to a general medical condition. Individuals may report **subjective complaints of**

impairment in cognitive functioning that cannot be corroborated by neuropsychological testing or are judged not to be associated with a general medical condition. This proposed disorder should not be considered for such presentations.

Research criteria for mild neurocognitive disorder

A. The presence of two (or more) of the following impairments in cognitive functioning, lasting most of the time for a period of at least 2 weeks (as reported by the individual or a reliable informant):
   (1) memory impairment as identified by a reduced ability to learn or recall information
   (2) disturbance in executive functioning (i.e., planning, organizing, sequencing, abstracting)
   (3) disturbance in attention or speed of information processing
   (4) impairment in perceptual-motor abilities
   (5) impairment in language (e.g., comprehension, word finding)

B. There is objective evidence from physical examination or laboratory findings (including neuroimaging techniques) of a neurological or general medical condition that is judged to be etiologically related to the cognitive disturbance.

C. There is evidence from neuropsychological testing or quantified cognitive assessment of an abnormality or decline in performance.

D. The cognitive deficits cause marked distress or impairment in social, occupational, or other important areas of functioning and represent a decline from a previous level of functioning.

E. The cognitive disturbance does not meet criteria for a delirium, a dementia, or an amnestic disorder and is not better accounted for by another mental disorder (e.g., a Substance-Related Disorder, Major Depressive Disorder).

Caffeine Withdrawal

Features

The essential feature is a characteristic withdrawal syndrome due to the abrupt cessation of, or reduction in, the use of caffeine-containing products after prolonged daily use. The syndrome includes headache and one (or more) of the following symptoms: marked fatigue or drowsiness, marked anxiety or depression, or nausea or vomiting. These symptoms appear to be more prevalent in individuals with heavy use (500 mg/day) but may occur in individuals with light use (100 mg/day). The symptoms must cause clinically

significant distress or impairment in social, occupational, or other important areas of functioning. The symptoms must not be due to the direct physiological effects of a general medical condition and must not be better accounted for by another mental disorder.

Associated Features

Associated symptoms include a strong desire for caffeine and worsened cognitive performance (especially on vigilance tasks). Symptoms can begin within 12 hours of cessation of caffeine use, peak around 24-48 hours, and last up to 1 week. Some individuals may seek medical treatment for these symptoms without realizing they are due to caffeine withdrawal.

m.[ferential magnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Caffeine-Related Disorder Not Otherwise Specified.**

For a general discussion of the differential diagnosis of Substance-Related Disorders, seep. 190. The symptoms must not be due to the direct physiological effects of a **general medical condition** (e.g., migraine, viral illness) and must not be better accounted for by **another mental disorder.** Headaches, fatigue, nausea, or vomiting due to a general medical condition or due to the **initiation or cessation of a medication** can cause a clinical picture similar to caffeine withdrawal. Drowsiness, fatigue, and mood changes from caffeine withdrawal can mimic **Amphetamine or Cocaine Withdrawal.** The temporal relationship of symptoms to caffeine cessation and the time-limited course of the symptoms usually establish the diagnosis. If the diagnosis is unclear, a diagnostic trial of caffeine can be of help.

Research criteria for caffeine withdrawal

A. Prolonged daily use of caffeine.

B. Abrupt cessation of caffeine use, or reduction in the amount of caffeine used, closely followed by headache and one (or more) of the following symptoms:
   (1) marked fatigue or drowsiness
   (2) marked anxiety or depression
   (3) nausea or vomiting

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 the direct physiological effects of a general medical condition (e.g., migraine, viral illness) and are not better accounted for by another mental disorder.

Alternative Dimensional Descriptors for Schizophrenia

Because of limitations in the classical subtyping of Schizophrenia (see p. 286), a three-factor dimensional model (psychotic, disorganized, and negative) has been suggested to describe current and lifetime symptomatology. The psychotic factor includes delusions and hallucinations. The disorganized factor includes disorganized speech, disorganized behavior, and inappropriate affect. The negative factor includes the various negative symptoms. Studies suggest that the severity of symptoms within each of these three factors tends to vary together, both cross-sectionally and over time, whereas this is less true for symptoms across factors. For example, as delusions become more severe, hallucinations tend to become more severe as well. In contrast, the severity of negative or disorganized symptoms is less related to the severity of hallucinations or delusions. One model for understanding the clinical heterogeneity of Schizophrenia suggests that each of these three dimensions may have different underlying patho- physiological processes and treatment responses. Various combinations of severity on the three dimensions are encountered in clinical practice, and it is relatively uncommon for one dimension to be present in the complete absence of both of the others. The following is a system for applying these dimensions in research and clinical studies.

Alternative dimensional descriptors for Schizophrenia

Specify: absent, mild, moderate, severe for each dimension. The prominence of these dimensions may be specified for either (or both) the current episode (ie., previous 6 months) or the lifetime course of the disorder.

psychotic (hallucinations/delusions) dimension: describes the degree to which hallucinations or delusions have been present

disorganized dimension: describes the degree to which disorganized speech, disorganized behavior, or inappropriate affect have been present

negative (deficit) dimension: describes the degree to which negative symptoms (i.e., affective flattening, alogia, avolition) have been present. **Note:** Do not include symptoms that appear to be secondary to depression, medication side effects, or hallucinations or delusions.

Two examples that include the DSM-IV subtype, course specifiers, and the proposed dimensional approach are

Example 1
295.30 Schizophrenia, Paranoid Type, Continuous
Current:
With severe psychotic dimension
With absent disorganized dimension
With moderate negative dimension

Lifetime:
With mild psychotic dimension
With absent disorganized dimension
With mild negative dimension

Example2
295.60 Schizophrenia, Residual Type, Episodic With Residual Symptoms
Current:
With mild psychotic dimension
With mild disorganized dimension
With mild negative dimension
Lifetime:
With moderate psychotic dimension
With mild disorganized dimension
With **mild** negative dimension

Postpsychotic Depressive Disorder of Schizophrenia

Features

The essential feature is a Major Depressive Episode (see p. 320) that is superimposed on, and occurs only during, the residual phase of Schizophrenia. The residual phase of Schizophrenia follows the active phase (i.e., symptoms meeting Criterion A) of Schizophrenia. It is characterized by the persistence of negative symptoms or of active-phase symptoms that are in an attenuated form (e.g., odd beliefs, unusual perceptual experiences). The superimposed Major Depressive Episode must include depressed mood (i.e., loss of interest or pleasure cannot serve as an alternate for sad or depressed mood). Most typically, the Major Depressive Episode follows immediately after remission of the active-phase symptoms of the psychotic episode. Sometimes it may follow after a short or extended interval during which there are no psychotic symptoms. Mood symptoms due to the direct physiological effects of a drug of abuse, a medication, or a general medical condition are not counted toward postpsychotic depressive disorder of Schizophrenia.

Associated Features

As compared with individuals with Schizophrenia without postpsychotic depressive episodes, these individuals are more likely to be living alone and to have fewer social supports. Other risk factors may include a larger number of previous hospitalizations, history of psychotic relapses while being treated with antipsychotic medications, insidious onset of psychotic episodes, prior episodes of depression, and prior suicide attempts. There may be recent losses, undesirable life events, and other stressors. Up to 25% of individuals with Schizophrenia may have this condition sometime in the course of their illness. Males and females seem equally vulnerable. These individuals appear more likely to relapse into a psychotic episode or to be rehospitalized than those without depression. Individuals with Schizophrenia who also have first-degree biological rela- tives with histories of Major Depressive Disorder may be at higher risk for postpsychotic depressions. This condition is associated with suicidal ideation, suicide attempts, and completed suicides.

Differential Diagnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Depressive Disorder Not Otherwise Specified.**

Mood Disorder Due to a General Medical Condition is distinguished from this disturbance by the fact that the depressive symptoms are due to the direct physiological effects of a general medical condition (e.g., hypothyroidism). **Substance-InducedMood Disorder** is distinguished from this disturbance by the fact that the depressive symptoms are due to the direct physiological effects of a drug of abuse (e.g., alcohol, cocaine) or the side effects of a medication. Individuals with Schizophrenia are often on maintenance neuroleptic medications, which can cause dysphoria or Medication-Induced Movement Disorders as side effects. These side effects can be confused with depressive symptoms. **Neuroleptic-Induced Parkinsonism** with akinesia (see p. 736) is characterized by a reduced ability to initiate or sustain behaviors, which can lead to a lack of spontaneity or anhedonia. **Neuroleptic-InducedAkathisia** (seep. 744) may be mistaken for anxiety or agitation, and depressed mood or suicidal ideation may be associated. Adjusting the medication type or dose may assist in reducing these side effects and clarifying the cause of such symptoms.

The differential diagnosis between postpsychotic depressive symptoms and the **negative symptoms of Schizophrenia** (i.e., avolition, alogia, affective flattening) may be particularly difficult. Negative symptoms must be distinguished from the other symptoms of depression (e.g., sadness, guilt, shame, hopelessness, helplessness, and low self-esteem). In **Schizoaffective Disorder** and **Mood Disorder With Psychotic Features,** there must be a period of overlap between the full psychotic episode and the mood episode. In contrast, this proposed disorder requires that the symptoms of a Major Depressive Episode occur only during the residual phase of Schizophrenia.

Demoralization may occur during the course of Schizophrenia but should not be considered postpsychotic depression unless the full criteria for a Major Depressive Episode are met. **Adjustment Disorder With Depressed Mood** is distinguished from postpsychotic depressive symptoms in Schizophrenia because the depressive symptoms in Adjustment Disorder do not meet the criteria for a Major Depressive Episode.

Research criteria for postpsychotic depressive disorder of Schizophrenia

A. Criteria are met for a Major Depressive Episode.

Note: The Major Depressive Episode must include Criterion Al: depressed mood. Do not include symptoms that are better accounted for as medication side effects or negative symptoms of Schizophrenia.

B. The Major Depressive Episode is superimposed on and occurs only during the residual phase of Schizophrenia.

C. The Major Depressive Episode is not due to the direct physiological effects of a substance or a general medical condition.

Simple Deteriorative Disorder (Simple Schizophrenia)

Features

The essential feature is the development of prominent negative symptoms, which represent a clear change from a preestablished baseline. These symptoms are severe enough to result in a marked decline in occupational or academic functioning. If positive psychotic symptoms (e.g., hallucinations, delusions, disorganized speech, disorganized behavior, catatonic behavior) have ever been present, they have not been prominent. This pattern should be considered only after all other possible causes for the deterioration have been ruled out, that is, the presentation is not better accounted for by Schizotypal or Schizoid Personality Disorder; a Psychotic, Mood, or Anxiety Disorder; a dementia; or Mental Retardation; nor are the symptoms due to the direct physiological effects of a substance or a general medical condition. There is an insidious and progressive development of negative symptoms over a period of at least 1 year beginning in adolescence or later. Emotional responses become blunted, shallow, flat, and empty. Speech becomes impoverished of words and meanings. There is a definite change in "personality," with a marked loss of interpersonal rapport. Close relationships lose warmth and mutuality, social interaction generally becomes awkward, and isolation and withdrawal result. Initiative gives way to apathy, and ambition to avolition. Loss of interest extends to the daily details of self-care. The person may appear forgetful and absentminded. Academic or job skills are lost, resulting in a pattern of brief, simple jobs and frequent unemployment.

Associated Features

Any of the features of Schizoid or Schizotypal Personality Disorder may be present. Most common are peculiarities of grooming and behavior, lapses in hygiene, overinvestment in odd ideas, or unusual perceptual experiences such as illusions. This proposed disorder may occur in adolescents and adults of both sexes. Good estimates of prevalence and incidence are not available, but it is clear that the disorder is rare. The course, at least for the first few years, is progressively downhill, with prominent deterioration of functioning. This deterioration in functioning resembles the characteristic course of Schizophrenia and distinguishes this condition from Schizoid and Schizotypal Personality Disorders. Symptoms meeting Criterion A for Schizophrenia may emerge, at which time the diagnosis is changed to Schizophrenia. In these instances, this pattern proves to have been a prolonged prodrome to Schizophrenia. In other cases this pattern recedes in severity, as can happen with Schizophrenia. For the majority of individuals, the course is continuous, with deterioration occurring within the first few years after prodromal symptoms and then plateauing to a marginal and reduced, but stable, functional capacity.

Differential Diagnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Unspecified Mental Disorder.**

This pattern should be considered only after all other possible causes of deterioration in functioning have been ruled out. This pattern is distinguished from the disorders included in the "Schizophrenia and Other Psychotic Disorders" section by the absence

of prominent positive psychotic symptoms. These disorders include **Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder, Brief Psychotic Disorder, Delusional Disorder, Shared Psychotic Disorder,** and **Psychotic Disorder Not Otherwise Specified,** all of which require at least one positive symptom for some period of time. This proposed disorder is distinguished from **Schizoid** and **Schizotypal Personality Disorders** as well as other Personality Disorders by the requirement of a clear change in personality and marked deterioration in functioning. In contrast, the Personality Disorders represent lifelong patterns without progressive deterioration. **Mood Disorders** may mimic the apathy and anhedonia of simple deteriorative disorder, but in a Mood Disorder depressive affect (sadness, hopelessness, helplessness, painful guilt) is experienced, and the course tends to be episodic. Furthermore, in simple deteriorative disorder, there is a sense of emptiness rather than a painful or prominently depressive mood, and the course is continuous and progressive. The distinction can be more difficult with **Dysthymic Disorder,** in which the course may also be continuous and in which vegetative symptoms and painfully depressive mood may not be prominent. This proposed disorder may mimic **chronic Substance Dependence** and should only be considered if the personality change and deterioration precede extensive substance use. **Personality Change Due to a General Medical Condition** is distinguished by the presence of an etiological general medical condition. The cognitive impairment of simple deteriorative disorder may be mistaken for **Mental Retardation** or **dementia.** Mental Retardation is distinguished by its typical onset in infancy or childhood. Dementia is distinguished by the presence of an etiological general medical condition or substance use.

Perhaps the most difficult differential diagnosis is with **no mental disorder.** Simple deteriorative disorder often leads a person to become a marginal member of society. It does not follow, however, that marginal members of society necessarily have this proposed disorder. The defining features of simple deteriorative disorder involve negative symptoms, which tend to be more on a continuum with normality than are positive symptoms and which may be mimicked by a variety of factors (see the relevant discussion in the "Schizophrenia" section, p. 276). Therefore, special caution must be taken not to apply this proposed disorder too broadly.

Research criteria for simple deteriorative disorder (simple Schizophrenia)

A. Progressive development over a period of at least a year of all of the following:
   (1) marked decline in occupational or academic functioning
   (2) gradual appearance and deepening of negative symptoms such as affective flattening, alogia, and avolition
   (3) poor interpersonal rapport, social isolation, or social withdrawal

B. Criterion A for Schizophrenia has never been met.

(continued)

☐ **Research criteria for simple deteriorative disorder (simple Schizophrenia)** *(continued)*

C. The symptoms are not better accounted for by Schizotypal or Schizoid Personality Disorder, a Psychotic Disorder, a Mood Disorder, an Anxiety Disorder, a dementia, or Mental Retardation and are not due to the direct physiological effects of a substance or a general medical condition.

Premenstrual Dysphoric Disorder

Features

The essential features are symptoms such as markedly depressed mood, marked anxiety, marked affective !ability, and decreased interest in activities. These symptoms have regularly occurred during the last week of the luteal phase in most menstrual cycles during the past year. The symptoms begin to remit within a few days of the onset of menses (the follicular phase) and are always absent in the week following menses.

Five (or more) of the following symptoms must have been present most of the time during the last week of the luteal phase, with at least one of the symptoms being one of the first four: 1) feeling sad, hopeless, or self-deprecating; 2) feeling tense, anxious or "on edge"; 3) marked !ability of mood interspersed with frequent tearfulness;
2) persistent irritability, anger, and increased interpersonal conflicts; 5) decreased interest in usual activities, which may be associated with withdrawal from social relationships;
6) difficulty concentrating; 7) feeling fatigued, lethargic, or lacking in energy; 8) marked changes in appetite, which may be associated with binge eating or craving certain foods;
9) hypersomnia or insomnia; 10) a subjective feeling of being overwhelmed or out of control; and 11) physical symptoms such as breast tenderness or swelling, headaches, or sensations of "bloating" or weight gain, with tightness of fit of clothing, shoes, or rings. There may also be joint or muscle pain. The symptoms may be accompanied by suicidal thoughts.

This pattern of symptoms must have occurred most months for the previous 12 months. The symptoms disappear completely shortly after the onset of menstruation. The most typical pattern seems to be that of dysfunction during the week prior to menses that ends mid-menses. Atypically, some females also have symptoms for a few days around ovulation; a few females with short cycles might, therefore, be symptom free for only 1 week per cycle.

Typically, the symptoms are of comparable severity (but not duration) to those of a Major Depressive Episode and must cause an obvious and marked impairment in the ability to function socially or occupationally in the week prior to menses. Impairment in social functioning may be manifested by marital discord and problems with friends and family. It is very important not to confuse long-standing marital or job problems with the dysfunction that occurs only premenstrually. There is a great contrast between the woman's depressed feelings and difficulty in functioning during these days and her mood and capabilities the rest of the month. These symptoms may be superimposed on another disorder but are not merely an exacerbation of the symptoms of another disorder, such as Major Depressive, Panic, or Dysthymic Disorder, or a Personality Disorder. The

presence of the cyclical pattern of symptoms must be confirmed by at least 2 consecutive months of prospective daily symptom ratings. Daily symptom ratings must be done by the woman and can also be done by someone with whom she lives. It is important that these diaries be kept on a daily basis rather than composed retrospectively from memory.

Associated Features

Females who have had recurrent Major Depressive Disorder or Bipolar I or II Disorder or a family history of such disorders may be at greater risk to have a disturbance that meets the research criteria for premenstrual dysphoric disorder. Females who have had severe postpartum Major Depressive, Manic, or psychotic episodes may also be at greater risk for severe premenstrual dysphoric mood changes. Frequently there is a history of prior Mood and Anxiety Disorders. Delusions and hallucinations have been described in the late luteal phase of the menstrual cycle but are very rare.

Although females with the combination of dysmenorrhea (painful menses) and premenstrual dysphoric disorder are somewhat more likely to seek treatment than females with only one of these conditions, most females with either of the conditions do not have the other condition. A wide range of general medical conditions may worsen in the premenstrual or luteal phase (e.g., migraine, asthma, allergies, and seizure disorders). There are no specific laboratory tests that are diagnostic of the disturbance. However, in several small preliminary studies, certain laboratory findings (e.g., serotonin or melatonin secretion patterns, sleep EEG findings) have been noted to be abnormal in groups of females with this proposed disorder relative to control subjects.

It is estimated that at least 75% of women report minor or isolated premenstrual changes. Limited studies suggest an occurrence of "premenstrual syndrome" (variably defined) of 20%-50%, and that 3%-5% of women experience symptoms that may meet the criteria for this proposed disorder. There has been very little systematic study on the course and stability of this condition. Premenstrual symptoms can begin at any age after menarche, with the onset most commonly occurring during the teens to late 20s. Those who seek treatment are usually in their 30s. Symptoms usually remit with menopause. Although symptoms do not necessarily occur every cycle, they are present for the majority of the cycles. Some months the symptoms may be worse than others. Women commonly report that their symptoms worsen with age until relieved by the onset of menopause.

Di.fferential Di.agnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Depressive Disorder Not Otherwise Specified.**

The transient mood changes that many females experience around the time of their period should not be considered a mental disorder. Premenstrual dysphoric disorder should be considered only when the symptoms markedly interfere with work or school or with usual social activities and relationships with others (e.g., avoidance of social activities, decreased productivity and efficiency at work or school). Premenstrual dysphoric disorder can be distinguished from the far more common **"premenstrual syndrome"** by using prospective daily ratings and the strict criteria listed below. It differs from the "premenstrual syndrome" in its characteristic pattern of symptoms, their severity, and the resulting impairment.

Premenstrual dysphoric disorder must be distinguished from the **premenstrual exacerbation of a current mental disorder** (e.g., Mood Disorders, Anxiety Disorders,

Somatoform Disorders, Bulimia Nervosa, Substance Use Disorders, and Personality Disorders). In such situations (which are far more common than premenstrual dysphoric disorder), there is a premenstrual worsening of the symptoms but the symptoms persist throughout the menstrual cycle. Although this condition should not be considered in females who are experiencing only a premenstrual exacerbation of another mental disorder, it can be considered in addition to the diagnosis of another current mental disorder if the woman experiences symptoms and changes in level of functioning that are characteristic of premenstrual dysphoric disorder and are markedly different from the symptoms experienced as part of the ongoing disorder.

Some individuals with **general medical conditions** may present with dysphoria and fatigue that are exacerbated during the premenstrual period. Examples include seizure disorders, thyroid and other endocrine disorders, cancer, systemic lupus erythematosus, anemias, endometriosis, and various infections. These general medical conditions can be distinguished from premenstrual dysphoric disorder by history, laboratory testing, or physical examination.

Research criteria for premenstrual dysphoric disorder

A. In most menstrual cycles during the past year, five (or more) of the following symptoms were present for most of the time during the last week of the luteal phase, began to remit within a few days after the onset of the follicular phase, and were absent in the week postmenses, with at least one of the symptoms being either (1), (2), (3), or (4):

(1) markedly depressed mood, feelings of hopelessness, or self-deprecating thoughts
(2) marked anxiety, tension, feelings of being "keyed up," or "on edge"
(3) marked affective lability (e.g., feeling suddenly sad or tearful or increased sensitivity to rejection)
(4) persistent and marked anger or irritability or increased interpersonal conflicts
(5) decreased interest in usual activities (e.g., work, school, friends, hobbies)
(6) subjective sense of difficulty in concentrating
(7) lethargy, easy fatigability, or marked lack of energy
(8) marked change in appetite, overeating, or specific food cravings
(9) hypersomnia or insomnia
(10) a subjective sense of being overwhelmed or out of control
(11) other physical symptoms, such as breast tenderness or swelling, headaches, joint or muscle pain, a sensation of "bloating," weight gain

Note: In menstruating females, the luteal phase corresponds to the period between ovulation and the onset of menses, and the follicular phase begins with menses. In nonmenstruating females (e.g., those who have had a hysterectomy), the timing of luteal and follicular phases may require measurement of circulating reproductive hormones.

(continued)

☐ Research criteria for premenstrual dysphoric disorder *(continued)*

B. The disturbance markedly interferes with work or school or with usual social activities and relationships with others (e.g., avoidance of social activities, decreased productivity and efficiency at work or school).

C. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as Major Depressive Disorder, Panic Disorder, Dysthymic Disorder, or a Personality Disorder (although it may be superimposed on any of these disorders).

D. Criteria A, B, and C must be confirmed by prospective daily ratings during at least two consecutive symptomatic cycles. (The diagnosis may be made provisionally prior to this confirmation.)

Alternative Criterion B for Dysthymic Disorder

There has been some controversy concerning which symptoms best define Dysthymic Disorder. The results of the DSM-IV Mood Disorders field trial suggest that the following alternative version of Criterion B may be more characteristic of Dysthymic Disorder than the version of Criterion B that was in DSM-III-R and is in DSM-IV. However, it was decided that additional confirmatory evidence needs to be collected before these items are incorporated in the official definition of Dysthymic Disorder.

■ Alternative Research Criterion B for Dysthymic Disorder

B. Presence, while depressed, of three (or more) of the following:

(1) low self-esteem or self-confidence, or feelings of inadequacy
(2) feelings of pessimism, despair, or hopelessness
(3) generalized loss of interest or pleasure
(4) social withdrawal
(5) chronic fatigue or tiredness
(6) feelings of guilt, brooding about the past
(7) subjective feelings of irritability or excessive anger
(8) decreased activity, effectiveness, or productivity
(9) difficulty in thinking, reflected by poor concentration, poor memory, or indecisiveness

Minor Depressive Disorder

Features

The essential feature is one or more periods of depressive symptoms that are identical to Major Depressive Episodes in duration, but which involve fewer symptoms and less impairment. An episode involves either a sad or "depressed" mood or loss of interest or pleasure in nearly all activities. In total, at least two but less than five additional symptoms must be present. See the text for a Major Depressive Episode (p. 320) for a more detailed description of the characteristic symptoms. At the onset of the episode, the symptoms are either newly present or must be clearly worsened compared with the person's preepisode status. During the episode, these symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. In some individuals, there may be near-normal functioning, but this is accomplished with significantly increased effort.

A number of disorders exclude consideration of this proposed disorder. There has never been a Major Depressive, Manic, Mixed, or Hypomanic Episode, and criteria are not met for Dysthymic or Cyclothymic Disorder. The mood disturbance does not occur exclusively during Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

Associated Features

The prevalence of this proposed disorder as defined here is unclear, but it may be relatively common, especially in primary care and outpatient mental health settings. A number of general medical conditions (e.g., stroke, cancer, and diabetes) appear to be associated. Family studies suggest an increase in this symptom pattern among relatives of probands with Major Depressive Disorder.

Differential Diagnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Adjustment Disorder With Depressed Mood** if the depressive symptoms occur in response to a psychosocial stressor; otherwise, the appropriate diagnosis is **Depressive Disorder Not Otherwise Specified.**

An episode of minor depressive disorder is distinguished from a **Major Depressive Episode** by the required number of symptoms (two to four symptoms for minor depressive disorder and at least five symptoms for a Major Depressive Episode). This proposed disorder is considered to be a residual category and is not to be used if there is a history of a **Major Depressive Episode, Manic Episode, Mixed Episode,** or **Hypomanic Episode,** or if the presentation meets criteria for **Dysthymic or Cyclothymic Disorder.** Symptoms meeting research criteria for minor depressive disorder can be difficult to distinguish from **periods of sadness** that are an inherent part of everyday life. This proposed disorder requires that the depressive symptoms be present for most of the day nearly every day for at least 2 weeks. In addition, the depressive symptoms must cause clinically significant distress or impairment. Depressive symptoms occurring in response to the loss of a loved one are considered **Bereavement** (unless they meet the criteria for a Major Depressive Episode; see p. 320). **Substance-Induced**

Mood Disorder is distinguished from this disturbance in that the depressive symptoms are due to the direct physiological effects of a drug of abuse (e.g., alcohol or cocaine) or the side effects of a medication (e.g., steroids) (see p. 370). **Mood Disorder Due to a General Medical Condition** is distinguished from this disturbance in that the depressive symptoms are due to the direct physiological effects of a general medical condition (e.g., hypothyroidism) (seep. 366). Because depressive symptoms are com- mon associated features of psychotic disorders, they do not receive a separate diagnosis if they occur exclusively during **Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder, or Psychotic Disorder Not Other- wise Specified.** The relationship between this proposed disorder and several other proposed categories included in this appendix (i.e., recurrent brief depressive disorder, depressive personality disorder, and mixed anxiety-depressive disorder) and with other Personality Disorders is not known, but substantial overlap may exist among them.

Research criteria for minor depressive disorder

A. A mood disturbance, defined as follows:

(1) at least two (but less than five) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (a) or (b):

(a) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
Note: In children and adolescents, can be irritable mood.

(b) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

(c) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.

(d) insomnia or hypersomnia nearly every day

(e) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

CD fatigue or loss of energy nearly every day

(g) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(h) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(continued)

☐ **Research criteria for minor depressive disorder** *(continued)*

(i) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

(2) the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

(3) the symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism)

(4) the symptoms are not better accounted for by Bereavement (i.e., a normal reaction to the death of a loved one)

B. There has never been a Major Depressive Episode (see p. 327), and criteria are not met for Dysthymic Disorder.

C. There has never been a Manic Episode (see p. 332), a Mixed Episode (see p. 335), or a Hypomanic Episode (see p. 338), and criteria are not met for Cyclothymic Disorder. **Note:** This exclusion does not apply if all of the manic-, mixed-, or hypomanic-like episodes are substance or treatment induced.

D. The mood disturbance does not occur exclusively during Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

Recurrent Brief Depressive Disorder

Features

The essential feature is the recurrence of brief episodes of depressive symptoms that are identical to Major Depressive Episodes in the number and severity of symptoms but that do not meet the 2-week duration requirement. See the text for a Major Depressive Episode (p. 320) for a more detailed description of the characteristic symptoms. The episodes last at least 2 days but less than 2 weeks and most typically have a duration of between 2 and 4 days. Episodes must recur at least once a month for a period of 12 consecutive months, and they must not be associated exclusively with the menstrual cycle. The brief depressive episodes must cause clinically significant distress or impair- ment in social, occupational, or other important areas of functioning. In some individuals, there may be

near-normal functioning, but this is accomplished with significantly increased effort.

A number of disorders exclude consideration of this proposed disorder. There has never been a Major Depressive, Manic, Mixed, or Hypomanic Episode, and criteria are not met for Dysthymic or Cyclothymic Disorder. The mood disturbance does not occur exclusively during Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

Associated Features

The pattern of lifetime or current comorbidity appears to be similar to that of Major Depressive Disorder. Associated disorders may include Substance-Related Disorders and Anxiety Disorders. The episodes may follow a seasonal pattern. The 1-year prevalence of this proposed disorder has been reported to be about 7% (although this was often in association with other established mental disorders). Males and females appear equally likely to experience recurrent brief depressive episodes, and the most typical age at onset appears to be in adolescence. Suicide attempts are the most serious complication. The rate of depressive disorders is increased in the first-degree biological relatives of individuals who have recurrent brief depressive episodes.

Differential Diagnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Depressive Disorder Not Otherwise Specified.**

An episode of recurrent brief depressive disorder is distinguished from a **Major Depressive Episode** by the duration of the episode (2-13 days for a brief depressive episode and 2 weeks or longer for a Major Depressive Episode). Recurrent brief depressive disorder is considered to be a residual category and is not to be used if there is a history of a **Major Depressive Episode, Manic Episode, Mixed Episode,** or **Hypomanic Episode,** or if criteria are met for **Cyclothymic Disorder or Dysthymic Disorder. Substance-Induced Mood Disorder** is distinguished from this disturbance in that the depressive symptoms are due to the direct physiological effects of a drug of abuse (e.g., alcohol or cocaine) or the side effects of a medication (e.g., steroids) (see p. 370). **Mood Disorder Due to a General Medical Condition** is distinguished from this disturbance in that the depressive symptoms are due to the direct physiological effects of a general medical condition (e.g., hypothyroidism) (see p. 366). Because depressive symptoms are common associated features of psychotic disorders, they do not receive a separate diagnosis if they occur exclusively during **Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder,** or **Psychotic Disorder Not Otherwise Specified.** Recurrent brief depressive disorder shares some clinical features with **Borderline Personality Disorder** (i.e., both disorders manifest brief and episodic depressive symptoms such as suicidal ideation or sadness). In cases where a Personality Disorder and this proposed disorder are both present, both may be noted (with recurrent brief depressive disorder noted as Depressive Disorder Not Otherwise Specified). The relationship between this proposed disorder and several other proposed categories included in this appendix (i.e., minor depressive disorder, depressive personality disorder, and mixed anxiety-depressive disorder) and with other Personality Disorders is not known, but substantial overlap may exist among them.

Research criteria for recurrent brief depressive disorder

A. Criteria, except for duration, are met for a Major Depressive Episode (see p. 327).

B. The depressive periods in Criterion A last at least 2 days but less than 2 weeks.

C. The depressive periods occur at least once a month for 12 consecutive months and are not associated with the menstrual cycle.

D. The periods of depressed mood cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

F. There has never been a Major Depressive Episode (see p. 327), and criteria are not met for Dysthymic Disorder.

G. There has never been a Manic Episode (seep. 332), a Mixed Episode (see p. 335), or a Hypomanic Episode (see p. 338), and criteria are not met for Cyclothymic Disorder. **Note:** This exclusion does not apply if all of the manic-, mixed-, or hypomanic-like episodes are substance or treatment induced.

H. The mood disturbance does not occur exclusively during Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

Mixed Anxiety.-Depressive Disorder

Features

The essential feature is a persistent or recurrent dysphoric mood lasting at least 1 month. The dysphoric mood is accompanied by additional symptoms that also must persist for at least 1 month and include at least four of the following: concentration or memory difficulties, sleep disturbance, fatigue or low energy, irritability, worry, being easily moved to tears, hypervigilance, anticipating the worst, hopelessness or pessimism about the future, and low self-esteem or feelings of worthlessness. The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. This proposed disorder should not be considered if the symptoms are due to the direct physiological effects of a substance or a general medical condition or if the criteria for Major Depressive Disorder, Dysthymic Disorder, Panic Disorder, or

Generalized Anxiety Disorder have ever been met. The diagnosis is also not made if the criteria for any other Anxiety or Mood Disorder are currently met, even if the Anxiety or Mood Disorder is in partial remission. The symptoms must also not be better accounted for by any other mental disorder. Much of the initial information about this condition has been collected in primary care settings, in which the disorder appears to be common; it may also be quite common in outpatient mental health settings.

Differential Diagnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Anxiety Disorder Not Otherwise Specified.**

Substance-Induced Anxiety Disorder is distinguished from this disturbance in that the symptoms of dysphoria are due to the direct physiological effects of a drug of abuse (e.g., alcohol or cocaine) or the side effects of a medication (e.g., steroids) (see p. 439). **AnxietyDisorderDuetoaGeneralMedicalCondition** is distinguished from this disturbance in that the symptoms of dysphoria are due to the direct physiological effects of a general medical condition (e.g., pheochromocytoma, hyperthyroidism) (see p. 436). The symptoms described in this presentation are a frequent **associated feature of many mental disorders** and therefore should not be diagnosed separately if better accounted for by any other mental disorder. This condition should also not be considered in individuals with a current or past history of **Major Depressive Disorder, Dysthymic Disorder, Panic Disorder, or Generalized Anxiety Disorder** or with any other current Mood or Anxiety Disorder (including those in partial remission). This presenta- tion is also distinguished from **no mental disorder** by the facts that the symptoms are persistent or recurrent and that they cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The relationship between this proposed disorder and several other proposed categories included in this appendix (i.e., minor depressive disorder, recurrent brief depressive disorder, and depressive personality disorder) and with other Personality Disorders is not known, but substantial overlap may exist among them.

Research criteria for mixed anxiety,-depressive disorder

A. Persistent or recurrent dysphoric mood lasting at least 1 month.

B. The dysphoric mood is accompanied by at least 1 month of four (or more) of the following symptoms:
   (1) difficulty concentrating or mind going blank
   (2) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
   (3) fatigue or low energy
   (4) irritability
   (5) worry

(continued)

☐ **Research criteria for mixed anxiety depressive disorder** *(continued)*

(6) being easily moved to tears
(7) hypervigilance
(8) anticipating the worst
(9) hopelessness (pervasive pessimism about the future)
(10) low self-esteem or feelings of worthlessness

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

E. All of the following:
(1) criteria have never been met for Major Depressive Disorder, Dysthymic Disorder, Panic Disorder, or Generalized Anxiety Disorder
(2) criteria are not currently met for any other Anxiety or Mood Disorder (including an Anxiety or Mood Disorder, In Partial Remission)
(3) the symptoms are not better accounted for by any other mental disorder

Factitious Disorder by Proxy

Features

The essential feature is the deliberate production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care. Typically the victim is a young child and the perpetrator is the child's mother. The motivation for the perpetrator's behavior is presumed to be a psychological need to assume the sick role by proxy. External incentives for the behavior, such as economic gain, are absent. The behavior is not better accounted for by another mental disorder. The perpetrator induces or simulates the illness or disease process in the victim and then presents the victim for medical care while disclaiming any knowledge about the actual etiology of the problem. The majority of induced and simulated conditions involve the gastrointestinal, the genitourinary, and the central nervous systems; the simulation of mental disorders in the victim is much less frequently reported. The type and severity of signs and symptoms are limited only by the medical sophistication and opportunities of the perpetrator. Cases are often characterized by an atypical clinical course in the victim and inconsistent laboratory test results that are at variance with the seeming health of the victim.

The victim is usually a preschool child, although newborns, adolescents, and adults

may be used as victims. With older children, consideration should be given to the possibility of collaboration with the perpetrator in the production of signs and symptoms. The perpetrator receives a diagnosis of factitious disorder by proxy. For the victim, Physical Abuse of Child (995.5) or Physical Abuse of Adult (995.81) may be noted if appropriate. In the event of voluntary collaboration, an additional diagnosis of Factitious Disorder may be appropriate for the collaborator.

Associated Features

Life stressors, especially marital conflict, may trigger the behavior. Perpetrators may exhibit pathological lying (or pseudologia fantastica) in describing everyday experiences and when presenting the victim for medical care. They commonly have considerable experience in health-related areas and seem to thrive in a medical environment. Despite their medical knowledge, they often seem insufficiently concerned with the apparent severity of the victim's condition. Victims may suffer a significant morbidity and mortality rate as a consequence of the induced conditions and are at increased risk of developing Factitious Disorder themselves as they mature. The perpetrator is usually the mother, and the father usually appears uninvolved. Sometimes, however, the father or husband may collaborate with the mother or may act alone. The perpetrator may also be a spouse or another caregiver (e.g., a baby-sitter). Perpetrators may have a history of having been abused. Somatoform Disorders and Personality Disorders may be present.

This proposed disorder often coexists with Factitious Disorder, which is usually quiescent as long as the perpetrator can induce or simulate a factitious illness in the victim. When confronted with the consequences of their behavior, perpetrators may become depressed and suicidal. Some become angry with the health care providers, deny the accusations, attempt to remove the victim from the hospital against medical advice, and seek care from other providers even at a considerable distance. Perpetrators may face criminal charges ranging from abuse to murder. Typically the perpetrator focuses on only one victim at a time, although other siblings or individuals may have been or might become victims.

Differential Diagnosis

In DSM-IV, an individual (i.e., the perpetrator) whose presentation meets these research criteria would be diagnosed as having **Factitious Disorder Not Otherwise Specified.** Factitious disorder by proxy must be distinguished from a **general medical condition** or a **mental disorder** in the individual being brought for treatment. Factitious disorder by proxy must also be distinguished from **physical or sexual abuse** that is not related to the goal of indirectly assuming the sick role. **Malingering** differs from factitious disorder by proxy in that the motivation for the symptom production in Malingering is an external incentive, whereas in Factitious Disorder external incentives are absent. Individuals with Malingering may seek hospitalization for an individual under their care by producing symptoms in an attempt to obtain compensation.

Research criteria for factitious disorder by proxy

A. Intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care.

B. The motivation for the perpetrator's behavior is to assume the sick role by proxy.

C. External incentives for the behavior (such as economic gain) are absent.

D. The behavior is not better accounted for by another mental disorder.

Dissociative Trance Disorder

Features

The essential feature is an involuntary state of trance that is not accepted by the person's culture as a normal part of a collective cultural or religious practice and that causes clinically significant distress or functional impairment. This proposed disorder should not be considered in individuals who enter trance or possession states voluntarily and without distress in the context of cultural and religious practices that are broadly accepted by the person's cultural group. Such voluntary and nonpathological states are common and constitute the overwhelming majority of trance and possession trance states encountered cross-culturally. However, some individuals undergoing culturally norma- tive trance or possession trance states may develop symptoms that cause distress or impairment and thus could be considered for this proposed disorder. Specific local instances of dissociative trance disorder show considerable variation cross-culturally with regard to the precise nature of the behaviors performed during the altered state, the presence or absence of dissociative sensory alterations (e.g., blindness), the identity assumed during these states, and the degree of amnesia experienced following the altered state (for examples, see Appendix I's Glossary of Culture-Bound Syndromes, p. 844).

In trance, the loss of customary identity is not associated with the appearance of alternate identities, and the actions performed during a trance state are generally not complex (e.g., convulsive movements, falling, running). In possession trance, there is the appearance of one (or several) distinct alternate identities with characteristic behaviors, memories, and attitudes, and the activities performed by the person tend to be more complex (e.g., coherent conversations, characteristic gestures, facial expres- sions, and specific verbalizations that are culturally established as belonging to a particular possessing agent). Full or partial amnesia is more regularly reported after an episode of possession trance than after an episode of trance (although reports of amnesia after trance are not uncommon). Many individuals with this proposed disorder exhibit features of only one type of trance, but some present with mixed symptomatology or fluctuate between types of trance over time according to local cultural parameters.

Associated Features

Variants of these conditions have been described in nearly every traditional society on every continent. The prevalence appears to decrease with increasing industrialization

but remains elevated among traditional ethnic minorities in industrialized societies. There are considerable local variations in age and mode of onset. The course is typically episodic, with variable duration of acute episodes from minutes to hours. It has been reported that during a trance state, individuals may have an increased pain threshold, may consume inedible materials (e.g., glass), and may experience increased muscular strength. The symptoms of a pathological trance may be heightened or reduced in response to environmental cues and the ministrations of others. Presumed possessing agents are usually spiritual in nature (e.g., spirits of the dead, supernatural entities, gods, demons) and are often experienced as making demands or expressing animosity. Individuals with pathological possession trance typically experience a limited number of agents (one to five) in a sequential, not simultaneous, fashion. Complications include suicide attempts, self-mutilation, and accidents. Sudden deaths have been reported as a possible outcome, perhaps due to cardiac arrhythmias.

Di,fferential magnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Dissociative Disorder Not Otherwise Specified.**

This diagnosis should not be made if the trance state is judged to be due to the direct physiological effects of a general medical condition (in which case the diagnosis would be **Mental Disorder Not Otherwise Specified Due to a General Medical Condition,** see p. 174) or a substance (in which case the diagnosis would be **Substance-Related Disorder Not Otherwise Specified).**

The symptoms of the trance state (e.g., hearing or seeing spiritual beings and being controlled or influenced by others) may be confused with the hallucinations and delusions of **Schizophrenia, Mood Disorder With Psychotic Features, or Brief Psychotic Disorder.** The trance state may be distinguished by its cultural congruency, its briefer duration, and the absence of the characteristic symptoms of these other disorders.

Individuals with **Dissociative Identity Disorder** can be distinguished from those with trance and possession symptoms by the fact that those with trance and possession symptoms typically describe external spirits or entities that have entered their bodies and taken over.

This proposed disorder should not be considered in individuals who enter trance or possession states voluntarily and without distress or impairment in the context of cultural and religious practices.

Research criteria for dissociative trance disorder

A. Either (1) or (2):

(1) trance, i.e., temporary marked alteration in the state of consciousness or loss of customary sense of personal identity without replacement by an alternate identity, associated with at least one of the following:

(continued)

D **Research criteria for dissociative trance disorder** *(continued)*

(a) narrowing of awareness of immediate surroundings, or unusually narrow and selective focusing on environmental stimuli
(b) stereotyped behaviors or movements that are experienced as being beyond one's control

(2) possession trance, a single or episodic alteration in the state of consciousness characterized by the replacement of customary sense of personal identity by a new identity. This is attributed to the influence of a spirit, power, deity, or other person, as evidenced by one (or more) of the following:

(a) stereotyped and culturally determined behaviors or movements that are experienced as being controlled by the possessing agent
(b) full or partial amnesia for the event

B. The trance or possession trance state is not accepted as a normal part of a coilective cultural or religious practice.

C. The trance or possession trance state causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The trance or possession trance state does not occur exclusively during the course of a Psychotic Disorder (including Mood Disorder With Psychotic Features and Brief Psychotic Disorder) or Dissociative Identity Disorder and is not due to the direct physiological effects of a substance or a general medical condition.

Binge...Eating Disorder

Diagnostic Features

The essential features are recurrent episodes of binge eating associated with subjective and behavioral indicators of impaired control over, and significant distress about, the binge eating and the absence of the regular use of inappropriate compensatory behaviors (such as self-induced vomiting, misuse of laxatives and other medications, fasting, and excessive exercise) that are characteristic of Bulimia Nervosa. The characteristics of a binge episode are discussed in the text for Bulimia Nervosa (p. 545). Indicators of impaired control include eating very rapidly, eating until feeling uncomfortably full, eating large amounts of food when not hungry, eating alone because of embarrassment over how much one is eating, and feeling disgust, guilt, or depression after overeating. The marked distress required for the diagnosis includes unpleasant feelings during and after the binge episodes, as well as concerns about the long-term effect of the recurrent binge episodes on body weight and shape.

Binge episodes must occur, on average, at least 2 days a week for a period of at least 6 months. The duration of a binge-eating episode can vary greatly, and many individuals have difficulty separating binge eating into discrete episodes. However, they usually have little difficulty recalling whether or not binge eating occurred on a given day. Thus, it is suggested that the number of days on which binge eating occurs be counted, rather than the number of episodes of binge eating, as is done in making the diagnosis of Bulimia Nervosa. Future research should address this issue.

The symptoms do not occur exclusively during Anorexia Nervosa or Bulimia Nervosa. In addition, although some inappropriate compensatory behavior (e.g., purg- ing, fasting, or excessive exercise) may occur occasionally, it is not regularly employed to counteract the effects of the binge eating. Research studies conducted to date have varied in how they have defined "regular use of inappropriate compensatory behaviors." Some studies have equated "regular" with the twice-a-week frequency criterion of Bulimia Nervosa and have considered individuals who engage in these behaviors less than twice a week (but as often as once a week) to be eligible for the diagnosis of binge-eating disorder. Other studies have excluded individuals who describe any use of inappropriate compensatory behaviors during the episode of illness. Future research should address this issue.

Associated Features and Disorders

Some individuals report that binge eating is triggered by dysphoric moods, such as depression and anxiety. Others are unable to identify specific precipitants but may report a nonspecific feeling of tension that is relieved by the binge eating. Some individuals describe a dissociative quality to the binge episodes (feeling "numb" or "spaced out"). Many individuals eat throughout the day with no planned mealtimes.

Individuals with this eating pattern seen in clinical settings have varying degrees of obesity. Most have a long history of repeated efforts to diet and feel desperate about their difficulty in controlling food intake. Some continue to make attempts to restrict calorie intake, whereas others have given up all efforts to diet because of repeated failures. In weight-control clinics, individuals with this eating pattern are, on average, more obese and have a history of more marked weight fluctuations than individuals without this pattern. In nonpatient community samples, most individuals with this eating pattern are overweight (although some have never been overweight).

Individuals with this eating pattern may report that their eating or weight interferes with their relationships with other people, with their work, and with their ability to feel good about themselves. In comparison with individuals of equal weight without this pattern of eating, they report higher rates of self-loathing, disgust about body size, depression, anxiety, somatic concern, and interpersonal sensitivity. There may be a higher lifetime prevalence of Major Depressive Disorder, Substance-Related Disorders, and Personality Disorders.

In samples drawn from weight-control programs, the overall prevalence varies from approximately 15% to 50% (with a mean of 30%), with females approximately 1.5 times more likely to have this eating pattern than males. In nonpatient community samples, a prevalence rate of 0.7%-4% has been reported. The onset of binge eating typically is in late adolescence or in the early 20s, often coming soon after significant weight loss from dieting. Among individuals presenting for treatment, the course appears to be chronic.

Di,.lferential Di,agnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Eating Disorder Not Otherwise Specified.**

In contrast to **BulimiaNervosa,** in which inappropriate compensatory mechanisms are employed to counteract the effects of the binges, in binge-eating disorder no such behavior is regularly employed to compensate for the binge eating. Overeating is frequently seen during episodes of **Major Depressive Disorder,** but usually does not involve binge eating. This appendix diagnosis should be considered only when the individual reports that, during episodes of overeating, both the subjective sense of impaired control and three of the associated symptoms listed in Criterion B are present. Many individuals are distressed by episodes of overeating that are not binge-eating episodes.

Research criteria for binge...eating disorder

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   (1) eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances
   (2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

B. The binge-eating episodes are associated with three (or more) of the following:
   (1) eating much more rapidly than normal
   (2) eating until feeling uncomfortably full
   (3) eating large amounts of food when not feeling physically hungry
   (4) eating alone because of being embarrassed by how much one is eating
   (5) feeling disgusted with oneself, depressed, or very guilty after overeating

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least 2 days a week for 6 months.

   Note: The method of determining frequency differs from that used for Bulimia Nervosa; future research should address whether the preferred method of setting a frequency threshold is counting the number of days on which binges occur or counting the number of episodes of binge eating.

E. The binge eating is not associated with the regular use of inappropriate compensatory behaviors (e.g., purging, fasting, excessive exercise) and does not occur exclusively during the course of Anorexia Nervosa or Bulimia Nervosa.

Depressive Personality Disorder

Features

The essential feature is a pervasive pattern of depressive cognitions and behaviors that begins by early adulthood and that occurs in a variety of contexts. This pattern does not occur exclusively during Major Depressive Episodes and is not better accounted for by Dysthymic Disorder. The depressive cognitions and behaviors include a persistent and pervasive feeling of dejection, gloominess, cheerlessness, joylessness, and unhappiness. These individuals are overly serious, incapable of enjoyment or relaxation, and lack a sense of humor. They may feel that they do not deserve to have fun or to be happy. They also tend to brood and worry, dwelling persistently on their negative and unhappy thoughts. Such individuals view the future as negatively as they view the present; they doubt that things will ever improve, anticipate the worst, and while priding themselves on being realistic, are considered by others to be pessimistic. They may be harsh in self-judgment and prone to feeling excessively guilty for shortcomings and failings. Self-esteem is low and particularly focused on feelings of inadequacy. Individuals with this proposed disorder tend to judge others as harshly as they judge themselves. They often focus on others' failings rather than their positive attributes, and they may be negativistic, critical, and judgmental toward others.

Associated Features

These individuals may be quiet, introverted, passive, and unassertive, preferring to follow others rather than taking the lead. This pattern may occur with approximately equal frequency in females and males. Individuals with this presentation may be predisposed to developing Dysthymic Disorder and possibly Major Depressive Disorder. These conditions may exist on a spectrum, with depressive personality disorder being the early-onset, persistent, traitlike variant of the Depressive Disorders. Preliminary evidence suggests that depressive personality disorder may have an increased prevalence in family members of probands with Major Depressive Disorder. Conversely, Major Depressive Disorder may occur with increased frequency in family members of probands with depressive personality disorder who do not themselves have Major Depressive Disorder.

Differential Diagnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Personality Disorder Not Otherwise Specified.**

It remains controversial whether the distinction between depressive personality disorder and **Dysthymic Disorder** is useful. The research criteria given for this proposed disorder differ from the diagnostic criteria for Dysthymic Disorder by their emphasis on cognitive, interpersonal, and intrapsychic personality traits. This proposed disorder should not be considered if the symptoms are better accounted for by Dysthymic Disorder or if they occur exclusively during **Major Depressive Episodes.** This proposed disorder differs from so-called normal depressive traits (e.g., unhappiness, pessimism, self-criticism, and proneness to guilt) in that the pattern is pervasive and causes marked distress or impairment in social or occupational functioning. The relationship between this proposed disorder and several other proposed categories included in this appendix

(i.e., minor depressive disorder, recurrent brief depressive disorder, and mixed anxiety-depressive disorder) and with other Personality Disorders is not known, but substantial overlap may exist among them.

Research criteria for depressive personality disorder

A. A pervasive pattern of depressive cognitions and behaviors beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
   (1) usual mood is dominated by dejection, gloominess, cheerlessness, joylessness, unhappiness
   (2) self-concept centers around beliefs of inadequacy, worthlessness, and low self-esteem
   (3) is critical, blaming, and derogatory toward self
   (4) is brooding and given to worry
   (5) is negativistic, critical, and judgmental toward others
   (6) is pessimistic
   (7) is prone to feeling guilty or remorseful

B. Does not occur exclusively during Major Depressive Episodes and is not better accounted for by Dysthymic Disorder.

Passive--Aggressive Personality Disorder (Negativistic Personality Disorder)

Features

The essential feature is a pervasive pattern of negativistic attitudes and passive resistance to demands for adequate performance in social and occupational situations that begins by early adulthood and that occurs in a variety of contexts. This pattern does not occur exclusively during Major Depressive Episodes and is not better accounted for by Dysthymic Disorder. These individuals habitually resent, oppose, and resist demands to function at a level expected by others. This opposition occurs most frequently in work situations but can also be evident in social functioning. The resistance is expressed by procrastination, forgetfulness, stubbornness, and intentional inefficiency, especially in response to tasks assigned by authority figures. These individuals obstruct the efforts of others by failing to do their share of the work. For example, when an executive gives a subordinate some material to review for a meeting the next morning, the subordinate may misplace or misfile the material rather than point out that there is insufficient time to do the work. These individuals feel cheated, unappreciated, and misunderstood and chronically complain to others. When difficulties appear, they blame their failures on the behaviors of others. They may be sullen, irritable, impatient, argumentative, cynical, skeptical, and contrary. Authority figures (e.g., a superior at work, a teacher at school, a parent, or a spouse who acts the role of a parent) often become the focus of discontent.

Because of their negativism and tendency to externalize blame, these individuals often criticize and voice hostility toward authority figures with minimal provocation. They are also envious and resentful of peers who succeed or who are viewed positively by authority figures. These individuals often complain about their personal misfortunes. They have a negative view of the future and may make comments such as, "It doesn't pay to be good" and "Good things don't last." These individuals may waver between expressing hostile defiance toward those they view as causing their problems and attempting to mollify these persons by asking forgiveness or promising to perform better in the future.

Associated Features

These individuals are often overtly ambivalent, wavering indecisively from one course of action to its opposite. They may follow an erratic path that causes endless wrangles with others and disappointments for themselves. An intense conflict between depen- dence on others and the desire for self-assertion is characteristic of these individuals. Their self-confidence is often poor despite a superficial bravado. They foresee the worst possible outcome for most situations, even those that are going well. This defeatist outlook can evoke hostile and negative responses from others who are subjected to the complaints of these individuals. This pattern of behavior often occurs in individuals with Borderline, Histrionic, Paranoid, Dependent, Antisocial, and Avoidant Personality Disorders.

Di,fferential Di,agnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Personality Disorder Not Otherwise Specified.**

In **Oppositional Defiant Disorder,** there is a similar pattern of negativistic attitudes and problems with authority figures, but Oppositional Defiant Disorder is usually diagnosed in children, whereas this proposed disorder should be considered only in adults. This pattern should not be considered if the symptoms are better accounted for by **Dysthymic Disorder** or if they occur exclusively during **Major Depressive Episodes.** Passive-aggressive behaviors are frequently encountered in everyday life, particularly among those in authoritarian situations (e.g., work, military, prison) that do not tolerate other forms of assertiveness. Only when these passive-aggressive personality traits are inflexible, maladaptive, and cause significant functional impairment or subjec- tive distress do they constitute a disorder.

Research criteria for passive aggressive personality disorder

A. A pervasive pattern of negativistic attitudes and passive resistance to demands for adequate performance, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

(continued)

☐ **Research criteria for passive.-aggressive personality disorder** *(continued)*

(1) passively resists fulfilling routine social and occupational tasks
(2) complains of being misunderstood and unappreciated by others
(3) is sullen and argumentative
(4) unreasonably criticizes and scorns authority
(5) expresses envy and resentment toward those apparently more fortunate
(6) voices exaggerated and persistent complaints of personal misfortune
(7) alternates between hostile defiance and contrition

B. Does not occur exclusively during Major Depressive Episodes and is not better accounted for by Dysthymic Disorder.

Medication.-Jnduced Movement Disorders

A consideration of Medication-Induced Movement Disorders is important in the management by medication of mental disorders or general medical conditions and in the differential diagnosis with Axis I disorders (e.g., Anxiety Disorder versus Neuroleptic-Induced Akathisia; catatonia versus Neuroleptic Malignant Syndrome). These conditions can lead to noncompliance with treatment and psychosocial and occupational impairments. Medication-Induced Movement Disorders should be coded on Axis I. Although these disorders are labeled "medication induced," it is often difficult to establish the causal relationship between medication exposure and the development of the movement disorder, especially because some of these conditions also occur in the absence of medication exposure. Criteria and text are provided for these disorders to facilitate research and to encourage appropriate diagnosis and treatment. The following Medication-Induced Movement Disorders are included in this section: Neuroleptic- Induced Parkinsonism, Neuroleptic Malignant Syndrome, Neuroleptic-Induced Acute Dystonia, Neuroleptic-Induced Acute Akathisia, Neuroleptic-Induced Tardive Dyskine- sia, and Medication-Induced Postural Tremor. A category for Medication-Induced Movement Disorder Not Otherwise Specified is also provided for medication-induced movement disorders that do not meet the criteria for any of the specific disorders listed above. These include movement disorders (e.g., parkinsonism, acute akathisia) that are associated with a medication other than a neuroleptic (e.g., a serotonin reuptake inhibitor).

The term *neuroleptic* is used broadly in this manual to refer to medications with dopamine-antagonist properties. These include so-called typical antipsychotic agents (e.g., chlorpromazine, haloperidol, fluphenazine), atypical antipsychotic agents (e.g., clozapine), certain dopamine receptor blocking drugs used in the treatment of physical symptoms such as nausea (e.g., prochlorperazine, promethazine, trimethobenzamide, metoclopramide), and amoxapine, which is marketed as an antidepressant.

332.1 Neuroleptic--Induced Parkinsonism

magnostic Features

The essential feature of Neuroleptic-Induced Parkinsonism is the presence of parkinsonian signs or symptoms (i.e., tremor, muscular rigidity, or akinesia) that develop in association with the use of neuroleptic medication. These symptoms usually develop within a few weeks of starting or raising the dose of a neuroleptic medication or after reducing a medication (e.g., an anticholinergic medication) that is being used to treat or prevent acute extrapyramidal symptoms. The symptoms must not be better accounted for by a mental disorder (e.g., catatonia, negative symptoms of Schizophrenia, psycho- motor retardation in a Major Depressive Episode) and are not due to a neurological or other general medical condition (e.g., idiopathic Parkinson's disease, Wilson's disease). Rigidity and akinesia are most frequent, whereas tremor is somewhat less common. It has been estimated that at least 50% of outpatients receiving long-term neuroleptic treatment develop some parkinsonian signs or symptoms at some point in their course of treatment. Symptoms may develop rapidly after starting or raising the dose of neuroleptic medication or may develop insidiously over time. The most typical course is the development of symptoms 2-4 weeks after starting a neuroleptic medication. The symptoms then tend to continue unchanged or to diminish gradually over the next few months. Symptoms will usually abate with a reduction of the dose (or discontinuation) of the neuroleptic medication, the addition of antiparkinsonian medication, or a switch to a neuroleptic medication with a lower incidence of these side effects.

Parkinsonian tremor is a steady, rhythmic oscillatory movement (3-6 cycles per second) that is typically slower than other tremors and is apparent at rest. It may occur intermittently and be unilateral or bilateral or depend on where the limb is located (positional tremor). The tremor may affect limbs, head, jaw, mouth, lip ("rabbit syndrome"), or tongue. The tremor can be suppressed, especially when the individual attempts to perform a task with the tremulous limb. Individuals may describe the tremor as "shaking" and report that it occurs especially during times of anxiety, stress, or fatigue.

Parkinsonian muscular rigidity is defined as excessive firmness and tensing of resting muscles. It may affect all skeletal muscles or it may only involve discrete muscular areas. Two kinds of rigidity occur: *continuous ("lead-pipe") rigidity* and *cogwheel rigidity.* In lead-pipe rigidity, the limb or joint resists movement and feels locked in place. The rigidity is continuous (i.e., the limb usually does not show moment-to-moment fluctuations). In cogwheel rigidity, as the muscle is stretched around a joint there is a rhythmic, ratchet-like resistance that interrupts the usual smooth motion of the joint. Cogwheel rigidity can be felt by placing the hand over the joint being moved. Cogwheel rigidity occurs when the muscles are passively moved, is most common in the wrists and elbows, and often waxes and wanes. Individuals with parkinsonian rigidity may complain of generalized muscle tenderness or stiffness, muscle or joint pain, body aching, or lack of coordination during sports.

Akinesia is a state of decreased spontaneous motor activity. There is global slowing as well as slowness in initiating and executing movements. Normal everyday behaviors (e.g., grooming) are reduced. Individuals may complain of feeling listless, lacking spontaneity and drive, or oversleeping. Parkinsonian rigidity and akinesia can be manifested as abnormalities **in** gait or decreases in length of stride, arm swing, or overall spontaneity of walking. Other signs include bent-over neck, stooped shoulders, a staring facial expression, and small shuffling steps. Drooling may arise due to a general decrease

in pharyngeal motor activity, although it may be less common in parkinsonism associated with neuroleptic medication because of the anticholinergic properties of these medications.

Associated Features

Associated behavioral symptoms may include depression and worsening of negative signs of Schizophrenia. Other associated signs and symptoms include small handwriting (micrographia), hypophonia, postural instability, inhibited blinking in response to glabellae tapping, and seborrhea. General medical complications can occur when parkinsonian symptoms are severe and result in decreased motor activity (e.g., contractures, bedsores, and pulmonary emboli). Decreased gag reflex and dysphagia can be life threatening and may present as aspiration pneumonia or unexplained weight loss. There may be urinary incontinence and increased rates of hip fractures in elderly persons. Risk factors for developing Neuroleptic-Induced Parkinsonism include a history of prior episodes of Neuroleptic-Induced Parkinsonism; older age; the presence of a coexisting delirium, dementia, or amnestic disorder; or a coexisting neurological condition. Children may also be at higher risk of developing Neuroleptic-Induced Parkinsonism. Furthermore, the risk of developing Neuroleptic-Induced Parkinsonism is associated with the type of neuroleptic medication, the rapidity of increases in dosage, and the absolute dose; the risk is reduced if individuals are taking anticholinergic medications.

Differential Diagnosis

It is important to distinguish between Neuroleptic-Induced Parkinsonism and other causes of parkinsonian symptoms in individuals being treated with a neuroleptic medication. Neuroleptic-Induced Parkinsonism should be distinguished from **parkinsonian symptoms due to another substance or medication or due to a neurological or othergeneral medical condition** (e.g., Parkinson's disease, Wilson's disease). Laboratory findings may help to establish other causes for the parkinsonian symptoms (e.g., positive urine heavy metal screen, basal ganglia calcification indicating hypercalcemia, serum ceruloplasmin indicating Wilson's disease). Tremor due to other causes of parkinsonian symptoms, familial tremor, non-neuroleptic-induced tremor, and tremor associated with Substance Withdrawal should be distinguished from tremor in Neuroleptic-Induced Parkinsonism. Nonparkinsonian tremors tend to be finer (e.g., smaller amplitude) and faster (10 cycles per second) and tend to worsen on intention (e.g., when the individual reaches out to hold a cup). Tremor associated with **Substance Withdrawal** will usually have associated hyperreflexia and increased autonomic signs. Tremor from **cerebellar disease** worsens on intention and may have associated nystagmus, ataxia, or scanning speech. Choreiform movements associated with **Neuroleptic-Induced Tardive Dyskinesia** can resemble parkinsonian tremor; however, the parkinsonian tremor is distinguished by its steady rhythmicity. **Strokes** and **other focal lesions of the central nervous system** can cause focal neurological signs as well as causing immobility from flaccid or spastic paralysis. In contrast, muscle strength is initially normal and muscles fatigue later in Neuroleptic-Induced Parkinsonism. Rigidity from parkinsonism also needs to be differentiated from the "clasp knife" phenomenon found in pyramidal lesions and oppositional behavior.

Some indications that the parkinsonian symptoms are not due to neuroleptics include family history of an inherited neurological condition, rapidly progressive

parkinsonism not accounted for by recent psychopharmacological changes, the presence of focal nonextrapyramidal neurological signs (e.g., frontal release signs, cranial nerve abnormalities, or a positive Babinski sign), and parkinsonian signs or symptoms that do not reverse within 3 months of neuroleptic discontinuation (or 1 year when the neuroleptic was given in a long-acting intramuscular form). Individuals with **Neuroleptic Malignant Syndrome** have both severe akinesia and rigidity but have additional physical and laboratory findings (e.g., fever, increased creatine phosphokinase [CPK]).

Distinguishing between symptoms of a **primary mental disorder** and behavioral disturbances from Neuroleptic-Induced Parkinsonism can be difficult. Often the diagnosis has to be based on multiple sources of information (e.g., physical examination findings, medication history, mental symptoms). The diagnosis of Neuroleptic-Induced Parkinsonism may have to be made provisionally and can sometimes only be confirmed by a trial of dosage reduction (or elimination) of the neuroleptic medication or by initiating anticholinergic treatment. Neuroleptic-induced akinesia and **Major Depressive Disorder** have many overlapping symptoms. Major Depressive Disorder is more likely to have vegetative signs (e.g., early morning awakening), hopelessness, and despair, whereas apathy is more typical of akinesia. Catatonia associated with **Schizophrenia, Catatonic Type, or Mood Disorders With Catatonic Features** can be particularly difficult to distinguish from severe akinesia. The **negative symptoms of Schizophrenia** may also be difficult to differentiate from akinesia. Rigidity may also be associated with **Psychotic Disorders, delirium, dementia, Anxiety Disorders,** and **Conversion Disorder.** The resistance to passive motion is constant through the full range of motion in parkinsonian rigidity, whereas it is inconsistent in mental disorders or other neurological conditions presenting with rigidity. Furthermore, individuals with parkinsonian rigidity generally have a constellation of signs and symptoms, including a characteristic walk and facial expression, drooling, decreased blinking, and other aspects of bradykinesia.

Research criteria for 332.1 Neuroleptic Induced Parkinsonism

A. One (or more) of the following signs or symptoms has developed in association with the use of neuroleptic medication:

(1) parkinsonian tremor (i.e., a coarse, rhythmic, resting tremor with a frequency between 3 and 6 cycles per second, affecting the limbs, head, mouth, or tongue)

(2) parkinsonian muscular rigidity (i.e., cogwheel rigidity or continuous "lead-pipe" rigidity)

(3) akinesia (i.e., a decrease in spontaneous facial expressions, gestures, speech, or body movements)

B. The symptoms in Criterion A developed within a few weeks of starting or raising the dose of a neuroleptic medication, or of reducing a medication used to treat (or prevent) acute extrapyramidal symptoms (e.g., anticholinergic agents).

(continued)

☐ **Research criteria for 332.1 Neuroleptic Induced Parkinsonism** *(continued)*

C. The symptoms in Criterion A are not better accounted for by a mental disorder (e.g., catatonic or negative symptoms in Schizophrenia, psychomotor retardation in a Major Depressive Episode). Evidence that the symptoms are better accounted for by a mental disorder might include the following: the symptoms precede the exposure to neuroleptic medication or are not compatible with the pattern of pharmacological intervention (e.g., no improvement after lowering the neuroleptic dose or administering anticholinergic medication).

D. The symptoms in Criterion A are not due to a nonneuroleptic substance or to a neurological or other general medical condition (e.g., Parkinson's disease, Wilson's disease). Evidence that the symptoms are due to a general medical condition might include the following: the symptoms precede exposure to neuroleptic medication, unexplained focal neurological signs are present, or the symptoms progress despite a stable medication regimen.

333.92 Neuroleptic Malignant Syndrome

Diagnostic Features

The essential feature of Neuroleptic Malignant Syndrome is the development of severe muscle rigidity and elevated temperature in an individual using neuroleptic medication. This is accompanied by two (or more) of the following symptoms: diaphoresis, dysphagia, tremor, incontinence, changes in level of consciousness ranging from confusion to coma, mutism, tachycardia, elevated or labile blood pressure, leukocytosis, and laboratory evidence of muscle injury (e.g., elevated creatine phosphokinase [CPK]). These symptoms are not due to another substance (e.g., phencyclidine) or to a neurological or other general medical condition (e.g., viral encephalitis) and are not better accounted for by a mental disorder (e.g., Mood Disorder With Catatonic Features). There may be accompanying agitation or acute dystonic reactions.

Elevated temperature ranges from mild elevations (e.g., 99'-lOffF) to markedly hyperthermic states (e.g., 106"F). Fever due to a general medical condition (e.g., infection) needs to be ruled out as a cause of the elevated temperature; however, individuals with Neuroleptic Malignant Syndrome often develop other medical condi- tions that can worsen an already elevated temperature. CPK is typically elevated, ranging from minor elevations to extremely high levels (exceeding 16,000 IU). It should be noted that mild to moderate elevations of CPK can also be seen with muscle damage due to various causes such as intramuscular injection and use of restraints and has also been reported in individuals with acute Psychotic Disorders. White blood cell counts are often high, usually ranging between 10,000 and 20,000. In severe cases, myoglobinuria may occur and may be a harbinger of renal failure.

The presentation and course of Neuroleptic Malignant Syndrome are quite variable. It may have a malignant, potentially fatal course or a relatively benign, self-limited course. There is currently no way to predict the evolution of the syndrome in any particular individual. Neuroleptic Malignant Syndrome usually develops within 4 weeks after starting a neuroleptic medication, with two-thirds of cases developing within the first week. However, some individuals develop Neuroleptic Malignant Syndrome after taking the same dose of neuroleptic medication for many months. After discontinuation of neuroleptic medication, resolution of the condition occurs within a mean duration of 2 weeks for nondepot neuroleptic medication and 1 month for depot neuroleptic medication, although there are cases that continue far beyond the mean duration of 2 weeks. In most cases, there is eventually a total resolution of symptoms. For a minority of individuals, the outcome is fatal. Fatality rates in the literature are in the 10%-20% range, but these rates may be artificially high as a result of reporting bias. With increasing recognition of this condition, estimates of fatality rates have decreased. There have been rare reports of neurological sequelae.

Associated Features

Most cases have been reported to occur in individuals with Schizophrenia, Manic Episodes, and Mental Disorders Due to a General Medical Condition (e.g., a delirium or a dementia). Prior episodes of Neuroleptic Malignant Syndrome, agitation, dehydration, high doses of neuroleptic medication, rapid increase in dosage, and intramuscular injection of neuroleptic medication appear to be risk factors. There is controversy in the literature about whether treatment with lithium carbonate enhances the likelihood of developing Neuroleptic Malignant Syndrome. Although this disorder can occur in both hot and cold environments, environments that are warm and humid may contribute to the development of this condition. Various general medical conditions may occur and complicate the clinical picture, including pneumonia, renal failure, cardiac or respiratory arrest, seizures, sepsis, pulmonary embolism, and disseminated intravascular coagulation.

Estimates of the prevalence of this condition in individuals exposed to neuroleptic medications range from 0.07% to 1.4%. Neuroleptic Malignant Syndrome has been reported to occur somewhat more frequently in males than in females. The condition may occur at any age but has been reported most frequently in young adults. Variations in reported prevalence may be due to a lack of consistency in the definition of caseness, neuroleptic prescribing practices, study design, and the demographics of the population being studied. Neuroleptic Malignant Syndrome may occur more frequently with high-potency neuroleptic medication. Some individuals who have developed this condition may be less likely to be compliant with taking neuroleptic medication. Although many individuals do not experience a recurrence when neuroleptic medication is reinstituted, some do experience a recurrence, especially when the neuroleptic medication is reinstituted soon after an episode of Neuroleptic Malignant Syndrome.

Di,fferential magnosis

Neuroleptic Malignant Syndrome must be distinguished from the symptoms of a **neurological or other general medical condition.** An elevated temperature that is due to a general medical condition (e.g., a viral infection) must be distinguished from the elevated temperature associated with Neuroleptic Malignant Syndrome. Extremely

elevated temperatures are more likely due to Neuroleptic Malignant Syndrome, especially in the absence of an identifiable general medical condition. In addition, in Neuroleptic Malignant Syndrome, other characteristic features (e.g., severe muscle rigidity) are also present. General medical conditions with a presentation that may resemble Neuroleptic Malignant Syndrome include central nervous system infection, status epilepticus, subcortical brain lesions (e.g., stroke, trauma, neoplasms), and systemic conditions (e.g., intermittent acute porphyria, tetanus). **Heat stroke** may mimic Neuroleptic Malignant Syndrome but can be distinguished by the presence of hot, dry skin (rather than diaphoresis), hypotension (rather than fluctuating or elevated blood pressure), and limb flaccidity (rather than rigidity). **Malignant hyperthermia** presents with high elevated temperature and rigidity and usually occurs in genetically susceptible individuals who have received halogenated inhalational anesthetics and depolarizing muscle relaxants. Malignant hyperthermia usually starts within minutes of receiving anesthesia. Because other general medical conditions can co-occur with or result from Neuroleptic Malignant Syndrome, it is important to determine whether the elevated temperature occurred before or subsequent to the superimposed medical problems. Abrupt discontinuation of antiparkinsonian medication in a person with **Parkinson's disease or treatment with dopamine-depletingagents** (e.g., reserpine, tetrabenazine) may precipitate a reaction similar to Neuroleptic Malignant Syndrome.

Neuroleptic Malignant Syndrome must be distinguished from similar syndromes resulting from the use of **other psychotropic medications** (e.g., monoamine oxidase inhibitors, monoamine oxidase inhibitor-tricyclic combinations, monoamine oxidase inhibitor-serotonergic agent combinations, monoamine oxidase inhibitor-meperidine combinations, lithium toxicity, anticholinergic delirium, amphetamines, fenfluramine, cocaine, and phencyclidine), all of which may present with hyperthermia, altered mental status, and autonomic changes. In such cases, a diagnosis of **Medication-Induced Movement Disorder Not Otherwise Specified** can be given.

Individuals with Schizophrenia or a Manic Episode who are not receiving a neuroleptic medication may sometimes present with extreme catatonic states (so-called **lethal catatonia),** which can mimic Neuroleptic Malignant Syndrome and may include elevated temperature, autonomic dysfunction, and abnormal laboratory findings. For individuals already receiving a neuroleptic medication, a history of prior extreme catatonic states when the individual was not receiving a neuroleptic is important in making the differential diagnosis. The problem is further confounded by the fact that neuroleptic medication may worsen the symptoms of lethal catatonia.

Research criteria for 333.92 Neuroleptic Malignant Syndrome

A. The development of severe muscle rigidity and elevated temperature associated with the use of neuroleptic medication.

B. Two (or more) of the following:

(1) diaphoresis
(2) dysphagia

(continued)

☐ **Research criteria for 333.92 Neuroleptic Malignant Syndrome** *(continued)*

(3) tremor
(4) incontinence
(5) changes in level of consciousness ranging from confusion to coma
(6) mutism
(7) tachycardia
(8) elevated or labile blood pressure
(9) leucocytosis
(10) laboratory evidence of muscle injury (e.g., elevated CPK)

C. The symptoms in Criteria A and B are not due to another substance (e.g., phencyclidine) or a neurological or other general medical condi- tion (e.g., viral encephalitis).

D. The symptoms in Criteria A and B are not better accounted for by a mental disorder (e.g., Mood Disorder With Catatonic Features).

333.7 Neuroleptic--Induced Acute Dystonia

Di.agnostic Features

The essential feature of Neuroleptic-Induced Acute Dystonia is sustained abnormal postures or muscle spasms that develop in association with the use of neuroleptic medication. These include abnormal positioning of the head and neck in relation to the body (e.g., retrocollis, torticollis); spasms of the jaw muscles (trismus, gaping, grimacing); impaired swallowing (dysphagia), speaking, or breathing (potentially life-threatening laryngeal-pharyngeal spasm, dysphonia); thickened or slurred speech due to hypertonic tongue (dysarthria, macroglossia); tongue protrusion or tongue dysfunction; eyes deviated up, down, or sideward (oculogyric crisis); or abnormal positioning of the distal limbs or trunk (opisthotonos). There is great variability in the severity of the symptoms and in the body areas that may be affected. Increased tone in the affected muscles is usually present. The signs or symptoms develop within 7 days of starting or rapidly raising the dose of neuroleptic medication or of reducing a medication being used to treat or prevent acute extrapyramidal symptoms (e.g., anticholinergic agents). The symptoms must not be better accounted for by a mental disorder (e.g., catatonic symptoms in Schizophrenia) and must not be due to a nonneuroleptic substance or to a neurological or other general medical condition.

Associated Features

Fear and anxiety often accompany the onset of Neuroleptic-Induced Acute Dystonia, especially in individuals who are unaware of the possibility of developing dystonia and who mistakenly regard the symptom as part of their mental disorder. Some individuals experience pain or cramps in affected muscles. Noncompliance with medication

treatment may result following the development of acute dystonic reactions. Neuroleptic-Induced Acute Dystonia occurs most commonly in young males. Risk factors for developing Neuroleptic-Induced Acute Dystonia include prior dystonic reactions to neuroleptic treatment and the use of high-potency neuroleptic medication.

Differential Diagnosis

It is important to distinguish between Neuroleptic-Induced Acute Dystonia and other causes of dystonia in individuals being treated with a neuroleptic medication. Evidence that the symptoms are due to a **neurological or other general medical condition** includes course (e.g., symptoms preceding exposure to the neuroleptic medication or progression of symptoms in the absence of change in medication) and the presence of focal neurological signs. **Spontaneously occurring focal or segmental dystonias** usually persist for several days or weeks independent of medication. Other neurological conditions (e.g., temporal lobe seizures, viral and bacterial infections, trauma, or space-occupying lesions in the peripheral or central nervous system) and endocrinopath- ies (e.g., hypoparathyroidism) can also produce symptoms (e.g., tetany) that resemble a Neuroleptic-Induced Acute Dystonia.

Neuroleptic Malignant Syndrome can produce dystonia but differs in that it is also accompanied by fever and generalized rigidity. Neuroleptic-Induced Acute Dystonia should be distinguished from **dystonia due to a nonneuroleptic medication** (e.g., anticonvulsant medications such as phenytoin and carbamazepine). In such cases, a diagnosis of **Medication-Induced Movement Disorder Not Otherwise Specified** can be given.

Catatonia associated with a Mood Disorder or Schizophrenia can be distinguished by the temporal relationship between the symptoms and the neuroleptic exposure (e.g., dystonia preceding exposure to neuroleptic medication) and response to pharmacological intervention (e.g., no improvement after lowering of neuroleptic dose or anticholinergic administration). Furthermore, individuals with Neuroleptic- Induced Acute Dystonia are generally distressed about the dystonic reaction and usually seek intervention. In contrast, individuals with catatonia are typically mute and with- drawn and do not express subjective distress about their condition.

Research criteria for 333.7 Neuroleptic Induced Acute Dystonia

A. One (or more) of the following signs or symptoms has developed in association with the use of neuroleptic medication:

(1) abnormal positioning of the head and neck in relation to the body (e.g., retrocollis, torticollis)

(2) spasms of the jaw muscles (trismus, gaping, grimacing)

(3) impaired swallowing (dysphagia), speaking, or breathing (laryngeal-pharyngeal spasm, dysphonia)

(continued)

☐ **Research criteria for 333.7 Neuroleptic Induced Acute Dystonia** *(continued)*

(4) thickened or slurred speech due to hypertonic or enlarged tongue (dysarthria, macroglossia)
(5) tongue protrusion or tongue dysfunction
(6) eyes deviated up, down, or sideward (oculogyric crisis)
(7) abnormal positioning of the distal limbs or trunk

B. The signs or symptoms in Criterion A developed within 7 days of starting or rapidly raising the dose of neuroleptic medication, or of reducing a medication used to treat (or prevent) acute extrapyramidal symptoms (e.g., anticholinergic agents).

C. The symptoms in Criterion A are not better accounted for by a mental disorder (e.g., catatonic symptoms in Schizophrenia). Evidence that the symptoms are better accounted for by a mental disorder might include the following: the symptoms precede the exposure to neuroleptic medication or are not compatible with the pattern of pharmacological intervention (e.g., no improvement after neuroleptic lowering or anti- cholinergic administration).

D. The symptoms in Criterion A are not due to a nonneuroleptic substance or to a neurological or other general medical condition. Evidence that the symptoms are due to a general medical condition might include the following: the symptoms precede the exposure to the neuroleptic medication, unexplained focal neurological signs are present, or the symptoms progress in the absence of change in medication.

333.99 Neuroleptic--Induced Acute Akathisia

Diagnostic Features

The essential features of Neuroleptic-Induced Acute Akathisia are subjective complaints of restlessness and at least one of the following observed movements: fidgety movements or swinging of the legs while seated, rocking from foot to foot or "walking on the spot" while standing, pacing to relieve the restlessness, or an inability to sit or stand still for at least several minutes. In its most severe form, the individual may be unable to maintain any position for more than a few seconds. The subjective complaints include a sense of inner restlessness, most often in the legs; a compulsion to move one's legs; distress if one is asked not to move one's legs; and dysphoria and anxiety. The symptoms typically occur within 4 weeks of initiating or increasing the dose of a neuroleptic medication and can occasionally follow the reduction of medication used to treat or prevent acute extrapyramidal symptoms (e.g., anticholinergic agents). The symptoms are not better accounted for by a mental disorder (e.g., Schizophrenia, Substance Withdrawal, agitation from a Major Depressive or Manic Episode, hyperactivity in Attention-Deficit/Hyperac-

tivity Disorder) and are not due to a nonneuroleptic substance or to a neurological or other general medical condition (e.g., Parkinson's disease, iron-deficiency anemi).

Associated Features and Disorders

The subjective distress resulting from akathisia is significant and can lead to noncompliance with neuroleptic treatment. Akathisia may be associated with dysphoria, irritability, aggression, or suicide attempts. Worsening of psychotic symptoms or behavioral dyscontrol may lead to an increase in neuroleptic medication dose, which may exacerbate the problem. Akathisia can develop very rapidly after initiating or increasing neuroleptic medication. The development of akathisia appears to be dose dependent and to be more frequently associated with particular neuroleptic medications. Acute akathisia tends to persist for as long as neuroleptic medications are continued, although the intensity may fluctuate over time. The reported prevalence of akathisia among individuals receiving neuroleptic medication has varied widely (20%--75%). Variations in reported prevalence may be due to a lack of consistency in the definition of caseness, neuroleptic prescribing practices, study design, and the demographics of the population being studied.

Differential Diagnosis

Neuroleptic-Induced Acute Akathisia may be clinically indistinguishable from syndromes of restlessness due to certain neurological or other general medical conditions, to nonneuroleptic substances, and to agitation presenting as part of a mental disorder (e.g., a Manic Episode). The akathisia of **Parkinson's disease** and **iron-deficiency anemia** are phenomenologically similar to Neuroleptic-Induced Acute Akathisia. The frequently abrupt appearance of restlessness soon after initiation or increase in neuroleptic medication usually distinguishes Neuroleptic-Induced Acute Akathisia.

Serotonin-specific reuptake inhibitor antidepressant medications may pro- duce akathisia that appears to be identical in phenomenology and treatment response to Neuroleptic-Induced Acute Akathisia. Akathisia due to nonneuroleptic medication can be diagnosed as **Medication-Induced Movement Disorder Not Otherwise Specified.** Other situations that might be included under Medication-Induced Movement Disorders Not Otherwise Specified are acute akathisia with only subjective or only objective complaints, but not both; and akathisia occurring late in the course of treatment (e.g., 6 months after initiation of, or increase in the dose of, a neuroleptic). **Neuroleptic- Induced Tardive Dyskinesia** also often has a component of generalized restlessness that may coexist with akathisia in an individual receiving neuroleptic medication. Neuroleptic-Induced Acute Akathisia is differentiated from Neuroleptic-Induced Tardive Dyskinesia by the nature of the movements and their relationship to the initiation of medication. The time course of symptomatic presentation relative to neuroleptic dose changes may aid in this distinction. An increase in neuroleptic medication will often exacerbate akathisia, whereas it often temporarily relieves the symptoms of Tardive Dyskinesia.

Neuroleptic-Induced Acute Akathisia should be distinguished from symptoms that are better accounted for by a mental disorder. Individuals with **Depressive Episodes, Manic Episodes, Generalized Anxiety Disorder, Schizophrenia and other Psychotic Disorders, Attention-Deficit/HyperactivityDisorder, dementia,delirium,**

Substance Intoxication (e.g., with cocaine), or **Substance Withdrawal** (e.g., from an opioid) may also display agitation that is difficult to distinguish from akathisia. Some of these individuals are able to differentiate akathisia from the anxiety, restlessness, and agitation characteristic of a mental disorder by their experience of akathisia as being different from previously experienced feelings. Other evidence that restlessness or agitation may be better accounted for by a mental disorder includes the onset of agitation prior to exposure to the neuroleptic medication, absence of increasing restlessness with increasing neuroleptic medication doses, and absence of relief with pharmacological interventions (e.g., no improvement after decreasing the neuroleptic dose or treatment with medication intended to treat the akathisia).

Research criteria for 333.99 Neuroleptic..fnduced Acute Akathisia

A. The development of subjective complaints of restlessness after exposure to a neuroleptic medication.

B. At least one of the following is observed:
   (1) fidgety movements or swinging of the legs
   (2) rocking from foot to foot while standing
   (3) pacing to relieve restlessness
   (4) inability to sit or stand still for at least several minutes

C. The onset of the symptoms in Criteria A and B occurs within 4 weeks of initiating or increasing the dose of the neuroleptic, or of reducing medication used to treat (or prevent) acute extrapyramidal symptoms (e.g., anticholinergic agents).

D. The symptoms in Criterion A are not better accounted for by a mental disorder (e.g., Schizophrenia, Substance Withdrawal, agitation from a Major Depressive or Manic Episode, hyperactivity in Attention-Deficit/ Hyperactivity Disorder). Evidence that symptoms may be better accounted for by a mental disorder might include the following: the onset of symptoms preceding the exposure to the neuroleptics, the absence of increasing restlessness with increasing neuroleptic doses, and the absence of relief with pharmacological interventions (e.g., no improve- ment after decreasing the neuroleptic dose or treatment with medication intended to treat the akathisia).

E. The symptoms in Criterion A are not due to a nonneuroleptic substance or to a neurological or other general medical condition. Evidence that symptoms are due to a general medical condition might include the onset of the symptoms preceding the exposure to neuroleptics or the progression of symptoms in the absence of a change in medication.

333.82 Neuroleptic-Induced Tardive Dyskinesia

Diagnostic Features

The essential features of Neuroleptic-Induced Tardive Dyskinesia are abnormal, involuntary movements of the tongue, jaw, trunk, or extremities that develop in association with the use of neuroleptic medication. The movements are present over a period of at least 4 weeks and may be choreiform (rapid, jerky, nonrepetitive), athetoid (slow, sinuous, continual), or rhythmic (e.g., stereotypies) in nature. The signs or symptoms develop during exposure to a neuroleptic medication or within 4 weeks of withdrawal from an oral (or within 8 weeks of withdrawal from a depot) neuroleptic medication. There must be a history of the use of neuroleptic medication for at least 3 months (or 1 month in individuals age 60 years or older). Although a large number of epidemio- logical studies have established the etiological relationship between neuroleptic use and Tardive Dyskinesia, any dyskinesia in an individual who is receiving neuroleptic medication is not necessarily Neuroleptic-Induced Tardive Dyskinesia. The movements must not be due to a neurological or other general medical condition (e.g., Huntington's disease, Sydenham's chorea, spontaneous dyskinesia, hyperthyroidism, Wilson's dis- ease), to ill-fitting dentures, or to exposure to other medications that can cause acute reversible dyskinesia (e.g., L-dopa, bromocriptine). The movements should also not be better accounted for by a neuroleptic-induced acute movement disorder (e.g., Neuro- leptic-Induced Acute Dystonia, Neuroleptic-Induced Acute Akathisia).

Over three-fourths of the individuals with Tardive Dyskinesia have abnormal orofacial movements, approximately one-half have limb involvement, and up to one-quarter have axial dyskinesia of the trunk. All three regions are affected in approximately 10% of individuals. Involvement of other muscle groups (e.g., pharyngeal, abdominal) may occur but is uncommon, especially in the absence of dyskinesia of the orofacial region, limbs, or trunk. Limb or truncal dyskinesia without orofacial involve- ment is more common in younger individuals, whereas orofacial dyskinesias are typical in elderly persons.

Associated Features

The symptoms of Tardive Dyskinesia tend to be worsened by stimulants, neuroleptic withdrawal, and anticholinergic medications and may be transiently worsened by emotional arousal, stress, and distraction during voluntary movements in unaffected parts of the body. The abnormal movements of dyskinesia are transiently reduced by relaxation and by voluntary movements in affected parts of the body. They are generally absent during sleep. Dyskinesia may be suppressed, at least temporarily, by increased doses of neuroleptics or sedatives.

The overall prevalence of Neuroleptic-Induced Tardive Dyskinesia in individuals who have received long-term neuroleptic treatment ranges from 20% to 30%. The overall incidence among younger individuals ranges from 3% to 5% per year. Elderly individuals appear to develop Neuroleptic-Induced Tardive Dyskinesia more often, with prevalence figures reported up to 50% and an incidence of 25%-30% after an average of 1 year's cumulative exposure to neuroleptic medication. Prevalence also varies depending on setting, with Tardive Dyskinesia tending to be more common among inpatients (especially chronically institutionalized individuals). Tardive Dyskinesia is diagnosed with approximately equal frequency in young males and females, whereas among elderly

individuals it may be seen more often in females than in males. Mood Disorders (especially Major Depressive Disorder), neurological conditions, greater cumulative amount of neuroleptic medication, and early development of extrapyramidal side effects have been suggested as risk factors for Tardive Dyskinesia. Variations in reported prevalence may be due to a lack of consistency in the definition of caseness, neuroleptic prescribing practices, study design, and the demographics of the population being studied.

Onset may occur at any age and is almost always insidious. The signs are typically minimal to mild at onset and escape notice except by a keen observer. In a majority of cases, Tardive Dyskinesia is mild and is primarily a cosmetic problem. In severe cases, however, it may be associated with general medical complications (e.g., ulcers in cheeks and tongue; loss of teeth; macroglossia; difficulty in walking, swallowing, or breathing; muffled speech; weight loss; depression; and suicidal ideation). If the individual with Tardive Dyskinesia remains off neuroleptic medication, the dyskinesia remits within 3 months in one-third of the cases and remits by 12-18 months in more than 50% of cases, although these percentages are lower in elderly persons. When individuals receiving neuroleptic medication are assessed periodically, Tardive Dyskinesia is found to be stable over time in about one-half, to worsen in one-quarter, and to improve in the rest. Younger individuals generally tend to improve more readily; in elderly persons there is a greater likelihood that Tardive Dyskinesia may become more severe or more generalized with continued neuroleptic use. When neuroleptic medications are discon- tinued, it is estimated that 5%-40% of all cases remit and between 50% and 90% of mild cases remit.

Di£ferential magnosis

Dyskinesia that emerges during neuroleptic withdrawal may remit with continued withdrawal from neuroleptic medication. If the dyskinesia persists for at least 4 weeks, a diagnosis of Tardive Dyskinesia may be warranted. Neuroleptic-Induced Tardive Dyskinesia must be distinguished from other causes of orofacial and body dyskinesia. These conditions include **Huntington's disease; Wilson's disease; Sydenham's (rheumatic) chorea; systemic lupus erythematosus; thyrotoxicosis; heavy metal poisoning; ill-fitting dentures; dyskinesia due to other medications such as L-dopa, bromocriptine, or amantadine;** and **spontaneous dyskinesias.** Factors that may be helpful in making the distinction are evidence that the symptoms preceded the exposure to the neuroleptic medication or that other focal neurological signs are present. It should be noted that other movement disorders may coexist with Neuroleptic-Induced Tardive Dyskinesia. Because spontaneous dyskinesia can occur in more than 5% of individuals and is also more common in elderly persons, it may be difficult to prove that neuroleptic medications produced Tardive Dyskinesia in a given individual. Neuroleptic-Induced Tardive Dyskinesia must be distinguished from symptoms that are due to a neuroleptic-induced acute movement disorder (e.g., **Neuroleptic-Induced Acute Dystonia or Neuroleptic-InducedAcuteAkathisia).** Neuroleptic-Induced Acute Dystonia develops within 7 days and Neuroleptic-Induced Acute Akathisia develops within 4 weeks of initiating or increasing the dose of a neuroleptic medication (or reducing the dose of a medication used to treat acute extrapyramidal symptoms). Neuroleptic-Induced Tardive Dyskinesia, on the other hand, develops during exposure to (or withdrawal from) neuroleptic medication in individuals with a history of neuroleptic use for at least 3 months (or 1 month in elderly persons).

Research criteria for 333.82 Neuroleptic--Induced Tardive Dyskinesia

A. Involuntary movements of the tongue, jaw, trunk, or extremities have developed in association with the use of neuroleptic medication.

B. The involuntary movements are present over a period of at least 4 weeks and occur in any of the following patterns:
   (1) choreiform movements (i.e., rapid, jerky, nonrepetitive)
   (2) athetoid movements (i.e., slow, sinuous, continual)
   (3) rhythmic movements (i.e., stereotypies)

C. The signs or symptoms in Criteria A and B develop during exposure to a neuroleptic medication or within 4 weeks of withdrawal from an oral (or within 8 weeks of withdrawal from a depot) neuroleptic medication.

D. There has been exposure to neuroleptic medication for at least 3 months (1 month if age 60 years or older).

E. The symptoms are not due to a neurological or general medical condition (e.g., Huntington's disease, Syqenham's chorea, spontaneous dyskinesia, hyperthyroidism, Wilson's disease), ill-fitting dentures, or exposure to other medications that cause acute reversible dyskinesia (e.g., L-dopa, bromocriptine). Evidence that the symptoms are due to one of these etiologies might include the following: the symptoms precede the exposure to the neuroleptic medication or unexplained focal neurological signs are present.

F. The symptoms are not better accounted for by a neuroleptic-induced acute movement disorder (e.g., Neuroleptic-Induced Acute Dystonia, Neuroleptic-Induced Acute Akathisia).

333.1 Medication--Induced Postural Tremor

Di-agnostic Features

The essential feature of Medication-Induced Postural Tremor is a fine postural tremor that has developed in association with the use of a medication. Medications with which such a tremor may be associated include lithium, beta-adrenergic medications (e.g., isoproterenol), stimulants (e.g., amphetamine), dopaminergic medications, anticonvulsant medications (e.g., valproic acid), neuroleptic medications, antidepressant medications, and methylxanthines (e.g., caffeine, theophylline). The tremor is a regular, rhythmic oscillation of the limbs (most commonly hands and fingers), head, mouth, or tongue with a frequency of between 8 and 12 cycles per second. It is most easily observed

when the affected body part is held in a sustained posture (e.g., hands outstretched, mouth held open). When an individual describes a tremor that is consistent with this definition, but the clinician does not directly observe the tremor, it may be helpful to try to re-create the situation in which the tremor occurred (e.g., drinking from a cup and saucer). The symptoms are not due to a preexisting, nonpharmacologically induced tremor and are not better accounted for by Neuroleptic-Induced Parkinsonism.

Associated Features

Most available information concerns lithium-induced tremor. Lithium tremor is a common, usually benign, and well-tolerated side effect of therapeutic doses. However, it may cause social embarrassment, occupational difficulties, and noncompliance in some individuals. As serum lithium levels approach toxic levels, the tremor may become more coarse and be accompanied by muscle twitching, fasciculations, or ataxia. Nontoxic lithium tremor may improve spontaneously over time. A variety of factors may increase the risk of lithium tremor (e.g., increasing age, high serum lithium levels, concurrent antidepressant or neuroleptic medication, excessive caffeine intake, personal or family history of tremor, presence of Alcohol Dependence, and associated anxiety). The frequency of complaints about tremor appears to decrease with duration of lithium treatment. Factors that may exacerbate the tremor include anxiety, stress, fatigue, hypoglycemia, thyrotoxicosis, pheochromocytoma, hypothermia, and Alcohol Withdrawal.

Differential Diagnosis

Medication-Induced Postural Tremor should be distinguished from a **preexisting tremor** that is not caused by the effects of a medication. Factors that help to establish that the tremor was preexisting include its temporal relationship to the initiation of medication, lack of correlation with serum levels of the medication, and persistence after the medication is discontinued. If a preexisting, nonpharmacologically induced tremor is present that worsens with medication, such a tremor would not be considered to meet the criteria for a Medication-Induced Postural Tremor and would be coded as **Medication-Induced Movement Disorder Not Otherwise Specified.** The factors described above that may contribute to the severity of a Medication-Induced Postural Tremor (e.g., anxiety, stress, fatigue, hypoglycemia, thyrotoxicosis, pheochromocytoma, hypothermia, and Alcohol Withdrawal) may also be a cause of tremor independent of the medication.

Medication-Induced Postural Tremor is not diagnosed if the tremor is better accounted for by **Neuroleptic-Induced Parkinsonism.** A Medication-Induced Postural Tremor is usually absent at rest and intensifies when the affected part is brought into action or held in a sustained position. In contrast, the tremor related to Neuroleptic-Induced Parkinsonism is usually lower in frequency, worse at rest, and suppressed during intentional movement and usually occurs in association with other symptoms of Neuroleptic-Induced Parkinsonism (e.g., akinesia, rigidity).

Research criteria for 333. I Medication-Induced Postural Tremor

A. A fine postural tremor that has developed in association with the use of a medication (e.g., lithium, antidepressant medication, valproic acid).

B. The tremor (i.e., a regular, rhythmic oscillation of the limbs, head, mouth, or tongue) has a frequency between 8 and 12 cycles per second.

C. The symptoms are not due to a preexisting nonpha1macologically induced tremor. Evidence that the symptoms are due to a preexisting tremor might include the following: the tremor was present prior to the introduction of the medication, the tremor does not correlate with serum levels of the medication, and the tremor persists after discontinuation of the medication.

D. The symptoms are not better accounted for by Neuroleptic-Induced Parkinsonism.

333.90 Medication-InducedMovement Disorder Not Otherwise Specified

This category is for Medication-Induced Movement Disorders that do not meet criteria for any of the specific disorders listed above. Examples include 1) parkinsonism, acute akathisia, acute dystonia, or dyskinetic movement that is associated with a medication other than a neuroleptic; 2) a presentation that resembles Neuroleptic Malignant Syndrome that is associated with a medication other than a neuroleptic; or 3) tardive dystonia.

Proposed Axes for Further Study

Defensive Functioning Scale

Defense mechanisms (or coping styles) are automatic psychological processes that protect the individual against anxiety and from the awareness of internal or external dangers or stressors. Individuals are often unaware of these processes as they operate. Defense mechanisms mediate the individual's reaction to emotional conflicts and to internal and external stressors. The individual defense mechanisms are divided concep- tually and empirically into related groups that are referred to as *Defense Levels.*

To use the Defensive Functioning Scale, the clinician should list up to seven of the specific defenses or coping styles (starting with the most prominent) and then indicate the predominant defense level exhibited by the individual. These should reflect the defenses or coping styles employed at the time of evaluation, supplemented by whatever

information is available about the individual's defenses or coping patterns during the recent time period that preceded the evaluation. The specific defense mechanisms listed may be drawn from the different Defense Levels.

The Defensive Functioning Axis is presented first, followed by a recording form. The rest of the section consists of a list of definitions for the specific defense mechanisms and coping styles.

Defense Levels and Individual Defense Mechanisms

High adaptive level. This level of defensive functioning results in optimal adaptation in the handling of stressors. These defenses usually maximize gratification and allow the conscious awareness of feelings, ideas, and their consequences. They also promote an optimum balance among conflicting motives. Examples of defenses at this level are

- anticipation
- affiliation
- altruism
- humor
- self-assertion
- self-observation
- sublimation
- suppression

Mental inhibitions (compromise formation) level. Defensive functioning at this level keeps potentially threatening ideas, feelings, memories, wishes, or fears out of awareness. Examples are

- displacement
- dissociation
- intellectualization
- isolation of affect
- reaction formation
- repression
- undoing

Minor image-distorting level. This level is characterized by distortions in the image of the self, body, or others that may be employed to regulate self-esteem. Examples are

- devaluation
- idealization
- omnipotence

Disavowal level. This level is characterized by keeping unpleasant or unacceptable stressors, impulses, ideas, affects, or responsibility out of awareness with or without a misattribution of these to external causes. Examples are

- denial
- projection
- rationalization

Major image-distorting level. This level is characterized by gross distortion or misattribution of the image of self or others. Examples are

- autistic fantasy
- projective identification
- splitting of self-image or image of others

Action level. This level is characterized by defensive functioning that deals with internal or external stressors by action or withdrawal. Examples are

- acting out
- apathetic withdrawal
- help-rejecting complaining
- passive aggression

Level of defensive dysregulation. This level is characterized by failure of defensive regulation to contain the individual's reaction to stressors, leading to a pronounced break with objective reality. Examples are

- delusional projection
- psychotic denial
- psychotic distortion

Recording Form: Defensive Functioning Scale

A. Current Defenses or Coping Styles: List in order, beginning with most prominent defenses or coping styles.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

B. Predominant Current Defense Level: _____

Example

Axis I:	296.32	Major Depressive Disorder, Recurrent, Moderate
	305.40	Sedative, Hypnotic, or Anxiolytic Abuse
Axis II:	301.83	Borderline Personality Disorder
		Antisocial personality features
Axis Ill:	881.02	Lacerations of wrist
Axis IV:		Recent arrest
		Expulsion from home by parents
Axis V:	GAF = 45 (current)	

Recording Form: Defensive Functioning Scale

A. Current Defenses or Coping Styles:

1. splitting
2. projection identification
3. acting out
4. devaluation
5. omnipotence
6. denial
7. projection

B. Predominant Current Defense Level: major image-distorting level

Glossary of Specific Defense Mechanisms and Coping Styles

acting out The individual deals with emotional conflict or internal or external stressors by actions rather than reflections or feelings. This definition is broader than the original concept of the acting out of transference feelings or wishes during psychotherapy and is intended to include behavior arising both within and outside the transference relationship. Defensive acting out is not synonymous with "bad behavior" because it requires evidence that the behavior is related to emotional conflicts.

affiliation The individual deals with emotional conflict or internal or external stressors by turning to others for help or support. This involves sharing problems with others but does not imply trying to make someone else responsible for them.

altruism The individual deals with emotional conflict or internal or external stressors by dedication to meeting the needs of others. Unlike the self-sacrifice sometimes characteristic of reaction formation, the individual receives gratification either vicariously or from the response of others.

anticipation The individual deals with emotional conflict or internal or external stressors by experiencing emotional reactions in advance of, or anticipating conse- quences of, possible future events and considering realistic, alternative responses or solutions.

autistic fantasy The individual deals with emotional conflict or internal or external stressors by excessive daydreaming as a substitute for human relationships, more effective action, or problem solving.

denial The individual deals with emotional conflict or internal or external stressors by refusing to acknowledge some painful aspect of external reality or subjective experience that would be apparent to others. The term *psychotic denial* is used when there is gross impairment in reality testing.

devaluation The individual deals with emotional conflict or internal or external stressors by attributing exaggerated negative qualities to self or others.

displacement The individual deals with emotional conflict or internal or external stressors by transferring a feeling about, or a response to, one object onto another (usually less threatening) substitute object.

dissociation The individual deals with emotional conflict or internal or external stressors with a breakdown in the usually integrated functions of consciousness, memory, perception of self or the environment, or sensory/motor behavior.

help-rejecting complaining The individual deals with emotional conflict or internal or external stressors by complaining or making repetitious requests for help that disguise covert feelings of hostility or reproach toward others, which are then expressed by rejecting the suggestions, advice, or help that others offer. The complaints or requests may involve physical or psychological symptoms or life problems.

humor The individual deals with emotional conflict or external stressors by empha- sizing the amusing or ironic aspects of the conflict or stressor.

idealization The individual deals with emotional conflict or internal or external stressors by attributing exaggerated positive qualities to others.

intellectualization The individual deals with emotional conflict or internal or external stressors by the excessive use of abstract thinking or the making of generalizations to control or minimize disturbing feelings.

isolation of affect The individual deals with emotional conflict or internal or external stressors by the separation of ideas from the feelings originally associated with them. The individual loses touch with the feelings associated with a given idea (e.g., a traumatic event) while remaining aware of the cognitive elements of it (e.g., descriptive details).

omnipotence The individual deals with emotional conflict or internal or external stressors by feeling or acting as if he or she possesses special powers or abilities and is superior to others.

passive aggression The individual deals with emotional conflict or internal or external stressors by indirectly and unassertively expressing aggression toward others. There is a facade of overt compliance masking covert resistance, resentment, or hostility. Passive aggression often occurs in response to demands for independent action or performance or the lack of gratification of dependent wishes but may be adaptive for individuals in subordinate positions who have no other way to express assertiveness more overtly.

projection The individual deals with emotional conflict or internal or external stressors by falsely attributing to another his or her own unacceptable feelings, impulses, or thoughts.

projective identification As in projection, the individual deals with emotional conflict or internal or external stressors by falsely attributing to another his or her own unacceptable feelings, impulses, or thoughts. Unlike simple projection, the individual does not fully disavow what is projected. Instead, the individual remains aware of his or her own affects or impulses but misattributes them as justifiable reactions to the other person. Not infrequently, the individual induces the very feelings in others that were first mistakenly believed to be there, making it difficult to clarify who did what to whom first.

rationalization The individual deals with emotional conflict or internal or external stressors by concealing the true motivations for his or her own thoughts, actions, or feelings through the elaboration of reassuring or self-serving but incorrect explanations.

reaction formation The individual deals with emotional conflict or internal or external stressors by substituting behavior, thoughts, or feelings that are diametrically opposed to his or her own unacceptable thoughts or feelings (this usually occurs in conjunction with their repression).

repression The individual deals with emotional conflict or internal or external stressors by expelling disturbing wishes, thoughts, or experiences from conscious awareness. The feeling component may remain conscious, detached from its associated ideas.

self-assertion The individual deals with emotional conflict or stressors by expressing his or her feelings and thoughts directly in a way that is not coercive or manipulative.

self-observation The individual deals with emotional conflict or stressors by reflecting on his or her own thoughts, feelings, motivation, and behavior, and responding appropriately.

splitting The individual deals with emotional conflict or internal or external stressors by compartmentalizing opposite affect states and failing to integrate the positive and negative qualities of the self or others into cohesive images. Because ambivalent affects cannot be experienced simultaneously, more balanced views and expectations of self or others are excluded from emotional awareness. Self and object images tend to alternate between polar opposites: exclusively loving, powerful, worthy, nurturant, and kind-or exclusively bad, hateful, angry, destructive, rejecting, or worthless.

sublimation The individual deals with emotional conflict or internal or external stressors by channeling potentially maladaptive feelings or impulses into socially acceptable behavior (e.g., contact sports to channel angry impulses).

suppression The individual deals with emotional conflict or internal or external stressors by intentionally avoiding thinking about disturbing problems, wishes, feelings, or experiences.

undoing The individual deals with emotional conflict or internal or external stressors by words or behavior designed to negate or to make amends symbolically for unacceptable thoughts, feelings, or actions.

Global Assessment of Relational Functioning (GARF) Scale

Instructions: The GARF Scale can be used to indicate an overall judgment of the functioning of a family or other ongoing relationship on a hypothetical continuum ranging from competent, optimal relational functioning to a disrupted, dysfunctional relationship. It is analogous to Axis V (Global Assessment of Functioning Scale) provided for individuals in DSM-IV. The GARF Scale permits the clinician to race the degree to which a family or other ongoing relational unit meets the affective or instrumental needs o(its members in the following areas:

A. *Problem solving-skills* in negotiating goals, rules, and routines; adaptability to stress; communication skills; ability to resolve conflict
B. O,;ganization---maintenance of interpersonal roles and subsystem boundaries; hierarchical functioning; coalitions and distribution of power, control, and responsibility
C. *Emotional climate-tone* and range of feelings; quality of caring, empathy, involvement, and attachment/commitment; sharing of values; mutual affective responsiveness, respect, and regard; quality of sexual functioning

In most instances, the GARF Scale should be used to rate functioning during the current period (i.e., the level of relational functioning at the time of the evaluation). In some settings, the GARF Scale may also be used to rate functioning for other time periods (i.e., the highest level of relational functioning for at least a few months during the past year).

Note: Use specific, intermediate codes when possible, for example, 45, 68, 72. If detailed information is not adequate to make specific ratings, use midpoints of the five ranges, that is, 90, 70, 50, 30, or 10.

81-100 ***Overall·*** *Relational unit is functioning satisfactorily from self-report of participants and from perspectives of observers.*

Agreed-on patterns or routines exist that help meet the usual needs of each family/couple member; there is flexibility for change in response to unusual demands or events; and occasional conflicts and stressful transitions are resolved through problem-solving communication and negotiation.

There is a shared understanding and agreement about roles and appropriate tasks, decision making is established for each functional area, and there is recognition of the unique characteristics and merit of each subsystem (e.g., parents/spouses, siblings, and individuals).

There is a situationally appropriate, optimistic atmosphere in the family; a wide range of feelings is freely expressed and managed within the family; and there is a general atmosphere of warmth, caring, and sharing of values among all family members. Sexual relations of adult members are satisfactory.

61--80 ***Overall·*** *Functioning of relational unit is somewhat unsatisfactory. Over a period of time, many but not all difficulties are resolved without complaints.*

Daily routines are present but there is some pain and difficulty in responding to the unusual. Some conflicts remain unresolved, but do not disrupt family functioning.

Decision making is usually competent, but efforts at control of one another quite often are greater than necessary or are ineffective. Individuals and relationships are clearly demarcated but sometimes a specific subsystem is depreciated or scapegoated.

A range of feeling is expressed, but instances of emotional blocking or tension are evident. Warmth and caring are present but are marred by a family member's irritability and frustrations. Sexual activity of adult members may be reduced or problematic.

41-60 ***Overall:*** *Relational unit has occasional times of satiefying and competent functioning together, but clearly dysfunctional, unsatisfying relationships tend to predominate.*

Communication is frequently inhibited by unresolved conflicts that often interfere with daily routines; there is significant difficulty in adapting to family stress and transitional change.

Decision making is only intermittently competent and effective; either excessive rigidity or significant lack of structure is evident at these times. Individual needs are quite often submerged by a partner or coalition.

Pain or ineffective anger or emotional deadness interfere with family enjoyment. Although there is some warmth and support for members, it is usually unequally distributed. Troublesome sexual difficulties between adults are often present.

21-40 ***Overall·*** *Relational unit is obviously and seriously dyefunctional; forms and time periods of satiefactory relating are rare.*

Family/couple routines do not meet the needs of members; they are grimly adhered to or blithely ignored. Life cycle changes, such as departures or entries into the relational unit, generate painful conflict and obviously frustrating failures of problem solving.

Decision making is tyrannical or quite ineffective. The unique characteristics of individuals are unappreciated or ignored by either rigid or confusingly fluid coalitions.

There are infrequent periods of enjoyment of life together; frequent distancing or open hostility reflect significant conflicts that remain unresolved and quite painful. Sexual dysfunction among adult members is commonplace.

1-20 ***Overall:*** *Relational unit has become too dy"'functional to retain continuizy of contact and attachment.*

Family/couple routines are negligible (e.g., no mealtime, sleeping, or waking schedule); family members often do not know where others are or when they will be in or out; there is a little effective communication among family members.

Family/couple members are not organized in such a way that personal or generational responsibilities are recognized. Boundaries of relational unit as a whole and subsystems cannot be identified or agreed on. Family members are physically endangered or injured or sexually attacked.

Despair and cynicism are pervasive; there is little attention to the emotional needs of others; there is almost no sense of attachment, commitment, or concern about one another's welfare.

0 Inadequate information.

Social and Occupational Functioning Assessment Scale (SOFAS)

The SOFAS is a new scale that differs from the Global Assessment of Functioning (GAF) Scale in that it focuses exclusively on the individual's level of social and occupational functioning and is not directly influenced by the overall severity of the individual's psychological symptoms. Also in contrast to the GAF Scale, any impairment in social and occupational functioning that is due to general medical conditions is considered in making the SOFAS rating. The SOFAS is usually used to rate functioning for the current period (i.e., the level of functioning at the time of the evaluation). The SOFAS may also be used to rate functioning for other time periods. For example, for some purposes it may be useful to evaluate functioning for the past year (i.e., the highest level of functioning for at least a few months during the past year).

Social and Occupational Functioning Assessment Scale (SOFAS)

Consider social and occupational functioning on a continuum from excellent functioning to grossly impaired functioning. Include impairments in functioning due to physical limitations, as well as those due to mental impairments. To be counted, impairment must be a direct consequence of mental and physical health problems; the effects of lack of opportunity and other environmental limitations are not to be considered.

Code (Note: Use intermediate codes when appropriate, e.g., 45, 68, 72.)

100 Superior functioning in a wide range of activities.
91

90 Good functioning in all areas, occupationally and socially effective.
81

80 No more than a slight impairment in social, occupational, or school functioning (e.g., infrequent interpersonal conflict, temporarily falling behind in schoolwork).
71

70 Some difficulty in social, occupational, or school functioning, but generally functioning well, has some meaningful interpersonal relationships.
61

60 Moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).
51

'iO Serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).
41

40 Major impairment in several areas, such as work or school, family relations (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children,
31 is defiant at home, and is failing at school).

30 Inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).
21

20 Occasionally fails to maintain minimal personal hygiene; unable to function independently.
11

10 Persistent inability to maintain minimal personal hygiene. Unable to function without harming self or others or without considerable external support (e.g., nursing care and supervision).

0 Inadequate information.

Note: 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], Spitzer RL, FleissJL, et al.: "The Global Assessment Scale: A Procedure for Measuring Overall Severity of Psychiatric Disturbance." *Archives of General Aychiatry* 33:766-771, 1976). The SOFAS is derived from the GAS and its development is described in Goldman HH, Skodol AE, Lave TR: "Revising Axis V for DSM-IV: A Review of Measures of Social Functioning." *American Journal of Psychiatry* 149:1148-1156, 1992.

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Appendix C

Glossary of Technical Terms

affect A pattern of observable behaviors that is the expression of a subjectively experienced feeling state (emotion). Common examples of affect are sadness, elation, and anger. In contrast to *mood,* which refers to a more pervasive and sustained emotional "climate," *affect* refers to more fluctuating changes in emotional "weather." What is considered the normal range of the expression of affect varies considerably, both within and among different cultures. Disturbances in affect include

blunted Significant reduction in the intensity of emotional expression.
flat Absence or near absence of any signs of affective expression.
inappropriate Discordance between affective expression and the content of speech or ideation.
labile Abnormal variability in affect with repeated, rapid, and abrupt shifts in affective expression.
restricted or constricted Mild reduction in the range and intensity of emotional expression.

agitation(psychomotor agitation) Excessive motor activity associated with a feeling of inner tension. The activity is usually nonproductive and repetitious and consists of such behavior as pacing, fidgeting, wringing of the hands, pulling of clothes, and inability to sit still.

agonistmedication A chemical entity extrinsic to endogenously produced substances that acts on a receptor and is capable of producing the maximal effect that can be produced by stimulating that receptor. A **partial agonist** is capable only of producing less than the maximal effect even when given in a concentration sufficient to bind with all available receptors.

agonist/antagonist medication A chemical entity extrinsic to endogenously produced substances that acts on a family of receptors (such as mu, delta, and kappa opiate

Glossary definitions were informed by the following sources: DSM-Ill; DSM-III-R; *American Psychiatric Glossary,* 6th Edition; *Penguin Dictionary of Psychology;* Campbell's *Psychiatric Dictionary,* 6th Edition; *Stedman'.s Medical Dictionary,* 19th Edition; *Dorland'.s Illustrated Medical Dictionary,* 25th Edition; and *Webster'. 7bird New International Dictionary.*

receptors) in such a fashion that it is an agonist or partial agonist on one type of receptor and an antagonist on another.

alogia An impoverishment in thinking that is inferred from observing speech and language behavior. There may be brief and concrete replies to questions and restriction in the amount of spontaneous speech *(poverty of speech).* Sometimes the speech is adequate in amount but conveys little information because it is overconcrete, over- abstract, repetitive, or stereotyped *(poverty of content).*

amnesia Loss of memory. Types of amnesia include

anterograde Loss of memory of events that occur after the onset of the etiological condition or agent.
retrograde Loss of memory of events that occurred before the onset of the etiological condition or agent.

antagonist medication A chemical entity extrinsic to endogenously produced substances that occupies a receptor, produces no physiologic effects, and prevents endogenous and exogenous chemicals from producing an effect on that receptor.

anxiety The apprehensive anticipation of future danger or misfortune accompanied by a feeling of dysphoria or somatic symptoms of tension. The focus of anticipated danger may be internal or external.

aphasia An impairment in the understanding or transmission of ideas by language in any of its forms-reading, writing, or speaking-that is due to injury or disease of the brain centers involved in language.

aphonia An inability to produce speech sounds that require the use of the larynx that is not due to a lesion in the central nervous system.

ataxia Partial or complete loss of coordination of voluntary muscular movement.

attention The ability to focus in a sustained manner on a particular stimulus or activity. A disturbance in attention may be manifested by easy distractibility or difficulty in finishing tasks or in concentrating on work

avolition An inability to initiate and persist in goal-directed activities. When severe enough to be considered pathological, avolition is pervasive and prevents the person from completing many different types of activities (e.g., work, intellectual pursuits, self-care).

catalepsy Waxy flexibility-rigid maintenance of a body position over an extended period of time.

cataplexy Episodes of sudden bilateral loss of muscle tone resulting in the individual collapsing, often in association with intense emotions such as laughter, anger, fear, or surprise.

catatonic behavior Marked motor abnormalities including *motoric immobility* (i.e., catalepsy or stupor), certain types of *excessive motor activity* (apparently purposeless agitation not influenced by external stimuli), *extreme negativism* (apparent motiveless

resistance to instructions or attempts to be moved) or *mutism, posturing* or *stereotyped movements,* and *echolalia* or *echopraxia.*

conversion symptom A loss of, or alteration in, voluntaty motor or sensoty function- ing suggesting a neurological or general medical condition. Psychological factors are judged to be associated with the development of the symptom, and the symptom is not fully explained by a neurological or general medical condition or the direct effects of a substance. The symptom is not intentionally produced or feigned and is not culturally sanctioned.

defense mechanism Automatic psychological process that protects the individual against anxiety and from awareness of internal or external stressors or dangers. Defense mechanisms mediate the individual's reaction to emotional conflicts and to external stressors. Some defense mechanisms (e.g., projection, splitting, and acting out) are almost invariably maladaptive. Others, such as suppression and denial, may be either maladaptive or adaptive, depending on their severity, their inflexibility, and the context in which they occur. Definitions of specific defense mechanisms and how they would be recorded using the Defensive Functioning Scale are presented on p. 751.

delusion A false belief based on incorrect inference about external reality that is firmly sustained despite what almost eveiyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contraty. The belief is not one ordinarily accepted by other members of the person's culture or subculture (e.g., it is not an article of religious faith). When a false belief involves a value judgment, it is regarded as a delusion only when the judgment is so extreme as to defy credibility. Delusional conviction occurs on a continuum and can sometimes be inferred from an individual's behavior. It is often difficult to distinguish between a delusion and an overvalued idea (in which case the individual has an unreasonable belief or idea but does not hold it as firmly as is the case with a delusion).

Delusions are subdivided according to their content. Some of the more common types are listed below:

bizarre A delusion that involves a phenomenon that the person's culture would regard as totally implausible.

delusional jealousy The delusion that one's sexual partner is unfaithful.

erotomanic A delusion that another person, usually of higher status, is in love with the individual.

grandiose A delusion of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person.

mood-congruent *See* mood-congruent psychotic features.

mood-incongruent *See* mood-incongruent psychotic features.

of being controlled A delusion in which feelings, impulses, thoughts, or actions are experienced as being under the control of some external force rather than being under one's own control.

of reference A delusion whose theme is that events, objects, or other persons in one's immediate environment have a particular and unusual significance. These delusions are usually of a negative or pejorative nature, but also may be grandiose in content. This differs from an *idea of reference,* in which the false belief is not as firmly held nor as fully organized into a true belief.

persecutory A delusion in which the central theme is that one (or someone to

whom one is close) is being attacked, harassed, cheated, persecuted, or conspired against.
somatic A delusion whose main content pertains to the appearance or functioning of one's body.
thought broadcasting The delusion that one's thoughts are being broadcast out loud so that they can be perceived by others.
thought insertion The delusion that certain of one's thoughts are not one's own, but rather are inserted into one's mind.

depersonalization An alteration in the perception or experience of the self so that one feels detached from, and as if one is an outside observer of, one's mental processes or body (e.g., feeling like one is in a dream).

derailment("loosening of associations") A pattern of speech in which a person's ideas slip off one track onto another that is completely unrelated or only obliquely related. In moving from one sentence or clause to another, the person shifts the topic idiosyncratically from one frame of reference to another and things may be said in juxtaposition that lack a meaningful relationship. This disturbance occurs *between* clauses, in contrast to incoherence, in which the disturbance is *within* clauses. An occasional change of topic without warning or obvious connection does not constitute derailment.

derealization An alteration in the perception or experience of the external world so that it seems strange or unreal (e.g., people may seem unfamiliar or mechanical).

disorientation Confusion about the time of day, date, or season (time), where one is (place), or who one is (person).

dissociation A disruption in the usually integrated functions of consciousness, mem- ory, identity, or perception of the environment. The disturbance may be sudden or gradual, transient or chronic.

distractibility The inability to maintain attention, that is, the shifting from one area or topic to another with minimal provocation, or attention being drawn too frequently to unimportant or irrelevant external stimuli.

dysarthria Imperfect articulation of speech due to disturbances of muscular control.

dyskinesia Distortion of voluntary movements with involuntary muscular activity.

dyssomnia Primary disorders of sleep or wakefulness characterized by insomnia or hypersomnia as the major presenting symptom. Dyssomnias are disorders of the amount, quality, or timing of sleep.

dystonia Disordered tonicity of muscles.

echolalia The pathological, parrotlike, and apparently senseless repetition (echoing) of a word or phrase just spoken by another person.

echopraxia Repetition by imitation of the movements of another. The action is not a willed or voluntary one and has a semiautomatic and uncontrollable quality.

flashback A recurrence of a memory, feeling, or perceptual experience from the past.

flight of ideas A nearly continuous flow of accelerated speech with abrupt changes from topic to topic that are usually based on understandable associations, distracting stimuli, or plays on words. When severe, speech may be disorganized and incoherent.

gender dysphoria A persistent aversion toward some or all of those physical characteristics or social roles that connote one's own biological sex.

gender identity A person's inner conviction of being male or female.

gender role Attitudes, patterns of behavior, and personality attributes defined by the culture in which the person lives as stereotypically "masculine" or "feminine" social roles.

grandiosity An inflated appraisal of one's worth, power, knowledge, importance, or identity. When extreme, grandiosity may be of delusional proportions.

hallucination A sensory perception that has the compelling sense of reality of a true perception but that occurs without external stimulation of the relevant sensory organ. Hallucinations should be distinguished from *illusions,* in which an actual external stimulus is misperceived or misinterpreted. The person may or may not have insight into the fact that he or she is having a hallucination. One person with auditory hallucinations may recognize that he or she is having a false sensory experience, whereas another may be convinced that the source of the sensory experience has an independent physical reality. The term *hallucination* is not ordinarily applied to the false perceptions that occur during dreaming, while falling asleep *(hypnagogic),* or when awakening *(hypno- pompic).* Transient hallucinatory experiences may occur in people without a mental disorder.

Types of hallucinations include

auditory A hallucination involving the perception of sound, most commonly of voices. Some clinicians and investigators would not include those experiences perceived as coming from inside the head and would instead limit the concept of true auditory hallucinations to those sounds whose source is perceived as being external. However, as used in DSM-IV, no distinction is made as to whether the source of the voices is perceived as being inside or outside of the head.

gustatory A hallucination involving the perception of taste (usually unpleasant).

mood-congruent *See* mood-congruent psychotic features.

mood-incongruent *See* mood-incongruent psychotic features.

olfactory A hallucination involving the perception of odor, such as of burning mbber or decaying fish.

somatic A hallucination involving the perception of a physical experience local- ized within the body (such as a feeling of electricity). A somatic hallucination is to be distinguished from physical sensations arising from an as-yet undiagnosed general medical condition, from hypochondriacal preoccupation with normal physical sensations, and from a tactile hallucination.

tactile A hallucination involving the perception of being touched or of something being under one's skin. The most common tactile hallucinations are the sensation of electric shocks and *formication* (the sensation of something creeping or crawling on or under the skin).

visual A hallucination involving sight, which may consist of formed images, such as of people, or of unformed images, such as flashes of light. Visual hallucinations should be distinguished from illusions, which are misperceptions of real external stimuli.

hyperacusis Painful sensitivity to sounds.

hypersomnia Excessive sleepiness, as evidenced by prolonged nocturnal sleep, difficulty maintaining an alert awake state during the day, or undesired daytime sleep episodes.

ideas of reference The feeling that casual incidents and external events have a particular and unusual meaning that is specific to the person. This is to be distinguished from a *delusion of reference,* in which there is a belief that is held with delusional conviction.

illusion A misperception or misinterpretation of a real external stimulus, such as hearing the rustling of leaves as the sound of voices. *See also* hallucination.

incoherence Speech or thinking that is essentially incomprehensible to others because words or phrases are joined together without a logical or meaningful connec- tion. This disturbance occurs *within* clauses, in contrast to derailment, in which the disturbance is *between* clauses. This has sometimes been referred to as "word salad" to convey the degree of linguistic disorganization. Mildly ungrammatical constructions or idiomatic usages characteristic of particular regional or cultural backgrounds, lack of education, or low intelligence should not be considered incoherence. The term is generally not applied when there is evidence that the disturbance in speech is due to an aphasia.

insomnia A subjective complaint of difficulty falling or staying asleep or poor sleep quality. Types of insomnia include

initial insomnia Difficulty in falling asleep.
middle insomnia Awakening in the middle of the night followed by eventually falling back to sleep, but with difficulty.
terminal insomnia Awakening before one's usual waking time and being unable to return to sleep.

intersexcondition A condition in which an individual shows intermingling, in various degrees, of the characteristics of each sex, including physical form, reproductive organs, and sexual behavior.

macropsia The visual perception that objects are larger than they actually are.

magical thinking The erroneous belief that one's thoughts, words, or actions will cause or prevent a specific outcome in some way that defies commonly understood laws of cause and effect. Magical thinking may be a part of normal child development.

micropsia The visual perception that objects are smaller than they actually are.

mood A pervasive and sustained emotion that colors the perception of the world. Common examples of mood include depression, elation, anger, and anxiety. In contrast to *affect,* which refers to more fluctuating changes in emotional "weather," mood refers to a more pervasive and sustained emotional "climate."

Types of mood include

dysphoric An unpleasant mood, such as sadness, anxiety, or irritability.
elevated An exaggerated feeling of well-being, or euphoria or elation. A person

with elevated mood may describe feeling "high," "ecstatic," "on top of the world," or "up in the clouds."
euthymic Mood in the "normal" range, which implies the absence of depressed or elevated mood.
expansive Lack of restraint in expressing one's feelings, frequently with an overvaluation of one's significance or importance.
irritable Easily annoyed and provoked to anger.

mood-congruent psychotic features Delusions or hallucinations whose content is entirely consistent with the typical themes of a depressed or manic mood. If the mood is depressed, the content of the delusions or hallucinations would involve themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment. The content of the delusion may include themes of persecution if these are based on self-derogatory concepts such as deserved punishment. If the mood is manic, the content of the delusions or hallucinations would involve themes of inflated worth, power, knowledge, or identity, or a special relationship to a deity or a famous person. The content of the delusion may include themes of persecution if these are based on concepts such as inflated worth or deserved punishment.

mood-incongruent psychotic features Delusions or hallucinations whose content is not consistent with the typical themes of a depressed or manic mood. In the case of depression, the delusions or hallucinations would not involve themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment. In the case of mania, the delusions or hallucinations would not involve themes of inflated worth, power, knowledge, or identity, or a special relationship to a deity or a famous person. Examples of mood-incongruent psychotic features include persecutory delusions (without self-derogatory or grandiose content), thought insertion, thought broadcasting, and delusions of being controlled whose content has no apparent relationship to any of the themes listed above.

nystagmus Involuntary rhythmic movements of the eyes that consist of small- amplitude rapid tremors in one direction and a larger, slower, recurrent sweep in the opposite direction. Nystagmus may be horizontal, vertical, or rotary.

overvalued idea An unreasonable and sustained belief that is maintained with less than delusional intensity (i.e., the person is able to acknowledge the possibility that the belief may not be true). The belief is not one that is ordinarily accepted by other members of the person's culture or subculture.

panic attacks Discrete periods of sudden onset of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom. During these attacks there are symptoms such as shortness of breath or smothering sensations; palpitations, pounding heart, or accelerated heart rate; chest pain or discomfort; choking; and fear of going crazy or losing control. Panic attacks may be **unexpected** (uncued), in which the onset of the attack is not associated with a situational trigger and instead occurs "out of the blue"; **situationally bound,** in which the panic attack almost invariably occurs immediately on exposure to, or in anticipation of, a situational trigger ("cue"); and **situationally predisposed,** in which the panic attack is more likely to occur on exposure to a situational trigger but is not invariably associated with it.

paranoid ideation Ideation, of less than delusional proportions, involving suspiciousness or the belief that one is being harassed, persecuted, or unfairly treated.

parasomnia Abnormal behavior or physiological events occurring during sleep or sleep-wake transitions.

personality Enduring patterns of perce1vmg, relating to, and thinking about the environment and oneself. *Personality traits* are prominent aspects of personality that are exhibited in a wide range of important social and personal contexts. Only when personality traits are inflexible and maladaptive and cause either significant functional impairment or subjective distress do they constitute a Personality Disorder.

phobia A persistent, irrational fear of a specific object, activity, or situation (the phobic stimulus) that results in a compelling desire to avoid it. This often leads either to avoidance of the phobic stimulus or to enduring it with dread.

pressured speech Speech that is increased in amount, accelerated, and difficult or impossible to interrupt. Usually it is also loud and emphatic. Frequently the person talks without any social stimulation and may continue to talk even though no one is listening.

prodrome An early or premonitory sign or symptom of a disorder.

psychomotor agitation *See* agitation.

psychomotor retardation Visible generalized slowing of movements and speech.

psychotic This term 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 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. Based on their characteristic features, the different disorders in DSM-IV emphasize different aspects of the various definitions of *psychotic.*

residual phase The phase of an illness that occurs after remission of the florid symptoms or the full syndrome.

sex A person's biological status as male, female, or uncertain. Depending on the circumstances, this determination may be based on the appearance of the external genitalia or on karyotyping.

sign An objective manifestation of a pathological condition. Signs are observed by the examiner rather than reported by the affected individual.

stereotyped movements 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 body orifices, hitting one's own body).

stressor, psychosocial Any life event or life change that may be associated temporally (and perhaps causally) with the onset, occurrence, or exacerbation of a mental disorder.

stupor A state of unresponsiveness with immobility and mutism.

symptom A subjective manifestation of a pathological condition. Symptoms are reported by the affected individual rather than observed by the examiner.

syndrome A grouping of signs and symptoms, based on their frequent co-occurrence, that may suggest a common underlying pathogenesis, course, familial pattern, or treatment selection.

synesthesia A condition in which a sensory experience associated with one modality occurs when another modality is stimulated, for example, a sound produces the sensation of a particular color.

tic An involuntary, sudden, rapid, recurrent, nonrhythmic, stereotyped motor move- ment or vocalization.

transsexualism Severe gender dysphoria, coupled with a persistent desire for the physical characteristics and social roles that connote the opposite biological sex.

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Appendix D

Annotated Listing of Changes in DSM IV

This appendix outlines the major changes from DSM-III-R that have been included in the DSM-IV terms and categories. The disorders listed are in the order in which they appear in the DSM-IV Classification. The annotation includes lists of those diagnoses that have been introduced into DSM-IV and those DSM-III-R diagnoses that have been deleted or subsumed into other DSM-IV categories. Please refer to "Use of the Manual" for an explanation of the conventions, text sections, and organizational plan used in DSM-IV.

Multiaxial system. Pervasive Developmental Disorders, Learning Disorders, Motor Skills Disorder, and Communication Disorders (which were coded on Axis II in DSM-III-R) are all coded on Axis I in DSM-IV. For DSM-IV, only Personality Disorders and Mental Retardation remain coded on Axis II. Axis III continues to be used for coding general medical conditions. (Appendix G, which lists selected general medical conditions with their ICD-9-CM codes, has been introduced into DSM-IV.) In DSM-IV, Axis IV is used for reporting psychosocial and environmental problems; in contrast, DSM-III-R Axis IV provided a rating scale for severity of stressors. Axis V (the Global Assessment of Functioning Scale) is essentially the same as in DSM-III-R, except that the scale extends over 100 points to include the highest level of functioning. Optional scales (for social and occupational functioning apart from symptomatology, for relational functioning, and for defense mechanisms) are included in Appendix B, on p. 751.

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

Mental Retardation. The criteria have been modified to be more compatible with the American Association of Mental Retardation definition.

Learning Disorders. The name has been changed from the DSM-III-R Academic Skills Disorders to reflect common clinical usage. The exclusion criterion (Criterion C)

has been modified to allow a diagnosis of Learning Disorder in the presence of a sensory deficit so long as the learning difficulties are in excess of those usually associated with the sensory deficit. In addition, the DSM-III-R exclusion criterion has been modified to allow the diagnosis of a Learning Disorder in the presence of a general medical (neurological) condition. In contrast to DSM-III-R, Learning Disorders are coded on Axis I in DSM-IV.

Communication Disorders. This section brings together under one heading all of the speech and language disorders that in DSM-III-R were listed in two separate sections-the Specific Developmental Disorders and Speech Disorders Not Elsewhere Classified.

Expressive Language Disorder. This diagnosis is no longer excluded in the pres- ence of a speech-motor deficit, a sensory deficit, or environmental deprivation so long as the language difficulties are in excess of those usually associated with these problems. In contrast to DSM-III-R, Expressive Language Disorder is coded on Axis I in DSM-IV.

Mixed Receptive-Expressive Language Disorder. This diagnosis replaces DSM-III-R Developmental Receptive Language Disorder in recognition of the fact that receptive language problems do not occur in isolation without accompanying expressive language problems. This diagnosis is no longer excluded in the presence of a speech-motor deficit, sensory deficit, or environmental deprivation so long as the language difficulties are in excess of those usually associated with these problems. In contrast to DSM-III-R, Mixed Receptive-Expressive Language Disorder is coded on Axis I in DSM-IV.

Phonological Disorder. The name has been changed from DSM-III-R Developmen- tal Articulation Disorder to conform to current terminology. This diagnosis is no longer excluded in the presence of a speech-motor deficit, sensory deficit, or environmental deprivation so long as the language difficulties are in excess of those usually associated with these problems. In contrast to DSM-III-R, Phonological Disorder is coded on Axis I in DSM-IV.

Stuttering. The DSM-III-R criteria set consisted of a one-sentence definition. An expanded and more specific criteria set has been added.

Pervasive Developmental Disorders. In contrast to DSM-III-R, Pervasive Develop- mental Disorders are coded on Axis I in DSM-IV.

Autistic Disorder. The DSM-III-R defining features (impaired social interaction, communication, and stereotyped patterns of behavior) are retained in DSM-IV, but the individual items and the overall diagnostic algorithm have been modified to 1) improve clinical utility by reducing the number of items from 16 to 12 and by increasing the clarity of individual items; 2) increase compatibility with the ICD-10 Diagnostic Criteria for Research; and 3) narrow the definition of caseness so that it conforms more closely with clinical judgment, DSM-III, and ICD-10. In addition, an "age at onset" requirement (before age 3 years in DSM-IV), which had been dropped in DSM-III-R, has been reinstated to conform to clinical usage and to increase the homogeneity of this category.

Rett's Disorder, Childhood Disintegrative Disorder, and Asperger's Disorder. These three disorders have been included to improve differential diagnosis and to provide greater specificity in describing those individuals who would have been diagnosed with either Autistic Disorder or Pervasive Developmental Disorder Not Otherwise Specified in DSM-III-R.

Attention-Deficit/HyperactivityDisorder. This integrates into one overarching category what were two categories in DSM-III-R: Attention-Deficit Hyperactivity Disorder and Undifferentiated Attention-Deficit Disorder (without hyperactivity). Literature reviews, data reanalysis, and results from the field trials suggest that this disorder is best viewed as a unitary disorder with different predominating symptom patterns. DSM-IV provides one criteria set with three subtypes (Combined Type, Predominantly Inattentive Type, Predominantly Hyperactive-Impulsive Type) that allow the clinician to note the predominance of either attention-deficit symptoms or hyperactivity-impulsivity symptoms. Criterion A organizes the items into three groupings: inattention, hyperactivity, and impulsivity. Criterion C, which requires the presence of symptoms in two or more situations (e.g., at school, work, and home), has been added to reduce false-positive diagnoses.

Conduct Disorder. The DSM-III-R item list was modified and expanded (by adding two items: "staying out at night" and "intimidating others"). This modification is based on the field-trial results and provides a definition that includes behaviors characteristic of females with Conduct Disorder. In addition, the items are organized into thematically related groups (aggression to people and animals, destruction of property, deceitfulness or theft, serious violations of rules) to facilitate their use. New subtypes based on age at onset have been provided in DSM-IV to reflect that earlier age at onset has a worse prognosis and is more likely to be associated with aggressive behavior and with adult Antisocial Personality Disorder.

Oppositional Defiant Disorder. Based on field-trial results, one item was deleted from Criterion A ("uses obscene language"). In addition, an impairment criterion was added to help demarcate the boundary with normality.

Feeding and Eating Disorders of Infancy or Early Childhood. The name of this category has been changed to reflect the placement of Anorexia Nervosa and Bulimia Nervosa in a separate Eating Disorders section.

Pica. The DSM-111-R criterion excluding this disorder in the presence of Schizophrenia or a Pervasive Developmental Disorder has been changed to allow the diagnosis in the presence of another mental disorder if the behavior is sufficiently severe to warrant independent clinical attention.

Rumination Disorder. The criterion requiring weight loss or failure to make ex- pected weight gain was omitted because clinically significant impairment can be present in the absence of these features and to clarify the boundary with Feeding Disorder of Infancy or Early Childhood.

Feeding Disorder of Infancy or Early Childhood. This new category was added to provide diagnostic coverage for infants and children who fail to eat adequately and who have attendant problems in gaining or maintaining weight.

Tic Disorders. The upper limit of age at onset has been reduced from age 21 years to age 18 years for compatibility with the ICD-10 Diagnostic Criteria for Research. A criterion that specifies that the tics cause clinically significant impairment or distress has also been added.

Encopresis. The duration requirement has been reduced from 6 months to 3 months to reflect clinical usage and to allow for earlier case finding. The disorder is now coded based on whether or not constipation with overflow incontinence is present.

Enuresis (Not Due to a General Medical Condition). The specified frequency and duration threshold has been raised (from twice a month to twice a week for 3 consecutive months) in an effort to reduce false-positive diagnoses. In an effo1t to avoid false-negative diagnoses, Criterion B also notes that the diagnosis can be made below these thresholds if there is clinically significant impairment or distress.

Separation Anxiety Disorder. Two DSM-III-R items (8 and 9) have been combined to reduce redundancy. The duration requirement has been increased to 4 weeks for compatibility with ICD-10 Diagnostic Criteria for Research.

Selective Mutism. Several provisions have been added to reduce false-positive identification: a duration criterion of 1 month, the exclusion of children who are quiet only during the first month of school, a criterion requiring clinically significant impair- ment, and a criterion requiring that the lack of speech is not better accounted for by a Communication Disorder or by lack of knowledge of the spoken language required in a social situation. In addition, the name has been changed from DSM-III-R Elective Mutism, which was less descriptive and implied motivation.

Reactive Attachment Disorder of Infancy or Early Childhood. Subtypes that designate inhibited type versus disinhibited type have been added to allow compatibility with ICD-10 (which divides this condition into two separate disorders).

Stereotypic Movement Disorder. The name has been changed from the DSM-III-R Stereotypy/Habit Disorder for compatibility with ICD-10. Unlike DSM-III-R, DSM-IV specifies that diagnoses of both Mental Retardation and Stereotypic Movement Disorder are only made if the stereotypic or self-injurious behavior is severe enough to become a focus of treatment. In addition, With Self-Injurious Behavior is available as a specifier.

Delirium, Dementia, and Amnestic and Other Cognitive Disorders

In DSM-III-R, these disorders were included in the Organic Mental Disorders section. The term "organic mental disorders" has been eliminated from DSM-IV because it implies that the other disorders in the manual do not have an "organic" component.

Delirium. To assist in differential diagnosis, this section includes Delirium Due to a General Medical Condition and Substance-Induced Delirium, which were listed separately in DSM-III-R, and adds a new category-Delirium Due to Multiple Etiologies. Several of the DSM-III-R criteria (reduced level of consciousness, sleep disturbance, psychomotor changes) were dropped because they often have other causes or are difficult to evaluate, particularly in a general medical/surgical population. Moreover, disorganized thinking is no longer a required criterion because it cannot be assessed in individuals who are mute.

Dementia. As in DSM-III-R, this subsection includes Dementia of the Alzheimer's Type and Vascular Dementia (which was called Multi-Infarct Dementia in DSM-III-R), but it also includes a specific listing of a variety of dementias due to general medical and neurological conditions, Substance-Induced Persisting Dementia, and Dementia Due to Multiple Etiologies. This organization is provided to assist in differential diagnosis. The definition of dementia has been reorganized and simplified to clarify that dementia is characterized by multiple cognitive deficits that must include memory impairment. Personality change, which was a diagnostic feature in DSM-III-R, has been moved to the "Associated Features and Disorders" section of the DSM-IV text because of its relative lack of specificity for dementia.

Amnestic Disorders. This section includes Amnestic Disorder Due to a General Medical Condition and Substance-Induced Persisting Amnestic Disorder, which were listed separately in DSM-III-R. This organization is provided to assist in differential diagnosis. The definition of an amnestic disorder has been simplified and the description of its essential feature (development of memory impairment) has been sharpened.

Mental Disorders Due to a General Medical Condition Not Elsewhere Classified

Catatonic Disorder Due to a General Medical Condition. This category is included because it is a frequent explanation for catatonic symptoms and is important in their differential diagnosis.

Personality Change Due to a General Medical Condition. For this disorder, called Organic Personality Disorder in DSM-III-R, subtypes including Labile, Disinhibited, Aggressive, Apathetic, and Paranoid have been added.

Substance--Related Disorders

In DSM-III-R, these disorders were located in two different sections: Psychoactive Substance Use Disorders (i.e., Dependence and Abuse) and Psychoactive Substance-Induced Organic Mental Disorders. For convenience of use, Substance Use Disorders and Substance-Induced Disorders are now contained in a single "Substance-Related Disorders" section.

Substance Dependence. The nine items included in DSM-III-R have been reduced to seven; two items tapping withdrawal in DSM-III-R have been combined and DSM-III-R Criterion 4 (i.e., failure to fulfill major role obligations) has been moved to the abuse

criteria set to sharpen the distinction between Dependence and Abuse. Subtyping for physiological dependence has been provided to allow the clinician to note the presence of tolerance or withdrawal. The duration criterion was dropped for two reasons: 1) it is redundant given that the individual items require a clinically significant duration to be counted as present; and 2) a clustering criterion has been added to DSM-IV that specifies that at least three items be present during the same 12-month period. The course specifiers have been expanded and made more specific to take into account differences between early and sustained remission, partial and full remission, and whether the remission occurred while the individual was on agonist therapy or in a controlled environment.

Substance Abuse. In DSM-III-R, Substance Abuse was a residual category without a clear conceptual framework. In DSM-IV, Substance Abuse is conceptualized as a maladaptive pattern of substance use leading to adverse consequences that occurs in the absence of Substance Dependence. The item list has been expanded from two to four items by adding "failure to fulfill major role obligations" and "recurrent substance-related legal problems."

Substance Intoxication. The general definition of intoxication has not been changed, but some of the substance-specific intoxication criteria sets have been refined. The criteria sets for Amphetamine Intoxication and Cocaine Intoxication are now equivalent.

Alcohol Idiosyncratic Intoxication. This has been omitted as a separate category because of lack of supporting evidence that it is distinct from Alcohol Intoxication.

Substance Withdrawal. The general definition of withdrawal has not been changed, but some of the substance-specific withdrawal criteria sets have been refined. The criteria sets for Alcohol Withdrawal and Sedative, Hypnotic, or Anxiolytic Withdrawal are now equivalent.

Table of Substance-Induced Disorders. DSM-III-R contained a table indicating the association between particular classes of substances and particular substance-induced syndromal presentations. Based on evidence supporting the existence and clinical relevance of some additional combinations, this table has been expanded in DSM-IV. The new categories include 1) for Alcohol-Mood, Anxiety, and Sleep Disorders and Sexual Dysfunction; 2) for Amphetamine-Mood, Anxiety, and Sleep Disorders and Sexual Dysfunction; 3) for Caffeine-Anxiety and Sleep Disorders; 4) for Cannabis- Delirium and Anxiety Disorder; 5) for Cocaine-Mood, Anxiety, and Sleep Disorders and Sexual Dysfunction; 6) for Hallucinogens-Delirium and Anxiety Disorder; 7) for Inhalants-Delirium, Persisting Dementia, and Psychotic, Mood, and Anxiety Disorders;
8) for Opioids-Delirium and Psychotic, Mood, and Sleep Disorders, and Sexual Dysfunction; 9) for Phencyclidine-Anxiety Disorder; 10) for Sedatives, Hypnotics, or Anxiolytics-Persisting Dementia, Psychotic, Mood, Anxiety, and Sleep Disorders, and Sexual Dysfunction. Specifiers are also provided to indicate whether the symptoms had their onset during intoxication or withdrawal.

Schizophrenia and Other Psychotic Disorders

This section brings together the contents of three sections in DSM-III-R: Schizophrenia, Delusional Disorder, and Psychotic Disorder Not Elsewhere Classified.

Schizophrenia. DSM-IV increases the required duration of the active-phase symp- toms from DSM-III-R's 1 week to 1 month to reduce false-positive diagnoses and to increase compatibility with ICD-10 Diagnostic Criteria for Research. The presentation of characteristic symptoms in Criterion A has been simplified. Additional negative symptoms (alogia and avolition) have been included in Criterion A. The definition of prodromal and residual phases has been simplified by eliminating the list of specific symptoms. New course specifiers have been adapted from ICD-10.

Schizoaffective Disorder. The criteria set has been changed to focus on an uninterrupted episode of illness rather than on the lifetime pattern of symptoms.

Brief Psychotic Disorder. The DSM-III-R construct of Brief Reactive Psychosis has been broadened by eliminating the requirement for a severe stressor (although this can be indicated by the subtype With Marked Stressor). The resulting category now includes all psychotic disturbances lasting less than 1 month that are not attributable to a mood disorder and are not due to the direct physiological effects of substance use or a general medical condition. In addition, the minimum duration of the psychotic symptoms has been increased from a few hours to 1 day.

Psychotic Disorder Due to a General Medical Condition. The DSM-III-R terms Organic Delusional Disorder and Organic Hallucinosis were applied to substance-induced conditions and to those due to a general medical condition. DSM-IV creates two disorders based on etiology (Psychotic Disorder Due to a General Medical Condition and Substance-Induced Psychotic Disorder [see below]) but combines delusional disorder and hallucinosis into a single Psychotic Disorder. The distinction between presentations that are predominantly delusional versus those that are predominantly characterized by hallucinations is preserved in the subtyping. Psychotic Disorder Due to a General Medical Condition is included in the "Schizophrenia and Other Psychotic Disorders" section to facilitate differential diagnosis.

Substance-Induced Psychotic Disorder. The DSM-III-R terms Organic Delusional Disorder and Organic Hallucinosis were applied to substance-induced conditions and to those due to a general medical condition. DSM-IV creates two disorders based on etiology (Psychotic Disorder Due to a General Medical Condition [see above] and Substance-Induced Psychotic Disorder) but combines delusional disorder and halluci- nosis into a single Psychotic Disorder. The distinction between presentations that are predominantly delusional versus those that are predominantly characterized by halluci- nations is preserved in the subtyping. Substance-Induced Psychotic Disorder is included in the "Schizophrenia and Other Psychotic Disorders" section to facilitate differential diagnosis.

Mood Disorders

Major Depressive Episode. DSM-IV adds a Criterion C to ensure the clinical significance of the symptomatic presentation. In addition, DSM-IV includes a Criterion E that clarifies the boundary with Bereavement-that is, a Major Depressive Episode may be diagnosed if the symptoms persist for longer than 2 months after the loss of a loved one.

Manic Episode. The DSM-III duration of 1 week (which had been dropped in DSM-III-R) has been reinstated in DSM-IV. In contrast to DSM-III-R, Manic Episodes that are clearly precipitated by antidepressant treatment are diagnosed as Substance-Induced Manic Episodes and do not count toward a diagnosis of Bipolar I Disorder.

Mixed Episode. In DSM-Ill-R, Mixed Episodes did not have a separate criteria set and instead were defined as one of the subtypes of Bipolar Disorder. In DSM-IV, a separate criteria set is provided that specifies that the symptom criteria for both a Manic Episode and a Major Depressive Episode are met nearly every day for 1 week.

Hypomanic Episode. In DSM-III-R, Hypomanic Episodes did not have a separate criteria set and instead were defined with the same criteria (except for severity) as for a Manic Episode. In DSM-IV, a separate criteria set is provided that specifies a duration of at least 4 days of mood change (distinct from the usual nondepressed mood) and an unequivocal change in functioning that is observable by others. In contrast to mania, hypomania is defined as not severe enough to cause marked impairment or to require hospitalization.

Dysthymic Disorder. The DSM-III-R subtyping of primary versus secondary was dropped because of difficulty in applying it and lack of supportive evidence. DSM-IV adds a criterion to ensure the clinical significance of the symptomatic presentation.

Bipolar Disorders. The organization and terminology for Bipolar Disorders has been changed in DSM-IV. Bipolar Disorders have been divided into Bipolar I Disorders and Bipolar II Disorder. Bipolar I Disorders have been divided into Single Manic Episode and Most Recent Episode Hypomanic, Manic, Mixed, Depressed, and Unspecified.

Bipolar I Disorder, Single Manic Episode. This disorder is new for DSM-IV and has been added to increase specificity and for compatibility with ICD-10 coding requirements. A duration of 2 months without manic symptoms has been established to define recurrence.

Bipolar I Disorder, Most Recent Episode Hypomanic. This disorder is new for DSM-IV and was added to increase specificity and coverage.

Bipolar I Disorder, Most Recent Episode Mixed. In DSM-III-R, the mixed type included presentations of manic and depressive symptoms that were intermixed or rapidly alternating every few days, with the requirement that the depressive symptoms last at least 1 full day. This disorder has been modified in DSM-IV to require at least 1 week of both manic and major depressive symptoms, and that both of these occur nearly every day.

Bipolar I Disorder, Most Recent Episode Unspecified. This disorder is new for DSM-IV and allows the clinician to note the onset of a new mood episode before the full duration criteria are met.

Bipolar II Disorder. This disorder has been introduced as a separate category in DSM-IV to cover what in DSM-III-R was an example in Bipolar Disorder Not Otherwise Specified. Bipolar II Disorder describes presentations in which there is at least one Major Depressive Episode and at least one Hypomanic Episode but, unlike Bipolar I Disorder, no history of Manic Episodes. Bipolar II Disorder has been added in response to the evidence from the literature review and data reanalysis that suggested its utility and to increase diagnostic coverage.

Mood Disorder Due to a General Medical Condition. Text and criteria for this disorder, which was called Organic Mood Disorder in DSM-III-R, are included in the "Mood Disorders" section to facilitate differential diagnosis.

Substance-Induced Mood Disorder. Text and criteria for this disorder, which was called Organic Mood Disorder in DSM-III-R, are included in the "Mood Disorders" section to facilitate differential diagnosis.

With Catatonic Features. This is a new specifier introduced into DSM-IV to reflect evidence that many catatonic presentations are associated with mood disorders.

With Melancholic Features. The DSM-IV criteria set for this specifier departs from that for DSM-III-Rand is essentially the same as that for DSM-III, except that it requires either loss of pleasure *or* lack of reactivity to pleasurable stimuli (rather than both). This reflects the evidence from the literature review that the DSM-III definition may have been too narrow but in other respects was superior to the definition in DSM-III-R.

With Atypical Features. This is a new specifier introduced into DSM-IV to reflect evidence that this presentation (e.g., mood reactivity, reverse vegetative symptoms, rejection sensitivity) may have implications for treatment selection.

With Postpartum Onset. This is a new specifier introduced into DSM-IV to reflect evidence that this presentation may have implications for prognosis and treatment selection.

Longitudinal Course Specifiers. Course specifiers describing the lifetime pattern of Major Depressive Disorder and Bipolar I and II Disorders have been introduced into DSM-IV to allow the clinician to specify the degree of interepisode recovery. Diagrams have also been provided to illustrate various course patterns.

With Seasonal Pattern. Several changes have been made to this specifier so that the criteria conform more closely to clinical and research usage. These changes include restricting the application of the seasonal pattern to Major Depressive Episodes only, elimination of the 60-day window for appearance of symptoms in Criterion A, and the inclusion of a more specific requirement regarding the relationship between seasonal and nonseasonal episodes.

With Rapid Cycling. This is a new specifier introduced into DSM-IV to reflect

evidence that this presentation may have implications for prognosis and treatment selection.

Anxiety Disorders

Panic Attack. The criteria set for Panic Attack has been provided separately at the beginning of the "Anxiety Disorders" section to clarify that Panic Attacks can occur as part of the presentation of a variety of Anxiety Disorders. The DSM-III-R items and the threshold for Panic Attack were supported by the data reanalysis and field-trial results and remain the same for DSM-IV, but the order of items has been changed to reflect their frequency.

Panic Disorder Without Agoraphobia. In response to the literature review, data reanalyses, and field-trial results, the threshold for Panic Disorder Without Agoraphobia has been revised. The DSM-IV definition requires recurrent unexpected Panic Attacks accompanied by a month or more of persistent concern about having additional attacks or about the implications of the attacks, or a significant change in behavior. This is in contrast to DSM-III-R, which required either four attacks in 4 weeks or one attack followed by a month of persistent fear of having another attack.

Panic Disorder With Agoraphobia. The threshold for Panic Attacks in Panic Disor- der With Agoraphobia has been revised in the same way as the threshold for Panic Disorder Without Agoraphobia. In addition, the definition of Agoraphobia has been modified to emphasize that agoraphobic fears typically involve a characteristic cluster of situations. Specific criteria for mild, moderate, and severe that were provided in DSM-III-R have been deleted. (The general severity specifiers provided in "Use of the Manual" can be used instead [see p. 2l.)

Agoraphobia Without History of Panic Disorder. DSM-III-R provided no guid- ance concerning whether avoidance associated with a general medical condition warrants this diagnosis. DSM-IV Criterion D indicates that the diagnosis might include avoidance associated with a general medical condition if the fear is clearly in excess of that usually associated with this condition.

Specific Phobia. For compatibility with ICD-10, the name of this category has been changed from Simple Phobia to Specific Phobia. The threshold of the fear in Criterion A has been raised by requiring that it be marked and excessive or unreasonable (as well as persistent). Based on literature review and data reanalysis, subtypes are provided that describe the focus of the phobias.

Social Phobia. This disorder now subsumes DSM-III-R Avoidant Disorder of Child- hood, and criteria have been modified for childhood presentations.

Obsessive-Compulsive Disorder. The distinction between obsessions and compul- sions has been clarified. Obsessions cause marked anxiety or distress, whereas compul- sions (including mental acts) prevent or reduce anxiety or distress. In recognition that insight into whether the obsessions or compulsions are unreasonable occurs on a

continuum, a specifier is provided to allow the clinician to note whether the condition is of the With Poor Insight type.

Posttraumatic Stress Disorder. Based on literature review, data reanalyses, and field-trial results, the phrase that describes the stressor in DSM-III-R Criterion A, "outside the range of normal human experience," has been deleted because it was unreliable and inaccurate (the prevalence of such stressors is not low in general populations). DSM-IV Criterion A2 instead requires that the person's response to the stressor must involve intense fear, helplessness, or horror. Physiological reactivity on exposure to cues was moved from Criterion D (increased arousal) to Criterion B (reexperiencing the trauma). A criterion requiring that the symptoms cause clinically significant distress or impairment has been included. Acute and Chronic specifiers are also provided.

Acute Stress Disorder. This category is new in DSM-IV and was added to describe acute reactions to extreme stress (i.e., occurring within 4 weeks of the stressor and lasting from 2 days to 4 weeks). It was added for compatibility with ICD-10 and to assist early case finding, because Acute Stress Disorder may predict the later development of Posttraumatic Stress Disorder.

Generalized Anxiety Disorder. This disorder now subsumes DSM-III-R Overanx- ious Disorder of Childhood. Criterion A requires excessive anxiety and worry, in contrast to DSM-III-R, which included unrealistic worries. A requirement that the person must find it difficult to control the worry has been added. Based on data reanalysis, Criterion C now has a 6-item set that is simpler, more reliable, and more coherent than the 18-item set in DSM-III-R.

Anxiety Disorder Due to a General Medical Condition. Text and criteria for this disorder, which was called Organic Anxiety Disorder in DSM-III-R, are included in the "Anxiety Disorders" section to facilitate differential diagnosis.

Substance-Induced Anxiety Disorder. Text and criteria for this disorder, which was called Organic Anxiety Disorder in DSM-III-R, are included in the "Anxiety Disorders" section to facilitate differential diagnosis.

Somatoform Disorders

Somatization Disorder. Based on the literature review, data reanalysis, and field-trial results, the DSM-III-R list of 35 items has been condensed, simplified, and divided into four symptom groupings (pain, gastrointestinal, sexual, and pseudoneurological).

Conversion Disorder. Unlike the broader definition in DSM-III-R, the presenting problem must be a symptom or deficit that affects voluntary motor or sensory functioning. Other problems that reflect a change in functioning (e.g., pseudocyesis) are listed under Somatoform Disorder Not Otherwise Specified. A subtyping scheme (Motor, Sensory, Seizure, Mixed) has been provided for increased specificity and for compatibility with ICD-10.

Pain Disorder. The name has been changed from DSM-III-R Somatoform Pain Disorder. The definition has been broadened to include two types of pain disorder: Pain Disorder Associated With Psychological Factors and Pain Disorder Associated With Both Psychological Factors and a General Medical Condition. In addition, Acute and Chronic specifiers are provided.

Hypochondriasis. A specifier is provided to allow the clinician to note whether the condition is of the With Poor Insight type.

Body Dysmorphic Disorder. The DSM-III-R exclusion that the belief not be of delusional intensity was dropped so that this diagnosis can now be made concurrently with a diagnosis of Delusional Disorder.

Factitious Disorders

DSM-IV provides one set of criteria for Factitious Disorder instead of the previous two, with separate types based on the predominance of presenting signs and symptoms (Psychological, Physical, Combined).

Dissociative Disorders

Dissociative Amnesia. The name has been changed from DSM-III-R Psychogenic Amnesia to be more descriptive and to be more compatible with ICD-10.

Dissociative Fugue. The name has been changed from DSM-III-R Psychogenic Fugue to be more descriptive and to be more compatible with ICD-10. The requirement for assumption of a new identity has been dropped because confusion about personal identity has been found to be the predominant symptom.

Dissociative Identity Disorder. The name has been changed from DSM-III-R Mul- tiple Personality Disorder to be more descriptive. The DSM-III requirement that there be an inability to recall important personal information has been reinstated.

Sexual and Gender Identity Disorders

Sexual Dysfunctions. Each of the disorders listed in this section now includes a clinical significance criterion (i.e., that the dysfunction causes marked distress or interpersonal difficulty).

Female Sexual Arousal Disorder. DSM-IV returns to the DSM-III definition by dropping the DSM-III-R Item A2 that stated that the diagnosis could be given if there were subjective complaints without any difficulty with physiological arousal.

Male Erectile Disorder. DSM-IV returns to the DSM-III definition by dropping DSM-III-R Item A2, which allowed the diagnosis to be given even if there were only subjective complaints without any difficulty with physiological arousal.

Female Orgasmic Disorder. The name has been changed from DSM-III-R Inhibited Female Orgasm. Criterion A has been simplified and revised to be more in accord with clinical usage.

Male Orgasmic Disorder. The name has been changed from DSM-III-R Inhibited Male Orgasm.

Sexual Dysfunction Due to a General Medical Condition. This disorder was in- cluded in the "Genitourinary System" section of ICD-9-CM, but was not included in the DSM-III-R Classification. It is included in DSM-IV to facilitate differential diagnosis.

Substance-Induced Sexual Dysfunction. This disorder was not included in DSM-III-R and is included in DSM-IV to increase coverage and to facilitate differential diagnosis.

Transvestic Fetishism. A specifier has been added for those individuals with Transvestic Fetishism who also have persistent discomfort with gender role that does not meet criteria for Gender Identity Disorder.

Gender Identity Disorder. This DSM-IV diagnosis subsumes three DSM-III-R diagnoses: Gender Identity Disorder of Childhood; Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (GIDAANT); and Transsexualism. It is placed in the "Sexual and Gender Identity Disorders" section rather than in the "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence," section as in DSM-III-R. The criteria set accommodates both sexes and all ages.

Eating Disorders

Anorexia Nervosa. This disorder has been moved from the "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence" section to the "Eating Disorders" section of the Classification. In DSM-IV, a presentation that includes binge eating and purging that occurs exclusively during Anorexia Nervosa is no longer given a separate diagnosis of Bulimia Nervosa, but rather is subsumed as a subtype under Anorexia Nervosa. The subtyping for Anorexia Nervosa now indicates the presence of binge-eating/purging versus restricting behavior.

Bulimia Nervosa. This disorder has been moved from the "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence" section to the "Eating Disorders" section of the Classification. An exclusion criterion has been added so that the diagnosis is not given if the behavior occurs exclusively during episodes of Anorexia Nervosa. Subtypes are provided to distinguish between purging and nonpurging types.

Sleep Disorders

The organization of this section has been changed from that in DSM-III-R. The disorders are grouped into four sections based on presumed etiology (primary, related to another

mental disorder, due to a general medical condition, and substance-induced), rather than on presenting symptoms. The section is compatible with the International Classifi- cation of Sleep Disorders.

Primary Insomnia. The frequency criterion of at least three times a week was dropped for DSM-IV, although the 1-month duration is retained. A clinical significance criterion has been added.

Primary Hypersomnia. Hypersomnia is no longer diagnosed if the presentation is better accounted for by insomnia. The DSM-III-R inclusion of sleep drunkenness (i.e., the prolonged transition to the fully awake state) has been deleted as a sufficient criterion for hypersomnia. A Recurrent subtype has been added for noting the presence of Kleine-Levin syndrome.

Narcolepsy. This disorder was included in the "Nervous System" section of ICD-9-CM, but was not included in DSM-III-R. It is included in the "Sleep Disorders" section of DSM-IV to assist in differential diagnosis.

Breathing-Related Sleep Disorder. This disorder was included outside the "Mental Disorders" chapter of ICD-9-CM, but was not included in DSM-III-R. It is included in the "Sleep Disorders" section of DSM-IV to assist in differential diagnosis.

Circadian Rhythm Sleep Disorder. The name has been changed from DSM-III-R Sleep-Wake Schedule Disorder. Subtyping (Delayed Sleep Phase, Jet Lag, Shift Work) has been revised to reflect clinical usage.

Nightmare Disorder. The name has been changed from DSM-III-R Dream Anxiety Disorder.

Insomnia Related to Another Mental Disorder. In DSM-IV, this diagnosis is used in addition to the related Axis I or Axis II diagnosis only when the insomnia is sufficiently severe to warrant independent clinical attention.

Hypersomnia Related to Another Mental Disorder. In DSM-IV, this diagnosis is used in addition to the related Axis I or Axis II diagnosis only when the hypersomnia is sufficiently severe to warrant independent clinical attention.

Sleep Disorder Due to a General Medical Condition. The DSM-III-R terms "Insomnia Related to a Known Organic Factor" and "Hypersomnia Related to a Known Organic Factor" were applied to both Substance-Induced Sleep Disorders and those due to a general medical condition. Two disorders based on etiology (Sleep Disorder Due to a General Medical Condition and Substance-Induced Sleep Disorder) have been created for DSM-IV. A provision to indicate insomnia, hypersomnia, parasomnia, or mixed type has been included. In contrast to DSM-III-R, in DSM-IV this diagnosis is used in addition to the general medical condition diagnosis only when the sleep disturbance is sufficiently severe to warrant independent clinical attention.

Substance-Induced Sleep Disorder. The DSM-III-R terms "Insomnia Related to a Known Organic Factor" and "Hypersomnia Related to a Known Organic Factor" were

applied to both Substance-Induced Sleep Disorders and to those due to a general medical condition. Two disorders were created for DSM-IV based on etiology (Sleep Disorder Due to a General Medical Condition and Substance-Induced Sleep Disorder). A provision to indicate insomnia, hypersomnia, parasomnia, or mixed type has been included. In contrast to DSM-III-R, in DSM-IV this diagnosis is used instead of a substance use diagnosis only when the sleep disturbance is sufficiently severe to warrant independent clinical attention.

Impulse..Control Disorders

Intermittent Explosive Disorder. The DSM-III-R criterion excluding this diagnosis in the presence of generalized impulsiveness or aggressiveness between episodes has been deleted.

Pathological Gambling. The criteria set has been revised to increase specificity.

Adjustment Disorders

DSM-III-R had a limit of 6 months of symptoms. This criterion has been modified in DSM-IV to allow for symptoms lasting up to an additional 6 months after the termination of a chronic stressor (or its consequences). Acute and Chronic specifications have been provided to indicate presentations lasting less than 6 months and 6 months or longer, respectively. In addition, several subtypes have been deleted (physical complaints, withdrawal, work or academic inhibition).

Personality Disorders

Based on literature reviews, data reanalysis, and desire for compatibility with ICD-10 Diagnostic Criteria for Research, items have been modified to increase clarity and specificity and to reduce possible gender bias.

Antisocial Personality Disorder. Based on the literature review, data reanalyses, and field-trial results, the criteria set has been condensed, simplified, and slightly altered: two items (irresponsible parenting and failure to sustain a monogamous relationship) have been deleted; two items tapping consistent irresponsibility (failure to sustain consistent work behavior or honor financial obligations) have been collapsed into one item; and Criterion C (specifying the relationship to Conduct Disorder) has been simplified.

Borderline Personality Disorder. An additional item for transient, stress-related paranoid ideation or severe dissociative symptoms has been added in DSM-IV.

Passive-Aggressive Personality Disorder. This disorder has been deleted from the Classification. A revised version has been moved to Appendix B, "Criteria Sets and Axes Provided for Further Study."

Other Conditions That May Be a Focus of Clinical Attention

The name of this section has been changed from DSM-III-R Conditions Not Attributable to a Mental Disorder, and a number of additional conditions have been added.

Psychological Factors Affecting Medical Condition. Because this category does not constitute a mental disorder, it has been moved into the "Other Conditions That May Be a Focus of Clinical Attention" section. The concept has been broadened to include factors that interfere with treatment and factors that constitute health risks to the individual. Subtypes are provided that allow specification of the particular type of psychological factor involved.

Medication-Induced Movement Disorders. These disorders have been included because of their importance in treatment and differential diagnosis.

Relational Problems. These problems are now named and grouped together. Two new relational problems have been added: Relational Problem Related to a Mental Disorder or General Medical Condition and Sibling Relational Problem.

Problems Related to Abuse or Neglect. This category has been introduced into this section to cover physical abuse, sexual abuse, and neglect of a child and physical abuse and sexual abuse of an adult. It is included because of the clinical and public health significance of these conditions.

Age-Related Cognitive Decline. This is a new problem added to DSM-IV to improve coverage.

Bereavement. The name has been changed from DSM-III-R Uncomplicated Bereavement because bereavement may cause significant impairment and complications. Guidelines relating to the duration of symptoms and particular types of symptoms have been provided to sharpen the boundary between Bereavement and Major Depressive Episode.

Identity Problem. In DSM-IV, this is listed in the "Other Conditions That May Be a Focus of Clinical Attention" section rather than being placed in the "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence" section (as in DSM-III-R).

Religious or Spiritual Problem. This is a new problem added to DSM-IV to improve coverage.

Acculturation Problem. This is a new problem added to DSM-IV to improve coverage.

New Disorders Introduced Into DSM--IV (Excluding Other Conditions That May Be a Focus of Clinical Attention)

Rett's Disorder
Childhood Disintegrative Disorder
Asperger's Disorder
Feeding Disorder of Infancy or Early Childhood
Delirium Due to Multiple Etiologies
Dementia Due to Multiple Etiologies
Catatonic Disorder Due to a General Medical Condition
Bipolar II Disorder
Acute Stress Disorder
Sexual Dysfunction Due to a General Medical Condition
Substance-Induced Sexual Dysfunction
Narcolepsy
Breathing-Related Sleep Disorder

DSM.-III.-R Disorders Deleted From DSM.-IV or Subsumed Into Other DSM.-IV Categories

Cluttering
Overanxious Disorder of Childhood
Avoidant Disorder of Childhood
Undifferentiated Attention-Deficit Disorder
Identity Disorder
Transsexualism
Idiosyncratic Alcohol Intoxication
Passive-Aggressive Personality Disorder

Appendixes

Appendix A-Decision Trees for Differential Diagnosis. The DSM-III-R decision tree for Organic Mental Disorders has been replaced by two separate decision trees: one for Mental Disorders Due to a General Medical Condition and one for Substance-Induced Disorders. Each of the other decision trees has been modified, and there is an increased emphasis throughout DSM-IV on the differential diagnosis with Mental Disorders *Due* to a General Medical Condition and Substance-Induced Disorders.

Appendix B--Criteria Sets and Axes Provided for Further Study. This appendix has been greatly expanded to include a number of new proposals:

Criteria Sets and Axes Provided for Further Study

Postconcussional disorder
Mild neurocognitive disorder
Caffeine withdrawal
Alternative dimensional descriptors for Schizophrenia

Postpsychotic depressive disorder of Schizophrenia
Simple deteriorative disorder
Premenstrual dysphoric disorder
Alternative Criterion B for Dysthymic Disorder
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 (negativistic personality disorder)
Medication-Induced Movement Disorders
- Neuroleptic-Induced Parkinsonism
- Neuroleptic Malignant Syndrome
- Neuroleptic-Induced Acute Dystonia
- Neuroleptic-Induced Acute Akathisia
- Neuroleptic-Induced Tardive Dyskinesia
- Medication-Induced Postural Tremor
- Medication-Induced Movement Disorder Not Otherwise Specified

Defensive Functioning Scale
Global Assessment of Relational Functioning (GARF) Scale
Social and Occupational Functioning Assessment Scale (SOFAS)

Appendix C----Glossary of Technical Terms. Existing definitions have been refined, and a number of new terms have been added.

Appendix D--Annotated Listing of Changes in DSM-IV. This appendix has been presented in a new format to clarify the ways in which DSM-IV differs from DSM-III-R.

Appendix E-Alphabetical Listing of DSM-IV Diagnoses and Codes. This listing of categories has been revised to include the DSM-IV disorders and conditions.

Appendix F-Numerical Listing of DSM-IV Diagnoses and Codes. This listing of categories has been revised to include the DSM-IV disorders and conditions.

Appendix G--ICD-9-CM Codes for Selected General Medical Conditions and Medication-Induced Disorders. This appendix is new for DSM-IV. It includes a selective index of conditions classified outside the "Mental Disorders" chapter of ICD-9-CM that are most relevant to diagnosis and care in mental health settings. In addition, the appendix contains a list of ICD-9-CM codes for selected medications that may cause Substance-Induced Disorders.

Appendix H-DSM-IV Classification With ICD-10 Codes. At some point within the next several years, the U.S. Department of Health and Human Services will require the use of codes from the *International Statistical Classification of Diseases and Related Health Problems,* Tenth Revision (ICD-10), for reporting purposes in the United States. To facilitate this transition, this appendix lists the DSM-IV Classification with codes from the ICD-10 system.

Appendix I-Outline for Cultural Formulation and Glossary of Culture-Bound Syndromes. This appendix is provided to assist the clinician in using DSM-IV in a multicultural environment. It is divided into two sections. The first section contains 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 section provides a list of "culture-bound syndromes" that denote recurrent, locality-specific patterns of aberrant behavior and experience that may not be linked specifically to a particular DSM-IV diagnostic category.

AppendixJ-DSM-IV Contributors. This appendix contains a list of individuals who participated in the preparation of DSM-IV.

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Appendix E

Alphabetical Listing of DSM IV Diagnoses and Codes

NOS= Not Otherwise Specified

V62.3	Academic Problem
V62.4	Acculturation Problem
308.3	Acute Stress Disorder
	Adjustment Disorders
309.9	Unspecified
309.24	With Anxiety
309.0	With Depressed Mood
309.3	With Disturbance of Conduct
309.28	With Mixed Anxiety and Depressed Mood
309.4	With Mixed Disturbance of Emotions and Conduct
V71.01	Adult Antisocial Behavior
995.2	Adverse Effects of Medication NOS
780.9	Age-Related Cognitive Decline
300.22	Agoraphobia Without History of Panic Disorder
	Alcohol
305.00	Abuse
303.90	Dependence
291.8	-Induced Anxiety Disorder
291.8	-Induced Mood Disorder
291.1	-Induced Persisting Amnestic Disorder
291.2	-Induced Persisting Dementia
	-Induced Psychotic Disorder
291.5	With Delusions
291.3	With Hallucinations
291.8	-Induced Sexual Dysfunction
291.8	-Induced Sleep Disorder

Alcohol *(continued)*
303.00 Intoxication
291.0 Intoxication Delirium
291.9 -Related Disorder NOS
291.8 Withdrawal
291.0 Withdrawal Delirium
294.0 Amnestic Disorder Due to ... */Indicate the General Medical Condition]*
294.8 Amnestic Disorder NOS
Amphetamine (or Amphetamine-Like)
305.70 Abuse
304.40 Dependence
292.89 -Induced Anxiety Disorder
292.84 -Induced Mood Disorder
-Induced Psychotic Disorder
292.11 With Delusions
292.12 With Hallucinations
292.89 -Induced Sexual Dysfunction
292.89 -Induced Sleep Disorder
292.89 Intoxication
292.81 Intoxication Delirium
292.9 -Related Disorder NOS
292.0 Withdrawal
307.1 Anorexia Neivosa
301.7 Antisocial Personality Disorder
293.89 Anxiety Disorder Due to ... *[Indicate the General Medical Condition}*
300.00 Anxiety Disorder NOS
299.80 Asperger's Disorder
Attention-Deficit/Hyperactivity Disorder
314.01 Combined Type
314.01 Predominantly Hyperactive-Impulsive Type
314.00 Predominantly Inattentive Type
314.9 Attention-Deficit/Hyperactivity Disorder NOS
299.00 Autistic Disorder
301.82 Avoidant Personality Disorder
V62.82 Bereavement
296.80 Bipolar Disorder NOS
Bipolar I Disorder, Most Recent Episode Depressed
296.56 In Full Remission
296.55 In Partial Remission
296.51 Mild
296.52 Moderate
296.53 Severe Without Psychotic Features
296.54 *Severe* With Psychotic Features
296.S0 Unspecified
296.40 Bipolar I Disorder, Most Recent Episode Hypomanic
Bipolar I Disorder, Most Recent Episode Manic
296.46 In Full Remission
296.45 In Partial Remission
296.41 Mild

Bipolar I Disorder, Most Recent Episode Manic *(continued)*
296.42 Moderate
296.43 Severe Without Psychotic Features
296.44 Severe With Psychotic Features
296.40 Unspecified
Bipolar I Disorder, Most Recent Episode Mixed
296.66 In Full Remission
296.65 In Partial Remission
296.61 Mild
296.62 Moderate
296.63 Severe Without Psychotic Features
296.64 Severe With Psychotic Features
296.60 Unspecified
296.7 Bipolar I Disorder, Most Recent Episode Unspecified
Bipolar I Disorder, Single Manic Episode
296.06 In Full Remission
296.05 In Partial Remission
296.01 Mild
296.02 Moderate
296.03 Severe Without Psychotic Features
296.04 Severe With Psychotic Features
296.00 Unspecified
296.89 Bipolar II Disorder
300.7 Body Dysmorphic Disorder
V62.89 Borderline Intellectual Functioning
301.83 Borderline Personality Disorder
780.59 Breathing-Related Sleep Disorder
298.8 Brief Psychotic Disorder
307.51 Bulimia Nervosa
Caffeine
292.89 -Induced Anxiety Disorder
292.89 -Induced Sleep Disorder
305.90 Intoxication
292.9 -Related Disorder NOS
Cannabis
305.20 Abuse
304.30 Dependence
292.89 -Induced Anxiety Disorder
-Induced Psychotic Disorder
292.11 With Delusions
292.12 With Hallucinations
292.89 Intoxication
292.81 Intoxication Delirium
292.9 -Related Disorder NOS
293.89 Catatonic Disorder Due to ... *[Indicate the General Medical Condition]*
299.10 Childhood Disintegrative Disorder
V71.02 Child or Adolescent Antisocial Behavior
307.22 Chronic Motor or Vocal Tic Disorder
307.45 Circadian Rhythm Sleep Disorder

	Cocaine
305.60	Abuse
304.20	Dependence
292.89	-Induced Anxiety Disorder
292.84	-Induced Mood Disorder
	-Induced Psychotic Disorder
292.11	With Delusions
292.12	With Hallucinations
292.89	-Induced Sexual Dysfunction
292.89	-Induced Sleep Disorder
292.89	Intoxication
292.81	Intoxication Delirium
292.9	-Related Disorder NOS
292.0	Withdrawal
294.9	Cognitive Disorder NOS
307.9	Communication Disorder NOS
312.8	Conduct Disorder
300.11	Conversion Disorder
301.13	Cyclothymic Disorder
293.0	Delirium Due to ... *[Indicate the General Medical Condition]*
780.09	Delirium NOS
297.1	Delusional Disorder
290.10	Dementia Due to Creutzfeldt-Jakob Disease
294.1	Dementia Due to Head Trauma
294.9	Dementia Due to HIV Disease
294.1	Dementia Due to Huntington's Disease
294.1	Dementia Due to Parkinson's Disease
290.10	Dementia Due to Pick's Disease
294.1	Dementia Due to ... *[Indicate Other General Medical Condition]*
294.8	Dementia NOS
	Dementia of the Alzheimer's Type, With Early Onset
290.10	Uncomplicated
290.11	With Delirium
290.12	With Delusions
290.13	With Depressed Mood
	Dementia of the Alzheimer's Type, With Late Onset
290.0	Uncomplicated
290.3	With Delirium
290.20	With Delusions
290.21	With Depressed Mood
301.6	Dependent Personality Disorder
300.6	Depersonalization Disorder
311	Depressive Disorder NOS
315.4	Developmental Coordination Disorder
799.9	Diagnosis Deferred on Axis II
799.9	Diagnosis or Condition Deferred on Axis I
313.9	Disorder of Infancy, Childhood, or Adolescence NOS
315.2	Disorder of Written Expression
312.9	Disruptive Behavior Disorder NOS

300.12 Dissociative Amnesia
300.15 Dissociative Disorder NOS
300.13 Dissociative Fugue
300.14 Dissociative Identity Disorder
302.76 Dyspareunia (Not Due to a General Medical Condition)
307.47 Dyssomnia NOS
300.4 Dysthymic Disorder
307.50 Eating Disorder NOS
787.6 Encopresis, With Constipation and Overflow Incontinence
307.7 Encopresis, Without Constipation and Overflow Incontinence
307.6 Enuresis (Not Due to a General Medical Condition)
302.4 Exhibitionism
315.31 Expressive Language Disorder
Factitious Disorder
300.19 With Combined Psychological and Physical Signs and Symptoms
300.19 With Predominantly Physical Signs and Symptoms
300.16 With Predominantly Psychological Signs and Symptoms
300.19 Factitious Disorder NOS
307.59 Feeding Disorder of Infancy or Early Childhood
625.0 Female Dyspareunia Due to ... *(Indicate the General Medical Condition}*
625.8 Female Hypoactive Sexual Desire Disorder Due to ... *[Indicate the General Medical Condition}*
302.73 Female Orgasmic Disorder
302.72 Female Sexual Arousal Disorder
302.81 Fetishism
302.89 Frotteurism
Gender Identity Disorder
302.85 in Adolescents or Adults
302.6 in Children
302.6 Gender Identity Disorder NOS
300.02 Generalized Anxiety Disorder
Hallucinogen
305.30 Abuse
304.50 Dependence
292.89 -Induced Anxiety Disorder
292.84 -Induced Mood Disorder
-Induced Psychotic Disorder
292.11 With Delusions
292.12 With Hallucinations
292.89 Intoxication
292.81 Intoxication Delirium
292.89 Persisting Perception Disorder
292.9 -Related Disorder NOS
301.50 Histrionic Personality Disorder
307.44 Hypersomnia related to ... *(Indicate the Axis I or Axis II Disorder}*
302.71 Hypoactive Sexual Desire Disorder
300.7 Hypochondriasis
313.82 Identity Problem
312.30 Impulse-Control Disorder NOS

Inhalant
305.90 Abuse
304.60 Dependence
292.89 -Induced Anxiety Disorder
292.84 -Induced Mood Disorder
292.82 -Induced Persisting Dementia
-Induced Psychotic Disorder
292.11 With Delusions
292.12 With Hallucinations
292.89 Intoxication
292.81 Intoxication Delirium
292.9 -Related Disorder NOS
307.42 Insomnia Related to ... *[Indicate the Axis I or Axis II Disorder}*
312.34 Intermittent Explosive Disorder
312.32 Kleptomania
315.9 Learning Disorder NOS
Major Depressive Disorder, Recurrent
296.36 In Full Remission
296.35 In Partial Remission
296.31 Mild
296.32 Moderate
296.33 Severe Without Psychotic Features
296.34 Severe With Psychotic Features
296.30 Unspecified
Major Depressive Disorder, Single Episode
296.26 In Full Remission
296.25 In Partial Remission
296 21 Mild
296.22 Moderate
296.23 Severe Without Psychotic Features
296.24 Severe With Psychotic Features
296.20 Unspecified
608.89 Male Dyspareunia Due to ... *[Indicate the General Medical Condition}*
302.72 Male Erectile Disorder
607.84 Male Erectile Disorder Due to ... *[Indicate the General Medical Condition}*
608.89 Male Hypoactive Sexual Desire Disorder Due to ... *[Indicate the General Medical Condition}*
302.74 Male Orgasmic Disorder
V65.2 Malingering
315.1 Mathematics Disorder
Medication-Induced
333.90 Movement Disorder NOS
333.1 Postural Tremor
293.9 Mental Disorder NOS Due to ... *[Indicate the General Medical Condition}*
319 Mental Retardation, Severity Unspecified
317 Mild Mental Retardation
315.31 Mixed Receptive-Expressive Language Disorder
318.0 Moderate Mental Retardation

293.83 Mood Disorder Due to ... *[Indicate the General Medical Condition]*
296.90 Mood Disorder NOS
301.81 Narcissistic Personality Disorder
347 Narcolepsy
V61.21 Neglect of Child
995.5 Neglect of Child *(if focus of attention is on victim)*
Neuroleptic-Induced
333.99 Acute Akathisia
333.7 Acute Dystonia
332.1 Parkinsonism
333.82 Tardive Dyskinesia
333.92 Neuroleptic Malignant Syndrome
Nicotine
305.10 Dependence
292.9 -Related Disorder NOS
292.0 Withdrawal
307.47 Nightmare Disorder
V71.09 No Diagnosis on Axis II
V71.09 No Diagnosis or Condition on Axis I
VIS.SI Noncompliance With Treatment
300.3 Obsessive-Compulsive Disorder
301.4 Obsessive-Compulsive Personality Disorder
V62.2 Occupational Problem
Opioid
305.50 Abuse
304.00 Dependence
292.84 -Induced Mood Disorder
-Induced Psychotic Disorder
292.11 With Delusions
292.12 With Hallucinations
292.89 -Induced Sexual Dysfunction
292.89 -Induced Sleep Disorder
292.89 Intoxication
292.81 Intoxication Delirium
292.9 -Related Disorder NOS
292.0 Withdrawal
313.81 Oppositional Defiant Disorder
625.8 Other Female Sexual Dysfunction Due to ... *{Indicate the General Medical Condition]*
608.89 Other Male Sexual Dysfunction Due to ... *{Indicate the General Medical Condition]*
Other (or Unknown) Substance
305.90 Abuse
304.90 Dependence
292.89 -Induced Anxiety Disorder
292.81 -Induced Delirium
292.84 -Induced Mood Disorder
292.83 -Induced Persisting Amnestic Disorder
292.82 -Induced Persisting Dementia

Other (or Unknown) Substance *(continued)*
-Induced Psychotic Disorder
292.11 With Delusions
292.12 With Hallucinations
292.89 -Induced Sexual Dysfunction
292.89 -Induced Sleep Disorder
292.89 Intoxication
292.9 -Related Disorder NOS
292.0 Withdrawal

Pain Disorder
307.89 Associated With Both Psychological Factors and a General Medical Condition
307.80 Associated With Psychological Factors
Panic Disorder
300.21 With Agoraphobia
300.01 Without Agoraphobia
301.0 Paranoid Personality Disorder
302.9 Paraphilia NOS
307.47 Parasomnia NOS
V61.20 Parent-Child Relational Problem
V61.1 Partner Relational Problem
312.31 Pathological Gambling
302.2 Pedophilia
310.1 Personality Change Due to ... *[Indicate the General Medical Condition}*
301.9 Personality Disorder NOS
299.80 Pervasive Developmental Disorder NOS
V62.89 Phase of Life Problem
Phencyclidine (or Phencyclidine-Like)
305.90 Abuse
304.90 Dependence
292.89 -Induced Anxiety Disorder
292.84 -Induced Mood Disorder
-Induced Psychotic Disorder
292.11 With Delusions
292.12 With Hallucinations
292.89 Intoxication
292.81 Intoxication Delirium
292.9 -Related Disorder NOS
315.39 Phonological Disorder
V61.1 Physical Abuse of Adult
995.81 Physical Abuse of Adult *(if focus of attention is on victim)*
V61.21 Physical Abuse of Child
995.5 Physical Abuse of Child *(if focus of attention is on victim)*
307.52 Pica
304.80 Polysubstance Dependence
309.81 Posttraumatic Stress Disorder
302.75 Premature Ejaculation
307.44 Primary Hypersomnia
307.42 Prima1y Insomnia

318.2 Profound Mental Retardation
316 Psychological Factors Affecting Medical Condition
Psychotic Disorder Due to ... *[Indicate the General Medical Condition}*
293.81 With Delusions
293.82 With Hallucinations
298.9 Psychotic Disorder NOS
312.33 Pyromania
313.89 Reactive Attachment Disorder of Infancy or Early Childhood
315.00 Reading Disorder
V62.81 Relational Problem NOS
V61.9 Relational Problem Related to a Mental Disorder or General Medical Condition
Religious or Spiritual Problem
V62.89 Rett's Disorder
299.80 Rumination Disorder
307.53 Schizoaffective Disorder
295.70 Schizoid Personality Disorder
301.20 Schizophrenia
Catatonic Type
295.20 Disorganized Type
295.10 Paranoid Type
295.30 Residual Type
295.60 Undifferentiated Type
295.90 Schizophreniform Disorder
295.40 Schizotypal Personality Disorder
301.22 Sedative, Hypnotic, or Anxiolytic
Abuse
305.40 Dependence
304.10 -Induced Anxiety Disorder
292.89 -Induced Mood Disorder
292.84 -Induced Persisting Amnestic Disorder
292.83 -Induced Persisting Dementia
292.82 -Induced Psychotic Disorder
With Delusions
292.11 With Hallucinations
292.12 -Induced Sexual Dysfunction
292.89 -Induced Sleep Disorder
292.89 Intoxication
292.89 Intoxication Delirium
292.81 -Related Disorder NOS
292.9 Withdrawal
292.0 Withdrawal Delirium
292.81 Selective Mutism
313.23 Separation Anxiety Disorder
309.21 Severe Mental Retardation
318.1 Sexual Abuse of Adult
V61.1 Sexual Abuse of Adult *(if focus of attention is on victim)*
995.81 Sexual Abuse of Child
V61.21 Sexual Abuse of Child *(if focus of attention is on victim)*
995.5

302.79 Sexual Aversion Disorder
302.9 Sexual Disorder NOS
302.70 Sexual Dysfunction NOS
302.83 Sexual Masochism
302.84 Sexual Sadism
297.3 Shared Psychotic Disorder
V61.8 Sibling Relational Problem
Sleep Disorder Due to ... *[Indicate the General Medical Condition}*
780.54 Hypersomnia Type
780.52 Insomnia Type
780.59 Mixed Type
780.59 Parasomnia Type
307.46 Sleep Terror Disorder
307.46 Sleepwalking Disorder
300.23 Social Phobia
300.81 Somatization Disorder
300.81 Somatoform Disorder NOS
300.29 Specific Phobia
307.3 Stereotypic Movement Disorder
307.0 Stuttering
307.20 Tic Disorder NOS
307.23 Tourette's Disorder
307.21 Transient Tic Disorder
302.3 Transvestic Fetishism
312.39 Trichotillomania
300.81 Undifferentiated Somatoform Disorder
300.9 Unspecified Mental Disorder (nonpsychotic)
306.51 Vaginismus (Not Due to a General Medical Condition)
Vascular Dementia
290.40 Uncomplicated
290.41 With Delirium
290.42 With Delusions
290.43 With Depressed Mood
302.82 Voyeurism

Appendix F

Numerical Listing of DSM IV Diagnoses and Codes

To maintain compatibility with ICD-9-CM, some DSM-IV diagnoses share the same code numbers. These are indicated in this list by brackets.

NOS= Not Otherwise Specified.

290.0	Dementia of the Alzheimer's Type, With Late Onset, Uncomplicated
290.10	Dementia Due to Creutzfeldt-Jakob Disease
290.10	Dementia Due to Pick's Disease
290.10	Dementia of the Alzheimer's Type, With Early Onset, Uncomplicated
290.11	Dementia of the Alzheimer's Type, With Early Onset, With Delirium
290.12	Dementia of the Alzheimer's Type, With Early Onset, With Delusions
290.13	Dementia of the Alzheimer's Type, With Early Onset, With Depressed Mood
290.20	Dementia of the Alzheimer's Type, With Late Onset, With Delusions
290.21	Dementia of the Alzheimer's Type, With Late Onset, With Depressed Mood
290.3	Dementia of the Alzheimer's Type, With Late Onset, With Delirium
290.40	Vascular Dementia, Uncomplicated
290.41	Vascular Dementia, With Delirium
290.42	Vascular Dementia, With Delusions
290.43	Vascular Dementia, With Depressed Mood
291.0	Alcohol Intoxication Delirium
291.0	Alcohol Withdrawal Delirium
291.1	Alcohol-Induced Persisting Amnestic Disorder
291.2	Alcohol-Induced Persisting Dementia
291.3	Alcohol-Induced Psychotic Disorder, With Hallucinations
291.5	Alcohol-Induced Psychotic Disorder, With Delusions
291.s	Alcohol-Induced Anxiety Disorder

291.8 Alcohol-Induced Mood Disorder
291.8 Alcohol-Induced Sexual Dysfunction
291.8 Alcohol-Induced Sleep Disorder
291.8 Alcohol Withdrawal
291.9 Alcohol-Related Disorder NOS
292.0 Amphetamine Withdrawal
292.0 Cocaine Withdrawal
292.0 Nicotine Withdrawal
292.0 Opioid Withdrawal
292.0 Other (or Unknown) Substance Withdrawal
292.0 Sedative, Hypnotic, or Anxiolytic Withdrawal
292.11 Amphetamine-Induced Psychotic Disorder, With Delusions
292.11 Cannabis-Induced Psychotic Disorder, With Delusions
292.11 Cocaine-Induced Psychotic Disorder, With Delusions
292.11 Hallucinogen-Induced Psychotic Disorder, With Delusions
292.11 Inhalant-Induced Psychotic Disorder, With Delusions
292.11 Opioid-Induced Psychotic Disorder, With Delusions
292.11 Other (or Unknown) Substance-Induced Psychotic Disorder, With Delusions
292.11 Phencyclidine-Induced Psychotic Disorder, With Delusions
292.11 Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder, With Delusions
292.12 Amphetamine-Induced Psychotic Disorder, With Hallucinations
292.12 Cannabis-Induced Psychotic Disorder, With Hallucinations
292.12 Cocaine-Induced Psychotic Disorder, With Hallucinations
292.12 Hallucinogen-Induced Psychotic Disorder, With Hallucinations
292.12 Inhalant-Induced Psychotic Disorder, With Hallucinations
292.12 Opioid-Induced Psychotic Disorder, With Hallucinations
292.12 Other (or Unknown) Substance-Induced Psychotic Disorder, With Hallucinations
292.12 Phencyclidine-Induced Psychotic Disorder, With Hallucinations
292.12 Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder, With Hallucinations
292.81 Amphetamine Intoxication Delirium
292.81 Cannabis Intoxication Delirium
292.81 Cocaine Intoxication Delirium
292.81 Hallucinogen Intoxication Delirium
292.81 Inhalant Intoxication Delirium
292.81 Opioid Intoxication Delirium
292.81 Other (or Unknown) Substance-Induced Delirium
292.81 Phencyclidine Intoxication Delirium
292.81 Sedative, Hypnotic, or Anxiolytic Intoxication Delirium
292.81 Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium
292.82 Inhalant-Induced Persisting Dementia
292.82 Other (or Unknown) Substance-Induced Persisting Dementia
292.82 Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Dementia
292.83 Other (or Unknown) Substance-Induced Persisting Amnestic Disorder
292.83 Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Amnestic Disorder
292.84 Amphetamine-Induced Mood Disorder

292.84 Cocaine-Induced Mood Disorder
292.84 Hallucinogen-Induced Mood Disorder
292.84 Inhalant-Induced Mood Disorder
292.84 Opioid-Induced Mood Disorder
292.84 Other (or Unknown) Substance-Induced Mood Disorder
292.84 Phencyclidine-Induced Mood Disorder
292.84 Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder
292.89 Amphetamine-Induced Anxiety Disorder
292.89 Amphetamine-Induced Sexual Dysfunction
292.89 Amphetamine-Induced Sleep Disorder
292.89 Amphetamine Intoxication
292.89 Caffeine-Induced Anxiety Disorder
292.89 Caffeine-Induced Sleep Disorder
292.89 Cannabis-Induced Anxiety Disorder
292.89 Cannabis Intoxication
292.89 Cocaine-Induced Anxiety Disorder
292.89 Cocaine-Induced Sexual Dysfunction
292.89 Cocaine-Induced Sleep Disorder
292.89 Cocaine Intoxication
292.89 Hallucinogen-Induced Anxiety Disorder
292.89 Hallucinogen Intoxication
292.89 Hallucinogen Persisting Perception Disorder
292.89 Inhalant-Induced Anxiety Disorder
292.89 Inhalant Intoxication
292.89 Opioid-Induced Sleep Disorder
292.89 Opioid-Induced Sexual Dysfunction
292.89 Opioid Intoxication
292.89 Other (or Unknown) Substance-Induced Anxiety Disorder
292.89 Other (or Unknown) Substance-Induced Sexual Dysfunction
292.89 Other (or Unknown) Substance-Induced Sleep Disorder
292.89 Other (or Unknown) Substance Intoxication
292.89 Phencyclidine-Induced Anxiety Disorder
292.89 Phencyclidine Intoxication
292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder
292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Sexual Dysfunction
292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Sleep Disorder
292.89 Sedative, Hypnotic, or Anxiolytic Intoxication
292.9 Amphetamine-Related Disorder NOS
292.9 Caffeine-Related Disorder NOS
292.9 Cannabis-Related Disorder NOS
292.9 Cocaine-Related Disorder NOS
292.9 Hallucinogen-Related Disorder NOS
292.9 Inhalant-Related Disorder NOS
292.9 Nicotine-Related Disorder NOS
292.9 Opioid-Related Disorder NOS
292.9 Other (or Unknown) Substance-Related Disorder NOS
292.9 Phencyclidine-Related Disorder NOS
292.9 Sedative-, Hypnotic-, or Anxiolytic-Related Disorder NOS
293.0 Delirium Due to ... *[Indicate the General Medical Condition}*

293.81 Psychotic Disorder Due to ... *[Indicate the General Medical Condition],* With Delusions

293.82 Psychotic Disorder Due to ... *[Indicate the General Medical Condition],* With Hallucinations

293.83 Mood Disorder Due to ... *!Indicate the General Medical Condition]*

293.89 Anxiety Disorder Due to ... *[Indicate the General Medical Condition]*

[293.89 Catatonic Disorder Due to ... *!Indicate the General Medical Condition]*

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

294.0 Amnestic Disorder Due to ... *!Indicate the General Medical Condition]*

294.1 Dementia Due to ... *!Indicate the General Medical Condition]*

294.8 Amnestic Disorder NOS

[294.8 Dementia NOS

294.9 Cognitive Disorder NOS

[294.9 Dementia Due to HIV Disease

295.10 Schizophrenia, Disorganized Type

295.20 Schizophrenia, Catatonic Type

295.30 Schizophrenia, Paranoid Type

295.40 Schizophreniform Disorder

295.60 Schizophrenia, Residual Type

295.70 Schizoaffective Disorder

295.90 Schizophrenia, Undifferentiated Type

296.00 Bipolar I Disorder, Single Manic Episode, Unspecified

296.01 Bipolar I Disorder, Single Manic Episode, Mild

296.02 Bipolar I Disorder, Single Manic Episode, Moderate

296.03 Bipolar I Disorder, Single Manic Episode, Severe Without Psychotic Features

296.04 Bipolar I Disorder, Single Manic Episode, Severe With Psychotic Features

296.05 Bipolar I Disorder, Single Manic Episode, In Partial Remission

296.06 Bipolar I Disorder, Single Manic Episode, In Full Remission

296.20 Major Depressive Disorder, Single Episode, Unspecified

296.21 Major Depressive Disorder, Single Episode, Mild

296.22 Major Depressive Disorder, Single Episode, Moderate

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

296.24 Major Depressive Disorder, Single Episode, Severe With Psychotic Features

296.25 Major Depressive Disorder, Single Episode, In Partial Remission

296.26 Major Depressive Disorder, Single Episode, In Full Remission

296.30 Major Depressive Disorder, Recurrent, Unspecified

296.31 Major Depressive Disorder, Recurrent, Mild

296.32 Major Depressive Disorder, Recurrent, Moderate

296.33 Major Depressive Disorder, Recurrent, Severe Without Psychotic Features

296.34 Major Depressive Disorder, Recurrent, Severe With Psychotic Features

296.35 Major Depressive Disorder, Recurrent, In Partial Remission

296.36 Major Depressive Disorder, Recurrent, In Full Remission

296.40 Bipolar I Disorder, Most Recent Episode Hypomanic

[296.40 Bipolar I Disorder, Most Recent Episode Manic, Unspecified

296.41 Bipolar I Disorder, Most Recent Episode Manic, Mild

296.42 Bipolar I Disorder, Most Recent Episode Manic, Moderate

296.43 Bipolar I Disorder, Most Recent Episode Manic, Severe Without Psychotic Features
296.44 Bipolar I Disorder, Most Recent Episode Manic, Severe With Psychotic Features
296.45 Bipolar I Disorder, Most Recent Episode Manic, In Partial Remission
296.46 Bipolar I Disorder, Most Recent Episode Manic, In Full Remission
296.50 Bipolar I Disorder, Most Recent Episode Depressed, Unspecified
296.51 Bipolar I Disorder, Most Recent Episode Depressed, Mild
296.52 Bipolar I Disorder, Most Recent Episode Depressed, Moderate
296.53 Bipolar I Disorder, Most Recent Episode Depressed, Severe Without Psychotic Features
296.54 Bipolar I Disorder, Most Recent Episode Depressed, Severe With Psychotic Features
296.55 Bipolar I Disorder, Most Recent Episode Depressed, In Partial Remission
296.56 Bipolar I Disorder, Most Recent Episode Depressed, In Full Remission
296.60 Bipolar I Disorder, Most Recent Episode Mixed, Unspecified
296.61 Bipolar I Disorder, Most Recent Episode Mixed, Mild
296.62 Bipolar I Disorder, Most Recent Episode Mixed, Moderate
296.63 Bipolar I Disorder, Most Recent Episode Mixed, Severe Without Psychotic Features
296.64 Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features
296.65 Bipolar I Disorder, Most Recent Episode Mixed, In Partial Remission
296.66 Bipolar I Disorder, Most Recent Episode Mixed, In Full Remission
296.7 Bipolar I Disorder, Most Recent Episode Unspecified
296.80 Bipolar Disorder NOS
296.89 Bipolar II Disorder
296.90 Mood Disorder NOS
297.1 Delusional Disorder
297.3 Shared Psychotic Disorder
298.8 Brief Psychotic Disorder
298.9 Psychotic Disorder NOS
299.00 Autistic Disorder
299.10 Childhood Disintegrative Disorder
299.80 Asperger's Disorder
299.80 Pervasive Developmental Disorder NOS
299.80 Rett's Disorder
300.00 Anxiety Disorder NOS
300.01 Panic Disorder Without Agoraphobia
300.02 Generalized Anxiety Disorder
300.11 Conversion Disorder
300.12 Dissociative Amnesia
300.13 Dissociative Fugue
300.14 Dissociative Identity Disorder
300.15 Dissociative Disorder NOS
300.16 Factitious Disorder With Predominantly Psychological Signs and Symptoms
300.19 Factitious Disorder NOS

300.19 Factitious Disorder With Combined Psychological and Physical Signs and Symptoms
300.19 Factitious Disorder With Predominantly Physical Signs and Symptoms
300.21 Panic Disorder With Agoraphobia
300.22 Agoraphobia Without History of Panic Disorder
300.23 Social Phobia
300.29 Specific Phobia
300.3 Obsessive-Compulsive Disorder
300.4 Dysthymic Disorder
300.6 Depersonalization Disorder
300.7 Body Dysmorphic Disorder
300.7 Hypochondriasis
300.81 Somatization Disorder
300.81 Somatoform Disorder NOS
300.81 Undifferentiated Somatoform Disorder
300.9 Unspecified Mental Disorder (nonpsychotic)
301.0 Paranoid Personality Disorder
301.13 Cyclothymic Disorder
301.20 Schizoid Personality Disorder
301.22 Schizotypal Personality Disorder
301.4 Obsessive-Compulsive Personality Disorder
301.50 Histrionic Personality Disorder
301.6 Dependent Personality Disorder
301.7 Antisocial Personality Disorder
301.81 Narcissistic Personality Disorder
301.82 Avoidant Personality Disorder
301.83 Borderline Personality Disorder
301.9 Personality Disorder NOS
302.2 Pedophilia
302.3 Transvestic Fetishism
302.4 Exhibitionism
302.6 Gender Identity Disorder in Children
302.6 Gender Identity Disorder NOS
302.70 Sexual Dysfunction NOS
302.71 Hypoactive Sexual Desire Disorder
302.72 Female Sexual Arousal Disorder
302.72 Male Erectile Disorder
302.73 Female Orgasmic Disorder
302.74 Male Orgasmic Disorder
302.75 Premature Ejaculation
302.76 Dyspareunia (Not Due to a General Medical Condition)
302.79 Sexual Aversion Disorder
302.81 Fetishism
302.82 Voyeurism
302.83 Sexual Masochism
302.84 Sexual Sadism
302.85 Gender Identity Disorder in Adolescents or Adults
302.89 Frotteurism
302.9 Paraphilia NOS

302.9 Sexual Disorder NOS
303.00 Alcohol Intoxication
303.90 Alcohol Dependence
304.00 Opioid Dependence
304.10 Sedative, Hypnotic, or Anxiolytic Dependence
304.20 Cocaine Dependence
304.30 Cannabis Dependence
304.40 Amphetamine Dependence
304.50 Hallucinogen Dependence
304.60 Inhalant Dependence
304.80 Polysubstance Dependence
304.90 Other (or Unknown) Substance Dependence
304.90 Phencyclidine Dependence
305.00 Alcohol Abuse
305.10 Nicotine Dependence
305.20 Cannabis Abuse
305.30 Hallucinogen Abuse
305.40 Sedative, Hypnotic, or Anxiolytic Abuse
305.50 Opioid Abuse
305.60 Cocaine Abuse
305.70 Amphetamine Abuse
305.90 Caffeine Intoxication
305.90 Inhalant Abuse
305.90 Other (or Unknown) Substance Abuse
305.90 Phencyclidine Abuse
306.51 Vaginismus (Not Due to a General Medical Condition)
307.0 Stuttering
307.1 Anorexia Nervosa
307.20 Tic Disorder NOS
307.21 Transient Tic Disorder
307.22 Chronic Motor or Vocal Tic Disorder
307.23 Tourette's Disorder
307.3 Stereotypic Movement Disorder
307.42 Insomnia Related to ... *[Indicate the Axis I or Axis II Disorder]*
307.42 Primary Insomnia
307.44 Hypersomnia Related to ... *[Indicate the Axis I or Axis II Disorder]*
307.44 Primary Hypersomnia
307.45 Circadian Rhythm Sleep Disorder
307.46 Sleep Terror Disorder
307.46 Sleepwalking Disorder
307.47 Dyssomnia NOS
307.47 Nightmare Disorder
307.47 Parasomnia NOS
307.50 Eating Disorder NOS
307.51 Bulimia Nervosa
307.52 Pica
307.53 Rumination Disorder
307.59 Feeding Disorder of Infancy or Early Childhood
307.6 Enuresis (Not Due to a General Medical Condition)

307.7 Encopresis, Without Constipation and Overflow Incontinence
307.80 Pain Disorder Associated With Psychological Factors
307.89 Pain Disorder Associated With Both Psychological Factors and a General Medical Condition
307.9 Communication Disorder NOS
308.3 Acute Stress Disorder
309.0 Adjustment Disorder With Depressed Mood
309.21 Separation Anxiety Disorder
309.24 Adjustment Disorder With Anxiety
309.28 Adjustment Disorder With Mixed Anxiety and Depressed Mood
309.3 Adjustment Disorder With Disturbance of Conduct
309.4 Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
309.81 Posttraumatic Stress Disorder
309.9 Adjustment Disorder Unspecified
310.1 Personality Change Due to ... *[Indicate the General Medical Condition}*
311 Depressive Disorder NOS
312.30 Impulse-Control Disorder NOS
312.31 Pathological Gambling
312.32 Kleptomania
312.33 Pyromania
312.34 Intermittent Explosive Disorder
312.39 Trichotillomania
312.8 Conduct Disorder
312.9 Disruptive Behavior Disorder NOS
313.23 Selective Mutism
313.81 Oppositional Defiant Disorder
313.82 Identity Problem
313.89 Reactive Attachment Disorder of Infancy or Early Childhood
313.9 Disorder of Infancy, Childhood, or Adolescence NOS
314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
[314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type
[314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type
314.9 Attention-Deficit/Hyperactivity Disorder NOS
315.00 Reading Disorder
315.1 Mathematics Disorder
315.2 Disorder of Written Expression
[315.31 Expressive Language Disorder
[315.31 Mixed Receptive-Expressive Language Disorder
315.39 Phonological Disorder
315.4 Developmental Coordination Disorder
315.9 Learning Disorder NOS
316 ... *[Specified Psychological Factor}* Affecting ... */Indicate the General Medical Condition]*
317 Mild Mental Retardation
318.0 Moderate Mental Retardation
318.1 Severe Mental Retardation
318.2 Profound Mental Retardation
319 Mental Retardation, Severity Unspecified

332.1 Neuroleptic-Induced Parkinsonism
333.1 Medication-Induced Postural Tremor
333.7 Neuroleptic-Induced Acute Dystonia
333.82 Neuroleptic-Induced Tardive Dyskinesia
333.90 Medication-Induced Movement Disorder NOS
333.92 Neuroleptic Malignant Syndrome
333.99 Neuroleptic-Induced Acute Akathisia
347 Narcolepsy
607.84 Male Erectile Disorder Due to ... *[Indicate the General Medical Condition}*
608.89 Male Dyspareunia Due to ... *[Indicate the General Medical Condition}*
608.89 Male Hypoactive Sexual Desire Disorder Due to ... *[Indicate the Medical Condition}*
608.89 Other Male Sexual Dysfunction Due to ... *[Indicate the General Medical Condition}*
625.0 Female Dyspareunia Due to ... *[Indicate the General Medical Condition}*
625.8 Female Hypoactive Sexual Desire Disorder Due to ... *[Indicate the General Medical Condition}*
625.8 Other Female Sexual Dysfunction Due to ... *[Indicate the General Medical Condition}*
780.09 Delirium NOS
780.52 Sleep Disorder Due to ... *[Indicate the General Medical Condition},* Insomnia Type
780.54 Sleep Disorder Due to ... *[Indicate the General Medical Condition},* Hypersomnia Type
780.59 Breathing-Related Sleep Disorder
780.59 Sleep Disorder Due to ... *[Indicate the General Medical Condition},* Mixed Type
780.59 Sleep Disorder Due to ... *[Indicate the General Medical Condition},* Parasomnia Type
780.9 Age-Related Cognitive Decline
787.6 Encopresis, With Constipation and Overflow Incontinence
799.9 Diagnosis Deferred on Axis II
799.9 Diagnosis or Condition Deferred on Axis I
995.2 Adverse Effects of Medication NOS
995.5 Neglect of Child *(if focus of attention is on victim)*
995.5 Physical Abuse of Child *(if focus of attention is on victim)*
995.5 Sexual Abuse of Child *(if focus of attention is on victim)*
995.81 Physical Abuse of Adult *(if focus of attention is on victim)*
995.81 Sexual Abuse of Adult *(if focus of attention is on victim)*
V15.81 Noncompliance With Treatment
V61.1 Partner Relational Problem
V61.1 Physical Abuse of Adult
V61.1 Sexual Abuse of Adult
V61.20 Parent-Child Relational Problem
V61.21 Neglect of Child
V61.21 Physical Abuse of Child
V61.21 Sexual Abuse of Child
V61.8 Sibling Relational Problem

V61.9	Relational Problem Related to a Mental Disorder or General Medical Condition
V62.2	Occupational Problem
V62.3	Academic Problem
V62.4	Acculturation Problem
V62.81	Relational Problem NOS
V62.82	Bereavement
V62.89	Borderline Intellectual Functioning
V62.89	Phase of Life Problem
V62.89	Religious or Spiritual Problem
V65.2	Malingering
V71.01	Adult Antisocial Behavior
V71.02	Child or Adolescent Antisocial Behavior
V71.09	No Diagnosis on Axis II
V71.09	No Diagnosis or Condition on Axis I

Appendix G

ICD--9--CM Codes for Selected General Medical Conditions and Medication--Induced Disorders

The official coding system in use as of the publication of DSM-IV is the *International Classification of Diseases,* 9th Revision, Clinical Modification (ICD-9-CM). This appendix contains two sections that are provided to facilitate ICD-9-CM coding: 1) codes for selected general medical conditions, and 2) codes for medication-induced disorders.

ICD--9--CM Codes for Selected General Medical Conditions

The codes specified for use on Axis I and Axis II of DSM-IV represent only a small fraction of the codes provided in ICD-9-CM. The conditions classified outside the "Mental Disorders" chapter of ICD-9-CM are also important for clinical diagnosis and management in mental health settings. Axis III is provided to facilitate the reporting of these conditions (seep. 27). To assist clinicians in finding the ICD-9-CM codes, this appendix provides a selective index of those ICD-9-CM codes for general medical conditions that are most relevant to diagnosis and care in mental health settings. ICD-9-CM offers diagnostic specificity beyond that reflected in many of the codes that appear in this appendix (e.g., to denote a specific anatomical site or the presence of a specific complication). In cases in which increased specificity is noted in the fifth digit of the code, the least specific code (usually "0") has been selected. For example, the code for lymphosarcoma is given as 200.10 (for unspecified site), although more specificity with regard to anatomical site can be noted in the other fifth-digit codes, for example, 200.12 lymphosarcoma, intrathoracic lymph nodes. In cases in which increased specificity is reflected in the fourth digit of the code, this appendix often provides the "unspecified" category (e.g., 555.9 is listed for regional enteritis; ICD-9-CM also includes 555.0 for enteritis involving the small intestine, 555.1 for involvement of the large intestine, and 555.2 for involvement of both). Diagnostic codes for which more specificity is available are indicated in this appendix by an asterisk(*). Clinicians interested in recording greater specificity should refer to the complete listing of codes published in the ICD-9-CM Diseases: Tabular List (Volume 1) and the ICD-9-CM Diseases: Alphabetic Index

(Volume 2). These documents are updated every October and are published by the U.S. Department of Health and Human Services. They are available from the Superintendent of Documents, U.S. Government Printing Office, as well as from a number of private publishers.

Note: An asterisk (*) following the ICD-9-CM code indicates that greater specificity (e.g., a specific complication or anatomical site) is available. Refer to the ICD-9-CM Diseases: Tabular List (Volume 1) entry for that code for additional information

Diseases of the Nervous System

324.0	Abscess, intracranial
331.0	Alzheimer's disease
437.0	Atherosclerosis, cerebral
354.0	Carpal tunnel syndrome
354.4	Causalgia
334.3	Cerebellar ataxia
850§	Concussion
851.80.	Contusion, cerebral
359.1	Dystrophy, Duchenne's muscular
348.5	Edema, cerebral
049§	Encephalitis, viral
572.2	Encephalopathy, hepatic
437.2	Encephalopathy, hypertensive
348.3.	Encephalopathy, unspecified
345_10·	Epilepsy, grand mal
345.40.	Epilepsy, partial, with impairment of consciousness (temporal lobe)
345.50·	Epilepsy, partial, without impairment of consciousness Qacksonian)
345.oo·	Epilepsy, petit mal (absences)
346.20	Headache, cluster
432.0	Hemorrhage, extradural, nontraumatic
852.40.	Hemorrhage, extradural, traumatic
431	Hemorrhage, intracerebral, nontraumatic
430	Hemorrhage, subarachnoid, nontraumatic
852.00·	Hemorrhage, subarachnoid, traumatic
432.1	Hemorrhage, subdural, nontraumatic
852.20·	Hemorrhage, subdural, traumatic
333.4	Huntington's chorea
331.3	Hydrocephalus, communicating
331.4	Hydrocephalus, obstructive
435§	Ischemic attack, transient
046.1	Creutzfeldt-Jakob disease
046.0	Kuru
046.3	Leukoencephalopathy, progressive multifocal
330.1	Lipidosis, cerebral
320§	Meningitis, bacterial (due to unspecified bacterium)
321.0	Meningitis, cryptococcal
054.72	Meningitis, herpes simplex virus

053.0	Meningitis, herpes zoster
321.1·	Meningitis, other fungal
094.2	Meningitis, syphilitic
047§	Meningitis, viral (due to unspecified virus)
346.oo·	Migraine, classical (with aura)
346.10·	Migraine, common
346.90·	Migraine, unspecified
358.0	Myasthenia gravis
350.1	Neuralgia, trigeminal
337.1	Neuropathy, peripheral autonomic
434§	Occlusion, cerebral artery
350.2	Pain, face, atypical
351.0	Palsy, Bell's
343§	Palsy, cerebral
335.23	Palsy, pseudobulbar
046.2	Panencephalitis, subacute sclerosing
094.1	Paresis, general
332.0	Parkinson's disease, primary
331.1	Pick's disease
357§	Polyneuropathy
348.2	Pseudotumor cerebri (benign intracranial hypertension)
335.20	Sclerosis, amyotrophic lateral
340	Sclerosis, multiple (MS)
345.3	Status, grand mal
345.2	Status, petit ma!
345.70	Status, temporal Jobe
433.1	Stenosis, carotid artery, without cerebral infarction
436	Stroke (CVA)
330.1	Tay-Sachs disease
333.1	Tremor, benign essential

Diseases of the Circulatory System

413§	Angina pectoris
424.1	Aortic valve disorder
440§	Atherosclerosis
414.0	Atherosclerotic heart disease
426.1•0	Block, atrioventricular
426.3 *	Block, left bundle branch
426.4	Block, right bundle branch
427.S	Cardiac arrest
425.5	Cardiomyopathy, alcoholic
425.4•	Cardiomyopathy, idiopathic
416§	Chronic pulmonary heart disease
427§	Dysrhythmia, cardiac, unspecified
415.1	Embolism, pulmonary
421.9°	Endocarditis, bacterial
428.o•	Failure, congestive heart

427.31	Fibrillation, atrial
427.41	Fibrillation, ventricular
427.32	Flutter, atrial
427.42	Flutter, ventricular
455.6'	Hemorrhoids
401.9'	Hypertension, essential
402.91*	Hypertensive heart disease with congestive heart failure
402.90*	Hypertensive heart disease without congestive heart failure
403.91*	Hypertensive renal disease with failure
403.90*	Hypertensive renal disease without failure
458.0	Hypotension, orthostatic
410.90*	Infarction, myocardial, acute
424.0	Mitra! valve insufficiency (nonrheumatic)
424.0	Mitra! valve prolapse
394.o·	Mitra! valve stenosis (rheumatic)
423§	Pericarditis
443§	Peripheral vascular disease
451§	Phlebitis/thrombophlebitis
446.0	Polyarteritis nodosa
427.60*	Premature beats
424.3	Pulmonary valve disease (nonrheumatic)
397.1	Pulmonary valve disease, rheumatic
427.0	Tachycardia, paroxysmal supraventricular
427.2	Tachycardia, paroxysmal, unspecified
427.1	Tachycardia, ventricular (paroxysmal)
424.2	Tricuspid valve disease (nonrheumatic)
397.0	Tricuspid valve disease, rheumatic
456.0	Varices, esophageal, with bleeding
456.1	Varices, esophageal, without bleeding
454§	Varicose veins, lower extremities

Diseases of *the Respiratory System*

513.0	Abscess of lung
518.0	Atelectasis
493,20*	Asthma, chronic obstructive
493,90"	Asthma, unspecified
494	Bronchiectasis
466.0	Bronchitis, acute
491.21	Bronchitis, obstructive chronic (COPD), with acute exacerbation
491.20	Bronchitis, obstructive chronic (COPD), without acute exacerbation
2n.oo·	Cystic fibrosis
511§	Effusion, pleural
492.8'	Emphysema
518.81'	Failure, respiratory
505	Pneumoconiosis
860.4'	Pneumohemothorax, traumatic
483.0	Pneumonia, mycoplasma

482§	Pneumonia, unspecified bacterial
481	Pneumonia, pneumococcal
136,3	Pneumonia, pneumocystis
482.30'	Pneumonia, streptococcus
486'	Pneumonia, unspecified organism
480§	Pneumonia, viral
512.8'	Pneumothorax, spontaneous
860.0*	Pneumothorax, traumatic
011§	Tuberculosis, pulmonary

Neoplasms

ICD-9-CM diagnostic codes for neoplasms are classified in the table of neoplasms in the ICD-9-CM Alphabetic Index (Volume 2) according to site and degree of malignancy (primary, secondary, in situ, benign, uncertain, unspecified). **Note:** For patients with a personal history of malignant neoplasms that have been surgically removed or eradicated by chemotherapy or radiation therapy, codes Vl0.0-Vl0.9 should be used; for specific sites, refer to the Alphabetic Index (Volume 2) of ICD-9-CM under "History (personal) of, malignant neoplasm."

Listed below are some of the most common codes assigned for neoplasms.

228.02	Hemangioma of brain
201.90'	Hodgkin's disease
176§	Kaposi's sarcoma
208.oi"	Leukemia, acute, in remission
208.00'	Leukemia, acute
208.11·	Leukemia, chronic, in remission
208.10·	Leukemia, chronic
200.10'	Lymphosarcoma
225.2	Meningioma (cerebral)
203.01	Multiple myeloma, in remission
203.00	Multiple myeloma
225.0	Neoplasm, benign, of brain
211.4	Neoplasm, benign, of colon
195.2	Neoplasm, malignant, abdominal cavity, primary
194.0	Neoplasm, malignant, adrenal gland, primary
188§	Neoplasm, malignant, bladder, primary
170.9'	Neoplasm, malignant, bone, primary
198.5	Neoplasm, malignant, bone, secondary
191.9'	Neoplasm, malignant, brain, primary
198.3	Neoplasm, malignant, brain, secondary
174§	Neoplasm, malignant, breast, female, primary
175§	Neoplasm, malignant, breast, male, primary
162§	Neoplasm, malignant, bronchus, primary
180§	Neoplasm, malignant, cervix, primary
153§	Neoplasm, malignant, colon, primary
197.5	Neoplasm, malignant, colon, secondary
171§	Neoplasm, malignant, connective tissue, primary
150§	Neoplasm, malignant, esophagus, primary

152§	Neoplasm, malignant, intestine, small, primary
1s9.o·	Neoplasm, malignant, kidney, primary
155.0	Neoplasm, malignant, liver, primary
197.7	Neoplasm, malignant, liver, secondary
162§	Neoplasm, malignant, lung, primary
197.0	Neoplasm, malignant, lung, secondary
196§	Neoplasm, malignant, lymph nodes, secondary
172§	Neoplasm, malignant, melanoma, primary
183.0·	Neoplasm, malignant, ovary, primary
157§	Neoplasm, malignant, pancreas, primary
185	Neoplasm, malignant, prostate, primary
154.1	Neoplasm, malignant, rectum, primary
173§	Neoplasm, malignant, skin, primary
151§	Neoplasm, malignant, stomach, site unspecified, primary
186§	Neoplasm, malignant, testis, primary
193	Neoplasm, malignant, thyroid, primary
179*	Neoplasm, malignant, uterus, prima1y
237.70.	Neurofibromatosis
227.0	Pheochromocytoma, benign
194.0	Pheochromocytoma, malignant
238.4	Polycythemia vera

Endocrine Diseases

253.0	Acromegaly
255.2	Adrenogenital disorder
259.2	Carcinoid syndrome
255.4	Corticoadrenal insufficiency
255.0	Cushing's syndrome
253.5	Diabetes insipidus
250.00·	Diabetes mellitus, type II/non-insulin-dependent
250.0(	Diabetes mellitus, type I/insulin-dependent
253.2	Dwarfism, pituitary
241§	Goiter, nontoxic nodular
240§	Goiter, simple
255.1	Hyperaldosteronism
252.0	Hyperparathyroidism
252.1	Hypoparathyroidism
244§	Hypothyroidism, acquired
243	Hypothyroidism, congenital
256§	Ovarian dysfunction
253.2	Panhypopituitarism
259.0	Sexual development and puberty, delayed
259.1	Sexual development and puberty, precocious
257§	Testicular dysfunction
245§	Thyroiditis
242§	Thyrotoxicosis

Nutritional Di,Seases

265.0	Beriberi
269.3	Calcium deficiency
266.2	Folic acid deficiency
269.3	Iodine deficiency
260	Kwashiorkor
262	Malnutrition, protein-caloric, severe
261	Nutritional marasmus
278.0	Obesity
265.2	Pellagra (niacin deficiency)
266.0	Riboflavin deficiency
264§	Vitamin A deficiency
266.1	Vitamin B6 deficiency
266.2	Vitamin B_{12} deficiency
267	Vitamin C deficiency
268§	Vitamin D deficiency
269.1	Vitamin E deficiency
269.0	Vitamin K deficiency

Metabolic Diseases

276.2	Acidosis
276.3	Alkalosis
277.3	Amyloidosis
276.5	Depletion, volume (dehydration)
271.3	Disaccharide malabsorption (lactose intolerance)
276§	Electrolyte imbalance
276.6	Fluid overload/retention
274§	Gout
275.0	Hemochromatosis
275.4	Hypercalcemia
276.7	Hyperkalemia
276.0	Hypernatremia
275.4	Hypocalcemia
276.8	Hypokalemia
276.1	Hyponatremia
270.1	Phenylketonuria (PKU)
277.1	Porphyria
277.2	Lesch-Nyhan syndrome
275.1	Wilson's disease

Diseases of the Digestive System

540§	Appendicitis, acute
578§	Bleeding, gastrointestinal
575.0	Cholecystitis, acute
575.1	Cholecystitis, chronic
571.2	Cirrhosis, alcoholic

556	Colitis, ulcerative
564.0	Constipation
555§	Crohn's disease
009.2	Diarrhea, infectious
558§	Diarrhea, unspecified
562.10	Diverticulitis of colon, unspecified
562.12	Diverticulitis of colon, with hemorrhage
562.11	Diverticulosis of colon, unspecified
562.13	Diverticulosis of colon, with hemorrhage
535_50·	Duodenitis and gastritis
555§	Enteritis, regional
535.50·	Gastritis and duodenitis
558§	Gastroenteritis
530.1	Esophagitis
571.1	Hepatitis, alcoholic, acute
571.40*	Hepatitis, chronic
573_3'	Hepatitis, toxic (includes drug induced)
070.1'	Hepatitis, viral A
070.30'	Hepatitis, viral **B**
070.Si*	Hepatitis, viral *C*
560.39.	Impaction, fecal
550.90·	Inguinal hernia
564.1	Irritable bowel syndrome
576.2	Obstruction, bile duct
560§	Obstruction, intestinal
577.0	Pancreatitis, acute
577.1	Pancreatitis, chronic
567§	Peritonitis
530.1	Reflux, esophageal
530.4	Rupture, esophageal
530.3	Stricture, esophageal
532.30'	Ulcer, duodenal, acute
532.70.	Ulcer, duodenal, chronic
531.30·	Ulcer, gastric, acute
531.70*	Ulcer, gastric, chronic

Genitourinary System Diseases

596.4	Atonic bladder
592.0	Calculus, renal
592.1	Calculus, ureter
592§	Calculus, urinary, unspecified
595§	Cystitis
625.3	Dysmenorrhea
617§	Endometriosis
584§	Failure, renal, acute
585	Failure, renal, chronic
403.91'	Failure, renal, hypertensive

586'	Failure, renal, unspecified
218§	Fibroid of uterus
580§	Glomerulonephritis, acute
600	Hypertrophy, prostatic, benign (BPH)
628§	Infertility, female
606§	Infertility, male
627§	Menopausal or postmenopausal disorder
626§	Menstruation, disorder of, and abnormal bleeding
625.2	Mittelschmerz
620.z*	Ovarian cyst
614§	Pelvic inflammatory disease (PID)
607.3	Priapism
618§	Prolapse, genital
601§	Prostatitis
593.3	Stricture, ureteral
598§	Stricture, urethral
599.0	Urinary tract infection CUTI)

Hematological Diseases

288.0	Agranulocytosis
287.0	Allergic purpura
284§	Anemia, aplastic
281.2	Anemia, folate-deficiency
283§	Anemia, hemolytic, acquired
283.11	Anemia, hemolytic-uremic syndrome
280§	Anemia, iron-deficiency
283.10	Anemia, nonautoimmune hemolytic, unspecified
283.19	Anemia, other autoimmune hemolytic
281.0	Anemia, pernicious
282.60*	Anemia, sickle-cell
286§	Coagulation defects
288.3	Eosinophilia
282.4	Thalassemia
237_5·	Thrombocytopenia

Diseases of the Eye

366§	369§
372§	
361§	
365§	
377_30·	
379_50·	
377.oo·	

Cataract	Optic hypoplasia
	Optic nystagmus
	Papilledema
	Visual loss
Conjunctivadisorder	
Detachment, retinal	
Glaucoma	
Neuritis	

Diseases of the Ear, Nose, and Throat

460	Common cold
389.9'	Hearing loss
464.0	Laryngitis, acute
386.oo·	Meniere's disease
382§	Otitis media
462	Pharyngitis, acute
477§	Rhinitis, allergic
461§	Sinusitis, acute
473§	Sinusitis, chronic
388.30'	Tinnitus, unspecified
463	Tonsillitis, acute

Musculoskeletal System and Connective Tissue Diseases

716.20·	Arthritis, allergic
711,90·	Arthritis, infective
714.0	Arthritis, rheumatoid
733,40•	Aseptic necrosis of bone
710.3	Dermatomyositis
722.91	Disc disorder, intervertebral, cervical
722.93	Disc disorder, intervertebral, lumbar
722.92	Disc disorder, intervertebral, thoracic
733.10·	Fracture, pathological
715,90*	Osteoarthrosis (osteoarthritis)
730.20·	Osteomyelitis
733.00·	Osteoporosis
710.1	Scleroderma (systemic sclerosis)
737.30	Scoliosis
710.2	Sjogren's disease
720.0	Spondylitis, ankylosing
710.0	Systemic lupus erythematosus

Diseases of the Skin

704.oo·	Alopecia
692§	Dermatitis, contact
693_0·	Dermatitis, due to substance (taken internally)
682§	Cellulitis, unspecified site
695.1	Erythema multiforme
703.0	Ingrowing nail
701.4	Keloid scar
696.ı*	Psoriasis
707.0	Ulcer, decubitus
708.0	Urticaria, allergic

Congenital Malformations, Deformations, and Chromosomal Abnormalities

749_10• Cleft lip
749.00• Cleft palate
758.3 Cri-du-chat syndrome (antimongolism)
758.0 Down's syndrome
760.71 Fetal alcohol syndrome
751.3 Hirschsprung's disease (congenital colon dysfunction)
742.3 Hydrocephalus, congenital
752.7 Indeterminate sex and pseudohermaphroditism
758.7 Klinefelter's syndrome
759.82 Marfan's syndrome
742.1 Microcephalus
741.90' Spina bifida
750.5 Stenosis, congenital hypertrophic pyloric
760.71 Toxic effects of alcohol
760.75 Toxic effects of cocaine
760.73 Toxic effects of hallucinogens
760.72 Toxic effects of narcotics
760.70 Toxic effects of other substances (including medications)
759.5 Tuberous sclerosis
758.6 Turner's syndrome
752.5 Undescended testicle

Diseases of Pregnancy, Childbirth, and the Puerperium

Diagnoses associated with pregnancies can be located in the Alphabetic Index (Vol- ume 2) of ICD-9-CM indented under "Pregnancy, complicated (by)," or "Pregnancy, management affected by." Listed below are some of the most common conditions.

642.00' Eclampsia
643.0' Hyperemesis gravidarum, mild
643.0" Hyperemesis gravidarum, with metabolic disturbance
642.0• Pre-eclampsia, mild
642.0' Pre-eclampsia, severe

HIV Infection

Common disorders associated with human immunodeficiency virus (HIV) infection are indexed under "Human immunodeficiency virus" in the Alphabetic Index (Volume 2) of ICD-9-CM.

HIV is classified into three categories depending on the progression of the disease, as follows:

042 HIV infection associated with specified conditions
043 HIV infection causing other specified conditions
044 Other HIV infections

Each category is further subdivided into fourth-digit subclassification for greater specificity. It is customary to report one diagnostic code for the HIV disease and one

code for the manifestation. Due to the complexity of the coding of HIV disease, direct reference to the Alphabetic Index (Volume 2) of ICD-9-CM is recommended.

042.0• AIDS with specified infections
42. •l AIDS with other specified infections
042.2' AIDS with specified malignant neoplasms
042§ AIDS, unspecified
43. o* AIDS-related complex (ARC) causing lymphadenopathy
43. •l HIV infection affecting central nervous system
043.2' ARC causing other disorders involving the immune mechanism
043.3' ARC causing other specific conditions
043§ ARC, unspecified
44. o* HIV infection causing specified acute infections
044§ HIV infections, unspecified

Infectious mseases

The following codes represent ICD-9-CM diagnostic codes for infections from specific organisms. Traditionally, codes for organisms from the 041 category are used as secondary codes (e.g., urinary tract infection due to *Escherichia coli* would be coded as 599.0 [primary diagnosis] and 041.4 [secondary diagnosis]).

006§ Amebiasis

112.5
112.4
112.0
112.2
112.3
112.9
112.1
099.41
001§
041.83
114§
078.1
079.2
117.5
041.4
007.1
098.1
041.5
070.1·
070.3'
070.51
054§
053§
115§
036§
079.99.
487.1

Candidiasis, disseminated
Candidiasis, lung Candidiasis,
mouth
Candidiasis, other urogenital sites Candidiasis,
skin and nails Candidiasis, unspecified site
Candidiasis, vulva and vagina *Chlamydia trachomatis*
Cholera
Clostridium peifrigens
Coccidioidomycosis
Condyloma acuminatum (viral warts) Coxsackie virus
Cryptococcosis *Escherichia coli (E. coli)* Giardiasis
Gonorrhea
Hemophilus influenzae (H. influenzae)
Hepatitis, viral A Hepatitis, viral B Hepatitis, viral C Herpes simplex Herpes zoster
Histoplasmosis
Infection, meningococcal Infection, viral, unspecified Influenza, unspecified

	Influenza, with pneumonia
041.3	*Klebsiella pneumoniae*
088.81	Lyme disease
084.6	Malaria
075	Mononucleosis
072.9*	Mumps
041.81	*Mycoplasma*
041.2	*Pneumococcus*
41.6	*Proteus*
41.7	*Pseudomonas*
071	Rabies
056.9*	Rubella
003.9*	Salmonella
135	Sarcoidosis
004.9	Shigellosis
041.10*	*Staphylococcus*
041.00*	*Streptococcus*
097.9*	Syphilis
082.9	Tick-borne rikettsiosis
130.9*	Toxoplasmosis
124	Trichinosis
131.9	Trichomoniasis
002.0	Typhoid fever
081.9*	Typhus

Overdose

Additional diagnostic codes for overdose/poisoning can be located in the Alphabetic Index (Volume 2) of ICD-9-CM in the table of drugs and chemicals, listed alphabetically by drug in the "Poisoning" column.

965.4	Acetaminophen
962.0	Adrenal cortical steroids
972.4	Amyl/butyl/ nitrite
962.1	Androgens and anabolic steroids
971.1	Anticholinergics
969.0	Antidepressants
967.0	Barbiturates
969.4	Benzodiazepine-based tranquilizers
969.2	Butyrophenone-based tranquilizers
967.1	Chloral hydrate
968.5	Cocaine
967.5	Glutethimide
969.6	Hallucinogens/cannabis
962.3	Insulin and antidiabetic agents
967.4	Methaqualone
968.2	Nitrous oxide
970.1	Opioid antagonists
965.00	Opioids

967.2 Paraldehyde
968.3 Phencyclidine
969.1 Phenothiazine-based tranquilizers
965.1 Salicylates
970.9 Stimulants
962.7 Thyroid and thyroid derivatives

Additional Codes for Medication.-fnduced Disorders

The following are the ICD-9-CM codes for selected medications that may cause Substance-Induced Disorders. They are made available for optional use by clinicians in situations in which these medications, prescribed at therapeutic dose levels, have resulted in one of the following: Substance-Induced Delirium, Substance-Induced Persisting Dementia, Substance-Induced Persisting Amnestic Disorder, Substance- Induced Psychotic Disorder, Substance-Induced Mood Disorder, Substance-Induced Anxiety Disorder, Substance-Induced Sexual Dysfunction, Substance-Induced Sleep Disorder, and Medication-Induced Movement Disorders. When used in multiaxial evaluation, the E-codes should be coded on Axis I immediately following the related disorder. It should be noted that these E-codes do not apply to poisonings or to a medication taken as an overdose.

Example: 292.39 Substance-Induced Mood Disorder, With Depressive Features
E932.2 Oral contraceptives

Analgesics and Antipyretics

E935.4 Acetaminophen/phenacetin
E935.1 Methadone
E935.6 Nonsteroidal anti-inflammatory agents
E935.2 Other narcotics (e.g., codeine, meperidine)
E935.3 Salicylates (e.g., aspirin)

Anticonvulsants

E936.3 Carbamazepine
E936.2 Ethosuximide
E937.0 Phenobarbital
E936.1 Phenytoin
E936.3 Valproic acid

Antiparkinsonian Medications

E936.4 Amantadine
E941.1 Benztropine
E933.0 Diphenhydramine
E936.4 L-Dopa

Neuroleptic Medications

E939.2 Butyrophenone-based neuroleptics (e.g., haloperidol)
E939.3 Other neuroleptics (e.g., thiothixene)
E939.1 Phenothiazine-hased neuroleptics (e.g., chlorpromazine)

Sedatives, Hypnotics, and Anxiolytics

E937.0 Barbiturates
E939.4 Benzodiazepine-based medications
E937.1 Chloral hydrate
E939.5 Hydroxyzine
E937.2 Paraldehyde

Other Psychotropic Medications

E939.0 Antidepressants
E939.6 Cannabis
E940.1 Opioid antagonists
E939.7 Stimulants (excluding central appetite depressants)

Cardiovascular Medications

E942.0 Antiarrhythmic medication (includes propranolol)
E942.2 Antilipemic and cholesterol-lowering medication
E942.1 Cardiac glycosides (e.g., digitalis)
E942.4 Coronary vasodilators (e.g., nitrates)
E942.3 Ganglion-blocking agents (pentamethonium)
E942.6 Other antihypertensive agents (e.g., clonidine, guanethidine, reserpine)
E942.S Other vasodilators (e.g., hydralazine)

Primarily Systemic Agents

E933.0 Antiallergic and antiemetic agents (excluding phenothiazines, hydroxyzine)
E941.1 Anticholinergics (e.g., atropine) and spasmolytics
E934.2 Anticoagulants
E933.1 Antineoplastic and immunosuppressive drugs
E941.0 Cholinergics (parasympathomimetics)
E941.2 Sympathomimetics (adrenergics)
E933.5 Vitamins (excluding vitamin K)

Medications Acting on Muscles and the Respiratory System

E945.7 Antiasthmatics (aminophylline)

E945.4	Antitussives (e.g., dextromethorphan)
E945.8	Other respiratory drugs
E945.0	Oxytocic agents (ergot alkaloids, prostaglandins)

E945.2 Skeletal muscle relaxants
E945.1 Smooth muscle relaxants (metaproterenol)

Hormones and Synthetic Substitutes

E932.0 Adrenal cortical steroids
E932.1 Anabolic steroids and androgens
E932.8 Antithyroid agents
E932.2 Ovarian hormones (includes oral contraceptives)
E932.7 Thyroid replacements

Diuretics and Mineral and Uric Acid Metabolism Drugs

E944.2 Carbonic acid anhydrase inhibitors
E944.3 Chlorthiazides
E944.0 Mercurial diuretics
E944.4 Other diuretics (furosemide, ethacrynic acid)
E944.1 Purine derivative diuretics
E944.7 Uric acid metabolism drugs (probenecid)

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 of Diseases and Related Health Problems,* Tenth Revision (ICD-10). To facilitate this transition process, the preparation of DSM-IV has been closely coordinated with the preparation of Chapter V, "Mental and Behavioural Disorders," of ICD-10 (developed by the World Health Organization). Consultations between the American Psychiatric Association and the World Health Organization have resulted in DSM-IV codes and terms that are fully compatible with the codes and terms in the tabular index of ICD-10. Presented below is the DSM-IV Classification with the ICD-10 codes.

NOS= Not Otherwise Specified.

An *x* appearing in a diagnostic code indicates that a specific code number is required.

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., F05.0 De- lirium Due to Hypothyroidism)

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

If criteria are no longer met, one of the following specifiers may be noted:

In Partial Remission
In Full Remission
Prior History

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence o - I

MENTAL RETARDATION (39)

Note: *These are coded on Axis II.*
F70.9 Mild Mental Retardation (41)
F71.9 Moderate Mental Retardation (41)
F72.9 Severe Mental Retardation (41)
F73.9 Profound Mental Retardation (41)
F79.9 Mental Retardation, Severity Unspecified (42)

LEARNING DISORDERS (46)
F81.0 Reading Disorder (48)
F81.2 Mathematics Disorder (50)
F81.8 Disorder of Written Expression (51)
F81.9 Learning Disorder NOS (53)

MOTOR SKILLS DISORDER
F82 Developmental Coordination Disorder (53)

COMMUNICATION DISORDERS (55)

F80.1 Expressive Language Disorder (55)
F80.2 Mixed Receptive-Expressive Language Disorder (58)
F80.0 Phonological Disorder (61)
F98.5 Stuttering (63)
F80.9 Communication Disorder NOS (65)

PERVASIVE DEVELOPMENTAL DISORDERS (65)
F84.0 Autistic Disorder (66)
F84.2 Rett's Disorder (71)
F84.3 Childhood Disintegrative Disorder (73)
F84.S Asperger's Disorder (75)
F84.9 Pervasive Developmental Disorder NOS (77)

ATTENTION-DEFICIT AND

DISRUPTIVE BEHAVIOR DISORDERS (78)
Attention-Deficit/Hyperactivity Disorder (78)
F90.0 Combined Type
F98.8 Predominantly Inattentive
F90.9 Attention-Deficit/Hyperactivity Disorder NOS (85)
F91.8 Conduct Disorder (85)
Spec/fy type: Childhood-Onset Type/ Adolescent-Onset Type

F91.3 Oppositional Defiant Disorder (91)
F91.9 Disruptive Behavior Disorder NOS (94)

FEEDING AND EATING DISORDERS OF INFANCY OR EARLY CHILDHOOD (94)
F98.3 Pica (95)

F98.2 Rumination Disorder (96)
F98.2 Feeding Disorder of Infancy or Early Childhood (98)

TIC DISORDERS (100)
F95.2 Tourette's Disorder (101)
F95.1 Chronic Motor or Vocal Tic Disorder 003)
F95.0 Transient Tic Disorder (104)
Specify If Single Episode/Recurrent
F95.9 Tic Disorder NOS (105)

ELIMINATION DISORDERS (106)
Encopresis (106)
R15 With Constipation and Overflow Incontinence *(also code K59.0 constipation on Axis JII)*

F98.1 Without Constipation and Overflow Incontinence
F98.0 Enuresis (Not Due to a General Medical Condition) (108)
Specify type: Nocturnal Only/Diurnal Only/Nocturnal and Diurnal

OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE
F93.0 Separation Anxiety Disorder (110)
Spec/fy if Early Onset
F94.0 Selective Mutism (114)

F94Tx
y
p1
e2
F98.4

Reactive Attachment Disorder of Infancy or Early Childhood (116)
Inhibited Type

F90.0 Predominantly Hyperactive-Impulsive Type

F98.9 Disorder of Infancy, Childhood, or Adolescence NOS (121)

Disinhibited Type

Stereotypic Movement Disorder (118)
Specify if With Self-Injurious Behavior

Delirium, Dementia, and Amnestic and Other Cognitive Disorders 023)

DELIRIUM (124)

F05.0 Delirium Due to ... *[Indicate the General Medical Condition] (code F05.1 if superimposed on Dementia)* (127)
Substance Intoxication Delirium *(refer to Substance-Related Disorders for substance-specific codes)* (129)
Substance Withdrawal Delirium *(refer to Substance-Related Disorders for substance-specific codes)* (129)
Delirium Due to Multiple Etiologies *(code each of the specific etiologies)* (132)

F05.9 Delirium NOS 033)

DEMENTIA 033)

FOO.xx Dementia of the Alzheimer's Type, With Early Onset *(also code G30.0Alzheimer's Disease, With Early Onset, on Axis III)* Cl39)
- .00 Uncomplicated
- .01 With Delusions
- .03 With Depressed Mood

Specify if With Behavioral Disturbance

FOO.xx Dementia of the Alzheimer's Type, With Late Onset *(also code G30.1 Alzheimer's Disease, With Late Onset, on Axis III)* 039)
- .10 Uncomplicated
- .11 With Delusions
- .13 With Depressed Mood

Specify (f With Behavioral Disturbance

F0l.xx Vascular Dementia (143)
- .80 Uncomplicated
- .81 With Delusions
- .83 With Depressed Mood

Specify if With Behavioral Disturbance

F02.4 Dementia Due to HIV Disease *(also code B22.0 HIV disease resulting in encephalopathy on Axis III)* (148)

F02.8 Dementia Due to Head Trauma *(also code S06.9 Intracranial injury on Axis III)* (148)

F02.3 Dementia Due to Parkinson's Disease *(also code G20 Parkinson's disease on Axis III)* (148)

F02.2 Dementia Due to Huntington's Disease *(also code Gl0 Huntington's disease on Axis III)* (149)

F02.0 Dementia Due to Pick's Disease *(also code G31.0 Pick's disease on Axis III)* (149)

F02.1 Dementia Due to Creutzfeldt-Jakob Disease *(also code A81.0 Creutzfeldt-Jakob disease on Axis III)* (150)

F02.8 Dementia Due to ... *!Indicate the General Medical Condition not listed above] (also code the general medical condition on Axis III)* (151)
Substance-Induced Persisting Dementia *(refer to Substance-Related Disorders for substance-specific codes)* 052)

F02.8 Dementia Due to Multiple Etiologies *(instead code F00.2 for mixed Alzheimer's and Vascular Dementia)* 054)

F03 Dementia NOS 055)

AMNESTIC DISORDERS (156)

F04 Amnestic Disorder Due to ... *[Indicate the General Medical Condition]* (158)

Specify if Transient/Chronic

Substance-Induced Persisting Amnestic Disorder *(refer to Substance-Related Disorders for substance-specific codes)* (161)

R41.3 Amnestic Disorder NOS (163)

OTHER COGNITIVE DISORDERS (163)
F06.9 Cognitive Disorder NOS (163)

Mental Disorders Due to a General Medical Condition Not Elsewhere Classified (16'))

F06.1 Catatonic Disorder Due to ... *[Indicate the General Medical Condition}* (169)
F07.0 Personality Change Due to ... *[Indicate the General Medical Condition}* (171)
Spec/fy type: Labile Type/Disinhibited Type/Aggressive Type/Apathetic Type/ Paranoid Type/Other Type/Combined Type/Unspecified Type
F09 Mental Disorder NOS Due to ... *[Indicate the General Medical Condition}* (174)

Substance-Related Disorders (175l

"The.following specifiers may be applied to Substance Dependence:

Specify **if** With Physiological Dependence/ Without Physiological Dependence

Code course of Dependence in.f(fth character:

0 = Early Full Remission/Early Partial Remission
0 = Sustained Full Remission/Sustained Partial Remission
1 = In a Controlled Environment
2 = On Agonise Therapy
4 = Mild/Moderate/Severe

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

[1]With Onset During Intoxication/wWith Onset During Withdrawal

ALCOHOL-REIATED DISORDERS 094)

Alcohol Use Disorders
F10.2x Alcohol Dependence" 095)
Fl0.1 Alcohol Abuse 096)

Alcohol-Induced Disorders
Fl0.00 Alcohol Intoxication (196)
Fl0.3 Alcohol Withdrawal (197)
Specify **if** With Perceptual Disturbances
Fl0.03 Alcohol Intoxication Delirium (129)
Fl0.4 Alcohol Withdrawal Delirium 029)
Fl0.73 Alcohol-Induced Persisting Dementia 052)
Fl0.6 Alcohol-Induced Persisting Amnestic Disorder (161)
FlO.xx Alcohol-Induced Psychotic Disorder (310)
.51 With Delusions[1]·w
.52 With Hallucinations [1]·w
Fl0.8 Alcohol-Induced Mood Disorder [1]·w (370)
Fl0.8 Alcohol-Induced Anxiety Disorder[1]·w (439)
Fl0.8 Alcohol-Induced Sexual Dysfunction' (519)
Fl0.8 Alcohol-Induced Sleep Disorder [1]·w (601)

Fl0.9 Alcohol-Related Disorder NOS (204)

AMPHETAMINE (OR AMPHETAMINE-LIKE}--

REIATED DISORDERS (204)

Amphetamine Use Disorders
Fl5.2x Amphetamine Dependence" (206)
F15.1 Amphetamine Abuse (206)

Amphetamine-Induced Disorders
F15.00 Amphetamine Intoxication (207)
F15.04 Amphetamine Intoxication, With Perceptual Disturbances (207)
F15.3 Amphetamine Withdrawal (208)
Fl5.03 Amphetamine Intoxication Delirium 029)
Fl5.xx Amphetamine-Induced Psychotic Disorder (310)
.51 With Delusions[1]
.52 With Hallu cinations[1] F15.8 Amphetamine-Induced Mood Disorder [1]·w (370)
F15.8 Amphetamine-Induced Anxiety Disorder' (439)
F15.8 Amphetamine-Induced Sexual Dysfunction' (519)
F15.8 Amphetamine-Induced Sleep Disorder [1]·w (601)

F18.8 Inhalant-Induced Mood Disorder [1] (370)
F18.8 Inhalant-Induced Anxiety Disorder [1] (439)

F18.9 Inhalant-Related Disorder NOS (242)

NICOTINE-REIATED DISORDERS (242)

Nicotine Use Disorder
F17.2x Nicotine Dependencea (243)

Nicotine-Induced Disorder
Fl7.3 Nicotine Withdrawal (244)

F17.9 Nicotine-Related Disorder NOS (247)

OPIOID-RELATED DISORDERS (247)

Opioid Use Disorders
Fll.2x Opioid Dependencea (248)
Fl1.1 Opioid Abuse (249)

Opioid-Induced Disorders
Fl1.00 Opioid Intoxication (249)
Fll.04 Opioid Intoxication, With Perceptual Disturbances (249)
Fll.3 Opioid Withdrawal (250)
Fl 1.03 Opioid Intoxication Delirium (129)

Fl I.xx Opioid-Induced Psychotic Disorder (310)
.51 With Delusions [1]
.52 With Hallucinations[1]

Fll.8 Opioid-Induced Mood Disorder[1] (370)

Fll.8 Opioid-Induced Sexual Dysfunction[1] (519)

Fll.8 Opioid-Induced Sleep Disorder[1]·w (601)

Fll.9 Opioid-Related Disorder NOS (255) Fl3.6

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

Phencyclidine-Induced Disorders
F19.00 Phencyclidine Intoxication (257)
F19.04 Phencyclidine Intoxication, With Perceptual Disturbances (257)
F19.03 Phencyclidine Intoxication Delirium (129)
F19.xx Phencyclidine-Induced Psychotic Disorder (310)
.51 With Delusions [1]
.52 With Hallucinations [1]
F19.8 Phencyclidine-Induced Mood Disorder [1] (370)
F19.8 Phencyclidine-Induced Anxiety Disorder [1] (439)

F19.9 Phencyclidine-Related Disorder NOS (261)

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

Sedative, Hypnotic, or Anxiolytic Use Disorders
F13.2x Sedative, Hypnotic, or Anxiolytic Dependencea (262)
F13.1 Sedative, Hypnotic, or Anxiolytic Abuse (263)

Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders
F13.00 Sedative, Hypnotic, or Anxiolytic Intoxication (263)
F13.3 Sedative, Hypnotic, or Anxiolytic Withdrawal (264)
Specify ***if*** With Perceptual Disturbances

F13.03 Sedative, Hypnotic, or Anxiolytic Intoxication Delirium (129)

F13.4 Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium (129)

F13.73 Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Dementia (152)
Sedative-, Hypnotic-, or

Phencyclidine Use Disorders
Fl9.2x Phencyclidine Dependencea (256) F19.1 Phencyclidine Abuse

Anxiolytic-Induced Persisting Amnestic Disorder (161)

F13.xx Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder (310)

.51 With Delusions [1]·w

.52 With Hallucinations [1]·w

F13.8 Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder [1]·w (370)
F13.8 Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorderw (439)
F13.8 Sedative-, Hypnotic-, or Anxiolytic-Induced Sexual Dysfunction[1] (519)
F13.8 Sedative-, Hypnotic-, or Anxiolytic-Induced Sleep Disorder [1]·w (601)

F13.9 Sedative-, Hypnotic-, or Anxiolytic-Related Disorder NOS (269)

POLYSUBSTANCE-RELATED DISORDER
F19.2x Polysubstance Dependencea (270)

OTHER (OR UNKNOWN) SUBSTANCE-RELATED DISORDERS (270)

Other (or Unknown) Substance Use Disorders
F19.2x Other (or Unknown) Substance Dependencea Cl76)
F19.1 Other (or Unknown) Substance Abuse (182)

Other (or Unknown) Substance-Induced Disorders
F19.00 Other (or Unknown) Substance Intoxication (183)
Fl9.04 Other (or Unknown) Substance Intoxication, With Perceptual Disturbances (183)
F19.3 Other (or Unknown) Substance Withdrawal (184)
Specify if With Perceptual Disturbances
F19.03 Other (or Unknown) Substance-Induced Delirium *(code F19.4 if onset during withdrawal)* (129)

F19.73 Other (or Unknown) Substance-Induced Persisting Dementia (152)
F19.6 Other (or Unknown) Substance-Induced Persisting Amnestic Disorder (161)
F19.xx Other (or Unknown) Substance-Induced Psychotic Disorder (310)
.51 With Delusions [1]·w
.52 With Hallucinations[1]·w
Fl9.8 Other (or Unknown) Substance-Induced Mood Disorder [1]·w (370)
Fl9.8 Other (or Unknown) Substance- Induced Anxiety Disorder [1]·w (439)
F19.8 Other (or Unknown) Substance-Induced Sexual Dysfunction [1] (519)

F19.8 Other (or Unknown) Substance-Induced Sleep Disorder[1]·w (601)

Fl9.9 Other (or Unknown) Substance-Related Disorder NOS (272)

Schizophrenia and Other Psychotic Disorders (273)

F20.xx Schizophrenia (274)
.Ox Paranoid Type (287)
.lx Disorganized Type (287)
.2x Catatonic Type (288)
.3x Undifferentiated Type (289)
.5x Residual Type (289)

Code course of Schizophrenia in fifth character:

2 = Episodic With Interepisode Residual Symptoms *(specify if* With Prominent Negative Symptoms)
3 = Episodic With No lnterepisode Residual Symptoms
0 = Continuous *(specify if* With Prominent Negative Symptoms)
4 = Single Episode In Partial Remission *(specffy if* With Prominent Negative Symptoms)
5 = Single Episode In Full Remission
8 = Other or Unspecified Pattern
9 = Less than 1 year since onset of initial active-phase symptoms

F20.8	Schizophreniform Disorder (290) *Specify if* Without Good Prognostic Features/With Good Prognostic Features
F25.x .0 .1	Schizoaffective Disorder (292) Bipolar Type Depressive Type

F22.0 Delusional Disorder (296)
Specify type: Erotomanic Type/Grandiose Type/Jealous Type/Persecutory Type/Somatic Type/Mixed Type/Unspecified Type

F23.xx Brief Psychotic Disorder (302)
.81 With Marked Stressor(s)
.80 Without Marked Stressor(s)
Specify ***if*** With Postpartum Onset

F24 Shared Psychotic Disorder (305)

F06.x Psychotic Disorder Due to ... *[Indicate the General Medical Condition}* (306)
.2 With Delusions
.0 With Hallucinations

Substance-Induced Psychotic Disorder *(refer to Substance-Related Disorders for substance-specific codes)* (310)
Specify ***if*** With Onset During Intoxication/With Onset During Withdrawal

F29 Psychotic Disorder NOS (315)

Mood Disorders (31 l

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

[3] Severity /Psychotic/Remission Specifiers!'Chronic/'With Catatonic Featurest1With 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 Pattern/With Rapid Cycling

DEPRESSIVE DISORDERS (339)

F32.x Major Depressive Disorder, Single Episode,b,c,d,e,f(339)

F33.x Major Depressive Disorder, Recurrenf,b,c,d,e,f,g,h(339)

Code current state of Major Depressive Episode in fourth character:

0=Mild
1 = Moderate
2 = Severe Without Psychotic Features
3 = Severe With Psychotic Features
Specij'y: Mood-Congruent Psychotic Features/Mood-Incongruent Psychotic Features
4 = In Partial Remission
4 = In Full Remission
9 = Unspecified

F34.1 Dysthymic Disorder (345)
Specify ***if*** Early Onset/Late Onset
Specify: With Atypical Features

F32.9 Depressive Disorder NOS (350)

BIPOIAR DISORDERS (350)

F30.x Bipolar I Disorder, Single Manic Episodea,c,f (350)
Specify ***if*** Mixed

Code current state of Manic Episode in fourth character:

1 = Mild, Moderate, or Severe Without Psychotic Features
2 = Severe With Psychotic Features
8 = In Partial or Full Remission

F31.0 Bipolar I Disorder, Most Recent Episode Hypomanicg,h,i (350)

F31.x Bipolar I Disorder, Most Recent Episode Manica,c,f,g,h,i (350)

Code current state of Manic Episode in fourth character:

1 = Mild, Moderate, or Severe Without Psychotic Features
2 = Severe With Psychotic Features
7 = In Partial or Full Remission

F31.6 Bipolar I Disorder, Most Recent Episode Mixeda,c,f,g,h,i(350)

F31.x Bipolar I Disorder, Most Recent Episode Depresseda,b,c,d,e,f,g,h,i (350)

Code current state of Major Depressive Episode in fourth character:

3 = Mild or Moderate
4 = Severe Without Psychotic Features
5 = Severe With Psychotic Features
7 = In Partial or Full Remission

F31.9 Bipolar I Disorder, Most Recent Episode Unspecifiedg,h,i (350)

F31.8 Bipolar II Disordef",b,c,d,e,f,g,h,i(359)
Specify (current or most recent episode): Hypomanic/Depressed

F34.0 Cyclothymic Disorder (363)

F31.9 Bipolar Disorder NOS (366)

F06.xx Mood Disorder Due to ...
[Indicate the General Medical Condition] (366)
.32 With Depressive Features
.32 With Major Depressive-Like Episode
.30 With Manic Features
.33 With Mixed Features Substance-Induced Mood Disorder *(refer to Substance-Related Disorders for substance-specffic codes)* (370)

Specify type: With Depressive Features/With Manic Features/With Mixed Features
Spec/fy !f With Onset During Intoxication/With Onset During Withdrawal

F39 Mood Disorder NOS (375)

Anxiety Disorders U95J

F41.0 Panic Disorder Without Agoraphobia (397)
F40.01 Panic Disorder With Agoraphobia (397)
F40.00 Agoraphobia Without History of Panic Disorder (403)
F40.2 Specific Phobia (405)
Specify type. Animal Type/Natural Environment Type/Blood-Injection-Injury Type/Situational Type/Other Type

F40.1 Social Phobia (411)
Specify if Generalized
F42.8 Obsessive-Compulsive Disorder (417)
Specijy if With Poor Insight
F43.1 Posttraumatic Stress Disorder (424)
Specijy if Acute/Chronic
Specify if With Delayed Onset
F43.0 Acute Stress Disorder (429)
F41.1 Generalized Anxiety Disorder (432)
F06.4 Anxiety Disorder Due to ...
[Indicate the General Medical Condition] (436)
Specify if With Generalized Anxiety/With Panic Attacks/With Obsessive-Compulsive Symptoms/With Phobic Symptoms
Substance-Induced Anxiety Disorder *(refer to Substance-Related Disorders for substance-specific codes)* (439)
Specify if With Generalized Anxiety/With Panic Attacks/With Obsessive-Compulsive Symptoms/With Phobic Symptoms
Specify if With Onset During Intoxication/With Onset During Withdrawal
F41.9 Anxiety Disorder NOS (444)

Somat oform Disorders (4 5)

F45.0 Somatization Disorder (446)
F45.1 Undifferentiated Somatoform Disorder (450)
F44.x Conversion Disorder (452)
.4 With Motor Symptom or Deficit
.5 With Seizures or Convulsions
.6 With Sensory Symptom or Deficit
.7 With Mixed Presentation
F45.4 Pain Disorder (458)

Spec/fy type: Associated With Psychological Factors/Associated With Both Psychological Factors and a General Medical Condition
Specify if Acute/Chronic
F45.2 Hypochondriasis (462)
Specify if With Poor Insight
F45.2 Body Dysmorphic Disorder (466)
F45.9 Somatoform Disorder NOS (468)

Factitious Disorders < 47 1 1

F68.1 Factitious Disorder (471)
Spec/fy type: With Predominantly Psychological Signs and Symptoms/With Predominantly Physical Signs and Symptoms/With Combined Psychological and Physical Signs and Symptoms
F68.l Factitious Disorder NOS (475)

Dissociative Disorders (477 1

Co ve Symptoms
mp
ulsi

Dissociative Amnesia (478)

Dissociative Fugue (481)

Dissociative Identity Disorder (484)

F48.1 Depersonalization Disorder (488)
F44.9 Dissociative Disorder NOS (490)

Sexual and Gender Identity Disorders (49.3>

SEXUAL DYSFUNCTIONS (493)
The 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
F52.0 Hypoactive Sexual Desire Disorder (496)
F52.10 Sexual Aversion Disorder (499)

Sexual Arousal Disorders
F52.2 Female Sexual Arousal Disorder (500)
F52.2 Male Erectile Disorder (502)

Orgasmic Disorders
F52.3 Female Orgasmic Disorder (505)
F52.3 Male Orgasmic Disorder (507)
F52.4 Premature Ejaculation (509)

Sexual Pain Disorders
F52.6 Dyspareunia (Not Due to a General Medical Condition) (511)

F52.5 Vaginismus (Not Due to a General Medical Condition) (513)

Sexual Dysfunction Due to a General Medical Condition (515)
N94.8 Female Hypoactive Sexual Desire Disorder Due to ... *!Indicate the General Medical Condition]* (515)
N50.8 Male Hypoactive Sexual Desire Disorder Due to ... *[Indicate the General Medical Condition]* (515)
N48.4 Male Erectile Disorder Due to ... *!Indicate the General Medical Condition]* (515)
N94.1 Female Dyspareunia Due to ... *!Indicate the General Medical Condition]* (515)
N50.8 Male Dyspareunia Due to ... *!Indicate the General Medical Condition]* (515)

N94.8 Other Female Sexual Dysfunction Due to ... *[Indicate the General Medical Condition]* (515)
N50.8 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

F52.9 Sexual Dysfunction NOS (522)

PARAPHILIAS (522)
F65.2 Exhibitionism (525)
F65.0 Fetishism (526)
F65.8 Frotteurism (527)
F65.4 Pedophilia (527)
Spec/fy ***if*** Sexually Attracted to Males/Sexually Attracted to Females/Sexually Attracted to Both
Specify ***if*** Limited *to* Incest
Specify type: Exclusive Type/Nonexclusive Type

F65.5 Sexual Masochism (529)
F65.5 Sexual Sadism (530)
F65.1 Transvestic Fetishism (530)
Specify ***!f*** With Gender Dysphoria
F65.3 Voyeurism (532)
F65.9 Paraphilia NOS (532)

GENDER IDENTIIT DISORDERS (532)
F64.x Gender Identity Disorder (532)
.2 in Children
.0 in Adolescents or Adults
Specify ***if*** Sexually Attracted to Males/Sexually Attracted *to* Females/Sexually Attracted *to* Both/Sexually Attracted to Neither
F64.9 Gender Identity Disorder NOS (538)

F52.9 Sexual Disorder NOS (538)

Eating Disorders (539)

F50.0 Anorexia Nervosa (539)
Spec/[Y type: Restricting Type; Binge-Eating/Purging Type
F50.2 Bulimia Nervosa (545)
Specify zype: Purging Type/ Nonpurging Type
F50.9 Eating Disorder NOS (550)

Sleep Disorders (551)

PRIMARY SLEEP DISORDERS (553)

Dyssomnias (553)
F51.0 Primary Insomnia (553)
F51.1 Primary Hypersomnia (557)
Specify if Recurrent
G47.4 Narcolepsy (562)
G47.3 Breathing-Related Sleep Disorder (567)
F51.2 Circadian Rhythm Sleep Disorder (573)
Specif.y zype. Delayed Sleep Phase Type/Jet Lag Type/Shift Work Type/ Unspecified Type
F51.9 Dyssomnia NOS (579)

Parasomnias (579)
F51.5 Nightmare Disorder (580)
F51.4 Sleep Terror Disorder (583)
F51.3 Sleepwalking Disorder (587)
F51.8 Parasomnia NOS (592)

SLEEP DISORDERS REIATED TO ANOTHER MENTAL DISORDER (592)
F51.0 Insomnia Related to ... *[Indicate the Axis I or Axis II Disorder}* (592)
F51.1 Hypersomnia Related to ... */Indicate the Axis I or Axis II Disorder}* (592)

OTHER SLEEP DISORDERS

G47.x Sleep Disorder Due to ... */Indicate the General Medical Condition}* (597)
.0 Insomnia Type
Substance-Induced Sleep Disorder *(refer to Substance-Related Disorders for substance-specific codes)* (601)
Specify zype. Insomnia Type/ Hypersomnia Type/Parasomnia Type/ Mixed Type
Spec/fy if With Onset During Intoxication/With Onset During Withdrawal

Impulse Control Disorders Not Elsewhere Classified (609)

F63.8 Intermittent Explosive Disorder (609)
F63.2 Kleptomania (612)
F63.1 Pyromania (614)
F63.0 Pathological Gambling (615)
F63.3 Trichotillomania (618)
F63.9 Impulse-Control Disorder NOS (621)

Adjustment Disorders (623)

F43.xx Adjustment Disorder (623)
.20 With Depressed Mood
.28 With Anxiety
.22 With Mixed Anxiety and Depressed Mood
.24 With Disturbance of Conduct
.25 With Mixed Disturbance of Emotions and Conduct
.9 Unspecified
Spec/fy if: Acute/Chronic

Personality Disorders <629)

Note: *These are coded on Axis II.*
F60.0 Paranoid Personality Disorder (634)
F60.1 Schizoid Personality Disorder (638)
F21 Schizotypal Personality Disorder (641)
F60.2 Antisocial Personality Disorder (645)
F60.31 Borderline Personality Disorder (650)

.1	Hypersomnia Type	F51.4	Histrionic Personality Disorder (655)
.8	Parasomnia Type	F60.8	Narcissistic Personality
.8	Mixed Type		Disorder (658)

Other Conditions That May Be a Focus of Clinical Attention (675)

PSYCHOLOGICAL FACTORS

AFFECTING MEDICAL CONDffiON (675)

F54 *... [Specified Psychological Factor}* Affecting *... [Indicate the General Medical Condition}* (675)
Choose name based on nature

ojfactors:
Mental Disorder Affecting Medical Condition
Psychological Symptoms Affecting Medical Condition
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)

G21.0 Neuroleptic-Induced Parkinsonism (679)
G21.0 Neuroleptic Malignant Syndrome (679)
G24.0 Neuroleptic-Induced Acute Dystonia (679)
G21.1 Neuroleptic-Induced Acute Akathisia (679)
G24.0 Neuroleptic-Induced Tardive Dyskinesia (679)
G25.1 Medication-Induced Postural Tremor (680)
G25.9 Medication-Induced Movement Disorder NOS (680)

OTHER MEDICATION-INDUCED DISORDER

T88.7 Adverse Effects of Medication NOS (680)

RELATIONAL PROBLEMS (680)

Z63.7 Relational Problem Related to a Mental Disorder or General Medical Condition (681)

Z63.8 Parent-Child Relational Problem *(code Z63.1 if focus of attention is on child)* (681)
Z63.0 Partner Relational Problem (681)
F93.3 Sibling Relational Problem (681)
Z63.9 Relational Problem NOS (681)

PROBLEMS RELATED TO ABUSE OR NEGLECT (682)

T74.1 Physical Abuse of Child (682)
T74.2 Sexual Abuse of Child (682)
T74.0 Neglect of Child (682)
T74.1 Physical Abuse of Adult (682)
T74.2 Sexual Abuse of Adult (682)

ADDITIONAL CONDffiONS THAT MAY BE A FOCUS OF CLINICAL ATTENTION (683)

Z91.1 Noncompliance With Treatment (683)
Z76.S Malingering (683)
Z72.8 Adult Antisocial Behavior (683)
Z72.8 Child or Adolescent Antisocial Behavior (684)
R41.8 Borderline Intellectual Functioning (684)
R41.8 Age-Related Cognitive Decline (684)
Z63.4 Bereavement (684)
Z55.8 Academic Problem (685)
Z56.7 Occupational Problem (685)
F93.8 Identity Problem (685)
Z71.8 Religious or Spiritual Problem (685)
Z60.3 Acculturation Problem (685)
Z60.0 Phase of Life Problem (685)

Additional Codes

F99 Unspecified Mental Disorder (nonpsychotic) (687)
203.2 No Diagnosis or Condition on Axis I (687)
R69 Diagnosis or Condition Deferred on Axis I (687)
203.2 No Diagnosis on Axis II (687)
R46.8 Diagnosis Deferred on Axis II (687)

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Appendix I

Outline for Cultural Formulation and Glossary of Culture Bound Syndromes

This appendix is divided into two sections. The first section 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.

Outline for Cultural Formulation

The following outline for cultural formulation is meant to supplement the multiaxial diagnostic assessment and to address difficulties that may be encountered in applying DSM-IV criteria in a multicultural environment. The cultural formulation provides a systematic review of the individual's cultural background, the role of the cultural context in the expression and evaluation of symptoms and dysfunction, and the effect that cultural differences may have on the relationship between the individual and the clinician.

As indicated in the introduction to the manual (seep. xxiv), it is important that the clinician take into account the individual's ethnic and cultural context in the evaluation of each of the DSM-IV axes. In addition, the cultural formulation suggested below provides an opportunity to describe systematically the individual's cultural and social reference group and ways in which the cultural context is relevant to clinical care. The clinician may provide a narrative summary for each of the following categories:

Cultural identity of the individual. Note the individual's ethnic or cultural refer- ence groups. For immigrants and ethnic minorities, note separately the degree of involvement with both the culture of origin and the host culture (where applicable). Also note language abilities, use, and preference (including multilingualism).

Cultural explanations of the individual's illness. The following may be identi- fied: the predominant idioms of distress through which symptoms or the need for social support are communicated (e.g., "nerves," possessing spirits, somatic complaints,

inexplicable misfortune), the meaning and perceived severity of the individual's symptoms in relation to norms of the cultural reference group, any local illness category used by the individual's family and community to identify the condition (see "Glossary of Culture-Bound Syndromes" below), the perceived causes or explanatory models that the individual and the reference group use to explain the illness, and current preferences for and past experiences with professional and popular sources of care.

Cultural factors related to psychosocial environment and levels of functioning. Note culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability. This would include stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and informational support.

Cultural elements of the relationship between the individual and the clinician. Indicate differences in culture and social status between the individual and the clinician and problems that these differences may cause in diagnosis and treatment (e.g., difficulty in communicating in the individual's first language, in eliciting symptoms or understanding their cultural significance, in negotiating an appropriate relationship or level of intimacy, in determining whether a behavior is normative or pathological).

Overall cultural assessment for diagnosis and care. The formulation concludes with a discussion of how cultural considerations specifically influence comprehensive diagnosis and care.

Glossary of Culture-Bound Syndromes

The term *culture-bound syndrome* denotes recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category. Many of these patterns are indigenously considered to be "illnesses," or at least afflictions, and most have local names. Although presentations conforming to the major DSM-IV categories can be found throughout the world, the particular symptoms, course, and social response are very often influenced by local cultural factors. In contrast, culture-bound syndromes are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations.

There is seldom a one-to-one equivalence of any culture-bound syndrome with a DSM diagnostic entity. Aberrant behavior that might be sorted by a diagnostician using DSM-IV into several categories may be included in a single folk category, and presentations that might be considered by a diagnostician using DSM-IV as belonging to a single category may be sorted into several by an indigenous clinician. Moreover, some conditions and disorders have been conceptualized as culture-bound syndromes specific to industrialized culture (e.g., Anorexia Nervosa, Dissociative Identity Disorder) given their apparent rarity or absence in other cultures. It should also be noted that all industrialized societies include distinctive subcultures and widely diverse immigrant groups who may present with culture-bound syndromes.

This glossary lists some of the best-studied culture-bound syndromes and idioms of

distress that may be encountered in clinical practice in North America and includes relevant DSM-IV categories when data suggest that they should be considered in a diagnostic formulation.

amok A dissociative episode characterized by a period of brooding followed by an outburst of violent, aggressive, or homicidal behavior directed at people and objects. The episode tends to be precipitated by a perceived slight or insult and seems to be prevalent only among males. The episode is often accompanied by persecutory ideas, automatism, amnesia, exhaustion, and a return to premorbid state following the episode. Some instances of amok may occur during a brief psychotic episode or constitute the onset or an exacerbation of a chronic psychotic process. The original reports that used this term were from Malaysia. A similar behavior pattern is found in Laos, Philippines, Polynesia *(cajard* or *cathard),* Papua New Guinea, and Puerto Rico *(mat depelea),* and among the Navajo *(iich'aa).*

ataque de nervios An idiom of distress principally reported among Latinos from the Caribbean, but recognized among many Latin American and Latin Mediterranean groups. Commonly reported symptoms include uncontrollable shouting, attacks of crying, trembling, heat in the chest rising into the head, and verbal or physical aggression. Dissociative experiences, seizurelike or fainting episodes, and suicidal gestures are prominent in some attacks but absent in others. A general feature of an ataque de nervios is a sense of being out of control. Ataques de nervios frequently occur as a direct result of a stressful event relating to the family (e.g., news of the death of a close relative, a separation or divorce from a spouse, conflicts with a spouse or children, or witnessing an accident involving a family member). People may experience amnesia for what occurred during the ataque de nervios, but they otherwise return rapidly to their usual level of functioning. Although descriptions of some ataques de nervios most closely fit with the DSM-IV description of Panic Attacks, the association of most ataques with a precipitating event and the frequent absence of the hallmark symptoms of acute fear or apprehension distinguish them from Panic Disorder. Ataques span the range from normal expressions of distress not associated with having a mental disorder to symptom presentations associated with the diagnoses of Anxiety, Mood, Dissociative, or Somato- form Disorders.

bills and **colera** (also referred to as *muina)* The underlying cause of these syndromes is thought to be strongly experienced anger or rage. Anger is viewed among many Latino groups as a particularly powerful emotion that can have direct effects on the body and can exacerbate existing symptoms. The major effect of anger is to disturb core body balances (which are understood as a balance between hot and cold valences in the body and between the material and spiritual aspects of the body). Symptoms can include acute nervous tension, headache, trembling, screaming, stomach disturbances, and, in more severe cases, loss of consciousness. Chronic fatigue may result from the acute episode.

boufee delirante A syndrome observed in West Africa and Haiti. This French term refers to a sudden outburst of agitated and aggressive behavior, marked confusion, and psychomotor excitement. It may sometimes be accompanied by visual and auditory hallucinations or paranoid ideation. These episodes may resemble an episode of Brief Psychotic Disorder.

brain fag A term initially used in West Africa to refer to a condition experienced by high school or university students in response to the challenges of schooling. Symptoms include difficulties in concentrating, remembering, and thinking. Students often state that their brains are "fatigued." Additional somatic symptoms are usually centered around the head and neck and include pain, pressure or tightness, blurring of vision, heat, or burning. "Brain tiredness" or fatigue from "too much thinking" is an idiom of distress in many cultures, and resulting syndromes can resemble certain Anxiety, Depressive, and Somatoform Disorders.

dhat A folk diagnostic term used in India to refer to severe anxiety and hypochondriacal concerns associated with the discharge of semen, whitish discoloration of the urine, and feelings of weakness and exhaustion. Similar to *jiryan* (India), *sukra prameha* (Sri Lanka), and *shen-k'uei* (China).

falling-out or blacking out These episodes occur primarily in southern United States and Caribbean groups. They are characterized by a sudden collapse, which sometimes occurs without warning but sometimes is preceded by feelings of dizziness or "swim- ming" in the head. The individual's eyes are usually open but the person claims an inability to see. The person usually hears and understands what is occurring around him or her but feels powerless to move. This may correspond to a diagnosis of Conversion Disorder or a Dissociative Disorder.

ghost sickness A preoccupation with death and the deceased (sometimes associated with witchcraft) frequently observed among members of many American Indian tribes. Various symptoms can be attributed to ghost sickness, including bad dreams, weakness, feelings of danger, loss of appetite, fainting, dizziness, fear, anxiety, hallucinations, loss of consciousness, confusion, feelings of futility, and a sense of suffocation.

hwa-byung (also known as **wool-hwa-byung)** A Korean folk syndrome literally translated into English as "anger syndrome" and attributed to the suppression of anger. The symptoms include insomnia, fatigue, panic, fear of impending death, dysphoric affect, indigestion, anorexia, dyspnea, palpitations, generalized aches and pains, and a feeling of a mass in the epigastrium.

koro A term, probably of Malaysian origin, that refers to an episode of sudden and intense anxiety that the penis (or, in females, the vulva and nipples) will recede into the body and possibly cause death. The syndrome is reported in south and east Asia, where it is known by a variety of local terms, such as *shuk yang, shook yong,* and *suo yang* (Chinese); *jinjinia bemar* (Assam); or *rok-joo* (Thailand). It is occasionally found in the West. Koro at times occurs in localized epidemic form in east Asian areas. This diagnosis is included in the *Chinese Classification of Mental Disorders,* Second Edition (CCMD-2).

latah Hypersensitivity to sudden fright, often with echopraxia, echolalia, command obedience, and dissociative or trancelike behavior. The term *latah* is of Malaysian or Indonesian origin, but the syndrome has been found in many parts of the world. Other terms for this condition are *amurakh, irkunii, ikota, olan, myriachit,* and *menkeiti* (Siberian groups); *bah tschi, bah-tsi, haah-ji* (Thailand); *imu* (Ainu, Sakhalin, Japan); and *mali-mali* and *silok* (Philippines). In Malaysia it is more frequent in middle-aged women.

locura A term used by Latinos in the United States and Latin America to refer to a severe form of chronic psychosis. The condition is attributed to an inherited vulnerability, to the effect of multiple life difficulties, or to a combination of both factors. Symptoms exhibited by persons with locura include incoherence, agitation, auditory and visual hallucinations, inability to follow rules of social interaction, unpredictability, and possible violence.

ma1 de ojo A concept widely found in Mediterranean cultures and elsewhere in the world. *Mal de ojo* is a Spanish phrase translated into English as "evil eye." Children are especially at risk. Symptoms include fitful sleep, crying without apparent cause_, diarrhea, vomiting, and fever in a child or infant. Sometimes adults (especially females) have the condition.

nervios A common idiom of distress among Latinos in the United States and Latin America. A number of other ethnic groups have related, though often somewhat distinctive, ideas of "nerves" (such as *nevra* among Greeks in North America). Nervios refers both to a general state of vulnerability to stressful life experiences and to a syndrome brought on by difficult life circumstances. The term *neroios* includes a wide range of symptoms of emotional distress, somatic disturbance, and inability to function. Common symptoms include headaches and "brain aches," irritability, stomach distur- bances, sleep difficulties, nervousness, easy tearfulness, inability to concentrate, trembling, tingling sensations, and *mareos* (dizziness with occasional vertigo-like exacerbations). Nervios tends to be an ongoing problem, although variable in the degree of disability manifested. Nervios is a very broad syndrome that spans the range from cases free of a mental disorder to presentations resembling Adjustment, Anxiety, Depressive, Dissociative, Somatoform, or Psychotic Disorders. Differential diagnosis will depend on the constellation of symptoms experienced, the kind of social events that are associated with the onset and progress of nervios, and the level of disability experienced.

pibloktoq An abrupt dissociative episode accompanied by extreme excitement of up to 30 minutes' duration and frequently followed by convulsive seizures and coma lasting up to 12 hours. This is observed primarily in arctic and subarctic Eskimo communities, although regional variations in name exist. The individual may be withdrawn or mildly irritable for a period of hours or days before the attack and will typically report complete amnesia for the attack. During the attack, the individual may tear off his or her clothing, break furniture, shout obscenities, eat feces, flee from protective shelters, or perform other irrational or dangerous acts.

qi-gong psychotic reaction A term describing an acute, time-limited episode characterized by dissociative, paranoid, or other psychotic or nonpsychotic symptoms that may occur after participation in the Chinese folk health-enhancing practice of qi-gong ("exercise of vital energy"). Especially vulnerable are individuals who become overly involved in the practice. This diagnosis is included in the *Chinese Classification of Mental Disorders,* Second Edition (CCMD-2).

rootwork A set of cultural interpretations that ascribe illness to hexing, witchcraft, sorcery, or the evil influence of another person. Symptoms may include generalized anxiety and gastrointestinal complaints (e.g., nausea, vomiting, diarrhea), weakness, dizziness, the fear of being poisoned, and sometimes fear of being killed ("voodoo

death"). "Roots," "spells," or "hexes" can be "put" or placed on other persons, causing a variety of emotional and psychological problems. The "hexed" person may even fear death until the "root" has been "taken off' (eliminated), usually through the work of a "root doctor" (a healer in this tradition), who can also be called on to bewitch an enemy. "Rootwork" is found in the southern United States among both African American and European American populations and in Caribbean societies. It is also known as *mat puesto* or *brujeria* in Latino societies.

sangue dormido ("sleeping blood") This syndrome is found among Portuguese Cape Verde Islanders (and immigrants from there to the United States) and includes pain, numbness, tremor, paralysis, convulsions, stroke, blindness, heart attack, infection, and miscarriage.

shenjing shuairuo ("neurasthenia") In China, a condition characterized by physical and mental fatigue, dizziness, headaches, other pains, concentration difficulties, sleep disturbance, and memory loss. Other symptoms include gastrointestinal problems, sexual dysfunction, irritability, excitability, and various signs suggesting disturbance of the autonomic nervous system. In many cases, the symptoms would meet the criteria for a DSM-IV Mood or Anxiety Disorder. This diagnosis is included in the *Chinese Classification of Mental Disorders,* Second Edition (CCMD-2).

shen-k'uei (Taiwan); **shenkui** (China) A Chinese folk label describing marked anxiety or panic symptoms with accompanying somatic complaints for which no physical cause can be demonstrated. Symptoms include dizziness, backache, fatigability, general weakness, insomnia, frequent dreams, and complaints of sexual dysfunction (such as premature ejaculation and impotence). Symptoms are attributed to excessive semen loss from frequent intercourse, masturbation, nocturnal emission, or passing of "white turbid urine" believed to contain semen. Excessive semen loss is feared because of the belief that it represents the loss of one's vital essence and can thereby be life threatening.

shin-byung A Korean folk label for a syndrome in which initial phases are character- ized by anxiety and somatic complaints (general weakness, dizziness, fear, anorexia, insomnia, gastrointestinal problems), with subsequent dissociation and possession by ancestral spirits.

spell A trance state in which individuals "communicate" with deceased relatives or with spirits. At times this state is associated with brief periods of personality change. This culture-specific syndrome is seen among African Americans and European Americans from the southern United States. Spells are not considered to be medical events in the folk tradition, but may be misconstrued as psychotic episodes in clinical settings.

susto ("fright," or "soul loss") A folk illness prevalent among some Latinos in the United States and among people in Mexico, Central America, and South America. Susto is also referred to as *espanto, pasmo, tripa ida, perdida del alma,* or *chibih.* Susto is an illness attributed to a frightening event that causes the soul to leave the body and results in unhappiness and sickness. Individuals with susto also experience significant strains in key social roles. Symptoms may appear any time from days to years after the fright is experienced. It is believed that in extreme cases, susto may result in death. Typical symptoms include appetite disturbances, inadequate or excessive sleep, troubled sleep or dreams, feeling of sadness, lack of motivation to do anything, and feelings of low

self-worth or dirtiness. Somatic symptoms accompanying susto include muscle aches and pains, headache, stomachache, and diarrhea. Ritual healings are focused on calling the soul back to the body and cleansing the person to restore bodily and spiritual balance. Different experiences of susto may be related to Major Depressive Disorder, Posttraumatic Stress Disorder, and Somatoform Disorders. Similar etiological beliefs and symptom configurations are found in may parts of the world.

taijin kyofusho A culturally distinctive phobia in Japan, in some ways resembling Social Phobia in DSM-IV. This syndrome refers to an individual's intense fear that his or her body, its parts or its functions, displease, embarrass, or are offensive to other people in appearance, odor, facial expressions, or movements. This syndrome is included in the official Japanese diagnostic system for mental disorders.

zar A general term applied in Ethiopia, Somalia, Egypt, Sudan, Iran, and other North African and Middle Eastern societies to the experience of spirits possessing an individual. Persons possessed by a spirit may experience dissociative episodes that may include shouting, laughing, hitting the head against a wall, singing, or weeping. Individuals may show apathy and withdrawal, refusing to eat or carry out daily tasks, or may develop a long-term relationship with the possessing spirit. Such behavior is not considered pathological locally.

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Appendix J

DSM IV Contributors

Because DSM-IV is meant to be used by a diverse group of mental health professionals in a variety of settings, the Task Force on DSM-IV and the Work Groups solicited and encouraged the participation of a wide range of professionals to serve as advisers to the Task Force and individual Work Groups. Advisers included individuals from other health associations; clinical practitioners; researchers; forensic specialists; experts on gender, age, and cultural issues; and international experts. Advisory groups identified pertinent questions regarding each diagnosis; developed and critiqued literature reviews, text, and criteria; and participated in field-trial and data- reanalysis projects. The Task Force on DSM-IV and the Work Group members extend their appreciation and heartfelt thanks to the individuals and organizations who contributed so generously of their time and expertise.

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MacArthur General Reliability Field Trial

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At the inception of the project, the Task Force on DSM-IV invited over 60 health associations to designate liaisons to the Task Force to ensure the openness of the revision process and to ensure that a variety of views would be represented. The associations listed below designated representatives who received regular communications from the Work Groups and the Task Force.

American Academy of Child and Adolescent Psychiatry
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American Academy of Pediatrics
American Academy of Psychiatrists in Alcoholism and Addictions
American Academy of Psychiatry and the Law
American Association for Geriatric Psychiatry
American Association for Marriage and Family Therapy
American Association of Chairmen of Departments of Psychiatry
American Association of Directors of Psychiatric Residency Training
American Association of Psychiatric Administrators
American Board of Family Practice
American College of Obstetricians and Gynecologists

American College of Physicians
American Group Psychotherapy Association
American Health Information Management Association
American Medical Society on Alcohol and Other Drug Dependencies
American Nurses' Association
American Occupational Therapy Association
American Psychoanalytic Association
American Psychological Association
American Psychological Society
American Psychosomatic Society, Inc.
American Society for Adolescent Psychiatry
Association of Departments of Family Medicine
Association of Gay and Lesbian Psychiatrists
Association of Mental Health Clergy
Coalition for the Family
Group for the Advancement of Psychiatry
National Alliance for the Mentally Ill
National Association of Social Workers
National Association of Veterans Affairs Chiefs of Psychiatry
National Center for Health Statistics
National Council of Community Mental Health Centers
National Depressive and Manic Depressive Association
National Medical Association
National Mental Health Association
Society of General Internal Medicine
Society of Teachers of Family Medicine
World Health Organization

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