lacrimation or rhinorrhea; pupillary dilation, piloerection, or increased sweating; diarrhea; yawning; fever; and insomnia (Criterion B). Piloerection and fever are associated with more severe withdrawal and are not often seen in routine clinical practice because individuals with Opioid Dependence usually obtain substances before withdrawal becomes that far advanced. These symptoms of Opioid Withdrawal must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C). The symptoms must not be due to a general medical condition and are not better accounted for by another mental disorder (Criterion D).

In most individuals who are dependent on short-acting drugs such as heroin, withdrawal symptoms begin within 6–12 hours after the last dose. Symptoms may take 2–4 days to emerge in the case of longer-acting drugs such as methadone or LAAM (L-alpha-acetylmethadol). Acute withdrawal symptoms for a short-acting opioid such as heroin usually peak within 1–3 days and gradually subside over a period of 5–7 days. Less acute withdrawal symptoms can last for weeks to months. These more chronic symptoms include anxiety, dysphoria, anhedonia, insomnia, and drug craving. Virtually all individuals with Opioid Dependence report a physiological component, including 50% who have experienced withdrawal.

Diagnostic criteria for 292.0 Opioid Withdrawal

A. Either of the following:

   (1) cessation of (or reduction in) opioid use that has been heavy and prolonged (several weeks or longer)
   (2) administration of an opioid antagonist after a period of opioid use

B. Three (or more) of the following, developing within minutes to several days after Criterion A:

   (1) dysphoric mood
   (2) nausea or vomiting
   (3) muscle aches
   (4) lacrimation or rhinorrhea
   (5) pupillary dilation, piloerection, or sweating
   (6) diarrhea
   (7) yawning
   (8) fever
   (9) insomnia

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

D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Other Opioid-Induced Disorders

The following Opioid-Induced Disorders are described in other sections of the manual with disorders with which they share phenomenology: **Opioid Intoxication Delirium** (p. 143), **Opioid-Induced Psychotic Disorder** (p. 338), **Opioid-Induced Mood Disorder** (p. 405), **Opioid-Induced Sexual Dysfunction** (p. 562), and **Opioid-Induced Sleep Disorder** (p. 655). These disorders are diagnosed instead of Opioid Intoxication or Opioid Withdrawal only when the symptoms are in excess of those usually associated with the Opioid Intoxication or Withdrawal syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention.

Additional Information on Opioid-Related Disorders

Associated Features and Disorders

Associated descriptive features and mental disorders. Opioid Dependence is commonly associated with a history of drug-related crimes (e.g., possession or distribution of drugs, forgery, burglary, robbery, larceny, or receiving stolen goods). Among health care professionals and individuals who have ready access to controlled substances, there is often a different pattern of illegal activities involving problems with state licensing boards, professional staffs of hospitals, or other administrative agencies. Divorce, unemployment, or irregular employment is often associated with Opioid Dependence at all socioeconomic levels.

For many individuals, the effect of taking an opioid for the first time is dysphoric rather than euphoric, and nausea and vomiting may result. Individuals with Opioid Dependence are at risk for the development of mild to moderate depression that meets symptomatic and duration criteria for Dysthymic Disorder, and sometimes for Major Depressive Disorder. These symptoms may represent an Opioid-Induced Mood Disorder (see p. 405) or exacerbations of a preexisting primary depressive disorder. Periods of depression are especially common during chronic intoxication or in association with physical or psychosocial stressors that are related to the Opioid Dependence. Insomnia is common, especially during withdrawal. Antisocial Personality Disorder is much more common in individuals with Opioid Dependence than in the general population. Posttraumatic Stress Disorder is also seen with increased frequency. A history of Conduct Disorder in childhood or adolescence has been identified as a significant risk factor for Substance-Related Disorders, especially Opioid Dependence.

Associated laboratory findings. Routine urine toxicology tests are often positive for opioid drugs in individuals with Opioid Dependence. Urine tests remain positive for most opioids for 12–36 hours after administration. Longer-acting opioids (e.g., methadone and LAAM) can be identified in urine for several days. Fentanyl is not detected by standard urine tests but can be identified by more specialized procedures. Laboratory evidence of the presence of other substances (e.g., cocaine, marijuana, alcohol, amphetamines, benzodiazepines) is common. Screening tests for hepatitis A, B,

and C are positive in as many as 80%–90% of intravenous users, either for hepatitis antigen (signifying active infection) or hepatitis antibody (signifying past infection). Mildly elevated liver function tests are common, either as a result of resolving hepatitis or from toxic injury to the liver due to contaminants that have been mixed with the injected opioid. Subtle changes in cortisol secretion patterns and body temperature regulation have been observed for up to 6 months following opioid detoxification.

Associated physical examination findings and general medical conditions. Acute and chronic opioid use are associated with a lack of secretions, causing dry mouth and nose, slowing of gastrointestinal activity, and constipation. Visual acuity may be impaired as a result of pupillary constriction. In individuals who use opioids intravenously, sclerosed veins ("tracks") and puncture marks on the lower portions of the upper extremities are common. Veins sometimes become so badly sclerosed that peripheral edema develops and individuals switch to veins in the legs, neck, or groin. When these veins become unusable or otherwise unavailable, individuals often inject directly into their subcutaneous tissue ("skin-popping"), resulting in cellulitis, abscesses, and circular-appearing scars from healed skin lesions. Tetanus and *Clostridium botulinum* infections are relatively rare but extremely serious consequences of injecting opioids, especially with contaminated needles. Infections may also occur in other organs and include bacterial endocarditis, hepatitis, and human immunodeficiency virus (HIV) infection. Tuberculosis is a particularly serious problem among individuals who use drugs intravenously, especially those dependent on heroin. Infection with the tubercle bacillus is usually asymptomatic and evident only by the presence of a positive tuberculin skin test. However, many cases of active tuberculosis have been found, especially among those who are infected with HIV. These individuals often have a newly acquired infection, but also are likely to experience reactivation of a prior infection due to impaired immune function. Persons who sniff heroin or other opioids ("snorting") often develop irritation of the nasal mucosa, sometimes accompanied by perforation of the nasal septum. Difficulties in sexual functioning are common. Males often experience erectile dysfunction during intoxication or chronic use. Females commonly have disturbances of reproductive function and irregular menses.

The incidence of HIV infection is high among individuals who use intravenous drugs, a large proportion of whom are individuals with Opioid Dependence. HIV infection rates have been reported to be as high as 60% among persons dependent on heroin in some areas of the United States.

In addition to infections such as cellulitis, hepatitis, HIV, tuberculosis, and endocarditis, Opioid Dependence is associated with a death rate as high as 1.5%–2% per year. Death most often results from overdose, accidents, injuries, AIDS, or other general medical complications. Accidents and injuries due to violence that is associated with buying or selling drugs are common. In some areas, violence accounts for more opioid-related deaths than overdose or HIV infection. Physiological dependence on opioids may occur in about half of the infants born to females with Opioid Dependence; this can produce a severe withdrawal syndrome requiring medical treatment. Although low birth weight is also seen in children of mothers with Opioid Dependence, it is usually not marked and is generally not associated with serious adverse consequences.

Specific Culture, Age, and Gender Features

Since the 1920s, in the United States, members of minority groups living in economically deprived areas have been overrepresented among persons with Opioid Dependence. However, in the late 1800s and early 1900s, Opioid Dependence was seen more often among white middle-class individuals, especially women, suggesting that differences in use reflect the availability of opioid drugs and other social factors. Medical personnel who have ready access to opioids may have an increased risk for Opioid Abuse and Dependence.

Increasing age is associated with a decrease in prevalence. This tendency for Dependence to remit generally begins after age 40 years and has been called "maturing out." However, many persons have remained opioid dependent for 50 years or longer. Males are more commonly affected, with the male-to-female ratio typically being 1.5:1 for opioids other than heroin (i.e., available by prescription) and 3:1 for heroin.

Prevalence

A 1996 national survey of drug use reported that 6.7% of men and 4.5% of women in the United States acknowledged ever using an analgesic drug in a manner other than that for which it was prescribed, including 2% who had used these drugs in the prior year and approximately 1% who had taken these drugs in the prior month. The medically inappropriate use of analgesics had its highest lifetime prevalence among individuals between ages 18 and 25 (9%), with 5% in this age group acknowledging ever having taken the drug in the prior year, and 2% acknowledging ever having taken the drug in the prior month. The lifetime prevalence for heroin use was around 1%, with 0.2% having taken the drug during the prior year. A 1997 survey of drug use among high school students reported that around 2% of high school seniors had ever taken heroin and 10% acknowledged the inappropriate use of other "analgesics." These lifetime heroin rates for high school seniors are higher than the 1990 and 1994 rates (1.3% and 1.2%, respectively) and represent the highest figures since the 1975 rate of over 2%.

Because the surveys assessed patterns of use rather than disorders, it is not known how many of those who used analgesics or heroin had symptoms that met criteria for Dependence or Abuse. A community study conducted in the United States from 1980 to 1985 that used the more narrowly defined DSM-III criteria found that 0.7% of the adult population had Opioid Dependence or Abuse at some time in their lives. Among those individuals with Dependence or Abuse, 18% reported use in the last month and 42% reported having had a problem with opioids in the last year.

Course

Opioid Dependence can begin at any age, but problems associated with opioid use are most commonly first observed in the late teens or early 20s. Once Dependence develops, it usually continues over a period of many years, even though brief periods of abstinence are frequent. Relapse following abstinence is common. Although relapses do occur, and while some long-term mortality rates have been reported to be as high as 2% per year, about 20%–30% of individuals with Opioid Dependence

achieve long-term abstinence. An exception to the chronic course of Opioid Dependence was observed in service personnel who became dependent on opioids in Vietnam. On their return to the United States, less than 10% of those who had been dependent on opioids relapsed, although they experienced increased rates of Alcohol or Amphetamine Dependence. Few data are available on the course of Opioid Abuse.

Familial Pattern

The family members of individuals with Opioid Dependence are likely to have higher levels of psychopathology, especially an increased incidence of other Substance-Related Disorders and Antisocial Personality Disorder.

Differential Diagnosis

For a general discussion of the differential diagnosis of Substance-Related Disorders, see p. 207. Opioid-Induced Disorders may be characterized by symptoms (e.g., depressed mood) that resemble **primary mental disorders** (e.g., Dysthymic Disorder versus Opioid-Induced Mood Disorder, With Depressive Features, With Onset During Intoxication). See p. 210 for a discussion of this differential diagnosis. Opioids are less likely to produce symptoms of mental disturbance than are most other drugs of abuse. **Alcohol Intoxication** and **Sedative, Hypnotic, or Anxiolytic Intoxication** can cause a clinical picture that resembles Opioid Intoxication. A diagnosis of Alcohol or Sedative, Hypnotic, or Anxiolytic Intoxication can usually be made based on the absence of pupillary constriction or the lack of a response to a naloxone challenge. In some cases, intoxication may be due both to opioids and to alcohol or other sedatives. In these cases, the naloxone challenge will not reverse all of the sedative effects. The anxiety and restlessness associated with Opioid Withdrawal resemble symptoms seen in **Sedative, Hypnotic, or Anxiolytic Withdrawal.** However, Opioid Withdrawal is also accompanied by rhinorrhea, lacrimation, and pupillary dilation, which are not seen in sedative-type withdrawal. Dilated pupils are also seen in **Hallucinogen Intoxication, Amphetamine Intoxication,** and **Cocaine Intoxication.** However, other signs or symptoms of Opioid Withdrawal such as nausea, vomiting, diarrhea, abdominal cramps, rhinorrhea, or lacrimation are not present. Opioid Intoxication and Opioid Withdrawal are distinguished from the **other Opioid-Induced Disorders** (e.g., Opioid-Induced Mood Disorder, With Onset During Intoxication) because the symptoms in these latter disorders are in excess of those usually associated with Opioid Intoxication or Opioid Withdrawal and are severe enough to warrant independent clinical attention.

292.9 Opioid-Related Disorder Not Otherwise Specified

The Opioid-Related Disorder Not Otherwise Specified category is for disorders associated with the use of opioids that are not classifiable as Opioid Dependence, Opioid Abuse, Opioid Intoxication, Opioid Withdrawal, Opioid Intoxication Delirium, Opioid-Induced Psychotic Disorder, Opioid-Induced Mood Disorder, Opioid-Induced Sexual Dysfunction, or Opioid-Induced Sleep Disorder.

Phencyclidine (or Phencyclidine-Like)–Related Disorders

The phencyclidines (or phencyclidine-like substances) include phencyclidine (PCP, Sernylan) and the less potent but similarly acting compounds such as ketamine (Ketalar, Ketaject), cyclohexamine, and dizocilpine. These substances were first developed as dissociative anesthetics in the 1950s and became street drugs in the 1960s. They can be taken orally or intravenously or can be smoked. Phencyclidine (sold illicitly under a variety of names such as PCP, Hog, Tranq, Angel Dust, and PeaCe Pill) is the most commonly abused substance in this class.

This section contains discussions specific to the Phencyclidine-Related Disorders. Texts and criteria sets have already been provided for the generic aspects of Substance Dependence (p. 192) and Substance Abuse (p. 198) that apply across all substances. The application of these general criteria to Phencyclidine Dependence and Abuse is provided below. However, there are no unique criteria sets for Phencyclidine Dependence or Phencyclidine Abuse. A specific text and criteria set for Phencyclidine Intoxication is also provided below. Although symptoms of phencyclidine withdrawal may occur, their clinical significance is uncertain, and a diagnosis of phencyclidine withdrawal is not included in this manual. The Phencyclidine-Induced Disorders (other than Phencyclidine Intoxication) are described in the sections of the manual with disorders with which they share phenomenology (e.g., Phencyclidine-Induced Psychotic Disorder is included in the "Schizophrenia and Other Psychotic Disorders" section). Listed below are the Phencyclidine Use Disorders and the Phencyclidine-Induced Disorders.

Phencyclidine Use Disorders

304.60 **Phencyclidine Dependence** (see p. 279)
305.90 **Phencyclidine Abuse** (see p. 279)

Phencyclidine-Induced Disorders

292.89 **Phencyclidine Intoxication** (see p. 280) *Specify if:* With Perceptual Disturbances
292.81 **Phencyclidine Intoxication Delirium** (see p. 143)
292.11 **Phencyclidine-Induced Psychotic Disorder, With Delusions** (see p. 338) *Specify if:* With Onset During Intoxication
292.12 **Phencyclidine-Induced Psychotic Disorder, With Hallucinations** (see p. 338) *Specify if:* With Onset During Intoxication
292.84 **Phencyclidine-Induced Mood Disorder** (see p. 405) *Specify if:* With Onset During Intoxication
292.89 **Phencyclidine-Induced Anxiety Disorder** (see p. 479) *Specify if:* With Onset During Intoxication
292.9 **Phencyclidine-Related Disorder Not Otherwise Specified** (see p. 283)

Phencyclidine Use Disorders

304.60 Phencyclidine Dependence

Refer, in addition, to the text and criteria for Substance Dependence (see p. 192). Some of the generic criteria for Substance Dependence do not apply to phencyclidine. Although "craving" has been reported by individuals with heavy use, neither tolerance nor withdrawal symptoms have been clearly demonstrated in humans (although both have been shown to occur in animal studies). Phencyclidine is usually not difficult to obtain, and individuals with Phencyclidine Dependence often use it at least two to three times per day, thus spending a significant proportion of their time using the substance and experiencing its effects. Phencyclidine use may continue despite the presence of psychological problems (e.g., disinhibition, anxiety, rage, aggression, panic, flashbacks) or medical problems (e.g., hyperthermia, hypertension, seizures) that the individual knows are caused by the substance. Individuals with Phencyclidine Dependence can manifest dangerous behavioral reactions due to lack of insight and judgment while intoxicated. Aggressive behavior involving fighting—probably the result of disorganized thinking, agitation, and impaired judgment—has been identified as an especially problematic adverse effect of phencyclidine. As with hallucinogens, adverse reactions to phencyclidine may be more common among individuals with preexisting mental disorders.

Specifiers

The following specifiers may be applied to a diagnosis of Phencyclidine Dependence (see p. 195 for more details):

Early Full Remission
Early Partial Remission
Sustained Full Remission
Sustained Partial Remission
In a Controlled Environment

305.90 Phencyclidine Abuse

Refer, in addition, to the text and criteria for Substance Abuse (see p. 198). Although individuals who abuse phencyclidine use the substance much less often than those with Dependence, they may repeatedly fail to fulfill major role obligations at school, work, or home because of Phencyclidine Intoxication. Individuals may use phencyclidine in situations where it is physically hazardous (such as while operating heavy machinery or driving a motorcycle or car). Legal difficulties may arise due to possession of phencyclidine or to behaviors resulting from Intoxication (e.g., fighting). There may be recurrent social or interpersonal problems due to the individual's behavior while intoxicated or to the chaotic lifestyle, multiple legal problems, or arguments with significant others.

Phencyclidine-Induced Disorders

292.89 Phencyclidine Intoxication

Refer, in addition, to the text and criteria for Substance Intoxication (see p. 199). The essential feature of Phencyclidine Intoxication is the presence of clinically significant maladaptive behavioral changes (e.g., belligerence, assaultiveness, impulsiveness, unpredictability, psychomotor agitation, impaired judgment, or impaired social or occupational functioning) that develop during, or shortly after, use of phencyclidine (or a related substance) (Criteria A and B). These changes are accompanied by two or more of the following signs that develop within an hour of using the substance (or less when it is smoked, "snorted," or used intravenously): vertical or horizontal nystagmus, hypertension or tachycardia, numbness or diminished responsiveness to pain, ataxia, dysarthria, muscle rigidity, seizures or coma, and hyperacusis (Criterion C). The symptoms must not be due to a general medical condition and are not better accounted for by another mental disorder (Criterion D).

Specific signs and symptoms are dose related. Lower doses of phencyclidine produce vertigo, ataxia, nystagmus, mild hypertension, abnormal involuntary movements, slurred speech, nausea, weakness, slowed reaction times, euphoria or affective dulling, and lack of concern. Disorganized thinking, changed body image and sensory perception, depersonalization, and feelings of unreality occur at intermediate doses. There is evidence that individuals with Schizophrenia may experience an exacerbation of psychotic symptoms. Higher doses produce amnesia and coma, with analgesia sufficient for surgery, and seizures with respiratory depression occur at the highest doses. Effects begin almost immediately after intravenous use or smoking, reaching a peak within minutes. Peak effects occur about 2 hours after oral doses. In milder intoxications, the effects resolve after 8–20 hours, whereas signs and symptoms of severe intoxications may persist for several days. Phencyclidine-Induced Psychotic Disorder (p. 338) may persist for weeks.

Specifier

The following specifier may be applied to a diagnosis of Phencyclidine Intoxication:

> **With Perceptual Disturbances.** This specifier may be noted when hallucinations with intact reality testing or auditory, visual, or tactile illusions occur in the absence of a delirium. *Intact reality testing* means that the person knows that the hallucinations are induced by the substance and do not represent external reality. When hallucinations occur in the absence of intact reality testing, a diagnosis of Substance-Induced Psychotic Disorder, With Hallucinations, should be considered.

Diagnostic criteria for 292.89 Phencyclidine Intoxication

A. Recent use of phencyclidine (or a related substance).

B. Clinically significant maladaptive behavioral changes (e.g., belligerence, assaultiveness, impulsiveness, unpredictability, psychomotor agitation, impaired judgment, or impaired social or occupational functioning) that developed during, or shortly after, phencyclidine use.

C. Within an hour (less when smoked, "snorted," or used intravenously), two (or more) of the following signs:

(1) vertical or horizontal nystagmus
(2) hypertension or tachycardia
(3) numbness or diminished responsiveness to pain
(4) ataxia
(5) dysarthria
(6) muscle rigidity
(7) seizures or coma
(8) hyperacusis

D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Specify if:

With Perceptual Disturbances

Other Phencyclidine-Induced Disorders

The following Phencyclidine-Induced Disorders are described in other sections of the manual with disorders with which they share phenomenology: **Phencyclidine Intoxication Delirium** (p. 143), **Phencyclidine-Induced Psychotic Disorder** (p. 338), **Phencyclidine-Induced Mood Disorder** (p. 405), and **Phencyclidine-Induced Anxiety Disorder** (p. 479). These disorders are diagnosed instead of Phencyclidine Intoxication only when the symptoms are in excess of those usually associated with the Phencyclidine Intoxication syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention.

Additional Information on Phencyclidine-Related Disorders

Associated Features and Disorders

Associated descriptive features and mental disorders. Although individuals with Phencyclidine Intoxication may remain alert and oriented, they may show delirium, coma, psychotic symptoms, or catatonic mutism with posturing. Repeated intoxica-

tions may lead to job, family, social, or legal problems. Violence, agitation, and bizarre behavior (e.g., confused wandering) may occur. Individuals with Phencyclidine Dependence or Abuse may report repeated intoxication-induced hospitalizations, emergency-room visits, and arrests for confused or bizarre behavior or for fighting. Conduct Disorder in adolescents and Antisocial Personality Disorder in adults may be associated with phencyclidine use. Dependence on other substances (especially cocaine, alcohol, and amphetamines) is common among those who have Phencyclidine Dependence.

Associated laboratory findings. Phencyclidine (or a related substance) is present in the urine of individuals who are acutely intoxicated with one of these substances. The substance may be detectable in urine for several weeks after the end of prolonged or very high dose use because of its high lipid solubility. Phencyclidine may be detected more readily in acidic urine. Creatine phosphokinase (CPK) and serum glutamic-oxaloacetic transaminase (SGOT) are often elevated, reflecting muscle damage.

Associated physical examination findings and general medical conditions. Phencyclidine Intoxication produces extensive cardiovascular and neurological (e.g., seizures, dystonias, dyskinesias, catalepsy, and hypothermia or hyperthermia) toxicity. Since almost half of individuals with Phencyclidine Intoxication present with nystagmus or elevated blood pressure, these physical signs can be useful in identifying a phencyclidine user. In those with Phencyclidine Dependence or Abuse, there may be physical evidence of injuries from accidents, fights, and falls. Needle tracks, hepatitis, human immunodeficiency virus (HIV) disease, and bacterial endocarditis may be found among the relatively few individuals who take phencyclidine intravenously. Drowning, even in small volumes of water, has been reported. Respiratory problems arise with apnea, bronchospasm, bronchorrhea, aspiration during coma, and hypersalivation. Rhabdomyolysis with renal impairment is seen in about 2% of individuals who seek emergency care. Cardiac arrest is a rare outcome.

Specific Culture, Age, and Gender Features

The prevalence of phencyclidine-related problems appears to be higher among males (about twofold), among those between ages 20 and 40 years, and among ethnic minorities (about twofold). Males compose about three-quarters of those with phencyclidine-related emergency-room visits.

Prevalence

Medical examiners nationally report that phencyclidine is involved in about 3% of deaths associated with substance use. It is mentioned as a problem in about 3% of substance-related emergency-room visits. According to a 1996 national survey of drug use in the United States, more than 3% of those age 12 and older acknowledged ever using phencyclidine, with 0.2% reporting use in the prior year. The highest lifetime prevalence was in those aged 26–34 years (4%), while the highest proportion using phencyclidine in the prior year (0.7%) was in those aged 12–17 years. It should be noted that because these surveys measured patterns of use rather than disorders, it is

not known how many of those in the survey who used phencyclidine had symptoms that met criteria for Dependence or Abuse. The prevalence of Phencyclidine Dependence or Abuse in the general population is unknown.

Differential Diagnosis

For a general discussion of the differential diagnosis of Substance-Related Disorders, see p. 207. Phencyclidine-Induced Disorders may be characterized by symptoms (e.g., depressed mood) that resemble **primary mental disorders** (e.g., Major Depressive Disorder versus Phencyclidine-Induced Mood Disorder, With Depressive Features, With Onset During Intoxication). See p. 210 for a discussion of this differential diagnosis. Recurring episodes of psychotic or mood symptoms due to Phencyclidine Intoxication may mimic **Schizophrenia** or **Mood Disorders.** History or laboratory evidence of phencyclidine use establishes a role for the substance but does not rule out the co-occurrence of other primary mental disorders. Rapid onset of symptoms, presence of delirium, or observation of nystagmus or hypertension also suggests Phencyclidine Intoxication rather than Schizophrenia, but phencyclidine use may induce acute psychotic episodes in individuals with preexisting Schizophrenia. Rapid resolution of symptoms and the absence of a history of Schizophrenia may aid in this differentiation. Drug-related violence or impaired judgment may co-occur with, or may mimic aspects of, **Conduct Disorder** or **Antisocial Personality Disorder.** Absence of behavioral problems before the onset of substance use, or during abstinence, may help to clarify this differentiation.

Phencyclidine and related substances may produce perceptual disturbances (e.g., scintillating lights, perception of sounds, illusions, or formed visual images) that the person usually recognizes as resulting from the drug use. If reality testing remains intact and the person neither believes that the perceptions are real nor acts on them, the specifier With Perceptual Disturbances is noted for Phencyclidine Intoxication. If reality testing is impaired, the diagnosis of **Phencyclidine-Induced Psychotic Disorder** should be considered.

Differentiating Phencyclidine Intoxication from **other Substance Intoxications** (with which it often coexists) depends on a history of having taken the substance, the presence of characteristic findings (e.g., nystagmus and mild hypertension), and positive urine toxicological tests. Individuals who use phencyclidine often use other drugs as well, and comorbid Abuse or Dependence on other drugs must be considered. Phencyclidine Intoxication is distinguished from the **other Phencyclidine-Induced Disorders** (e.g., Phencyclidine-Induced Mood Disorder, With Onset During Intoxication) because the symptoms in these latter disorders are in excess of those usually associated with Phencyclidine Intoxication and are severe enough to warrant independent clinical attention.

292.9 Phencyclidine-Related Disorder Not Otherwise Specified

The Phencyclidine-Related Disorder Not Otherwise Specified category is for disorders associated with the use of phencyclidine that are not classifiable as Phencycli-

dine Dependence, Phencyclidine Abuse, Phencyclidine Intoxication, Phencyclidine Intoxication Delirium, Phencyclidine-Induced Psychotic Disorder, Phencyclidine-Induced Mood Disorder, or Phencyclidine-Induced Anxiety Disorder.

Sedative-, Hypnotic-, or Anxiolytic-Related Disorders

The sedative, hypnotic, and anxiolytic (antianxiety) substances include the benzodiazepines, benzodiazepine-like drugs such as zolpidem and zaleplon, the carbamates (e.g., glutethimide, meprobamate), the barbiturates (e.g., secobarbital), and the barbiturate-like hypnotics (e.g., glutethimide, methaqualone). This class of substances includes all prescription sleeping medications and almost all prescription antianxiety medications. The nonbenzodiazepine antianxiety agents (e.g., buspirone, gepirone) are not included in this class. Some medications in this class have other important clinical uses (e.g., as anticonvulsants). Like alcohol, these agents are brain depressants and can produce similar Substance-Induced and Substance Use Disorders. At high doses, sedatives, hypnotics, and anxiolytics can be lethal, particularly when mixed with alcohol. Sedatives, hypnotics, and anxiolytics are available both by prescription and from illegal sources. Occasionally, individuals who obtain these substances by prescription will abuse them; conversely, some of those who purchase substances from this class "on the street" do not develop Dependence or Abuse. Medications with rapid onset and/or short to intermediate lengths of action may be especially vulnerable to being abused.

This section contains discussions specific to the Sedative-, Hypnotic-, or Anxiolytic-Related Disorders. Texts and criteria sets have already been provided to define the generic aspects of Substance Dependence (p. 192) and Substance Abuse (p. 198) that apply across all substances. The application of these general criteria to Sedative, Hypnotic, or Anxiolytic Dependence and Abuse is provided below. However, there are no unique criteria sets for Sedative, Hypnotic, or Anxiolytic Dependence and Sedative, Hypnotic, or Anxiolytic Abuse. Specific texts and criteria sets for Sedative, Hypnotic, or Anxiolytic Intoxication and Sedative, Hypnotic, or Anxiolytic Withdrawal are also provided below. The Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders (other than Sedative, Hypnotic, or Anxiolytic Intoxication and Withdrawal) are described in the sections of the manual with disorders with which they share phenomenology (e.g., Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder is included in the "Anxiety Disorders" section). Listed below are the Sedative, Hypnotic, or Anxiolytic Use Disorders and the Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders.

Sedative, Hypnotic, or Anxiolytic Use Disorders

304.10 **Sedative, Hypnotic, or Anxiolytic Dependence** (see p. 285)
305.40 **Sedative, Hypnotic, or Anxiolytic Abuse** (see p. 286)

Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders

292.89 **Sedative, Hypnotic, or Anxiolytic Intoxication** (see p. 286)

292.0 **Sedative, Hypnotic, or Anxiolytic Withdrawal** (see p. 287)
Specify if: With Perceptual Disturbances

292.81 **Sedative, Hypnotic, or Anxiolytic Intoxication Delirium** (see p. 143)

292.81 **Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium** (see p. 143)

292.82 **Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Dementia** (see p. 168)

292.83 **Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Amnestic Disorder** (see p. 177)

292.11 **Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder, With Delusions** (see p. 338) *Specify if:* With Onset During Intoxication/With Onset During Withdrawal

292.12 **Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder, With Hallucinations** (see p. 338) *Specify if:* With Onset During Intoxication/With Onset During Withdrawal

292.84 **Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder** (see p. 405) *Specify if:* With Onset During Intoxication/With Onset During Withdrawal

292.89 **Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder** (see p. 479) *Specify if:* With Onset During Withdrawal

292.89 **Sedative-, Hypnotic-, or Anxiolytic-Induced Sexual Dysfunction** (see p. 562) *Specify if:* With Onset During Intoxication

292.89 **Sedative-, Hypnotic-, or Anxiolytic-Induced Sleep Disorder** (see p. 655) *Specify if:* With Onset During Intoxication/With Onset During Withdrawal

292.9 **Sedative-, Hypnotic-, or Anxiolytic-Related Disorder Not Otherwise Specified** (see p. 293)

Sedative, Hypnotic, or Anxiolytic Use Disorders

304.10 Sedative, Hypnotic, or Anxiolytic Dependence

Refer, in addition, to the text and criteria for Substance Dependence (see p. 192) and Alcohol-Related Disorders (see p. 212). Very significant levels of physiological dependence, marked by both tolerance and withdrawal, can develop to the sedatives, hypnotics, and anxiolytics. The timing and severity of the withdrawal syndrome will differ depending on the specific substance and its pharmacokinetics and pharmacodynamics. For example, withdrawal from shorter-acting substances that are rapidly absorbed and that have no active metabolites (e.g., triazolam) can begin within hours after the substance is stopped; withdrawal from substances with long-acting metabolites (e.g., diazepam) may not begin for 1–2 days or longer. The withdrawal syndrome produced by substances in this class may be characterized by the development

of a delirium that can be life threatening. There may be evidence of tolerance and withdrawal in the absence of a diagnosis of Substance Dependence in an individual who has abruptly discontinued benzodiazepines that were taken for long periods of time at prescribed and therapeutic doses. A diagnosis of Substance Dependence should be considered only when, in addition to having physiological dependence, the individual using the substance shows evidence of a range of problems (e.g., an individual who has developed drug-seeking behavior to the extent that important activities are given up or reduced to obtain the substance).

Specifiers

The following specifiers may be applied to a diagnosis of Sedative, Hypnotic, or Anxiolytic Dependence (see p. 195 for more details):

With Physiological Dependence
Without Physiological Dependence

Early Full Remission
Early Partial Remission
Sustained Full Remission
Sustained Partial Remission
In a Controlled Environment

305.40 Sedative, Hypnotic, or Anxiolytic Abuse

Refer, in addition, to the text and criteria for Substance Abuse (see p. 198). Abuse of substances from this class may occur on its own or in conjunction with use of other substances. For example, individuals may use intoxicating doses of sedatives or benzodiazepines to "come down" from cocaine or amphetamines or use high doses of benzodiazepines in combination with methadone to "boost" its effects. Abuse of substances from this class may result in use in hazardous situations, such as getting "high" and then driving. The individual may miss work or school or neglect home duties as a result of intoxication or get into arguments with spouse or parents about episodes of substance use. When these problems are accompanied by evidence of tolerance, withdrawal, or compulsive behavior related to the use of sedatives, hypnotics, or anxiolytics, a diagnosis of Sedative, Hypnotic, or Anxiolytic Dependence should be considered.

Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders

292.89 Sedative, Hypnotic, or Anxiolytic Intoxication

Refer, in addition, to the text and criteria for Substance Intoxication (see p. 199). The essential feature of Sedative, Hypnotic, or Anxiolytic Intoxication is the presence of clinically significant maladaptive behavioral or psychological changes (e.g., inappro-

priate sexual or aggressive behavior, mood lability, impaired judgment, impaired social or occupational functioning) that develop during, or shortly after, use of a sedative, hypnotic, or anxiolytic substance (Criteria A and B). As with other brain depressants such as alcohol, these behaviors may be accompanied by slurred speech, an unsteady gait, nystagmus, memory or attentional problems, levels of incoordination that can interfere with driving abilities and with performing usual activities to the point of causing falls or automobile accidents, and stupor or coma (Criterion C). Memory impairment is a prominent feature of Sedative, Hypnotic, or Anxiolytic Intoxication and is most often characterized by an anterograde amnesia that resembles "alcoholic blackouts," which can be quite disturbing to the individual. The symptoms must not be due to a general medical condition and are not better accounted for by another mental disorder (Criterion D). Intoxication may occur in individuals who are receiving these substances by prescription, are borrowing the medication from friends or relatives, or are deliberately taking the substance to achieve intoxication.

Diagnostic criteria for 292.89 Sedative, Hypnotic, or Anxiolytic Intoxication

A. Recent use of a sedative, hypnotic, or anxiolytic.

B. Clinically significant maladaptive behavioral or psychological changes (e.g., inappropriate sexual or aggressive behavior, mood lability, impaired judgment, impaired social or occupational functioning) that developed during, or shortly after, sedative, hypnotic, or anxiolytic use.

C. One (or more) of the following signs, developing during, or shortly after, sedative, hypnotic, or anxiolytic use:

   (1) slurred speech
   (2) incoordination
   (3) unsteady gait
   (4) nystagmus
   (5) impairment in attention or memory
   (6) stupor or coma

D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

292.0 Sedative, Hypnotic, or Anxiolytic Withdrawal

Refer, in addition, to the text and criteria for Substance Withdrawal (see p. 201). The essential feature of Sedative, Hypnotic, or Anxiolytic Withdrawal is the presence of a characteristic syndrome that develops after a marked decrease in or cessation of intake after several weeks or more of regular use (Criteria A and B). This withdrawal syndrome is characterized by two or more symptoms (similar to Alcohol Withdrawal) that include autonomic hyperactivity (e.g., increases in heart rate, respiratory rate,

blood pressure, or body temperature, along with sweating); a tremor of the hands; insomnia, anxiety, and nausea sometimes accompanied by vomiting; and psychomotor agitation. A grand mal seizure may occur in perhaps as many as 20%–30% of individuals undergoing untreated withdrawal from these substances. In severe Withdrawal, visual, tactile, or auditory hallucinations or illusions can occur but are usually in the context of a delirium. If the person's reality testing is intact (i.e., he or she knows the substance is causing the hallucinations) and the illusions occur in a clear sensorium, the specifier With Perceptual Disturbances can be noted (see below). The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C). The symptoms must not be due to a general medical condition and are not better accounted for by another mental disorder (e.g., Alcohol Withdrawal or Generalized Anxiety Disorder) (Criterion D). Relief of withdrawal symptoms with administration of any sedative-hypnotic agent would support a diagnosis of Sedative, Hypnotic, or Anxiolytic Withdrawal.

The withdrawal syndrome is characterized by signs and symptoms that are generally the opposite of the acute effects that are likely to be observed in a first-time user of these agents. The time course of the withdrawal syndrome is generally predicted by the half-life of the substance. Medications whose actions typically last about 10 hours or less (e.g., lorazepam, oxazepam, and temazepam) produce withdrawal symptoms within 6–8 hours of decreasing blood levels that peak in intensity on the second day and improve markedly by the fourth or fifth day. For substances with longer half-lives (e.g., diazepam), symptoms may not develop for more than a week, peak in intensity during the second week, and decrease markedly during the third or fourth week. There may be additional longer-term symptoms at a much lower level of intensity that persist for several months. As with alcohol, these lingering withdrawal symptoms (e.g., anxiety, moodiness, and trouble sleeping) can be mistaken for non-substance-induced Anxiety or Depressive Disorders (e.g., Generalized Anxiety Disorder).

The longer the substance has been taken and the higher the dosages used, the more likely it is that there will be severe Withdrawal. However, Withdrawal has been reported with as little as 15 mg of diazepam (or its equivalent in other benzodiazepines) when taken daily for several months. Dosages of approximately 40 mg of diazepam (or its equivalent) daily are more likely to produce clinically relevant withdrawal symptoms, and even higher doses (e.g., 100 mg of diazepam) are more likely to be followed by withdrawal seizures or delirium. Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium (see p. 143) is characterized by disturbances in consciousness and cognition, with visual, tactile, or auditory hallucinations. When present, Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium should be diagnosed instead of Withdrawal.

Specifier

The following specifier may be applied to a diagnosis of Sedative, Hypnotic, or Anxiolytic Withdrawal:

> **With Perceptual Disturbances.** This specifier may be noted when hallucinations with intact reality testing or auditory, visual, or tactile illusions occur in

the absence of a delirium. *Intact reality testing* means that the person knows that the hallucinations are induced by the substance and do not represent external reality. When hallucinations occur in the absence of intact reality testing, a diagnosis of Substance-Induced Psychotic Disorder, With Hallucinations, should be considered.

Diagnostic criteria for 292.0 Sedative, Hypnotic, or Anxiolytic Withdrawal

A. Cessation of (or reduction in) sedative, hypnotic, or anxiolytic use that has been heavy and prolonged.

B. Two (or more) of the following, developing within several hours to a few days after Criterion A:

(1) autonomic hyperactivity (e.g., sweating or pulse rate greater than 100)
(2) increased hand tremor
(3) insomnia
(4) nausea or vomiting
(5) transient visual, tactile, or auditory hallucinations or illusions
(6) psychomotor agitation
(7) anxiety
(8) grand mal seizures

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

D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Specify if:

With Perceptual Disturbances

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

The following Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders are described in other sections of the manual with disorders with which they share phenomenology: **Sedative, Hypnotic, or Anxiolytic Intoxication Delirium** (p. 143), **Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium** (p. 143), **Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Dementia** (p. 168), **Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Amnestic Disorder** (p. 177), **Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder** (p. 338), **Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder** (p. 405), **Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder** (p. 479), **Sedative-, Hypnotic-, or Anxiolytic-Induced Sexual Dysfunction** (p. 562), and **Sedative-, Hypnotic-, or Anxiolytic-Induced Sleep Disorder** (p. 655). These disorders are diagnosed instead of Sedative, Hypnotic, or Anxiolytic Intoxication or

Sedative, Hypnotic, or Anxiolytic Withdrawal only when the symptoms are in excess of those usually associated with the Sedative, Hypnotic, or Anxiolytic Intoxication or Withdrawal syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention.

Additional Information on Sedative-, Hypnotic-, or Anxiolytic-Related Disorders

Associated Features and Disorders

Associated descriptive features and mental disorders. Sedative, Hypnotic, or Anxiolytic Dependence and Abuse may often be associated with Dependence on, or Abuse of, other substances (e.g., alcohol, cannabis, cocaine, heroin, methadone, amphetamines). Sedatives are often used to alleviate the unwanted effects of these other substances. Acute Intoxication can result in accidental injury through falls and automobile accidents. For elderly individuals, even short-term use of these sedating medications at prescribed doses can be associated with an increased risk for cognitive problems and falls. Some data indicate that the disinhibiting effects of these agents can, like alcohol, actually contribute to overly aggressive behavior, with subsequent interpersonal and legal problems. Intense or repeated Sedative, Hypnotic, or Anxiolytic Intoxication may be associated with severe depressions that, although temporary, can be intense enough to lead to suicide attempts and completed suicides. Accidental or deliberate overdoses, similar to those observed for Alcohol Abuse or Dependence or repeated Alcohol Intoxication, can occur. In contrast to their wide margin of safety when used alone, benzodiazepines taken in combination with alcohol appear to be particularly dangerous, and accidental overdoses have been reported. Accidental overdoses have also been reported in individuals who deliberately misuse barbiturates and other nonbenzodiazepine sedatives (e.g., methaqualone). With repeated use in search of euphoria, tolerance develops to the sedative effects, and a progressively higher dose is used. However, tolerance to brain stem depressant effects develops much more slowly, and as the person takes more substance to achieve euphoria, there may be a sudden onset of respiratory depression and hypotension, which may result in death. Antisocial behavior and Antisocial Personality Disorder are associated with Sedative, Hypnotic, or Anxiolytic Dependence and Abuse, especially when the substances are obtained illegally.

Associated laboratory findings. Almost all of these substances can be identified through laboratory evaluations of urine or blood (the latter of which can quantify the amounts of these agents in the body). Urine tests are likely to remain positive for up to a week or so after the use of long-acting substances (e.g., flurazepam).

Associated physical examination findings and general medical conditions. Physical examination is likely to reveal evidence of a mild decrease in most aspects of autonomic nervous system functioning, including a slower pulse, a slightly decreased respiratory rate, and a slight drop in blood pressure (most likely to occur with postural changes). Overdoses of sedatives, hypnotics, and anxiolytics may be associ-

ated with a deterioration in vital signs that may signal an impending medical emergency (e.g., respiratory arrest from barbiturates). There may be consequences of trauma (e.g., internal bleeding or a subdural hematoma) from accidents that occur while intoxicated. Intravenous use of these substances can result in medical complications related to the use of contaminated needles (e.g., hepatitis and human immunodeficiency virus [HIV] infection).

Specific Culture, Age, and Gender Features

There are marked variations in prescription patterns (and availability) of this class of substances in different countries, which may lead to variations in prevalence of Sedative-, Hypnotic-, or Anxiolytic-Related Disorders. Deliberate Intoxication to achieve a "high" is most likely to be observed in teenagers and individuals in their 20s. Withdrawal, Dependence, and Abuse are also seen in individuals in their 40s and older who escalate the dose of prescribed medications. Both acute and chronic toxic effects of these substances, especially effects on cognition, memory, and motor coordination, are likely to increase with age as a consequence of pharmacodynamic and pharmacokinetic age-related changes. Individuals with dementia are more likely to develop Intoxication and impaired physiological functioning at lower doses. Women may be at higher risk for prescription drug abuse of substances of this class.

Prevalence

In the United States, up to 90% of individuals hospitalized for medical care or surgery receive orders for sedative, hypnotic, or anxiolytic medications during their hospital stay, and more than 15% of American adults use these medications (usually by prescription) during any 1 year. Most of these individuals take the medication as directed, without evidence of misuse. Among the medications in this class, the benzodiazepines are the most widely used, with perhaps 10% of adults having taken a benzodiazepine for at least 1 month during the prior year. In both the United States and elsewhere, these drugs are usually prescribed by a primary care provider, and prescribed use of these medications is higher in women and increases with age.

A 1996 national survey of drug use indicated that around 6% of individuals acknowledged using either sedatives or "tranquilizers" illicitly, including 0.3% who reported illicit use of sedatives in the prior year and 0.1% who reported use of sedatives in the prior month. The age group with the highest lifetime prevalence of sedatives (3%) or "tranquilizers" (6%) was 26- to 34-year-olds, while those aged 18–25 were most likely to have used in the prior year.

Because most surveys assessed patterns of use rather than disorders, it is not known how many of those who used substances from this class had symptoms that met criteria for Dependence or Abuse. A 1992 U.S. national survey reported a lifetime prevalence for Abuse or Dependence of less than 1%, including less than 0.1% for 12-month prevalence.

Course

The more usual course involves young people in their teens or 20s who may escalate their occasional use of sedatives, hypnotics, and anxiolytics to the point at which they

develop problems that might qualify for a diagnosis of Dependence or Abuse. This pattern may be especially likely among individuals who have other Substance Use Disorders (e.g., related to alcohol, opioids, cocaine, amphetamine). An initial pattern of intermittent use at parties can lead to daily use and high levels of tolerance. Once this occurs, an increasing level of interpersonal, work, and legal difficulties, as well as increasingly severe episodes of memory impairment and physiological withdrawal, can be expected to ensue.

The second and less frequently observed clinical course begins with an individual who originally obtained the medication by prescription from a physician, usually for the treatment of anxiety, insomnia, or somatic complaints. Although the great majority of those who are prescribed a medication from this class do not develop problems, a small proportion do. In these individuals, as either tolerance or a need for higher doses of the medication develops, there is a gradual increase in the dose and frequency of self-administration. The person is likely to continue to justify use on the basis of the original symptoms of anxiety or insomnia, but substance-seeking behavior becomes more prominent and the person may seek out multiple physicians to obtain sufficient supplies of the medication. Tolerance can reach high levels, and Withdrawal (including seizures and Withdrawal Delirium) may occur. Other individuals at heightened risk might include those with Alcohol Dependence who may receive repeated prescriptions in response to their complaints of alcohol-related anxiety or insomnia.

Differential Diagnosis

For a general discussion of the differential diagnosis of Substance-Related Disorders, see p. 207. Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders may present with symptoms (e.g., anxiety) that resemble **primary mental disorders** (e.g., Generalized Anxiety Disorder versus Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder, With Onset During Withdrawal). See p. 210 for a discussion of this differential diagnosis.

Sedative, Hypnotic, or Anxiolytic Intoxication closely resembles **Alcohol Intoxication,** except for the smell of alcohol on the breath. In older persons, the clinical picture of intoxication can resemble a progressive dementia. In addition, the slurred speech, incoordination, and other associated features characteristic of Sedative, Hypnotic, or Anxiolytic Intoxication could be the result of a **general medical condition** (e.g., multiple sclerosis) or of a **prior head trauma** (e.g., a subdural hematoma).

Alcohol Withdrawal produces a syndrome very similar to that of Sedative, Hypnotic, or Anxiolytic Withdrawal. The anxiety, insomnia, and autonomic nervous system hyperactivity that is a consequence of **intoxication with other drugs** (e.g., stimulants such as amphetamines or cocaine), that are **consequences of physiological conditions** (e.g., hyperthyroidism), or that are related to **primary Anxiety Disorders** (e.g., Panic Disorder or Generalized Anxiety Disorder) can resemble some aspects of Sedative, Hypnotic, or Anxiolytic Withdrawal.

Sedative, Hypnotic, or Anxiolytic Intoxication and Withdrawal are distinguished from the **other Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders** (e.g., Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder, With Onset During Withdrawal) because the symptoms in these latter disorders are in excess of those usually

associated with Sedative, Hypnotic, or Anxiolytic Intoxication or Withdrawal and are severe enough to warrant independent clinical attention.

It should be noted that there are individuals who continue to take benzodiazepine medication according to a physician's direction for a legitimate medical indication over extended periods of time. Even if physiologically dependent on the medication, many of these individuals do not develop symptoms that meet the criteria for Dependence because they are not preoccupied with obtaining the substance and its use does not interfere with their performance of usual social or occupational roles.

292.9 Sedative-, Hypnotic-, or Anxiolytic-Related Disorder Not Otherwise Specified

The Sedative-, Hypnotic-, or Anxiolytic-Related Disorder Not Otherwise Specified category is for disorders associated with the use of sedatives, hypnotics, or anxiolytics that are not classifiable as Sedative, Hypnotic, or Anxiolytic Dependence; Sedative, Hypnotic, or Anxiolytic Abuse; Sedative, Hypnotic, or Anxiolytic Intoxication; Sedative, Hypnotic, or Anxiolytic Withdrawal; Sedative, Hypnotic, or Anxiolytic Intoxication Delirium; Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium; Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Dementia; Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Amnestic Disorder; Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder; Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder; Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder; Sedative-, Hypnotic-, or Anxiolytic-Induced Sexual Dysfunction; or Sedative-, Hypnotic-, or Anxiolytic-Induced Sleep Disorder.

Polysubstance-Related Disorder

304.80 Polysubstance Dependence

This diagnosis is reserved for behavior during the same 12-month period in which the person was repeatedly using at least three groups of substances (not including caffeine and nicotine), but no single substance predominated. Further, during this period, the Dependence criteria were met for substances as a group but not for any specific substance. For example, a diagnosis of Polysubstance Dependence would apply to an individual who, during the same 12-month period, missed work because of his heavy use of alcohol, continued to use cocaine despite experiencing severe depressions after nights of heavy consumption, and was repeatedly unable to stay within his self-imposed limits regarding his use of codeine. In this instance, although the problems associated with the use of any one substance were not pervasive enough to justify a diagnosis of Dependence, his overall use of substances significantly impaired his functioning and thus warranted a diagnosis of Dependence on the substances as a group. Such a pattern might be observed, for example, in a setting where substance

use was highly prevalent but where the drugs of choice changed frequently. For those situations in which there is a pattern of problems associated with multiple drugs and the criteria are met for more than one specific Substance-Related Disorder (e.g., Cocaine Dependence, Alcohol Dependence, and Cannabis Dependence), each diagnosis should be made.

Other (or Unknown) Substance–Related Disorders

The Other (or Unknown) Substance–Related Disorders category is for classifying Substance-Related Disorders associated with substances not listed above. Examples of these substances, which are described in more detail below, include anabolic steroids, nitrite inhalants ("poppers"), nitrous oxide, over-the-counter and prescription medications not otherwise covered by the 11 categories (e.g., cortisol, antihistamines, benztropine), and other substances that have psychoactive effects. In addition, this category may be used when the specific substance is unknown (e.g., an intoxication after taking a bottle of unlabeled pills).

Anabolic steroids sometimes produce an initial sense of enhanced well-being (or even euphoria), which is replaced after repeated use by lack of energy, irritability, and other forms of dysphoria. Continued use of these substances may lead to more severe symptoms (e.g., depressive symptomatology) and general medical conditions (liver disease).

Nitrite inhalants ("poppers"—forms of amyl, butyl, and isobutyl nitrite) produce an intoxication that is characterized by a feeling of fullness in the head, mild euphoria, a change in the perception of time, relaxation of smooth muscles, and a possible increase in sexual feelings. In addition to possible compulsive use, these substances carry dangers of potential impairment of immune functioning, irritation of the respiratory system, a decrease in the oxygen-carrying capacity of the blood, and a toxic reaction that can include vomiting, severe headache, hypotension, and dizziness.

Nitrous oxide ("laughing gas") causes rapid onset of an intoxication that is characterized by light-headedness and a floating sensation that clears in a matter of minutes after administration is stopped. There are reports of temporary but clinically relevant confusion and reversible paranoid states when nitrous oxide is used regularly.

Other substances that are capable of producing mild intoxications include **catnip,** which can produce states similar to those observed with marijuana and which in high doses is reported to result in LSD-type perceptions; **betel nut,** which is chewed in many cultures to produce a mild euphoria and floating sensation; and **kava** (a substance derived from the South Pacific pepper plant), which produces sedation, incoordination, weight loss, mild forms of hepatitis, and lung abnormalities. In addition, individuals can develop dependence and impairment through repeated self-administration of **over-the-counter** and **prescription drugs,** including **cortisol, antiparkinsonian agents** that have anticholinergic properties, and **antihistamines.** A discussion of how to code medication-related disorders is found on p. 205.

Texts and criteria sets have already been provided to define the generic aspects of Substance Dependence (p. 192), Substance Abuse (p. 198), Substance Intoxication

(p. 199), and Substance Withdrawal (p. 201) that are applicable across classes of substances. The Other (or Unknown) Substance–Induced Disorders are described in the sections of the manual with disorders with which they share phenomenology [e.g., Other (or Unknown) Substance–Induced Mood Disorder is included in the "Mood Disorders" section]. Listed below are the Other (or Unknown) Substance Use Disorders and the Other (or Unknown) Substance–Induced Disorders.

Other (or Unknown) Substance Use Disorders

304.90 **Other (or Unknown) Substance Dependence** (see p. 192)
305.90 **Other (or Unknown) Substance Abuse** (see p. 198)

Other (or Unknown) Substance–Induced Disorders

292.89 **Other (or Unknown) Substance Intoxication** (see p. 199)
Specify if: With Perceptual Disturbances
292.0 **Other (or Unknown) Substance Withdrawal** (see p. 201)
Specify if: With Perceptual Disturbances
292.81 **Other (or Unknown) Substance–Induced Delirium** (see p. 143)
292.82 **Other (or Unknown) Substance–Induced Persisting Dementia** (see p. 168)
292.83 **Other (or Unknown) Substance–Induced Persisting Amnestic Disorder** (see p. 177)
292.11 **Other (or Unknown) Substance–Induced Psychotic Disorder, With Delusions** (see p. 338) *Specify if:* With Onset During Intoxication/With Onset During Withdrawal
292.12 **Other (or Unknown) Substance–Induced Psychotic Disorder, With Hallucinations** (see p. 338) *Specify if:* With Onset During Intoxication/With Onset During Withdrawal
292.84 **Other (or Unknown) Substance–Induced Mood Disorder** (see p. 405) *Specify if:* With Onset During Intoxication/With Onset During Withdrawal
292.89 **Other (or Unknown) Substance–Induced Anxiety Disorder** (see p. 479) *Specify if:* With Onset During Intoxication/With Onset During Withdrawal
292.89 **Other (or Unknown) Substance–Induced Sexual Dysfunction** (see p. 562) *Specify if:* With Onset During Intoxication
292.89 **Other (or Unknown) Substance–Induced Sleep Disorder** (see p. 655) *Specify if:* With Onset During Intoxication/With Onset During Withdrawal
292.9 **Other (or Unknown) Substance–Related Disorder Not Otherwise Specified**

Schizophrenia and Other Psychotic Disorders

The disorders in this section include Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder, Brief Psychotic Disorder, Shared Psychotic Disorder, Psychotic Disorder Due to a General Medical Condition, Substance-Induced Psychotic Disorder, and Psychotic Disorder Not Otherwise Specified. These disorders have been grouped together to facilitate the differential diagnosis of disorders that include psychotic symptoms as a prominent aspect of their presentation. Other disorders that may present with psychotic symptoms as associated features are included elsewhere in the manual (e.g., Dementia of the Alzheimer's Type and Substance-Induced Delirium in the "Delirium, Dementia, and Amnestic and Other Cognitive Disorders" section; Major Depressive Disorder, With Psychotic Features, in the "Mood Disorders" section). Despite the fact that these disorders are grouped together in this chapter, it should be understood that psychotic symptoms are not necessarily considered to be core or fundamental features of these disorders, nor do the disorders in this section necessarily have a common etiology. In fact, a number of studies suggest closer etiological associations between Schizophrenia and other disorders that, by definition, do not present with psychotic symptoms (e.g., Schizotypal Personality Disorder).

The term *psychotic* has historically received a number of different definitions, none of which has achieved universal acceptance. The narrowest definition of *psychotic* is restricted to delusions or prominent hallucinations, with the hallucinations occurring in the absence of insight into their pathological nature. A slightly less restrictive definition would also include prominent hallucinations that the individual realizes are hallucinatory experiences. Broader still is a definition that also includes other positive symptoms of Schizophrenia (i.e., disorganized speech, grossly disorganized or catatonic behavior). Unlike these definitions based on symptoms, the definition used in earlier classifications (e.g., DSM-II and ICD-9) was probably far too inclusive and focused on the severity of functional impairment. In that context, a mental disorder was termed "psychotic" if it resulted in "impairment that grossly interferes with the capacity to meet ordinary demands of life." The term has also previously been defined as a "loss of ego boundaries" or a "gross impairment in reality testing."

In this manual, the term *psychotic* refers to the presence of certain symptoms. However, the specific constellation of symptoms to which the term refers varies to some extent across the diagnostic categories. In Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, and Brief Psychotic Disorder, the term *psychotic* refers to delusions, any prominent hallucinations, disorganized speech, or disorganized or catatonic behavior. In Psychotic Disorder Due to a General Medical Condition and in

Substance-Induced Psychotic Disorder, *psychotic* refers to delusions or only those hallucinations that are not accompanied by insight. Finally, in Delusional Disorder and Shared Psychotic Disorder, *psychotic* is equivalent to delusional.

The following disorders are included in this section:

Schizophrenia is a disorder that lasts for at least 6 months and includes at least 1 month of active-phase symptoms (i.e., two [or more] of the following: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms). Definitions for the Schizophrenia subtypes (Paranoid, Disorganized, Catatonic, Undifferentiated, and Residual) are also included in this section.

Schizophreniform Disorder is characterized by a symptomatic presentation that is equivalent to Schizophrenia except for its duration (i.e., the disturbance lasts from 1 to 6 months) and the absence of a requirement that there be a decline in functioning.

Schizoaffective Disorder is a disorder in which a mood episode and the active-phase symptoms of Schizophrenia occur together and were preceded or are followed by at least 2 weeks of delusions or hallucinations without prominent mood symptoms.

Delusional Disorder is characterized by at least 1 month of nonbizarre delusions without other active-phase symptoms of Schizophrenia.

Brief Psychotic Disorder is a disorder that lasts more than 1 day and remits by 1 month.

Shared Psychotic Disorder is characterized by the presence of a delusion in an individual who is influenced by someone else who has a longer-standing delusion with similar content.

In **Psychotic Disorder Due to a General Medical Condition,** the psychotic symptoms are judged to be a direct physiological consequence of a general medical condition.

In **Substance-Induced Psychotic Disorder,** the psychotic symptoms are judged to be a direct physiological consequence of a drug of abuse, a medication, or toxin exposure.

Psychotic Disorder Not Otherwise Specified is included for classifying psychotic presentations that do not meet the criteria for any of the specific Psychotic Disorders defined in this section or psychotic symptomatology about which there is inadequate or contradictory information.

Schizophrenia

The essential features of Schizophrenia are a mixture of characteristic signs and symptoms (both positive and negative) that have been present for a significant portion of time during a 1-month period (or for a shorter time if successfully treated), with some signs of the disorder persisting for at least 6 months (Criteria A and C). These signs and symptoms are associated with marked social or occupational dysfunction (Criterion B). The disturbance is not better accounted for by Schizoaffective Disorder or a Mood Disorder With Psychotic Features and is not due to the direct physiological effects of a substance or a general medical condition (Criteria D and E). In individuals with a previous diagnosis of Autistic Disorder (or another Pervasive Developmental Disorder), the additional diagnosis of Schizophrenia is warranted

only if prominent delusions or hallucinations are present for at least a month (Criterion F). The characteristic symptoms of Schizophrenia involve a range of cognitive and emotional dysfunctions that include perception, inferential thinking, language and communication, behavioral monitoring, affect, fluency and productivity of thought and speech, hedonic capacity, volition and drive, and attention. No single symptom is pathognomonic of Schizophrenia; the diagnosis involves the recognition of a constellation of signs and symptoms associated with impaired occupational or social functioning.

Characteristic symptoms (Criterion A) may be conceptualized as falling into two broad categories: positive and negative. The positive symptoms appear to reflect an excess or distortion of normal functions, whereas the negative symptoms appear to reflect a diminution or loss of normal functions. The positive symptoms (Criteria A1–A4) include distortions in thought content (delusions), perception (hallucinations), language and thought process (disorganized speech), and self-monitoring of behavior (grossly disorganized or catatonic behavior). These positive symptoms may comprise two distinct dimensions, which may in turn be related to different underlying neural mechanisms and clinical correlates. The "psychotic dimension" includes delusions and hallucinations, whereas the "disorganization dimension" includes disorganized speech and behavior. Negative symptoms (Criterion A5) include restrictions in the range and intensity of emotional expression (affective flattening), in the fluency and productivity of thought and speech (alogia), and in the initiation of goal-directed behavior (avolition).

Delusions (Criterion A1) are erroneous beliefs that usually involve a misinterpretation of perceptions or experiences. Their content may include a variety of themes (e.g., persecutory, referential, somatic, religious, or grandiose). Persecutory delusions are most common; the person believes he or she is being tormented, followed, tricked, spied on, or ridiculed. Referential delusions are also common; the person believes that certain gestures, comments, passages from books, newspapers, song lyrics, or other environmental cues are specifically directed at him or her. The distinction between a delusion and a strongly held idea is sometimes difficult to make and depends in part on the degree of conviction with which the belief is held despite clear contradictory evidence regarding its veracity.

Although bizarre delusions are considered to be especially characteristic of Schizophrenia, "bizarreness" may be difficult to judge, especially across different cultures. Delusions are deemed bizarre if they are clearly implausible and not understandable and do not derive from ordinary life experiences. An example of a bizarre delusion is a person's belief that a stranger has removed his or her internal organs and has replaced them with someone else's organs without leaving any wounds or scars. An example of a nonbizarre delusion is a person's false belief that he or she is under surveillance by the police. Delusions that express a loss of control over mind or body are generally considered to be bizarre; these include a person's belief that his or her thoughts have been taken away by some outside force ("thought withdrawal"), that alien thoughts have been put into his or her mind ("thought insertion"), or that his or her body or actions are being acted on or manipulated by some outside force ("delusions of control"). If the delusions are judged to be bizarre, only this single symptom is needed to satisfy Criterion A for Schizophrenia.

Hallucinations (Criterion A2) may occur in any sensory modality (e.g., auditory,

visual, olfactory, gustatory, and tactile), but auditory hallucinations are by far the most common. Auditory hallucinations are usually experienced as voices, whether familiar or unfamiliar, that are perceived as distinct from the person's own thoughts. The hallucinations must occur in the context of a clear sensorium; those that occur while falling asleep (hypnagogic) or waking up (hypnopompic) are considered to be within the range of normal experience. Isolated experiences of hearing one's name called or experiences that lack the quality of an external percept (e.g., a humming in one's head) should also not be considered as symptomatic of Schizophrenia or any other Psychotic Disorder. Hallucinations may be a normal part of religious experience in certain cultural contexts. Certain types of auditory hallucinations (i.e., two or more voices conversing with one another or voices maintaining a running commentary on the person's thoughts or behavior) have been considered to be particularly characteristic of Schizophrenia. If these types of hallucinations are present, then only this single symptom is needed to satisfy Criterion A.

Disorganized thinking ("formal thought disorder") has been argued by some to be the single most important feature of Schizophrenia. Because of the difficulty inherent in developing an objective definition of "thought disorder," and because in a clinical setting inferences about thought are based primarily on the individual's speech, the concept of disorganized speech (Criterion A3) has been emphasized in the definition for Schizophrenia used in this manual. The speech of individuals with Schizophrenia may be disorganized in a variety of ways. The person may "slip off the track" from one topic to another ("derailment" or "loose associations"); answers to questions may be obliquely related or completely unrelated ("tangentiality"); and, rarely, speech may be so severely disorganized that it is nearly incomprehensible and resembles receptive aphasia in its linguistic disorganization ("incoherence" or "word salad"). Because mildly disorganized speech is common and nonspecific, the symptom must be severe enough to substantially impair effective communication. Less severe disorganized thinking or speech may occur during the prodromal and residual periods of Schizophrenia (see Criterion C).

Grossly disorganized behavior (Criterion A4) may manifest itself in a variety of ways, ranging from childlike silliness to unpredictable agitation. Problems may be noted in any form of goal-directed behavior, leading to difficulties in performing activities of daily living such as preparing a meal or maintaining hygiene. The person may appear markedly disheveled, may dress in an unusual manner (e.g., wearing multiple overcoats, scarves, and gloves on a hot day), or may display clearly inappropriate sexual behavior (e.g., public masturbation) or unpredictable and untriggered agitation (e.g., shouting or swearing). Care should be taken not to apply this criterion too broadly. For example, a few instances of restless, angry, or agitated behavior should not be considered to be evidence of Schizophrenia, especially if the motivation is understandable.

Catatonic motor behaviors (Criterion A4) include a marked decrease in reactivity to the environment, sometimes reaching an extreme degree of complete unawareness (catatonic stupor), maintaining a rigid posture and resisting efforts to be moved (catatonic rigidity), active resistance to instructions or attempts to be moved (catatonic negativism), the assumption of inappropriate or bizarre postures (catatonic posturing), or purposeless and unstimulated excessive motor activity (catatonic excitement). Although catatonia has historically been associated with Schizophrenia, the

clinician should keep in mind that catatonic symptoms are nonspecific and may occur in other mental disorders (see Mood Disorders With Catatonic Features, p. 417), in general medical conditions (see Catatonic Disorder Due to a General Medical Condition, p. 185), and Medication-Induced Movement Disorders (see Neuroleptic-Induced Parkinsonism, p. 792).

The negative symptoms of Schizophrenia (Criterion A5) account for a substantial degree of the morbidity associated with the disorder. Three negative symptoms—affective flattening, alogia, and avolition—are included in the definition of Schizophrenia; other negative symptoms (e.g., anhedonia) are noted in the "Associated Features and Disorders" section below. Affective flattening is especially common and is characterized by the person's face appearing immobile and unresponsive, with poor eye contact and reduced body language. Although a person with affective flattening may smile and warm up occasionally, his or her range of emotional expressiveness is clearly diminished most of the time. It may be useful to observe the person interacting with peers to determine whether affective flattening is sufficiently persistent to meet the criterion. Alogia (poverty of speech) is manifested by brief, laconic, empty replies. The individual with alogia appears to have a diminution of thoughts that is reflected in decreased fluency and productivity of speech. This must be differentiated from an unwillingness to speak, a clinical judgment that may require observation over time and in a variety of situations. Avolition is characterized by an inability to initiate and persist in goal-directed activities. The person may sit for long periods of time and show little interest in participating in work or social activities.

Although common in Schizophrenia, negative symptoms are difficult to evaluate because they occur on a continuum with normality, are relatively nonspecific, and may be due to a variety of other factors (including positive symptoms, medication side effects, depression, environmental understimulation, or demoralization). If a negative symptom is judged to be clearly attributable to any of these factors, then it should not be considered in making the diagnosis of Schizophrenia. For example, the behavior of an individual who has the delusional belief that he will be in danger if he leaves his room or talks to anyone may mimic social isolation, avolition, and alogia. Certain antipsychotic medications often produce extrapyramidal side effects, such as bradykinesia, that may mimic affective flattening. The distinction between true negative symptoms and medication side effects often depends on clinical judgment concerning the type of antipsychotic medication, the effects of anticholinergic medications, and dosage adjustments. The difficult distinction between negative symptoms and depressive symptoms may be informed by the other accompanying symptoms that are present and the fact that individuals with symptoms of depression typically experience an intensely painful affect, whereas those with Schizophrenia have a diminution or emptiness of affect. Finally, chronic environmental understimulation or demoralization may result in learned apathy and avolition. In establishing the presence of negative symptoms that are to be used in making the diagnosis of Schizophrenia, perhaps the best test is their persistence for a considerable period of time despite efforts directed at resolving each of the potential causes described above. It has been suggested that enduring negative symptoms that are not attributable to the secondary causes described above be referred to as "deficit" symptoms.

Criterion A for Schizophrenia requires that at least two of the five items be present concurrently for much of at least 1 month. However, if delusions are bizarre or hallu-

cinations involve "voices commenting" or "voices conversing," then the presence of only one item is required. The presence of this relatively severe constellation of signs and symptoms is referred to as the "active phase." In those situations in which the active-phase symptoms remit within a month in response to treatment, Criterion A can still be considered to have been met if the clinician judges that the symptoms would have persisted for a month in the absence of effective treatment. In children, evaluation of the characteristic symptoms should include due consideration of the presence of other disorders or developmental difficulties. For example, the disorganized speech in a child with a Communication Disorder should not count toward a diagnosis of Schizophrenia unless the degree of disorganization is significantly greater than would be expected on the basis of the Communication Disorder alone.

Schizophrenia involves dysfunction in one or more major areas of functioning (e.g., interpersonal relations, work or education, or self-care) (Criterion B). Typically, functioning is clearly below that which had been achieved before the onset of symptoms. If the disturbance begins in childhood or adolescence, however, there may be a failure to achieve what would have been expected for the individual rather than a deterioration in functioning. Comparing the individual with unaffected siblings may be helpful in making this determination. Educational progress is frequently disrupted, and the individual may be unable to finish school. Many individuals are unable to hold a job for sustained periods of time and are employed at a lower level than their parents ("downward drift"). The majority (60%–70%) of individuals with Schizophrenia do not marry, and most have relatively limited social contacts. The dysfunction persists for a substantial period during the course of the disorder and does not appear to be a direct result of any single feature. For example, if a woman quits her job because of the circumscribed delusion that her boss is trying to kill her, this alone is not sufficient evidence for this criterion unless there is a more pervasive pattern of difficulties (usually in multiple domains of functioning).

Some signs of the disturbance must persist for a continuous period of at least 6 months (Criterion C). During that time period, there must be at least 1 month of symptoms (or less than 1 month if symptoms are successfully treated) that meet Criterion A of Schizophrenia (the active phase). Prodromal symptoms are often present prior to the active phase, and residual symptoms may follow it. Some prodromal and residual symptoms are relatively mild or subthreshold forms of the positive symptoms specified in Criterion A. Individuals may express a variety of unusual or odd beliefs that are not of delusional proportions (e.g., ideas of reference or magical thinking); they may have unusual perceptual experiences (e.g., sensing the presence of an unseen person or force in the absence of formed hallucinations); their speech may be generally understandable but digressive, vague, or overly abstract or concrete; and their behavior may be peculiar but not grossly disorganized (e.g., mumbling to themselves, collecting odd and apparently worthless objects). In addition to these positive-like symptoms, negative symptoms are particularly common in the prodromal and residual phases and can often be quite severe. Individuals who had been socially active may become withdrawn; they lose interest in previously pleasurable activities; they may become less talkative and inquisitive; and they may spend the bulk of their time in bed. Such negative symptoms are often the first sign to the family that something is wrong; family members may ultimately report that they experienced the individual as "gradually slipping away."

Subtypes and Course Specifiers

The diagnosis of a particular subtype is based on the clinical picture that occasioned the most recent evaluation or admission to clinical care and may therefore change over time. Separate text and criteria are provided for each of the following subtypes:

295.30 Paranoid Type (see p. 313)
295.10 Disorganized Type (see p. 314)
295.20 Catatonic Type (see p. 315)
295.90 Undifferentiated Type (see p. 316)
295.60 Residual Type (see p. 316)

The following specifiers may be used to indicate the characteristic course of symptoms of Schizophrenia over time. These specifiers can be applied only after at least 1 year has elapsed since the initial onset of active-phase symptoms. During this initial 1-year period, no course specifiers can be given.

Episodic With Interepisode Residual Symptoms. This specifier applies when the course is characterized by episodes in which Criterion A for Schizophrenia is met and there are clinically significant residual symptoms between the episodes. **With Prominent Negative Symptoms** can be added if prominent negative symptoms are present during these residual periods.

Episodic With No Interepisode Residual Symptoms. This specifier applies when the course is characterized by episodes in which Criterion A for Schizophrenia is met and there are no clinically significant residual symptoms between the episodes.

Continuous. This specifier applies when characteristic symptoms of Criterion A are met throughout all (or most) of the course. **With Prominent Negative Symptoms** can be added if prominent negative symptoms are also present.

Single Episode In Partial Remission. This specifier applies when there has been a single episode in which Criterion A for Schizophrenia is met and some clinically significant residual symptoms remain. **With Prominent Negative Symptoms** can be added if these residual symptoms include prominent negative symptoms.

Single Episode In Full Remission. This specifier applies when there has been a single episode in which Criterion A for Schizophrenia has been met and no clinically significant residual symptoms remain.

Other or Unspecified Pattern. This specifier is used if another or an unspecified course pattern has been present.

Recording Procedures

The diagnostic code for Schizophrenia is selected based on the appropriate subtype: 295.30 for Paranoid Type, 295.10 for Disorganized Type, 295.20 for Catatonic Type, 295.90 for Undifferentiated Type, and 295.60 for Residual Type. There are no fifth-digit codes available for the course specifiers. In recording the name of the disorder, the course specifiers are noted after the appropriate subtype (e.g., 295.30 Schizophrenia, Paranoid Type, Episodic With Interepisode Residual Symptoms, With Prominent Negative Symptoms).

Associated Features and Disorders

Associated descriptive features and mental disorders. The individual with Schizophrenia may display inappropriate affect (e.g., smiling, laughing, or a silly facial expression in the absence of an appropriate stimulus), which is one of the defining features of the Disorganized Type. Anhedonia is common and is manifested by a loss of interest or pleasure. Dysphoric mood may take the form of depression, anxiety, or anger. There may be disturbances in sleep pattern (e.g., sleeping during the day and nighttime activity or restlessness). The individual may show a lack of interest in eating or may refuse food as a consequence of delusional beliefs. Often there are abnormalities of psychomotor activity (e.g., pacing, rocking, or apathetic immobility). Difficulty in concentration, attention, and memory is frequently evident.

A majority of individuals with Schizophrenia have poor insight regarding the fact that they have a psychotic illness. Evidence suggests that poor insight is a manifestation of the illness itself rather than a coping strategy. It may be comparable to the lack of awareness of neurological deficits seen in stroke, termed *anosognosia*. This symptom predisposes the individual to noncompliance with treatment and has been found to be predictive of higher relapse rates, increased number of involuntary hospital admissions, poorer psychosocial functioning, and a poorer course of illness.

Depersonalization, derealization, and somatic concerns may occur and sometimes reach delusional proportions. Anxiety and phobias are common in Schizophrenia. Motor abnormalities (e.g., grimacing, posturing, odd mannerisms, ritualistic or stereotyped behavior) are sometimes present. The life expectancy of individuals with Schizophrenia is shorter than that of the general population for a variety of reasons. Suicide is an important factor, because approximately 10% of individuals with Schizophrenia commit suicide—and between 20% and 40% make at least one attempt over the course of the illness. Although the risk remains high over the whole lifespan, specific risk factors for suicide include male gender, being under 45 years of age, depressive symptoms, feelings of hopelessness, unemployment, and recent hospital discharge. Suicide risk is also elevated during postpsychotic periods. Males successfully complete suicide more often than females, but both groups are at increased risk relative to the general population.

Many studies have reported that subgroups of individuals diagnosed with Schizophrenia have a higher incidence of assaultive and violent behavior. The major predictors of violent behavior are male gender, younger age, past history of violence, noncompliance with antipsychotic medication, and excessive substance use. However, it should be noted that most individuals with Schizophrenia are not more dangerous to others than those in the general population.

Rates of comorbidity with Substance-Related Disorders are high. Nicotine Dependence is especially high, with estimates ranging from 80% to 90% of individuals with Schizophrenia being regular cigarette smokers. Furthermore, these individuals tend to smoke heavily and to choose cigarettes with high nicotine content. Comorbidity with Anxiety Disorders has also been increasingly recognized in Schizophrenia. In particular, rates of Obsessive-Compulsive Disorder and Panic Disorder are elevated in individuals with Schizophrenia relative to the general population. Schizotypal, Schizoid, or Paranoid Personality Disorder may sometimes precede the onset of Schizophrenia. Whether these Personality Disorders are simply prodromal to Schizo-

phrenia or whether they constitute a separate earlier disorder is not clear.

An increased risk of Schizophrenia has been found in association with prenatal and childhood factors (e.g., prenatal exposure to flu, prenatal exposure to famine, obstetric complications, central nervous system infection in early childhood).

Associated laboratory findings. No laboratory findings have been identified that are diagnostic of Schizophrenia. However, a variety of measures from neuroimaging, neuropsychological, and neurophysiological studies have shown differences between groups of individuals with Schizophrenia and appropriately matched control subjects. In the structural neuroimaging literature, the most widely studied and most consistently replicated finding continues to be enlargement of the lateral ventricles. Many studies have also demonstrated decreased brain tissue as evidenced by widened cortical sulci and decreased volumes of gray and white matter. However, there is ongoing controversy as to whether the apparent decrease in brain tissue is a focal as opposed to a more diffuse process. When examined by region, the temporal lobe has most consistently been found to be decreased in volume, while the frontal lobe is implicated less often. Within the temporal lobe, there is evidence of focal abnormalities, with medial temporal structures (hippocampus, amygdala, and entorhinal cortex), as well as the superior temporal gyrus and planum temporale, most consistently found to be smaller in volume. Decreased thalamic volume has also been observed in both individuals with Schizophrenia and their unaffected first-degree relatives, but fewer studies have looked at this. Another finding that has been consistently replicated is that of increased basal ganglia size, but there is increasing evidence that this may be an epiphenomenon of treatment with typical neuroleptic medication. An increased incidence of large cavum septum pellucidi has also been demonstrated in individuals with Schizophrenia. This may have important pathophysiological implications, because it is suggestive of an early (i.e., prenatal) midline developmental brain abnormality, at least in a subgroup of individuals with Schizophrenia.

In terms of functional brain imaging studies, hypofrontality (i.e., a relative decrease in cerebral blood flow, metabolism, or some other proxy for neural activity) continues to be the most consistently replicated finding. However, there is increasing recognition that functional abnormalities are unlikely to be limited to any one brain region, and most of the more recent studies suggest more widespread abnormalities involving cortical-subcortical circuitry.

Neuropsychological deficits are a consistent finding in groups of individuals with Schizophrenia. Deficits are evident across a range of cognitive abilities, including memory, psychomotor abilities, attention, and difficulty in changing response set. In addition to the presence of these deficits among chronically ill individuals with Schizophrenia, there is increasing evidence that many of these deficits are found among individuals during their first psychotic episode and prior to treatment with antipsychotic medication, in individuals with Schizophrenia who are in clinical remission, as well as in unaffected first-degree relatives. For these reasons, some of the neuropsychological deficits are thought to reflect more fundamental features of the illness and, perhaps, to reveal vulnerability factors for Schizophrenia. These deficits are clinically meaningful in that they are related to the degree of difficulty that some individuals with Schizophrenia have with activities of daily living as well as the ability to acquire skills in psychosocial rehabilitation. Accordingly, the severity of neu-

ropsychological deficits is a relatively strong predictor of social and vocational outcome.

Several neurophysiological abnormalities have been demonstrated in groups of individuals with Schizophrenia. Among the most common are deficits in the perception and processing of sensory stimuli (e.g., impairment in sensory gating), abnormal smooth pursuit and saccadic eye movements, slowed reaction time, alterations in brain laterality, and abnormalities in evoked potential electroencephalograms.

Abnormal laboratory findings may also be noted as a complication either of Schizophrenia or of its treatment. Some individuals with Schizophrenia drink excessive amounts of fluid ("water intoxication") and develop abnormalities in urine specific gravity or electrolyte imbalances. Elevated creatine phosphokinase (CPK) levels may result from Neuroleptic Malignant Syndrome (see p. 795).

Associated physical examination findings and general medical conditions. Individuals with Schizophrenia are sometimes physically awkward and may display neurological "soft signs," such as left/right confusion, poor coordination, or mirroring. Some minor physical anomalies (e.g., highly arched palate, narrow- or wide-set eyes or subtle malformations of the ears) may be more common among individuals with Schizophrenia. Perhaps the most common associated physical findings are motor abnormalities. Most of these are likely to be related to side effects from treatment with antipsychotic medications. Motor abnormalities that are secondary to neuroleptic treatment include Neuroleptic-Induced Tardive Dyskinesia (see p. 803), Neuroleptic-Induced Parkinsonism (see p. 792), Neuroleptic-Induced Acute Akathisia (see p. 800), Neuroleptic-Induced Acute Dystonia (see p. 798), and Neuroleptic Malignant Syndrome (see p. 795). Spontaneous motor abnormalities resembling those that may be induced by neuroleptics (e.g., sniffing, tongue clucking, grunting) had been described in the preneuroleptic era and are also still observed, although they may be difficult to distinguish from neuroleptic effects. Other physical findings may be related to frequently associated disorders. For example, because Nicotine Dependence is so common in Schizophrenia, these individuals are more likely to develop cigarette-related pathology (e.g., emphysema and other pulmonary and cardiac problems).

Specific Culture, Age, and Gender Features

Clinicians assessing the symptoms of Schizophrenia in socioeconomic or cultural situations that are different from their own must take cultural differences into account. Ideas that may appear to be delusional in one culture (e.g., sorcery and witchcraft) may be commonly held in another. In some cultures, visual or auditory hallucinations with a religious content may be a normal part of religious experience (e.g., seeing the Virgin Mary or hearing God's voice). In addition, the assessment of disorganized speech may be made difficult by linguistic variation in narrative styles across cultures that affects the logical form of verbal presentation. The assessment of affect requires sensitivity to differences in styles of emotional expression, eye contact, and body language, which vary across cultures. If the assessment is conducted in a language that is different from the individual's primary language, care must be taken to ensure that alogia is not related to linguistic barriers. Because the cultural meaning of self-initiated, goal-directed activity can be expected to vary across diverse settings, disturbances of volition must also be carefully assessed.

There is some evidence that clinicians may have a tendency to overdiagnose Schizophrenia in some ethnic groups. Studies conducted in the United Kingdom and the United States suggest that Schizophrenia may be diagnosed more often in individuals who are African American and Asian American than in other racial groups. It is not clear, however, whether these findings represent true differences among racial groups or whether they are the result of clinician bias or cultural insensitivity. Cultural differences have been noted in the presentation, course, and outcome of Schizophrenia. Catatonic behavior has been reported as relatively uncommon among individuals with Schizophrenia in the United States but is more common in non-Western countries. Individuals with Schizophrenia in developing nations tend to have a more acute course and a better outcome than do individuals in industrialized nations.

The onset of Schizophrenia typically occurs between the late teens and the mid-30s, with onset prior to adolescence rare (although cases with age at onset of 5 or 6 years have been reported). The essential features of the condition are the same in children, but it may be particularly difficult to make the diagnosis in this age group. In children, delusions and hallucinations may be less elaborated than those observed in adults, and visual hallucinations may be more common. Disorganized speech is observed in a number of disorders with childhood onset (e.g., Communication Disorders, Pervasive Developmental Disorders), as is disorganized behavior (e.g., Attention-Deficit/Hyperactivity Disorder, Stereotypic Movement Disorder). These symptoms should not be attributed to Schizophrenia without due consideration of these more common disorders of childhood. Schizophrenia can also begin later in life (e.g., after age 45 years). Late-onset cases tend to be similar to earlier-onset Schizophrenia, although a number of differences have been observed. For example, the proportion of affected women is greater, and individuals with late onset are more likely to have been married than individuals with an earlier age at onset, but they are nonetheless more socially isolated and impaired when contrasted to the general population. Clinical factors such as the postmenopausal state, human leukocyte antigen subtypes, and cerebrovascular disease are possible risk factors. The clinical presentation is more likely to include persecutory delusions and hallucinations, and less likely to include disorganized and negative symptoms. Often the course is characterized by a predominance of positive symptoms with preservation of affect and social functioning. The course is typically chronic, although individuals may be quite responsive to antipsychotic medications in lower doses. Among those with the oldest age at onset (i.e., over age 60 years), sensory deficits (e.g., auditory and visual loss) occur more commonly than in the general adult population, although their specific role in pathogenesis remains unknown. There is also evidence suggesting that cognitive impairment accompanies the clinical picture. However, the issue of whether identifiable brain pathology defines late-onset illness remains unclear.

Evidence from a large body of literature demonstrates that Schizophrenia is expressed differently in men and women. The modal age at onset for men is between 18 and 25 years, and that for women is between 25 and the mid-30s. The age-at-onset distribution is bimodal for women, with a second peak occurring later in life, but unimodal among men. Approximately 3%–10% of women have an age at onset after 40, whereas late onset is much less common in men. Women also have better premorbid functioning than men. Women with Schizophrenia tend to express more affective

symptomatology, paranoid delusions, and hallucinations, whereas men tend to express more negative symptoms (flat affect, avolition, social withdrawal). Regarding the course of Schizophrenia, women have a better prognosis than men, as defined by number of rehospitalizations and lengths of hospital stay, overall duration of illness, time to relapse, response to neuroleptics, and social and work functioning. However, the gender advantage in these parameters appears to attenuate to some degree with age (i.e., short- to medium-term outcome is better in women, but long-term outcome for women, especially in the postmenopausal period, becomes more like that for men). A slightly higher incidence of Schizophrenia has been observed in men than in women. Further, a number of studies have demonstrated gender differences in the genetic transmission of Schizophrenia. Rates of Schizophrenia among family members of women with Schizophrenia are higher than those among family members of men with Schizophrenia, while relatives of men have a higher incidence of schizotypal and schizoid personality traits than do those of women.

Prevalence

Schizophrenia has been observed worldwide. Prevalences among adults are often reported to be in the range of 0.5% to 1.5%. Annual incidences are most often in the range of 0.5 to 5.0 per 10,000. Incidence estimates beyond this range have been reported for some population groups—for instance, a far higher incidence for second-generation African Caribbeans living in the United Kingdom.

Birth cohort studies suggest some geographic and historical variations in incidence. For example, an elevated risk has been reported among urban-born individuals compared with rural-born individuals, as well as a gradually declining incidence for later-born birth cohorts.

Course

The median age at onset for the first psychotic episode of Schizophrenia is in the early to mid-20s for men and in the late 20s for women. The onset may be abrupt or insidious, but the majority of individuals display some type of prodromal phase manifested by the slow and gradual development of a variety of signs and symptoms (e.g., social withdrawal, loss of interest in school or work, deterioration in hygiene and grooming, unusual behavior, outbursts of anger). Family members may find this behavior difficult to interpret and assume that the person is "going through a phase." Eventually, however, the appearance of some active-phase symptom marks the disturbance as Schizophrenia. The age at onset may have both pathophysiological and prognostic significance. Individuals with an early age at onset are more often male and have a poorer premorbid adjustment, lower educational achievement, more evidence of structural brain abnormalities, more prominent negative signs and symptoms, more evidence of cognitive impairment as assessed with neuropsychological testing, and a worse outcome. Conversely, individuals with a later onset are more often female, have less evidence of structural brain abnormalities or cognitive impairment, and display a better outcome.

Most studies of course and outcome in Schizophrenia suggest that the course may be variable, with some individuals displaying exacerbations and remissions, whereas

others remain chronically ill. Because of variability in definition and ascertainment, an accurate summary of the long-term outcome of Schizophrenia is not possible. Complete remission (i.e., a return to full premorbid functioning) is probably not common in this disorder. Of those who remain ill, some appear to have a relatively stable course, whereas others show a progressive worsening associated with severe disability. Early in the illness, negative symptoms may be prominent, appearing primarily as prodromal features. Subsequently, positive symptoms appear. Because these positive symptoms are particularly responsive to treatment, they typically diminish, but in many individuals, negative symptoms persist between episodes of positive symptoms. There is some suggestion that negative symptoms may become steadily more prominent in some individuals during the course of the illness. Numerous studies have indicated a group of factors that are associated with a better prognosis. These include good premorbid adjustment, acute onset, later age at onset, absence of anosognosia (poor insight), being female, precipitating events, associated mood disturbance, treatment with antipsychotic medication soon after the onset of the illness, consistent medication compliance (i.e., early and consistent treatment predicts better response to later treatment with antipsychotic medication), brief duration of active-phase symptoms, good interepisode functioning, minimal residual symptoms, absence of structural brain abnormalities, normal neurological functioning, a family history of Mood Disorder, and no family history of Schizophrenia.

Familial Pattern

The first-degree biological relatives of individuals with Schizophrenia have a risk for Schizophrenia that is about 10 times greater than that of the general population. Concordance rates for Schizophrenia are higher in monozygotic twins than in dizygotic twins. Adoption studies have shown that biological relatives of individuals with Schizophrenia have a substantially increased risk for Schizophrenia, whereas adoptive relatives have no increased risk. Although much evidence suggests the importance of genetic factors in the etiology of Schizophrenia, the existence of a substantial discordance rate in monozygotic twins also indicates the importance of environmental factors. Some relatives of individuals with Schizophrenia may also have an increased risk for a group of mental disorders, termed the *schizophrenia spectrum.* Although the exact boundaries of the spectrum remain unclear, family and adoption studies suggest that it probably includes Schizoaffective Disorder and Schizotypal Personality Disorder. Other psychotic disorders and Paranoid, Schizoid, and Avoidant Personality Disorders may belong to the schizophrenia spectrum as well, but the evidence is more limited.

Differential Diagnosis

A wide variety of general medical conditions can present with psychotic symptoms. **Psychotic Disorder Due to a General Medical Condition,** a **delirium,** or a **dementia** is diagnosed when there is evidence from the history, physical examination, or laboratory tests that indicates that the delusions or hallucinations are the direct physiological consequence of a general medical condition (e.g., Cushing's syndrome, brain tumor) (see p. 334). **Substance-Induced Psychotic Disorder, Substance-Induced De-**

lirium, and **Substance-Induced Persisting Dementia** are distinguished from Schizophrenia by the fact that a substance (e.g., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the delusions or hallucinations (see p. 338). Many different types of **Substance-Related Disorders** may produce symptoms similar to those of Schizophrenia (e.g., sustained amphetamine or cocaine use may produce delusions or hallucinations; phencyclidine use may produce a mixture of positive and negative symptoms). Based on a variety of features that characterize the course of Schizophrenia and Substance-Related Disorders, the clinician must determine whether the psychotic symptoms have been initiated and maintained by the substance use. Ideally, the clinician should attempt to observe the individual during a sustained period (e.g., 4 weeks) of abstinence. However, because such prolonged periods of abstinence are often difficult to achieve, the clinician may need to consider other evidence, such as whether the psychotic symptoms appear to be exacerbated by the substance and to diminish when it has been discontinued, the relative severity of psychotic symptoms in relation to the amount and duration of substance use, and knowledge of the characteristic symptoms produced by a particular substance (e.g., amphetamines typically produce delusions and stereotypies, but not affective blunting or prominent negative symptoms).

Distinguishing Schizophrenia from **Mood Disorder With Psychotic Features** and **Schizoaffective Disorder** is made difficult by the fact that mood disturbance is common during the prodromal, active, and residual phases of Schizophrenia. If psychotic symptoms occur exclusively during periods of mood disturbance, the diagnosis is Mood Disorder With Psychotic Features. In Schizoaffective Disorder, there must be a mood episode that is concurrent with the active-phase symptoms of Schizophrenia, mood symptoms must be present for a substantial portion of the total duration of the disturbance, and delusions or hallucinations must be present for at least 2 weeks in the absence of prominent mood symptoms. In contrast, mood symptoms in Schizophrenia either have a duration that is brief in relation to the total duration of the disturbance, occur only during the prodromal or residual phases, or do not meet full criteria for a mood episode. When mood symptoms that meet full criteria for a mood episode are superimposed on Schizophrenia and are of particular clinical significance, an additional diagnosis of **Depressive Disorder Not Otherwise Specified** or **Bipolar Disorder Not Otherwise Specified** may be given. Schizophrenia, Catatonic Type, may be difficult to distinguish from a **Mood Disorder With Catatonic Features.**

By definition, Schizophrenia differs from **Schizophreniform Disorder** on the basis of duration. Schizophrenia involves the presence of symptoms (including prodromal or residual symptoms) for at least 6 months, whereas the total duration of symptoms in Schizophreniform Disorder must be at least 1 month but less than 6 months. Schizophreniform Disorder also does not require a decline in functioning. **Brief Psychotic Disorder** is defined by the presence of delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior lasting for at least 1 day but for less than 1 month.

The differential diagnosis between Schizophrenia and **Delusional Disorder** rests on the nature of the delusions (nonbizarre in Delusional Disorder) and the absence of other characteristic symptoms of Schizophrenia (e.g., hallucinations, disorganized speech or behavior, or prominent negative symptoms). Delusional Disorder may be

particularly difficult to differentiate from the Paranoid Type of Schizophrenia, because this subtype does not include prominent disorganized speech, disorganized behavior, or flat or inappropriate affect and is often associated with less decline in functioning than is characteristic of the other subtypes of Schizophrenia. When poor psychosocial functioning is present in Delusional Disorder, it arises directly from the delusional beliefs themselves.

A diagnosis of **Psychotic Disorder Not Otherwise Specified** may be made if insufficient information is available to choose between Schizophrenia and other Psychotic Disorders (e.g., Schizoaffective Disorder) or to determine whether the presenting symptoms are substance induced or are the result of a general medical condition. Such uncertainty is particularly likely to occur early in the course of the disorder.

Although Schizophrenia and **Pervasive Developmental Disorders** (e.g., Autistic Disorder) share disturbances in language, affect, and interpersonal relatedness, they can be distinguished in a number of ways. Pervasive Developmental Disorders are characteristically recognized during infancy or early childhood (usually before age 3 years), whereas such early onset is rare in Schizophrenia. Moreover, in Pervasive Developmental Disorders, there is an absence of prominent delusions and hallucinations; more pronounced abnormalities in affect; and speech that is absent or minimal and characterized by stereotypies and abnormalities in prosody. Schizophrenia may occasionally develop in individuals with a Pervasive Developmental Disorder; a diagnosis of Schizophrenia is warranted in individuals with a preexisting diagnosis of Autistic Disorder or another Pervasive Developmental Disorder only if prominent hallucinations or delusions have been present for at least a month. Childhood-onset Schizophrenia must be distinguished from **childhood presentations combining disorganized speech** (from a **Communication Disorder**) and disorganized behavior (from **Attention-Deficit/Hyperactivity Disorder**).

Schizophrenia shares features (e.g., paranoid ideation, magical thinking, social avoidance, and vague and digressive speech) with and may be preceded by **Schizotypal, Schizoid,** or **Paranoid Personality Disorder.** An additional diagnosis of Schizophrenia is appropriate when the symptoms are severe enough to satisfy Criterion A of Schizophrenia. The preexisting Personality Disorder may be noted on Axis II followed by "Premorbid" in parentheses [e.g., Schizotypal Personality Disorder (Premorbid)].

Diagnostic criteria for Schizophrenia

A. *Characteristic symptoms:* Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

(1) delusions
(2) hallucinations
(3) disorganized speech (e.g., frequent derailment or incoherence)
(4) grossly disorganized or catatonic behavior
(5) negative symptoms, i.e., affective flattening, alogia, or avolition

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

B. *Social/occupational dysfunction:* For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. *Duration:* Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. *Schizoaffective and Mood Disorder exclusion:* Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. *Substance/general medical condition exclusion:* The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

F. *Relationship to a Pervasive Developmental Disorder:* If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

Classification of longitudinal course (can be applied only after at least 1 year has elapsed since the initial onset of active-phase symptoms):

Episodic With Interepisode Residual Symptoms (episodes are defined by the reemergence of prominent psychotic symptoms); *also specify if:* **With Prominent Negative Symptoms**
Episodic With No Interepisode Residual Symptoms
Continuous (prominent psychotic symptoms are present throughout the period of observation); *also specify if:* **With Prominent Negative Symptoms**

Diagnostic criteria for Schizophrenia *(continued)*

Single Episode In Partial Remission; *also specify if:* **With Prominent Negative Symptoms**
Single Episode In Full Remission
Other or Unspecified Pattern

Schizophrenia Subtypes

The subtypes of Schizophrenia are defined by the predominant symptomatology at the time of evaluation. Although the prognostic and treatment implications of the subtypes are variable, the Paranoid and Disorganized Types tend to be the least and most severe, respectively. The diagnosis of a particular subtype is based on the clinical picture that occasioned the most recent evaluation or admission to clinical care and may therefore change over time. Not infrequently, the presentation may include symptoms that are characteristic of more than one subtype. The choice among subtypes depends on the following algorithm: Catatonic Type is assigned whenever prominent catatonic symptoms are present (regardless of the presence of other symptoms); Disorganized Type is assigned whenever disorganized speech and behavior and flat or inappropriate affect are prominent (unless Catatonic Type is also present); Paranoid Type is assigned whenever there is a preoccupation with delusions or frequent hallucinations are prominent (unless the Catatonic or Disorganized Type is present). Undifferentiated Type is a residual category describing presentations that include prominent active-phase symptoms not meeting criteria for the Catatonic, Disorganized, or Paranoid Type; and Residual Type is for presentations in which there is continuing evidence of the disturbance, but the criteria for the active-phase symptoms are no longer met.

Because of the limited value of the schizophrenia subtypes in clinical and research settings (e.g., prediction of course, treatment response, correlates of illness), alternative subtyping schemes are being actively investigated. The alternative with the most empirical support to date proposes that three dimensions of psychopathology (psychotic, disorganized, and negative) may come together in different ways among individuals with Schizophrenia. This dimensional alternative is described in Appendix B (p. 765).

295.30 Paranoid Type

The essential feature of the Paranoid Type of Schizophrenia is the presence of prominent delusions or auditory hallucinations in the context of a relative preservation of cognitive functioning and affect. Symptoms characteristic of the Disorganized and Catatonic Types (e.g., disorganized speech, flat or inappropriate affect, catatonic or disorganized behavior) are not prominent. Delusions are typically persecutory or grandiose, or both, but delusions with other themes (e.g., jealousy, religiosity, or somatization) may also occur. The delusions may be multiple, but are usually organized around a coherent theme. Hallucinations are also typically related to the content of

the delusional theme. Associated features include anxiety, anger, aloofness, and argumentativeness. The individual may have a superior and patronizing manner and either a stilted, formal quality or extreme intensity in interpersonal interactions. The persecutory themes may predispose the individual to suicidal behavior, and the combination of persecutory and grandiose delusions with anger may predispose the individual to violence. Onset tends to be later in life than the other types of Schizophrenia, and the distinguishing characteristics may be more stable over time. These individuals usually show little or no impairment on neuropsychological or other cognitive testing. Some evidence suggests that the prognosis for the Paranoid Type may be considerably better than for the other types of Schizophrenia, particularly with regard to occupational functioning and capacity for independent living.

Diagnostic criteria for 295.30 Paranoid Type

A type of Schizophrenia in which the following criteria are met:

A. Preoccupation with one or more delusions or frequent auditory hallucinations.

B. None of the following is prominent: disorganized speech, disorganized or catatonic behavior, or flat or inappropriate affect.

295.10 Disorganized Type

The essential features of the Disorganized Type of Schizophrenia are disorganized speech, disorganized behavior, and flat or inappropriate affect. The disorganized speech may be accompanied by silliness and laughter that are not closely related to the content of the speech. The behavioral disorganization (i.e., lack of goal orientation) may lead to severe disruption in the ability to perform activities of daily living (e.g., showering, dressing, or preparing meals). Criteria for the Catatonic Type of Schizophrenia are not met, and delusions or hallucinations, if present, are fragmentary and not organized into a coherent theme. Associated features include grimacing, mannerisms, and other oddities of behavior. Impaired performance may be noted on a variety of neuropsychological and cognitive tests. This subtype is also usually associated with poor premorbid personality, early and insidious onset, and a continuous course without significant remissions. Historically, and in other classification systems, this type is termed *hebephrenic*.

Diagnostic criteria for 295.10 Disorganized Type

A type of Schizophrenia in which the following criteria are met:

A. All of the following are prominent:

(1) disorganized speech
(2) disorganized behavior
(3) flat or inappropriate affect

B. The criteria are not met for Catatonic Type.

295.20 Catatonic Type

The essential feature of the Catatonic Type of Schizophrenia is a marked psychomotor disturbance that may involve motoric immobility, excessive motor activity, extreme negativism, mutism, peculiarities of voluntary movement, echolalia, or echopraxia. Motoric immobility may be manifested by catalepsy (waxy flexibility) or stupor. The excessive motor activity is apparently purposeless and is not influenced by external stimuli. There may be extreme negativism that is manifested by the maintenance of a rigid posture against attempts to be moved or resistance to all instructions. Peculiarities of voluntary movement are manifested by the voluntary assumption of inappropriate or bizarre postures or by prominent grimacing. Echolalia is the pathological, parrotlike, and apparently senseless repetition of a word or phrase just spoken by another person. Echopraxia is the repetitive imitation of the movements of another person. Additional features include stereotypies, mannerisms, and automatic obedience or mimicry. During severe catatonic stupor or excitement, the person may need careful supervision to avoid self-harm or harming others. There are potential risks from malnutrition, exhaustion, hyperpyrexia, or self-inflicted injury. To diagnose this subtype, the individual's presentation must first meet the full criteria for Schizophrenia and not be better accounted for by another etiology: substance induced (e.g., Neuroleptic-Induced Parkinsonism, see p. 792), a general medical condition (see p. 185), or a Manic or Major Depressive Episode (see p. 417).

Diagnostic criteria for 295.20 Catatonic Type

A type of Schizophrenia in which the clinical picture is dominated by at least two of the following:

(1) motoric immobility as evidenced by catalepsy (including waxy flexibility) or stupor
(2) excessive motor activity (that is apparently purposeless and not influenced by external stimuli)
(3) extreme negativism (an apparently motiveless resistance to all instructions or maintenance of a rigid posture against attempts to be moved) or mutism
(4) peculiarities of voluntary movement as evidenced by posturing (voluntary assumption of inappropriate or bizarre postures), stereotyped movements, prominent mannerisms, or prominent grimacing
(5) echolalia or echopraxia

295.90 Undifferentiated Type

The essential feature of the Undifferentiated Type of Schizophrenia is the presence of symptoms that meet Criterion A of Schizophrenia but that do not meet criteria for the Paranoid, Disorganized, or Catatonic Type.

Diagnostic criteria for 295.90 Undifferentiated Type

A type of Schizophrenia in which symptoms that meet Criterion A are present, but the criteria are not met for the Paranoid, Disorganized, or Catatonic Type.

295.60 Residual Type

The Residual Type of Schizophrenia should be used when there has been at least one episode of Schizophrenia, but the current clinical picture is without prominent positive psychotic symptoms (e.g., delusions, hallucinations, disorganized speech or behavior). There is continuing evidence of the disturbance as indicated by the presence of negative symptoms (e.g., flat affect, poverty of speech, or avolition) or two or more attenuated positive symptoms (e.g., eccentric behavior, mildly disorganized speech, or odd beliefs). If delusions or hallucinations are present, they are not prominent and are not accompanied by strong affect. The course of the Residual Type may be time limited and represent a transition between a full-blown episode and complete remission. However, it may also be continuously present for many years, with or without acute exacerbations.

Diagnostic criteria for 295.60 Residual Type

A type of Schizophrenia in which the following criteria are met:

A. Absence of prominent delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior.

B. There is continuing evidence of the disturbance, as indicated by the presence of negative symptoms or two or more symptoms listed in Criterion A for Schizophrenia, present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

295.40 Schizophreniform Disorder

Diagnostic Features

The essential features of Schizophreniform Disorder are identical to those of Schizophrenia (Criterion A) except for two differences: the total duration of the illness (including prodromal, active, and residual phases) is at least 1 month but less than 6 months (Criterion B) and impaired social or occupational functioning during some part of the illness is not required (although it may occur). The duration requirement for Schizophreniform Disorder is intermediate between that for Brief Psychotic Disorder (in which symptoms last for at least 1 day but for less than 1 month) and Schizophrenia (in which the symptoms persist for at least 6 months). The diagnosis of Schizophreniform Disorder is made under two conditions. In the first, the diagnosis is applied without qualification to an episode of illness of between 1 and 6 months' duration from which the individual has already recovered. In the second instance, the diagnosis is applied when a person who, although symptomatic, has been so for less than the 6 months required for a diagnosis of Schizophrenia. In this case, the diagnosis of Schizophreniform Disorder should be qualified as "Provisional" because there is no certainty that the individual will actually recover from the disturbance within the 6-month period. If the disturbance persists beyond 6 months, the diagnosis would be changed to Schizophrenia.

Specifiers

The following specifiers for Schizophreniform Disorder may be used to indicate the presence or absence of features that may be associated with a better prognosis:

With Good Prognostic Features. This specifier is used if at least two of the following features are present: onset of prominent psychotic symptoms within 4 weeks of the first noticeable change in usual behavior or functioning, confusion or perplexity at the height of the psychotic episode, good premorbid social and occupational functioning, and absence of blunted or flat affect.

Without Good Prognostic Features. This specifier is used if two or more of the above features have not been present.

Associated Features and Disorders

Also see the discussion in the Associated Features and Disorders section for Schizophrenia, p. 304. Unlike Schizophrenia, impairment in social or occupational functioning is not required for a diagnosis of Schizophreniform Disorder. However, most individuals do experience dysfunction in various areas of daily functioning (e.g., work or school, interpersonal relationships, and self-care).

Specific Culture, Age, and Gender Features

For additional discussion of culture, age, and gender factors relevant to the diagnosis of Schizophreniform Disorder, see the Specific Culture, Age, and Gender Features section for Schizophrenia (p. 306). There are suggestions that in developing countries, recovery from Psychotic Disorders may be more rapid, which would result in higher rates of Schizophreniform Disorder than of Schizophrenia.

Prevalence

Available evidence suggests variations in incidence across sociocultural settings. In the United States and other developed countries, the incidence is low, possibly fivefold less than that of Schizophrenia. In developing countries, the incidence is substantially higher, especially for the subtype "With Good Prognostic Features"; in some of these settings Schizophreniform Disorder may be as common as Schizophrenia.

Course

There is little available information on the course of Schizophreniform Disorder. Approximately one-third of individuals with an initial diagnosis of Schizophreniform Disorder (Provisional) recover within the 6-month period and receive Schizophreniform Disorder as their final diagnosis. Of the remaining two-thirds, the majority will progress to the diagnosis of Schizophrenia or Schizoaffective Disorder.

Familial Pattern

Few family studies have focused on Schizophreniform Disorder. Available evidence suggests that relatives of individuals with Schizophreniform Disorder have an increased risk for Schizophrenia.

Differential Diagnosis

Because the diagnostic criteria for Schizophrenia and Schizophreniform Disorder differ primarily in terms of duration of illness, the discussion of the differential diagnosis of Schizophrenia (p. 309) also applies to Schizophreniform Disorder. Schizophreniform Disorder differs from **Brief Psychotic Disorder,** which has a duration of less than 1 month.

Diagnostic criteria for 295.40 Schizophreniform Disorder

A. Criteria A, D, and E of Schizophrenia are met.

B. An episode of the disorder (including prodromal, active, and residual phases) lasts at least 1 month but less than 6 months. (When the diagnosis must be made without waiting for recovery, it should be qualified as "Provisional.")

Specify if:

Without Good Prognostic Features

With Good Prognostic Features: as evidenced by two (or more) of the following:

(1) onset of prominent psychotic symptoms within 4 weeks of the first noticeable change in usual behavior or functioning
(2) confusion or perplexity at the height of the psychotic episode
(3) good premorbid social and occupational functioning
(4) absence of blunted or flat affect

295.70 Schizoaffective Disorder

Diagnostic Features

The essential feature of Schizoaffective Disorder is an uninterrupted period of illness during which, at some time, there is a Major Depressive, Manic, or Mixed Episode concurrent with symptoms that meet Criterion A for Schizophrenia (Criterion A). In addition, during the same period of illness, there have been delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms (Criterion B). Finally, the mood symptoms are present for a substantial portion of the total duration of the illness (Criterion C). The symptoms must not be due to the direct physiological effects of a substance (e.g., cocaine) or a general medical condition (e.g., hyperthyroidism or temporal lobe epilepsy) (Criterion D). To meet criteria for Schizoaffective Disorder, the essential features must occur within a single uninterrupted period of illness. The phrase "period of illness" as used here refers to a time period during which the individual continues to display active or residual symptoms of psychotic illness. For some individuals, this period of illness may last for years or even decades. A period of illness is considered to have ended when the individual has completely recovered for a significant interval of time and no longer demonstrates any significant symptoms of the disorder.

The phase of the illness with concurrent mood and psychotic symptoms is characterized by the full criteria being met for both the active phase of Schizophrenia (i.e., Criterion A) (see p. 298) and for a Major Depressive Episode (p. 349), a Manic Episode (p. 357), or a Mixed Episode (p. 362). The duration of the Major Depressive Episode must be at least 2 weeks; the duration of the Manic or Mixed Episode must be at least 1 week. Because the psychotic symptoms must have a total duration of at least 1 month to meet Criterion A for Schizophrenia, the minimum duration of a schizoaffective

episode is also 1 month. An essential feature of a Major Depressive Episode is the presence of either depressed mood or markedly diminished interest or pleasure. Because loss of interest or pleasure is so common in nonaffective Psychotic Disorders, to meet Criterion A for Schizoaffective Disorder the Major Depressive Episode must include pervasive depressed mood (i.e., the presence of markedly diminished interest or pleasure is not sufficient). The phase of the illness with psychotic symptoms alone is characterized by delusions or hallucinations that last at least 2 weeks. Although some mood symptoms may be present during this phase, they are not prominent. This determination can be difficult and may require longitudinal observation and multiple sources of information.

The symptoms of Schizoaffective Disorder may occur in a variety of temporal patterns. The following is a typical pattern: An individual may have pronounced auditory hallucinations and persecutory delusions for 2 months before the onset of a prominent Major Depressive Episode. The psychotic symptoms and the full Major Depressive Episode are then present for 3 months. Then, the person recovers completely from the Major Depressive Episode, but the psychotic symptoms persist for another month before they too disappear. During this period of illness, the individual's symptoms concurrently met criteria for a Major Depressive Episode and Criterion A for Schizophrenia, and, during this same period of illness, auditory hallucinations and delusions were present both before and after the depressive phase. The total period of illness lasted for about 6 months, with psychotic symptoms alone present during the initial 2 months, both depressive and psychotic symptoms present during the next 3 months, and psychotic symptoms alone present during the last month. In this instance, the duration of the depressive episode was not brief relative to the total duration of the psychotic disturbance, and thus the presentation qualifies for a diagnosis of Schizoaffective Disorder.

Criterion C for Schizoaffective Disorder specifies that mood symptoms that meet criteria for a mood episode must be present for a substantial portion of the entire period of illness. If the mood symptoms are present for only a relatively brief period of time, the diagnosis is Schizophrenia, not Schizoaffective Disorder. In evaluating this criterion, the clinician should determine the proportion of time during the continuous period of psychotic illness (i.e., both active and residual symptoms) in which there were significant mood symptoms accompanying the psychotic symptoms. The operationalization of what is meant by "a substantial portion of time" requires clinical judgment. For example, an individual with a 4-year history of active and residual symptoms of Schizophrenia develops a superimposed Major Depressive Episode that lasts for 5 weeks during which the psychotic symptoms persist. This presentation would not meet the criterion for "a substantial portion of the total duration" because the symptoms that meet criteria for a mood episode occurred for only 5 weeks out of a total of 4 years of disturbance. The diagnosis in this example remains Schizophrenia with the additional diagnosis of Depressive Disorder Not Otherwise Specified to indicate the superimposed Major Depressive Episode.

Subtypes

Two subtypes of Schizoaffective Disorder may be noted based on the mood component of the disorder:

Bipolar Type. This subtype applies if a Manic Episode or Mixed Episode is part of the presentation. Major Depressive Episodes may also occur.
Depressive Type. This subtype applies if only Major Depressive Episodes are part of the presentation.

Associated Features and Disorders

There may be poor occupational functioning, a restricted range of social contact, difficulties with self-care, and increased risk of suicide associated with Schizoaffective Disorder. Residual and negative symptoms are usually less severe and less chronic than those seen in Schizophrenia. Anosognosia (i.e., poor insight) is also common in Schizoaffective Disorder, but the deficits in insight may be less severe and pervasive than in Schizophrenia. Individuals with Schizoaffective Disorder may be at increased risk for later developing episodes of pure Mood Disorder (e.g., Major Depressive or Bipolar Disorder) or of Schizophrenia or Schizophreniform Disorder. There may be associated Alcohol and other Substance-Related Disorders. Limited clinical evidence suggests that Schizoaffective Disorder may be preceded by Schizoid, Schizotypal, Borderline, or Paranoid Personality Disorder.

Specific Culture, Age, and Gender Features

For additional discussion of culture, age, and gender factors relevant to evaluating psychotic symptoms, see the text for Schizophrenia (p. 306), and for a discussion of such factors relevant to diagnosing Mood Disorders, see p. 372 and p. 385. Schizoaffective Disorder, Bipolar Type, may be more common in young adults, whereas Schizoaffective Disorder, Depressive Type, may be more common in older adults. The incidence of Schizoaffective Disorder is higher in women than in men—a difference that is mostly accounted for by an increased incidence among women of the Depressive Type.

Prevalence

Detailed information is lacking, but Schizoaffective Disorder appears to be less common than Schizophrenia.

Course

The typical age at onset of Schizoaffective Disorder is early adulthood, although onset can occur anywhere from adolescence to late in life. The prognosis for Schizoaffective Disorder is somewhat better than the prognosis for Schizophrenia, but considerably worse than the prognosis for Mood Disorders. Substantial occupational and social dysfunction are common. The presence of precipitating events or stressors is associated with a better prognosis. The outcome for Schizoaffective Disorder, Bipolar Type, may be better than that for Schizoaffective Disorder, Depressive Type.

Familial Pattern

There is substantial evidence that there is an increased risk for Schizophrenia in first-degree biological relatives of individuals with Schizoaffective Disorder. Most studies also show that relatives of individuals with Schizoaffective Disorder are at increased risk for Mood Disorders.

Differential Diagnosis

General medical conditions and substance use can present with a combination of psychotic and mood symptoms. **Psychotic Disorder Due to a General Medical Condition,** a **delirium,** or a **dementia** is diagnosed when there is evidence from the history, physical examination, or laboratory tests indicating that the symptoms are the direct physiological consequence of a specific general medical condition (see p. 334). **Substance-Induced Psychotic Disorder** and **Substance-Induced Delirium** are distinguished from Schizoaffective Disorder by the fact that a substance (e.g., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the symptoms (see p. 338).

Distinguishing Schizoaffective Disorder from **Schizophrenia** and from **Mood Disorder With Psychotic Features** is often difficult. In Schizoaffective Disorder, there must be a mood episode that is concurrent with the active-phase symptoms of Schizophrenia, mood symptoms must be present for a substantial portion of the total duration of the disturbance, and delusions or hallucinations must be present for at least 2 weeks in the absence of prominent mood symptoms. In contrast, mood symptoms in Schizophrenia either have a duration that is brief relative to the total duration of the disturbance, occur only during the prodromal or residual phases, or do not meet full criteria for a mood episode. If psychotic symptoms occur exclusively during periods of mood disturbance, the diagnosis is Mood Disorder With Psychotic Features. In Schizoaffective Disorder, symptoms should not be counted toward a mood episode if they are clearly the result of symptoms of Schizophrenia (e.g., difficulty sleeping because of disturbing auditory hallucinations, weight loss because food is considered poisoned, difficulty concentrating because of psychotic disorganization). Loss of interest or pleasure is common in nonaffective Psychotic Disorders; therefore, to meet Criterion A for Schizoaffective Disorder, the Major Depressive Episode must include pervasive depressed mood.

Because the relative proportion of mood to psychotic symptoms may change over the course of the disturbance, the appropriate diagnosis for an individual episode of illness may change from Schizoaffective Disorder to Schizophrenia (e.g., a diagnosis of Schizoaffective Disorder for a severe and prominent Major Depressive Episode lasting 3 months during the first 6 months of a chronic psychotic illness would be changed to Schizophrenia if active psychotic or prominent residual symptoms persist over several years without a recurrence of another mood episode). The diagnosis may also change for different episodes of illness separated by a period of recovery. For example, an individual may have an episode of psychotic symptoms that meet Criterion A for Schizophrenia during a Major Depressive Episode, recover fully from this episode, and then later develop 6 weeks of delusions and hallucinations without prominent mood symptoms. The diagnosis in this instance would not be Schizoaffective

Disorder because the period of delusions and hallucinations was not continuous with the initial period of disturbance. Instead, the appropriate diagnoses for the first episode would be Mood Disorder With Psychotic Features, In Full Remission, and Schizophreniform Disorder (Provisional) for the current episode.

Mood disturbances, especially depression, commonly develop during the course of **Delusional Disorder.** However, such presentations do not meet criteria for Schizoaffective Disorder because the psychotic symptoms in Delusional Disorder are restricted to nonbizarre delusions and therefore do not meet Criterion A for Schizoaffective Disorder.

If there is insufficient information concerning the relationship between psychotic and mood symptoms, **Psychotic Disorder Not Otherwise Specified** may be the most appropriate diagnosis.

Diagnostic criteria for 295.70 Schizoaffective Disorder

A. An uninterrupted period of illness during which, at some time, there is either a Major Depressive Episode, a Manic Episode, or a Mixed Episode concurrent with symptoms that meet Criterion A for Schizophrenia.

   Note: The Major Depressive Episode must include Criterion A1: depressed mood.

B. During the same period of illness, there have been delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms.

C. Symptoms that meet criteria for a mood episode are present for a substantial portion of the total duration of the active and residual periods of the illness.

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

Specify type:

Bipolar Type: if the disturbance includes a Manic or a Mixed Episode (or a Manic or a Mixed Episode and Major Depressive Episodes)
Depressive Type: if the disturbance only includes Major Depressive Episodes

297.1 Delusional Disorder

Diagnostic Features

The essential feature of Delusional Disorder is the presence of one or more nonbizarre delusions that persist for at least 1 month (Criterion A). A diagnosis of Delusional Disorder is not given if the individual has ever had a symptom presentation that met Criterion A for Schizophrenia (Criterion B). Auditory or visual hallucinations, if present, are not prominent. Tactile or olfactory hallucinations may be present (and prominent) if they are related to the delusional theme (e.g., the sensation of being infested with insects associated with delusions of infestation, or the perception that one emits a foul odor from a body orifice associated with delusions of reference). Apart

from the direct impact of the delusions, psychosocial functioning is not markedly impaired, and behavior is neither obviously odd nor bizarre (Criterion C). If mood episodes occur concurrently with the delusions, the total duration of these mood episodes is relatively brief compared to the total duration of the delusional periods (Criterion D). The delusions are not due to the direct physiological effects of a substance (e.g., cocaine) or a general medical condition (e.g., Alzheimer's disease, systemic lupus erythematosus) (Criterion E).

Although the determination of whether delusions are bizarre is considered to be especially important in distinguishing between Delusional Disorder and Schizophrenia, "bizarreness" may be difficult to judge, especially across different cultures. Delusions are deemed bizarre if they are clearly implausible, not understandable, and not derived from ordinary life experiences (e.g., an individual's belief that a stranger has removed his or her internal organs and replaced them with someone else's organs without leaving any wounds or scars). In contrast, nonbizarre delusions involve situations that can conceivably occur in real life (e.g., being followed, poisoned, infected, loved at a distance, or deceived by one's spouse or lover).

Psychosocial functioning is variable. Some individuals may appear to be relatively unimpaired in their interpersonal and occupational roles. In others, the impairment may be substantial and include low or absent occupational functioning and social isolation. When poor psychosocial functioning is present in Delusional Disorder, it arises directly from the delusional beliefs themselves. For example, an individual who is convinced that he will be murdered by "Mafia hit men" may quit his job and refuse to leave his house except late at night and only when dressed in clothes quite different from his normal attire. All of this behavior is an understandable attempt to prevent being identified and killed by his presumed assassins. In contrast, poor functioning in Schizophrenia may be due to both positive and negative symptoms (particularly avolition). Similarly, a common characteristic of individuals with Delusional Disorder is the apparent normality of their behavior and appearance when their delusional ideas are not being discussed or acted on. In general, social and marital functioning are more likely to be impaired than intellectual and occupational functioning.

Subtypes

The type of Delusional Disorder may be specified based on the predominant delusional theme:

> **Erotomanic Type.** This subtype applies when the central theme of the delusion is that another person is in love with the individual. The delusion often concerns idealized romantic love and spiritual union rather than sexual attraction. The person about whom this conviction is held is usually of higher status (e.g., a famous person or a superior at work), but can be a complete stranger. Efforts to contact the object of the delusion (through telephone calls, letters, gifts, visits, and even surveillance and stalking) are common, although occasionally the person keeps the delusion secret. Most individuals with this subtype in clinical samples are female; most individuals with this subtype in forensic samples are male. Some individuals with this subtype, particularly males, come into conflict with the law in their efforts to pursue the object of

their delusion or in a misguided effort to "rescue" him or her from some imagined danger.

Grandiose Type. This subtype applies when the central theme of the delusion is the conviction of having some great (but unrecognized) talent or insight or having made some important discovery. Less commonly, the individual may have the delusion of having a special relationship with a prominent person (e.g., an adviser to the president) or being a prominent person (in which case the actual person may be regarded as an impostor). Grandiose delusions may have a religious content (e.g., the person believes that he or she has a special message from a deity).

Jealous Type. This subtype applies when the central theme of the person's delusion is that his or her spouse or lover is unfaithful. This belief is arrived at without due cause and is based on incorrect inferences supported by small bits of "evidence" (e.g., disarrayed clothing or spots on the sheets), which are collected and used to justify the delusion. The individual with the delusion usually confronts the spouse or lover and attempts to intervene in the imagined infidelity (e.g., restricting the spouse's autonomy, secretly following the spouse, investigating the imagined lover, attacking the spouse).

Persecutory Type. This subtype applies when the central theme of the delusion involves the person's belief that he or she is being conspired against, cheated, spied on, followed, poisoned or drugged, maliciously maligned, harassed, or obstructed in the pursuit of long-term goals. Small slights may be exaggerated and become the focus of a delusional system. The focus of the delusion is often on some injustice that must be remedied by legal action ("querulous paranoia"), and the affected person may engage in repeated attempts to obtain satisfaction by appeal to the courts and other government agencies. Individuals with persecutory delusions are often resentful and angry and may resort to violence against those they believe are hurting them.

Somatic Type. This subtype applies when the central theme of the delusion involves bodily functions or sensations. Somatic delusions can occur in several forms. Most common are the person's conviction that he or she emits a foul odor from the skin, mouth, rectum, or vagina; that there is an infestation of insects on or in the skin; that there is an internal parasite; that certain parts of the body are definitely (contrary to all evidence) misshapen or ugly; or that parts of the body (e.g., the large intestine) are not functioning.

Mixed Type. This subtype applies when no one delusional theme predominates.

Unspecified Type. This subtype applies when the dominant delusional belief cannot be clearly determined or is not described in the specific types (e.g., referential delusions without a prominent persecutory or grandiose component).

Associated Features and Disorders

Social, marital, or work problems can result from the delusional beliefs of Delusional Disorder. Ideas of reference (e.g., that random events are of special significance) are common in individuals with this disorder. Their interpretation of these events is usu-

ally consistent with the content of their delusional beliefs. Many individuals with Delusional Disorder develop irritable or dysphoric mood, which can usually be understood as a reaction to their delusional beliefs. Especially with the Persecutory and Jealous Types, marked anger and violent behavior can occur. The individual may engage in litigious behavior, sometimes leading to hundreds of letters of protest to government and judicial officials and many court appearances. Legal difficulties can occur in Delusional Disorder, Jealous Type and Erotomanic Type. Individuals with Delusional Disorder, Somatic Type, may be subject to unnecessary medical tests and procedures. Hearing deficiency, severe psychosocial stressors (e.g., immigration), and low socioeconomic status may predispose an individual to the development of certain types of Delusional Disorder (e.g., Paranoid Type). Major Depressive Episodes probably occur in individuals with Delusional Disorder more frequently than in the general population. Delusional Disorder may be associated with Obsessive-Compulsive Disorder, Body Dysmorphic Disorder, and Paranoid, Schizoid, or Avoidant Personality Disorders.

Specific Culture and Gender Features

An individual's cultural and religious background must be taken into account in evaluating the possible presence of Delusional Disorder. Some cultures have widely held and culturally sanctioned beliefs that might be considered delusional in other cultures. The content of delusions also varies in different cultures and subcultures. Delusional Disorder, Jealous Type, is probably more common in men than in women, but there appears to be no major gender difference in the overall frequency of Delusional Disorder.

Prevalence

Delusional Disorder is relatively uncommon in clinical settings, with most studies suggesting that the disorder accounts for 1%–2% of admissions to inpatient mental health facilities. Precise information about the population prevalence of this disorder is lacking, but the best estimate is around 0.03%. Because of its usually late age at onset, the lifetime morbidity risk may be between 0.05% and 0.1%.

Course

The age at onset of Delusional Disorder is variable, ranging from adolescence to late in life. The Persecutory Type is the most common subtype. The course is quite variable. Especially in the Persecutory Type, the disorder may be chronic, although a waxing and waning of the preoccupation with the delusional beliefs often occurs. In other cases, full periods of remission may be followed by subsequent relapses. In yet other cases, the disorder remits within a few months, often without subsequent relapse. Some evidence suggests that the Jealous Type may have a better prognosis than the Persecutory Type. When the Persecutory Type is associated with a precipitating event or stressor, it may have a better prognosis.

Familial Pattern

Some studies have found that Delusional Disorder is more common among relatives of individuals with Schizophrenia than would be expected by chance, whereas other studies have found no familial relationship between Delusional Disorder and Schizophrenia. There is limited evidence that Avoidant and Paranoid Personality Disorders may be especially common among first-degree biological relatives of individuals with Delusional Disorder.

Differential Diagnosis

The diagnosis of Delusional Disorder is made only when the delusion is not due to the direct physiological effects of a substance or a general medical condition. A **delirium,** a **dementia,** and **Psychotic Disorder Due to a General Medical Condition** may present with symptoms that suggest Delusional Disorder. For example, simple persecutory delusions (e.g., "someone comes into my room at night and steals my clothes") in the early phase of Dementia of the Alzheimer's Type would be diagnosed as Dementia of the Alzheimer's Type, With Delusions. A **Substance-Induced Psychotic Disorder,** especially due to stimulants such as amphetamines or cocaine, cross-sectionally may be identical in symptomatology to Delusional Disorder, but can usually be distinguished by the chronological relationship of substance use to the onset and remission of the delusional beliefs.

Delusional Disorder can be distinguished from **Schizophrenia** and **Schizophreniform Disorder** by the absence of the other characteristic symptoms of the active phase of Schizophrenia (e.g., prominent auditory or visual hallucinations, bizarre delusions, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms). Compared with Schizophrenia, Delusional Disorder usually produces less impairment in occupational and social functioning.

It can be difficult to differentiate **Mood Disorders With Psychotic Features** from Delusional Disorder, because the psychotic features associated with Mood Disorders usually involve nonbizarre delusions without prominent hallucinations, and Delusional Disorder frequently has associated mood symptoms. The distinction depends on the temporal relationship between the mood disturbance and the delusions and on the severity of the mood symptoms. If delusions occur exclusively during mood episodes, the diagnosis is Mood Disorder With Psychotic Features. Although depressive symptoms are common in Delusional Disorder, they are usually mild, remit while the delusional symptoms persist, and do not warrant a separate Mood Disorder diagnosis. Occasionally, mood symptoms that meet full criteria for a mood episode are superimposed on the delusional disturbance. Delusional Disorder can be diagnosed only if the total duration of all mood episodes remains brief relative to the total duration of the delusional disturbance. If symptoms that meet criteria for a mood episode are present for a substantial portion of the delusional disturbance (i.e., the delusional equivalent of Schizoaffective Disorder), then a diagnosis of **Psychotic Disorder Not Otherwise Specified** accompanied by either **Depressive Disorder Not Otherwise Specified** or **Bipolar Disorder Not Otherwise Specified** is appropriate.

Individuals with **Shared Psychotic Disorder** can present with symptoms that are similar to those seen in Delusional Disorder, but the disturbance has a characteristic

etiology and course. In Shared Psychotic Disorder, the delusions arise in the context of a close relationship with another person, are identical in form to the delusions of that other person, and diminish or disappear when the individual with Shared Psychotic Disorder is separated from the individual with the primary Psychotic Disorder. **Brief Psychotic Disorder** is differentiated from Delusional Disorder by the fact that the delusional symptoms last less than 1 month. A diagnosis of **Psychotic Disorder Not Otherwise Specified** may be made if insufficient information is available to choose between Delusional Disorder and other Psychotic Disorders or to determine whether the presenting symptoms are substance induced or the result of a general medical condition.

It may be difficult to differentiate **Hypochondriasis** (especially With Poor Insight) from Delusional Disorder. In Hypochondriasis, the fears of having a serious disease or the concern that one has such a serious disease are held with less than delusional intensity (i.e., the individual can entertain the possibility that the feared disease is not present). **Body Dysmorphic Disorder** involves a preoccupation with some imagined defect in appearance. Many individuals with this disorder hold their beliefs with less than delusional intensity and recognize that their view of their appearance is distorted. However, a significant proportion of individuals whose symptoms meet criteria for Body Dysmorphic Disorder hold their beliefs with delusional intensity. When criteria for both disorders are met, both Body Dysmorphic Disorder and Delusional Disorder, Somatic Type, may be diagnosed. The boundary between **Obsessive-Compulsive Disorder** (especially With Poor Insight) and Delusional Disorder can sometimes be difficult to establish. The ability of individuals with Obsessive-Compulsive Disorder to recognize that the obsessions or compulsions are excessive or unreasonable occurs on a continuum. In some individuals, reality testing may be lost, and the obsession may reach delusional proportions (e.g., the belief that one has caused the death of another person by having willed it). If the obsessions develop into sustained delusional beliefs that represent a major part of the clinical picture, an additional diagnosis of Delusional Disorder may be appropriate.

In contrast to Delusional Disorder, there are no clear-cut or persisting delusional beliefs in **Paranoid Personality Disorder.** Whenever a person with a Delusional Disorder has a preexisting Personality Disorder, the Personality Disorder should be listed on Axis II, followed by "Premorbid" in parentheses.

Diagnostic criteria for 297.1 Delusional Disorder

A. Nonbizarre delusions (i.e., involving situations that occur in real life, such as being followed, poisoned, infected, loved at a distance, or deceived by spouse or lover, or having a disease) of at least 1 month's duration.

B. Criterion A for Schizophrenia has never been met. **Note:** Tactile and olfactory hallucinations may be present in Delusional Disorder if they are related to the delusional theme.

C. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired and behavior is not obviously odd or bizarre.

D. If mood episodes have occurred concurrently with delusions, their total duration has been brief relative to the duration of the delusional periods.

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

Specify type (the following types are assigned based on the predominant delusional theme):

Erotomanic Type: delusions that another person, usually of higher status, is in love with the individual
Grandiose Type: delusions of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person
Jealous Type: delusions that the individual's sexual partner is unfaithful
Persecutory Type: delusions that the person (or someone to whom the person is close) is being malevolently treated in some way
Somatic Type: delusions that the person has some physical defect or general medical condition
Mixed Type: delusions characteristic of more than one of the above types but no one theme predominates
Unspecified Type

298.8 Brief Psychotic Disorder

Diagnostic Features

The essential feature of Brief Psychotic Disorder is a disturbance that involves the sudden onset of at least one of the following positive psychotic symptoms: delusions, hallucinations, disorganized speech (e.g., frequent derailment or incoherence), or grossly disorganized or catatonic behavior (Criterion A). An episode of the disturbance lasts at least 1 day but less than 1 month, and the individual eventually has a full return to the premorbid level of functioning (Criterion B). The disturbance is not better accounted for by a Mood Disorder With Psychotic Features, by Schizoaffective Disorder, or by Schizophrenia and is not due to the direct physiological effects of a substance (e.g., a hallucinogen) or a general medical condition (e.g., subdural hematoma) (Criterion C).

Specifiers

The following specifiers for Brief Psychotic Disorder may be noted based on the presence or absence of precipitating stressors:

With Marked Stressor(s). This specifier may be noted if the psychotic symptoms develop shortly after and apparently in response to one or more events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in that person's culture. This type of Brief Psychotic Disorder was called "brief reactive psychosis" in DSM-III-R. The precipitating event(s) may be any major stress, such as the loss of a loved one or the psychological trauma of combat. Determining whether a specific stressor was a precipitant or a consequence of the illness may sometimes be clinically difficult. In such instances, the decision will depend on related factors such as the temporal relationship between the stressor and the onset of the symptoms, ancillary information from a spouse or friend about level of functioning prior to the stressor, and history of similar responses to stressful events in the past.

Without Marked Stressor(s). This specifier may be noted if the psychotic symptoms are not apparently in response to events that would be markedly stressful to almost anyone in similar circumstances in the person's culture.

With Postpartum Onset. This specifier may be noted if the onset of the psychotic symptoms is within 4 weeks postpartum.

Associated Features and Disorders

Individuals with Brief Psychotic Disorder typically experience emotional turmoil or overwhelming confusion. They may have rapid shifts from one intense affect to another. Although brief, the level of impairment may be severe, and supervision may be required to ensure that nutritional and hygienic needs are met and that the individual is protected from the consequences of poor judgment, cognitive impairment, or acting on the basis of delusions. There appears to be an increased risk of mortality (with a particularly high risk for suicide), especially among younger individuals. Preexisting Personality Disorders (e.g., Paranoid, Histrionic, Narcissistic, Schizotypal, or Borderline Personality Disorder) may predispose the individual to the development of the disorder.

Specific Culture Features

It is important to distinguish symptoms of Brief Psychotic Disorder from culturally sanctioned response patterns. For example, in some religious ceremonies, an individual may report hearing voices, but these do not generally persist and are not perceived as abnormal by most members of the person's community.

Prevalence

Cases of Brief Psychotic Disorder are rarely seen in clinical settings in the United States and other developed countries. The incidence and prevalence of cases that do not come to clinical attention are unknown. However, psychotic disturbances that

meet the A and C criteria for Brief Psychotic Disorder but not the B criterion (i.e., the duration of active symptoms is 1–6 months as opposed to remitting within a month) are more common in developing countries than in developed countries.

Course

Brief Psychotic Disorder may appear in adolescence or early adulthood, with the average age at onset being in the late 20s or early 30s. By definition, a diagnosis of Brief Psychotic Disorder requires a full remission of all symptoms and a return to the premorbid level of functioning within 1 month of the onset of the disturbance. In some individuals, the duration of psychotic symptoms may be quite brief (e.g., a few days).

Familial Pattern

Some evidence suggests that Brief Psychotic Disorder may be related to Mood Disorders, whereas other evidence suggests that it may be distinct from both Schizophrenia and Mood Disorders.

Differential Diagnosis

A wide variety of general medical conditions can present with psychotic symptoms of short duration. **Psychotic Disorder Due to a General Medical Condition** or a **delirium** is diagnosed when there is evidence from the history, physical examination, or laboratory tests that indicates that the delusions or hallucinations are the direct physiological consequence of a specific general medical condition (e.g., Cushing's syndrome, brain tumor) (see p. 334). **Substance-Induced Psychotic Disorder, Substance-Induced Delirium,** and **Substance Intoxication** are distinguished from Brief Psychotic Disorder by the fact that a substance (e.g., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the psychotic symptoms (see p. 338). Laboratory tests, such as a urine drug screen or a blood alcohol level, may be helpful in making this determination, as may a careful history of substance use with attention to temporal relationships between substance intake and onset of the symptoms and the nature of the substance being used.

The diagnosis of Brief Psychotic Disorder cannot be made if the psychotic symptoms are better accounted for by a **mood episode** (i.e., the psychotic symptoms occur exclusively during a full Major Depressive, Manic, or Mixed Episode). If the psychotic symptoms persist for 1 month or longer, the diagnosis is either **Schizophreniform Disorder, Delusional Disorder, Mood Disorder With Psychotic Features,** or **Psychotic Disorder Not Otherwise Specified,** depending on the other symptoms in the presentation. The differential diagnosis between Brief Psychotic Disorder and Schizophreniform Disorder is difficult when the psychotic symptoms have remitted before 1 month in response to successful treatment with medication. Because recurrent episodes of Brief Psychotic Disorder are rare, careful attention should be given to the possibility that a recurrent disorder (e.g., Bipolar Disorder, recurrent acute exacerbations of Schizophrenia) may be responsible for any recurring psychotic episodes.

An episode of **Factitious Disorder, With Predominantly Psychological Signs and Symptoms,** may have the appearance of Brief Psychotic Disorder, but in such cases

there is evidence that the symptoms are intentionally produced. When **Malingering** involves apparently psychotic symptoms, there is usually evidence that the illness was feigned for an understandable goal.

In certain individuals with **Personality Disorders,** psychosocial stressors may precipitate brief periods of psychotic symptoms. These are usually transient and do not warrant a separate diagnosis. If psychotic symptoms persist for at least 1 day, an additional diagnosis of Brief Psychotic Disorder may be appropriate.

Diagnostic criteria for 298.8 Brief Psychotic Disorder

A. Presence of one (or more) of the following symptoms:

(1) delusions
(2) hallucinations
(3) disorganized speech (e.g., frequent derailment or incoherence)
(4) grossly disorganized or catatonic behavior

Note: Do not include a symptom if it is a culturally sanctioned response pattern.

B. Duration of an episode of the disturbance is at least 1 day but less than 1 month, with eventual full return to premorbid level of functioning.

C. The disturbance is not better accounted for by a Mood Disorder With Psychotic Features, Schizoaffective Disorder, or Schizophrenia and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify if:

With Marked Stressor(s) (brief reactive psychosis): if symptoms occur shortly after and apparently in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the person's culture
Without Marked Stressor(s): if psychotic symptoms do *not* occur shortly after, or are not apparently in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the person's culture
With Postpartum Onset: if onset within 4 weeks postpartum

297.3 Shared Psychotic Disorder (Folie à Deux)

Diagnostic Features

The essential feature of Shared Psychotic Disorder (Folie à Deux) is a delusion that develops in an individual who is involved in a close relationship with another person (sometimes termed the "inducer" or "the primary case") who already has a Psychotic Disorder with prominent delusions (Criterion A). The individual comes to share the delusional beliefs of the primary case in whole or in part (Criterion B). The delusion is not better accounted for by another Psychotic Disorder (e.g., Schizophrenia) or a Mood Disorder With Psychotic Features and is not due to the direct physiological

effects of a substance (e.g., amphetamine) or a general medical condition (e.g., brain tumor) (Criterion C). Schizophrenia is probably the most common diagnosis of the primary case, although other diagnoses may include Delusional Disorder or Mood Disorder With Psychotic Features. The content of the shared delusional beliefs may be dependent on the diagnosis of the primary case and can include relatively bizarre delusions (e.g., that radiation is being transmitted into an apartment from a hostile foreign power, causing indigestion and diarrhea), mood-congruent delusions (e.g., that the primary case will soon receive a film contract for $2 million, allowing the family to purchase a much larger home with a swimming pool), or the nonbizarre delusions that are characteristic of Delusional Disorder (e.g., the FBI is tapping the family telephone and trailing family members when they go out). Usually the primary case in Shared Psychotic Disorder is dominant in the relationship and gradually imposes the delusional system on the more passive and initially healthy second person. Individuals who come to share delusional beliefs are often related by blood or marriage and have lived together for a long time, sometimes in relative social isolation. If the relationship with the primary case is interrupted, the delusional beliefs of the other individual usually diminish or disappear. Although most commonly seen in relationships of only two people, Shared Psychotic Disorder can occur among a larger number of individuals, especially in family situations in which the parent is the primary case and the children, sometimes to varying degrees, adopt the parent's delusional beliefs. Individuals with this disorder rarely seek treatment and usually are brought to clinical attention when the primary case receives treatment.

Associated Features and Disorders

Aside from the delusional beliefs, behavior is usually not otherwise odd or unusual in Shared Psychotic Disorder. Impairment is often less severe in the individual with Shared Psychotic Disorder than in the primary case.

Prevalence

Little systematic information about the prevalence of Shared Psychotic Disorder is available. This disorder is rare in clinical settings, although it has been argued that some cases go unrecognized. Limited evidence suggests that Shared Psychotic Disorder is somewhat more common in women than in men.

Course

Little is known about the age at onset of Shared Psychotic Disorder, but it appears to be quite variable. Without intervention, the course is usually chronic, because this disorder most commonly occurs in relationships that are long-standing and resistant to change. With separation from the primary case, the individual's delusional beliefs disappear, sometimes quickly and sometimes quite slowly.

Differential Diagnosis

The diagnosis of Shared Psychotic Disorder is made only when the delusion is not due to the direct physiological effects of a substance or a general medical condition.

Differential diagnosis is rarely a problem because the history of close association with the primary case and the similarity of delusions between the two individuals is unique to Shared Psychotic Disorder. In **Schizophrenia, Delusional Disorder, Schizoaffective Disorder,** and **Mood Disorder With Psychotic Features,** there is either no close relationship with a dominant person who has a Psychotic Disorder and shares similar delusional beliefs or, if there is such a person, the psychotic symptoms usually precede the onset of any shared delusions. In rare cases, an individual may present with what appears to be Shared Psychotic Disorder, but the delusions do not disappear when the individual is separated from the primary case. In such a situation, it is probably appropriate to consider another Psychotic Disorder diagnosis.

Diagnostic criteria for 297.3 Shared Psychotic Disorder

A. A delusion develops in an individual in the context of a close relationship with another person(s), who has an already-established delusion.

B. The delusion is similar in content to that of the person who already has the established delusion.

C. The disturbance is not better accounted for by another Psychotic Disorder (e.g., Schizophrenia) or a Mood Disorder With Psychotic Features and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Psychotic Disorder Due to a General Medical Condition

Diagnostic Features

The essential features of Psychotic Disorder Due to a General Medical Condition are prominent hallucinations or delusions that are judged to be due to the direct physiological effects of a general medical condition (Criterion A). There must be evidence from the history, physical examination, or laboratory findings that the delusions or hallucinations are the direct physiological consequence of a general medical condition (Criterion B). The psychotic disturbance is not better accounted for by another mental disorder (e.g., the symptoms are not a psychologically mediated response to a severe general medical condition, in which case a diagnosis of Brief Psychotic Disorder, With Marked Stressor, would be appropriate) (Criterion C). The diagnosis is not made if the disturbance occurs only during the course of a delirium (Criterion D). Because of ICD-9-CM coding requirements, a separate diagnosis of Psychotic Disorder Due to a General Medical Condition is not given if delusions occur only during the course of Vascular Dementia; a diagnosis of Vascular Dementia with the subtype With Delusions is given instead.

Hallucinations can occur in any sensory modality (i.e., visual, olfactory, gustatory, tactile, or auditory), but certain etiological factors are likely to evoke specific halluci-

natory phenomena. Olfactory hallucinations, especially those involving the smell of burning rubber or other unpleasant smells, are highly suggestive of temporal lobe epilepsy. Hallucinations may vary from simple and unformed to highly complex and organized, depending on etiological factors, environmental surroundings, nature and focus of the insult rendered to the central nervous system, and the reactive response to impairment. Psychotic Disorder Due to a General Medical Condition is generally not diagnosed if the individual maintains reality testing for the hallucination and appreciates that the perceptual experiences result from the general medical condition. Delusions may express a variety of themes, including somatic, grandiose, religious, and, most commonly, persecutory. Religious delusions have been specifically associated in some cases with temporal lobe epilepsy. Individuals with right parietal brain lesions can develop a contralateral neglect syndrome in which they may disown parts of their body to a delusional extent. On the whole, however, associations between delusions and particular general medical conditions appear to be less specific than is the case for hallucinations.

In determining whether the psychotic disturbance is due to a general medical condition, the clinician must first establish the presence of a general medical condition. Further, the clinician must establish that the psychotic disturbance is etiologically related to the general medical condition through a physiological mechanism. A careful and comprehensive assessment of multiple factors is necessary to make this judgment. Although there are no infallible guidelines for determining whether the relationship between the psychotic disturbance and the general medical condition is etiological, several considerations provide some guidance in this area. One consideration is the presence of a temporal association between the onset, exacerbation, or remission of the general medical condition and that of the psychotic disturbance. A second consideration is the presence of features that are atypical for a primary Psychotic Disorder (e.g., atypical age at onset or presence of visual or olfactory hallucinations). Evidence from the literature that suggests that there can be a direct association between the general medical condition in question and the development of psychotic symptoms can provide a useful context in the assessment of a particular situation. In addition, the clinician must also judge that the disturbance is not better accounted for by a primary Psychotic Disorder, a Substance-Induced Psychotic Disorder, or another primary mental disorder (e.g., Adjustment Disorder). This determination is explained in greater detail in the "Mental Disorders Due to a General Medical Condition" section (p. 181).

Subtypes

One of the following subtypes may be used to indicate the predominant symptom presentation. If both delusions and hallucinations are present, code whichever is predominant:

293.81 With Delusions. This subtype is used if delusions are the predominant symptom.

293.82 With Hallucinations. This subtype is used if hallucinations are the predominant symptom.

Recording Procedures

In recording the diagnosis of Psychotic Disorder Due to a General Medical Condition, the clinician should first note the presence of the Psychotic Disorder, then the identified general medical condition judged to be causing the disturbance, and finally the appropriate specifier indicating the predominant symptom presentation on Axis I (e.g., Psychotic Disorder Due to Thyrotoxicosis, With Hallucinations). The diagnostic code on Axis I is selected based on the subtype: 293.81 for Psychotic Disorder Due to a General Medical Condition, With Delusions, and 293.82 for Psychotic Disorder Due to a General Medical Condition, With Hallucinations. The ICD-9-CM code for the general medical condition should also be noted on Axis III (e.g., 242.9 thyrotoxicosis). (See Appendix G for a list of ICD-9-CM diagnostic codes for selected general medical conditions.)

Associated General Medical Conditions

A variety of general medical conditions may cause psychotic symptoms, including neurological conditions (e.g., neoplasms, cerebrovascular disease, Huntington's disease, multiple sclerosis, epilepsy, auditory or visual nerve injury or impairment, deafness, migraine, central nervous system infections), endocrine conditions (e.g., hyper- and hypothyroidism, hyper- and hypoparathyroidism, hyper- and hypoadrenocorticism), metabolic conditions (e.g., hypoxia, hypercarbia, hypoglycemia), fluid or electrolyte imbalances, hepatic or renal diseases, and autoimmune disorders with central nervous system involvement (e.g., systemic lupus erythematosus). Those neurological conditions that involve subcortical structures or the temporal lobe are more commonly associated with delusions. The associated physical examination findings, laboratory findings, and patterns of prevalence or onset reflect the etiological general medical condition.

Prevalence

Prevalence rates for Psychotic Disorder Due to a General Medical Condition are difficult to estimate given the wide variety of underlying medical etiologies. Research does suggest that the syndrome is underdiagnosed in the general medical setting. Psychotic symptoms may be present in as many as 20% of individuals presenting with untreated endocrine disorders, 15% of those with systemic lupus erythematosus, and up to 40% or more of individuals with temporal lobe epilepsy.

Course

Psychotic Disorder Due to a General Medical Condition may be a single transient state or it may be recurrent, cycling with exacerbations and remissions of the underlying general medical condition. Although treatment of the underlying general medical condition often results in a resolution of the psychotic symptoms, this is not always the case, and psychotic symptoms may persist long after the causative medical event (e.g., Psychotic Disorder Secondary to Focal Brain Injury).

Differential Diagnosis

Hallucinations and delusions commonly occur in the context of a **delirium;** however, a separate diagnosis of Psychotic Disorder Due to a General Medical Condition is not given if the disturbance occurs exclusively during the course of a delirium. In contrast, a diagnosis of Psychotic Disorder Due to a General Medical Condition may be given in addition to a diagnosis of **dementia** if the psychotic symptoms are a direct etiological consequence of the pathological process causing the dementia. Because of ICD-9-CM coding requirements, an exception to this is when delusions occur exclusively during the course of **Vascular Dementia.** In this case, only a diagnosis of Vascular Dementia with the subtype With Delusions is given; a separate diagnosis of Psychotic Disorder Due to a General Medical Condition is not made. If the presentation includes a mix of different types of symptoms (e.g., psychotic and anxiety), the diagnosis is usually Psychotic Disorder Due to a General Medical Condition because in such situations psychotic symptoms typically predominate in the clinical picture.

If there is evidence of recent or prolonged substance use (including medications with psychoactive effects), withdrawal from a substance, or exposure to a toxin (e.g., LSD Intoxication, Alcohol Withdrawal), a **Substance-Induced Psychotic Disorder** should be considered. It may be useful to obtain a urine or blood drug screen or other appropriate laboratory evaluation. Symptoms that occur during or shortly after (i.e., within 4 weeks of) Substance Intoxication or Withdrawal or after medication use may be especially indicative of a Substance-Induced Psychotic Disorder, depending on the character, duration, or amount of the substance used. If the clinician has ascertained that the disturbance is due to both a general medical condition and substance use, both diagnoses (i.e., Psychotic Disorder Due to a General Medical Condition and Substance-Induced Psychotic Disorder) can be given.

Psychotic Disorder Due to a General Medical Condition must be distinguished from a **primary Psychotic Disorder** (e.g., Schizophrenia, Delusional Disorder, Schizoaffective Disorder) or a **primary Mood Disorder With Psychotic Features.** In primary Psychotic Disorders and in primary Mood Disorders With Psychotic Features, no specific and direct causative physiological mechanisms associated with a general medical condition can be demonstrated. Late age at onset (e.g., the first appearance of delusions in an individual over age 35 years) and the absence of a personal or family history of Schizophrenia or Delusional Disorder suggest the need for a thorough assessment to rule out the diagnosis of Psychotic Disorder Due to a General Medical Condition. Auditory hallucinations that involve voices speaking complex sentences are more characteristic of Schizophrenia than of Psychotic Disorder Due to a General Medical Condition. Other types of hallucinations (e.g., visual, olfactory) commonly signal a Psychotic Disorder Due to a General Medical Condition or a Substance-Induced Psychotic Disorder.

Psychotic Disorder Not Otherwise Specified is diagnosed when the clinician cannot determine if the psychotic disturbance is primary, substance induced, or due to a general medical condition. **Hypnagogic** and **hypnopompic hallucinations** may occur in individuals without a mental disorder, but they occur only on falling asleep or on awakening.

Diagnostic criteria for 293.xx Psychotic Disorder Due to . . . *[Indicate the General Medical Condition]*

A. Prominent hallucinations or delusions.

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

C. The disturbance is not better accounted for by another mental disorder.

D. The disturbance does not occur exclusively during the course of a delirium.

Code based on predominant symptom:

.81 With Delusions: if delusions are the predominant symptom
.82 With Hallucinations: if hallucinations are the predominant symptom

Coding note: Include the name of the general medical condition on Axis I, e.g., 293.81 Psychotic Disorder Due to Malignant Lung Neoplasm, With Delusions; also code the general medical condition on Axis III (see Appendix G for codes).

Coding note: If delusions are part of Vascular Dementia, indicate the delusions by coding the appropriate subtype, e.g., 290.42 Vascular Dementia, With Delusions.

Substance-Induced Psychotic Disorder

Diagnostic Features

The essential features of Substance-Induced Psychotic Disorder are prominent hallucinations or delusions (Criterion A) that are judged to be due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication, or toxin exposure) (Criterion B). Hallucinations that the individual realizes are substance induced are not included here and instead would be diagnosed as Substance Intoxication or Substance Withdrawal with the accompanying specifier With Perceptual Disturbances. The disturbance must not be better accounted for by a Psychotic Disorder that is not substance induced (Criterion C). The diagnosis is not made if the psychotic symptoms occur only during the course of a delirium (Criterion D). This diagnosis should be made instead of a diagnosis of Substance Intoxication or Substance Withdrawal only when the psychotic symptoms are in excess of those usually associated with the intoxication or withdrawal syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention. For a more detailed discussion of Substance-Related Disorders, see p. 191.

A Substance-Induced Psychotic Disorder is distinguished from a primary Psychotic Disorder by considering the onset, course, and other factors. For drugs of abuse, there must be evidence from the history, physical examination, or laboratory findings of Dependence, Abuse, intoxication, or withdrawal. Substance-Induced Psychotic

Disorders arise only in association with intoxication or withdrawal states but can persist for weeks, whereas primary Psychotic Disorders may precede the onset of substance use or may occur during times of sustained abstinence. Once initiated, the psychotic symptoms may continue as long as the substance use continues. Another consideration is the presence of features that are atypical of a primary Psychotic Disorder (e.g., atypical age at onset or course). For example, the appearance of delusions de novo in a person over age 35 years without a known history of a primary Psychotic Disorder should alert the clinician to the possibility of a Substance-Induced Psychotic Disorder. Even a prior history of a primary Psychotic Disorder does not rule out the possibility of a Substance-Induced Psychotic Disorder. It has been suggested that 9 out of 10 nonauditory hallucinations are the product of a Substance-Induced Psychotic Disorder or a Psychotic Disorder Due to a General Medical Condition. In contrast, factors that suggest that the psychotic symptoms are better accounted for by a primary Psychotic Disorder include persistence of psychotic symptoms for a substantial period of time (i.e., a month or more) after the end of Substance Intoxication or acute Substance Withdrawal; the development of symptoms that are substantially in excess of what would be expected given the type or amount of the substance used or the duration of use; or a history of prior recurrent primary Psychotic Disorders. Other causes of psychotic symptoms must be considered even in a person with Intoxication or Withdrawal, because substance use problems are not uncommon among persons with (presumably) non-substance-induced Psychotic Disorders.

Subtypes and Specifiers

One of the following subtypes may be used to indicate the predominant symptom presentation. If both delusions and hallucinations are present, code whichever is predominant:

With Delusions. This subtype is used if delusions are the predominant symptom.

With Hallucinations. This subtype is used if hallucinations are the predominant symptom.

The context of the development of the psychotic symptoms may be indicated by using one of the specifiers listed below:

With Onset During Intoxication. This specifier should be used if criteria for intoxication with the substance are met and the symptoms develop during the intoxication syndrome.

With Onset During Withdrawal. This specifier should be used if criteria for withdrawal from the substance are met and the symptoms develop during, or shortly after, a withdrawal syndrome.

Recording Procedures

The name of the Substance-Induced Psychotic Disorder begins with the specific substance (e.g., cocaine, methylphenidate, dexamethasone) that is presumed to be causing the psychotic symptoms. The diagnostic code is selected from the listing of classes

of substances provided in the criteria set. For substances that do not fit into any of the classes (e.g., dexamethasone), the code for "Other Substance" should be used. In addition, for medications prescribed at therapeutic doses, the specific medication can be indicated by listing the appropriate E-code on Axis I (see Appendix G). The code for each of the specific Substance-Induced Psychotic Disorders depends on whether the presentation is predominated by delusions or hallucinations: 292.11 for With Delusions and 292.12 for With Hallucinations, except for alcohol, for which the code is 291.5 for With Delusions and 291.3 for With Hallucinations. The name of the disorder (e.g., Cocaine-Induced Psychotic Disorder; Methylphenidate-Induced Psychotic Disorder) is followed by the subtype indicating the predominant symptom presentation and the specifier indicating the context in which the symptoms developed (e.g., 292.11 Cocaine-Induced Psychotic Disorder, With Delusions, With Onset During Intoxication; 292.12 Phencyclidine-Induced Psychotic Disorder, With Hallucinations, With Onset During Intoxication). When more than one substance is judged to play a significant role in the development of the psychotic symptoms, each should be listed separately. If a substance is judged to be the etiological factor, but the specific substance or class of substance is unknown, the category 292.11 Unknown Substance–Induced Psychotic Disorder, With Delusions, or 292.12 Unknown Substance–Induced Psychotic Disorder, With Hallucinations, may be used.

Specific Substances

Psychotic Disorders can occur in association with **intoxication** with the following classes of substances: alcohol; amphetamine and related substances; cannabis; cocaine; hallucinogens; inhalants; opioids (meperidine); phencyclidine and related substances; sedatives, hypnotics, and anxiolytics; and other or unknown substances. Psychotic Disorders can occur in association with **withdrawal** from the following classes of substances: alcohol; sedatives, hypnotics, and anxiolytics; and other or unknown substances. The initiation of the disorder may vary considerably with the substance. For example, smoking a high dose of cocaine may produce psychosis within minutes, whereas days or weeks of high-dose alcohol or sedative use may be required to produce psychosis. Hallucinations may occur in any modality, but, in the absence of delirium, they are usually auditory. Alcohol-Induced Psychotic Disorder, With Hallucinations, usually occurs only after prolonged, heavy ingestion of alcohol in people who apparently have Alcohol Dependence. The auditory hallucinations are usually voices.

The Psychotic Disorders induced by intoxication with amphetamine and cocaine share similar clinical features. Persecutory delusions may rapidly develop shortly after use of amphetamine or a similarly acting sympathomimetic. Distortion of body image and misperception of people's faces may occur. The hallucination of bugs or vermin crawling in or under the skin (formication) can lead to scratching and extensive skin excoriations. Cannabis-Induced Psychotic Disorder may develop shortly after high-dose cannabis use and usually involves persecutory delusions. The disorder is apparently rare. Marked anxiety, emotional lability, depersonalization, and subsequent amnesia for the episode can occur. The disorder usually remits within a day, but in some cases may persist for a few days.

Substance-Induced Psychotic Disorders may at times not resolve promptly when

the offending agent is removed. Agents such as amphetamines, phencyclidine, and cocaine have been reported to evoke temporary psychotic states that can sometimes persist for weeks or longer despite removal of the agent and treatment with neuroleptic medication. These may be initially difficult to distinguish from non-substance-induced Psychotic Disorders.

Some of the medications reported to evoke psychotic symptoms include anesthetics and analgesics, anticholinergic agents, anticonvulsants, antihistamines, antihypertensive and cardiovascular medications, antimicrobial medications, antiparkinsonian medications, chemotherapeutic agents (e.g., cyclosporine and procarbazine), corticosteroids, gastrointestinal medications, muscle relaxants, nonsteroidal anti-inflammatory medications, other over-the-counter medications (e.g., phenylephrine, pseudoephedrine), antidepressant medication, and disulfiram. Toxins reported to induce psychotic symptoms include anticholinesterase, organophosphate insecticides, nerve gases, carbon monoxide, carbon dioxide, and volatile substances such as fuel or paint.

Differential Diagnosis

A diagnosis of Substance-Induced Psychotic Disorder should be made instead of a diagnosis of **Substance Intoxication** or **Substance Withdrawal** only when the psychotic symptoms are judged to be in excess of those usually associated with the intoxication or withdrawal syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention. Individuals intoxicated with stimulants, cannabis, the opioid meperidine, or phencyclidine, or those withdrawing from alcohol or sedatives, may experience altered perceptions (scintillating lights, sounds, visual illusions) that they recognize as drug effects. If reality testing for these experiences remains intact (i.e., the person recognizes that the perception is substance induced and neither believes in nor acts on it), the diagnosis is not Substance-Induced Psychotic Disorder. Instead, **Substance Intoxication** or **Withdrawal, With Perceptual Disturbances,** is diagnosed (e.g., Cocaine Intoxication, With Perceptual Disturbances). "Flashback" hallucinations that can occur long after the use of hallucinogens has stopped are diagnosed as **Hallucinogen Persisting Perception Disorder** (see p. 253). Moreover, if substance-induced psychotic symptoms occur exclusively during the course of a **delirium,** as in some severe forms of Alcohol Withdrawal, the psychotic symptoms are considered to be an associated feature of the delirium and are not diagnosed separately.

A Substance-Induced Psychotic Disorder is distinguished from a **primary Psychotic Disorder** by the fact that a substance is judged to be etiologically related to the symptoms (see p. 338).

A Substance-Induced Psychotic Disorder due to a prescribed treatment for a mental or general medical condition must have its onset while the person is receiving the medication (or during withdrawal, if there is a withdrawal syndrome associated with the medication). Once the treatment is discontinued, the psychotic symptoms will usually remit within days to several weeks (depending on the half-life of the substance and the presence of a withdrawal syndrome). If symptoms persist beyond 4 weeks, other causes for the psychotic symptoms should be considered. Because individuals with general medical conditions often take medications for those conditions, the clinician must consider the possibility that the psychotic symptoms are

caused by the physiological consequences of the general medical condition rather than the medication, in which case **Psychotic Disorder Due to a General Medical Condition** is diagnosed. The history often provides the primary basis for such a judgment. At times, a change in the treatment for the general medical condition (e.g., medication substitution or discontinuation) may be needed to determine empirically for that person whether the medication is the causative agent. If the clinician has ascertained that the disturbance is due to both a general medical condition and substance use, both diagnoses (i.e., Psychotic Disorder Due to a General Medical Condition and Substance-Induced Psychotic Disorder) may be given. When there is insufficient evidence to determine whether the psychotic symptoms are due to a substance (including a medication) or to a general medical condition or are primary (i.e., not due to either a substance or a general medical condition), **Psychotic Disorder Not Otherwise Specified** would be indicated.

Diagnostic criteria for Substance-Induced Psychotic Disorder

A. Prominent hallucinations or delusions. **Note:** Do not include hallucinations if the person has insight that they are substance induced.

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

   (1) the symptoms in Criterion A developed during, or within a month of, Substance Intoxication or Withdrawal
   (2) medication use is etiologically related to the disturbance

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

D. The disturbance does not occur exclusively during the course of a delirium.

Note: This diagnosis should be made instead of a diagnosis of Substance Intoxication or Substance Withdrawal only when the symptoms are in excess of those usually associated with the intoxication or withdrawal syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention.

Diagnostic criteria for Substance-Induced Psychotic Disorder *(continued)*

Code [Specific Substance]–Induced Psychotic Disorder:

(291.5 Alcohol, With Delusions; 291.3 Alcohol, With Hallucinations; 292.11 Amphetamine [or Amphetamine-Like Substance], With Delusions; 292.12 Amphetamine [or Amphetamine-Like Substance], With Hallucinations; 292.11 Cannabis, With Delusions; 292.12 Cannabis, With Hallucinations; 292.11 Cocaine, With Delusions; 292.12 Cocaine, With Hallucinations; 292.11 Hallucinogen, With Delusions; 292.12 Hallucinogen, With Hallucinations; 292.11 Inhalant, With Delusions; 292.12 Inhalant, With Hallucinations; 292.11 Opioid, With Delusions; 292.12 Opioid, With Hallucinations; 292.11 Phencyclidine [or Phencyclidine-Like Substance], With Delusions; 292.12 Phencyclidine [or Phencyclidine-Like Substance], With Hallucinations; 292.11 Sedative, Hypnotic, or Anxiolytic, With Delusions; 292.12 Sedative, Hypnotic, or Anxiolytic, With Hallucinations; 292.11 Other [or Unknown] Substance, With Delusions; 292.12 Other [or Unknown] Substance, With Hallucinations)

Specify if (see table on p. 193 for applicability by substance):

With Onset During Intoxication: if criteria are met for Intoxication with the substance and the symptoms develop during the intoxication syndrome
With Onset During Withdrawal: if criteria are met for Withdrawal from the substance and the symptoms develop during, or shortly after, a withdrawal syndrome

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298.9 Psychotic Disorder Not Otherwise Specified

This category includes psychotic symptomatology (i.e., delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior) about which there is inadequate information to make a specific diagnosis or about which there is contradictory information, or disorders with psychotic symptoms that do not meet the criteria for any specific Psychotic Disorder.

Examples include

1. Postpartum psychosis that does not meet criteria for Mood Disorder With Psychotic Features, Brief Psychotic Disorder, Psychotic Disorder Due to a General Medical Condition, or Substance-Induced Psychotic Disorder
2. Psychotic symptoms that have lasted for less than 1 month but that have not yet remitted, so that the criteria for Brief Psychotic Disorder are not met
3. Persistent auditory hallucinations in the absence of any other features
4. Persistent nonbizarre delusions with periods of overlapping mood episodes that have been present for a substantial portion of the delusional disturbance
5. Situations in which the clinician has concluded that a Psychotic Disorder is present, but is unable to determine whether it is primary, due to a general medical condition, or substance induced

Mood Disorders

The Mood Disorders section includes disorders that have a disturbance in mood as the predominant feature. The section is divided into three parts. The first part describes mood episodes (Major Depressive Episode, Manic Episode, Mixed Episode, and Hypomanic Episode) that have been included separately at the beginning of this section for convenience in diagnosing the various Mood Disorders. These episodes do not have their own diagnostic codes and cannot be diagnosed as separate entities; however, they serve as the building blocks for the disorder diagnoses. The second part describes the Mood Disorders (e.g., Major Depressive Disorder, Dysthymic Disorder, Bipolar I Disorder). The criteria sets for most of the Mood Disorders require the presence or absence of the mood episodes described in the first part of the section. The third part includes the specifiers that describe either the most recent mood episode or the course of recurrent episodes.

The Mood Disorders are divided into the Depressive Disorders ("unipolar depression"), the Bipolar Disorders, and two disorders based on etiology—Mood Disorder Due to a General Medical Condition and Substance-Induced Mood Disorder. The Depressive Disorders (i.e., Major Depressive Disorder, Dysthymic Disorder, and Depressive Disorder Not Otherwise Specified) are distinguished from the Bipolar Disorders by the fact that there is no history of ever having had a Manic, Mixed, or Hypomanic Episode. The Bipolar Disorders (i.e., Bipolar I Disorder, Bipolar II Disorder, Cyclothymic Disorder, and Bipolar Disorder Not Otherwise Specified) involve the presence (or history) of Manic Episodes, Mixed Episodes, or Hypomanic Episodes, usually accompanied by the presence (or history) of Major Depressive Episodes.

Major Depressive Disorder is characterized by one or more Major Depressive Episodes (i.e., at least 2 weeks of depressed mood or loss of interest accompanied by at least four additional symptoms of depression).

Dysthymic Disorder is characterized by at least 2 years of depressed mood for more days than not, accompanied by additional depressive symptoms that do not meet criteria for a Major Depressive Episode.

Depressive Disorder Not Otherwise Specified is included for coding disorders with depressive features that do not meet criteria for Major Depressive Disorder, Dysthymic Disorder, Adjustment Disorder With Depressed Mood, or Adjustment Disorder With Mixed Anxiety and Depressed Mood (or depressive symptoms about which there is inadequate or contradictory information).

Bipolar I Disorder is characterized by one or more Manic or Mixed Episodes, usually accompanied by Major Depressive Episodes.

Bipolar II Disorder is characterized by one or more Major Depressive Episodes accompanied by at least one Hypomanic Episode.

Cyclothymic Disorder is characterized by at least 2 years of numerous periods of hypomanic symptoms that do not meet criteria for a Manic Episode and numerous periods of depressive symptoms that do not meet criteria for a Major Depressive Episode.

Bipolar Disorder Not Otherwise Specified is included for coding disorders with bipolar features that do not meet criteria for any of the specific Bipolar Disorders defined in this section (or bipolar symptoms about which there is inadequate or contradictory information).

Mood Disorder Due to a General Medical Condition is characterized by a prominent and persistent disturbance in mood that is judged to be a direct physiological consequence of a general medical condition.

Substance-Induced Mood Disorder is characterized by a prominent and persistent disturbance in mood that is judged to be a direct physiological consequence of a drug of abuse, a medication, another somatic treatment for depression, or toxin exposure.

Mood Disorder Not Otherwise Specified is included for coding disorders with mood symptoms that do not meet the criteria for any specific Mood Disorder and in which it is difficult to choose between Depressive Disorder Not Otherwise Specified and Bipolar Disorder Not Otherwise Specified (e.g., acute agitation).

The specifiers described in the third part of the section are provided to increase diagnostic specificity, create more homogeneous subgroups, assist in treatment selection, and improve the prediction of prognosis. Some of the specifiers describe the clinical status of the current (or most recent) mood episode (i.e., **Severity/Psychotic/Remission Specifiers**), whereas others describe features of the current episode (or most recent episode if the episode is currently in partial or full remission) (i.e., **Chronic, With Catatonic Features, With Melancholic Features, With Atypical Features, With Postpartum Onset**). Table 1 (p. 411) indicates which episode specifiers apply to each codable Mood Disorder. Other specifiers describe the course of recurrent mood episodes (i.e., **Longitudinal Course Specifiers, With Seasonal Pattern, With Rapid Cycling**). Table 2 (p. 424) indicates which course specifiers apply to each codable Mood Disorder. The specifiers that indicate severity, remission, and psychotic features can be coded in the fifth digit of the diagnostic code for most of the Mood Disorders. The other specifiers cannot be coded.

The Mood Disorders section is organized as follows:

- **Mood Episodes**
  Major Depressive Episode (p. 349)
  Manic Episode (p. 357)
  Mixed Episode (p. 362)
  Hypomanic Episode (p. 365)

- **Depressive Disorders**
  296.xx Major Depressive Disorder (p. 369)
  300.4 Dysthymic Disorder (p. 376)
  311 Depressive Disorder Not Otherwise Specified (p. 381)

- **Bipolar Disorders**
  296.xx Bipolar I Disorder (p. 382)
  296.89 Bipolar II Disorder (p. 392)
  301.13 Cyclothymic Disorder (p. 398)
  296.80 Bipolar Disorder Not Otherwise Specified (p. 400)

- **Other Mood Disorders**
  293.83 Mood Disorder Due to . . . *[Indicate the General Medical Condition]* (p. 401)
  29x.xx Substance-Induced Mood Disorder (p. 405)
  296.90 Mood Disorder Not Otherwise Specified (p. 410)

- **Specifiers describing the clinical status of the current (or most recent) mood episode**
  Mild, Moderate, Severe Without Psychotic Features, Severe With Psychotic Features, In Partial Remission, In Full Remission (for Major Depressive Episode, p. 411; for Manic Episode, p. 413; for Mixed Episode, p. 415)

- **Specifiers describing features of the current episode (or most recent episode if currently in partial or full remission)**
  Chronic (p. 417)
  With Catatonic Features (p. 417)
  With Melancholic Features (p. 419)
  With Atypical Features (p. 420)
  With Postpartum Onset (p. 422)

- **Specifiers describing course of recurrent episodes**
  Longitudinal Course Specifiers (With and Without Full Interepisode Recovery) (p. 424)
  With Seasonal Pattern (p. 425)
  With Rapid Cycling (p. 427)

Recording Procedures for Major Depressive Disorder and Bipolar I and Bipolar II Disorders

Selecting diagnostic codes. The diagnostic codes are selected as follows:

For Major Depressive Disorder:

1. The first three digits are 296.
2. The fourth digit is either 2 (if there is only a single Major Depressive Episode) or 3 (if there are recurrent Major Depressive Episodes).
3. The fifth digit indicates the severity of the current Major Depressive Episode if full criteria are met as follows: 1 for Mild severity, 2 for Moderate severity, 3 for Severe Without Psychotic Features, 4 for Severe With Psychotic Features. If full criteria are not currently met for a Major Depressive Episode, the fifth digit indicates the current clinical status of the Major Depressive Disorder as follows: 5 for In Partial Remission, 6 for In Full Remission. If current severity or clinical status is unspecified, the fifth digit is 0.

For Bipolar I Disorder:

1. The first three digits are also 296.
2. The fourth digit is 0 if there is a single Manic Episode. For recurrent episodes, the fourth digit indicates the nature of the current episode (or, if the Bipolar I Disorder is currently in partial or full remission, the nature of the most recent episode) as follows: 4 if the current or most recent episode is a Hypomanic Episode or a Manic Episode, 6 if it is a Mixed Episode, 5 if it is a Major Depressive Episode, and 7 if the current or most recent episode is Unspecified.
3. The fifth digit (except for Bipolar I Disorder, Most Recent Episode Hypomanic, and Bipolar I Disorder, Most Recent Episode Unspecified) indicates the severity of the current episode if full criteria are met for a Manic, Mixed, or Major Depressive Episode as follows: 1 for Mild severity, 2 for Moderate severity, 3 for Severe Without Psychotic Features, 4 for Severe With Psychotic Features. If full criteria are not met for a Manic, Mixed, or Major Depressive Episode, the fifth digit indicates the current clinical status of the Bipolar I Disorder as follows: 5 for In Partial Remission, 6 for In Full Remission. If current severity or clinical status is unspecified, the fifth digit is 0. For Bipolar I Disorder, Most Recent Episode Hypomanic, the fifth digit is always 0. For Bipolar Disorder, Most Recent Episode Unspecified, there is no fifth digit.

For Bipolar II Disorder, the diagnostic code is 296.89.

Recording the name of the diagnosis. In recording the name of a diagnosis, terms should be listed in the following order:

1. Name of disorder (e.g., Major Depressive Disorder, Bipolar Disorder)
2. Specifiers coded in the fourth digit (e.g., Recurrent, Most Recent Episode Manic)
3. Specifiers coded in the fifth digit (e.g., Mild, Severe With Psychotic Features, In Partial Remission)
4. As many specifiers (without codes) as apply to the current or most recent episode (e.g., With Melancholic Features, With Postpartum Onset)
5. As many specifiers (without codes) as apply to the course of recurrent episodes (e.g., With Seasonal Pattern, With Rapid Cycling)

The following examples illustrate how to record a Mood Disorder diagnosis with specifiers:

- 296.32 Major Depressive Disorder, Recurrent, Moderate, With Atypical Features, With Seasonal Pattern, With Full Interepisode Recovery
- 296.54 Bipolar I Disorder, Most Recent Episode Depressed, Severe With Psychotic Features, With Melancholic Features, With Rapid Cycling

Mood Episodes

Major Depressive Episode

Episode Features

The essential feature of a Major Depressive Episode is a period of at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities. In children and adolescents, the mood may be irritable rather than sad. The individual must also experience at least four additional symptoms drawn from a list that includes changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts. To count toward a Major Depressive Episode, a symptom must either be newly present or must have clearly worsened compared with the person's preepisode status. The symptoms must persist for most of the day, nearly every day, for at least 2 consecutive weeks. The episode must be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning. For some individuals with milder episodes, functioning may appear to be normal but requires markedly increased effort.

The mood in a Major Depressive Episode is often described by the person as depressed, sad, hopeless, discouraged, or "down in the dumps" (Criterion A1). In some cases, sadness may be denied at first, but may subsequently be elicited by interview (e.g., by pointing out that the individual looks as if he or she is about to cry). In some individuals who complain of feeling "blah," having no feelings, or feeling anxious, the presence of a depressed mood can be inferred from the person's facial expression and demeanor. Some individuals emphasize somatic complaints (e.g., bodily aches and pains) rather than reporting feelings of sadness. Many individuals report or exhibit increased irritability (e.g., persistent anger, a tendency to respond to events with angry outbursts or blaming others, or an exaggerated sense of frustration over minor matters). In children and adolescents, an irritable or cranky mood may develop rather than a sad or dejected mood. This presentation should be differentiated from a "spoiled child" pattern of irritability when frustrated.

Loss of interest or pleasure is nearly always present, at least to some degree. Individuals may report feeling less interested in hobbies, "not caring anymore," or not feeling any enjoyment in activities that were previously considered pleasurable (Criterion A2). Family members often notice social withdrawal or neglect of pleasurable avocations (e.g., a formerly avid golfer no longer plays, a child who used to enjoy soccer finds excuses not to practice). In some individuals, there is a significant reduction from previous levels of sexual interest or desire.

Appetite is usually reduced, and many individuals feel that they have to force themselves to eat. Other individuals, particularly those encountered in ambulatory settings, may have increased appetite and may crave specific foods (e.g., sweets or other carbohydrates). When appetite changes are severe (in either direction), there

may be a significant loss or gain in weight, or, in children, a failure to make expected weight gains may be noted (Criterion A3).

The most common sleep disturbance associated with a Major Depressive Episode is insomnia (Criterion A4). Individuals typically have middle insomnia (i.e., waking up during the night and having difficulty returning to sleep) or terminal insomnia (i.e., waking too early and being unable to return to sleep). Initial insomnia (i.e., difficulty falling asleep) may also occur. Less frequently, individuals present with oversleeping (hypersomnia) in the form of prolonged sleep episodes at night or increased daytime sleep. Sometimes the reason that the individual seeks treatment is for the disturbed sleep.

Psychomotor changes include agitation (e.g., the inability to sit still, pacing, handwringing; or pulling or rubbing of the skin, clothing, or other objects) or retardation (e.g., slowed speech, thinking, and body movements; increased pauses before answering; speech that is decreased in volume, inflection, amount, or variety of content, or muteness) (Criterion A5). The psychomotor agitation or retardation must be severe enough to be observable by others and not represent merely subjective feelings.

Decreased energy, tiredness, and fatigue are common (Criterion A6). A person may report sustained fatigue without physical exertion. Even the smallest tasks seem to require substantial effort. The efficiency with which tasks are accomplished may be reduced. For example, an individual may complain that washing and dressing in the morning are exhausting and take twice as long as usual.

The sense of worthlessness or guilt associated with a Major Depressive Episode may include unrealistic negative evaluations of one's worth or guilty preoccupations or ruminations over minor past failings (Criterion A7). Such individuals often misinterpret neutral or trivial day-to-day events as evidence of personal defects and have an exaggerated sense of responsibility for untoward events. For example, a realtor may become preoccupied with self-blame for failing to make sales even when the market has collapsed generally and other realtors are equally unable to make sales. The sense of worthlessness or guilt may be of delusional proportions (e.g., an individual who is convinced that he or she is personally responsible for world poverty). Blaming oneself for being sick and for failing to meet occupational or interpersonal responsibilities as a result of the depression is very common and, unless delusional, is not considered sufficient to meet this criterion.

Many individuals report impaired ability to think, concentrate, or make decisions (Criterion A8). They may appear easily distracted or complain of memory difficulties. Those in intellectually demanding academic or occupational pursuits are often unable to function adequately even when they have mild concentration problems (e.g., a computer programmer who can no longer perform complicated but previously manageable tasks). In children, a precipitous drop in grades may reflect poor concentration. In elderly individuals with a Major Depressive Episode, memory difficulties may be the chief complaint and may be mistaken for early signs of a dementia ("pseudodementia"). When the Major Depressive Episode is successfully treated, the memory problems often fully abate. However, in some individuals, particularly elderly persons, a Major Depressive Episode may sometimes be the initial presentation of an irreversible dementia.

Frequently there may be thoughts of death, suicidal ideation, or suicide attempts (Criterion A9). These thoughts range from a belief that others would be better off if

the person were dead, to transient but recurrent thoughts of committing suicide, to actual specific plans of how to commit suicide. The frequency, intensity, and lethality of these thoughts can be quite variable. Less severely suicidal individuals may report transient (1- to 2-minute), recurrent (once or twice a week) thoughts. More severely suicidal individuals may have acquired materials (e.g., a rope or a gun) to be used in the suicide attempt and may have established a location and time when they will be isolated from others so that they can accomplish the suicide. Although these behaviors are associated statistically with suicide attempts and may be helpful in identifying a high-risk group, many studies have shown that it is not possible to predict accurately whether or when a particular individual with depression will attempt suicide. Motivations for suicide may include a desire to give up in the face of perceived insurmountable obstacles or an intense wish to end an excruciatingly painful emotional state that is perceived by the person to be without end.

A diagnosis of a Major Depressive Episode is not made if the symptoms meet criteria for a Mixed Episode (Criterion B). A Mixed Episode is characterized by the symptoms of both a Manic Episode and a Major Depressive Episode occurring nearly every day for at least a 1-week period.

The degree of impairment associated with a Major Depressive Episode varies, but even in mild cases, there must be either clinically significant distress or some interference in social, occupational, or other important areas of functioning (Criterion C). If impairment is severe, the person may lose the ability to function socially or occupationally. In extreme cases, the person may be unable to perform minimal self-care (e.g., feeding or clothing self) or to maintain minimal personal hygiene.

A careful interview is essential to elicit symptoms of a Major Depressive Episode. Reporting may be compromised by difficulties in concentrating, impaired memory, or a tendency to deny, discount, or explain away symptoms. Information from additional informants can be especially helpful in clarifying the course of current or prior Major Depressive Episodes and in assessing whether there have been any Manic or Hypomanic Episodes. Because Major Depressive Episodes can begin gradually, a review of clinical information that focuses on the worst part of the current episode may be most likely to detect the presence of symptoms. The evaluation of the symptoms of a Major Depressive Episode is especially difficult when they occur in an individual who also has a general medical condition (e.g., cancer, stroke, myocardial infarction, diabetes). Some of the criterion items of a Major Depressive Episode are identical to the characteristic signs and symptoms of general medical conditions (e.g., weight loss with untreated diabetes, fatigue with cancer). Such symptoms should count toward a Major Depressive Episode except when they are clearly and fully accounted for by a general medical condition. For example, weight loss in a person with ulcerative colitis who has many bowel movements and little food intake should not be counted toward a Major Depressive Episode. On the other hand, when sadness, guilt, insomnia, or weight loss are present in a person with a recent myocardial infarction, each symptom would count toward a Major Depressive Episode because these are not clearly and fully accounted for by the physiological effects of a myocardial infarction. Similarly, when symptoms are clearly due to mood-incongruent delusions or hallucinations (e.g., a 30-pound weight loss related to not eating because of a delusion that one's food is being poisoned), these symptoms do not count toward a Major Depressive Episode.

By definition, a Major Depressive Episode is not due to the direct physiological effects of a drug of abuse (e.g., in the context of Alcohol Intoxication or Cocaine Withdrawal), to the side effects of medications or treatments (e.g., steroids), or to toxin exposure. Similarly, the episode is not due to the direct physiological effects of a general medical condition (e.g., hypothyroidism) (Criterion D). Moreover, if the symptoms begin within 2 months of the loss of a loved one and do not persist beyond these 2 months, they are generally considered to result from Bereavement (see p. 740), unless they are associated with marked functional impairment or include morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation (Criterion E).

Associated Features and Disorders

Associated descriptive features and mental disorders. Individuals with a Major Depressive Episode frequently present with tearfulness, irritability, brooding, obsessive rumination, anxiety, phobias, excessive worry over physical health, and complaints of pain (e.g., headaches or joint, abdominal, or other pains). During a Major Depressive Episode, some individuals have Panic Attacks that occur in a pattern that meets criteria for Panic Disorder. In children, separation anxiety may occur. Some individuals note difficulty in intimate relationships, less satisfying social interactions, or difficulties in sexual functioning (e.g., anorgasmia in women or erectile dysfunction in men). There may be marital problems (e.g., divorce), occupational problems (e.g., loss of job), academic problems (e.g., truancy, school failure), Alcohol or Other Substance Abuse, or increased utilization of medical services. The most serious consequence of a Major Depressive Episode is attempted or completed suicide. Suicide risk is especially high for individuals with psychotic features, a history of previous suicide attempts, a family history of completed suicides, or concurrent substance use. There may also be an increased rate of premature death from general medical conditions. Major Depressive Episodes often follow psychosocial stressors (e.g., the death of a loved one, marital separation, divorce). Childbirth may precipitate a Major Depressive Episode, in which case the specifier With Postpartum Onset is noted (see p. 422).

Associated laboratory findings. No laboratory findings that are diagnostic of a Major Depressive Episode have been identified. However, a variety of laboratory findings have been noted to be abnormal more often in groups of individuals with Major Depressive Episodes compared with control subjects. It appears that the same laboratory abnormalities are associated with a Major Depressive Episode regardless of whether the episode is part of a Major Depressive, Bipolar I, or Bipolar II Disorder. Most laboratory abnormalities are state dependent (i.e., affected by the presence or absence of depressive symptoms), but some findings may precede the onset of the episode or persist after its remission. Laboratory tests are more likely to be abnormal in episodes with melancholic or psychotic features and in more severely depressed individuals.

Sleep EEG abnormalities may be evident in 40%–60% of outpatients and in up to 90% of inpatients with a Major Depressive Episode. The most frequently associated polysomnographic findings include 1) sleep continuity disturbances, such as pro-

longed sleep latency, increased intermittent wakefulness, and early morning awakening; 2) reduced non–rapid eye movement (NREM) stages 3 and 4 sleep (slow-wave sleep), with a shift in slow-wave activity away from the first NREM period; 3) decreased rapid eye movement (REM) latency (i.e., shortened duration of the first NREM period); 4) increased phasic REM activity (i.e., the number of actual eye movements during REM); and 5) increased duration of REM sleep early in the night. There is evidence that these sleep abnormalities may persist after clinical remission or precede the onset of the initial Major Depressive Episode among those at high risk for a Mood Disorder (e.g., first-degree family members of individuals with Major Depressive Disorder).

The pathophysiology of a Major Depressive Episode may involve a dysregulation of a number of neurotransmitter systems, including the serotonin, norepinephrine, dopamine, acetylcholine, and gamma-aminobutyric acid systems. There is also evidence of alterations of several neuropeptides, including corticotropin-releasing hormone. In some depressed individuals, hormonal disturbances have been observed, including elevated glucocorticoid secretion (e.g., elevated urinary free cortisol levels or dexamethasone nonsuppression of plasma cortisol) and blunted growth hormone, thyroid-stimulating hormone, and prolactin responses to various challenge tests. Functional brain imaging studies document alterations in cerebral blood flow and metabolism in some individuals, including increased blood flow in limbic and paralimbic regions and decreased blood flow in the lateral prefrontal cortex. Depression beginning in late life is associated with alterations in brain structure, including periventricular vascular changes. None of these changes are present in all individuals in a Major Depressive Episode, however, nor is any particular disturbance specific to depression.

Specific Culture, Age, and Gender Features

Culture can influence the experience and communication of symptoms of depression. Underdiagnosis or misdiagnosis can be reduced by being alert to ethnic and cultural specificity in the presenting complaints of a Major Depressive Episode. For example, in some cultures, depression may be experienced largely in somatic terms, rather than with sadness or guilt. Complaints of "nerves" and headaches (in Latino and Mediterranean cultures), of weakness, tiredness, or "imbalance" (in Chinese and Asian cultures), of problems of the "heart" (in Middle Eastern cultures), or of being "heartbroken" (among Hopi) may express the depressive experience. Such presentations combine features of the Depressive, Anxiety, and Somatoform Disorders. Cultures also may differ in judgments about the seriousness of experiencing or expressing dysphoria (e.g., irritability may provoke greater concern than sadness or withdrawal). Culturally distinctive experiences (e.g., fear of being hexed or bewitched, feelings of "heat in the head" or crawling sensations of worms or ants, or vivid feelings of being visited by those who have died) must be distinguished from actual hallucinations or delusions that may be part of a Major Depressive Episode, With Psychotic Features. It is also imperative that the clinician not routinely dismiss a symptom merely because it is viewed as the "norm" for a culture.

The core symptoms of a Major Depressive Episode are the same for children and adolescents, although there are data that suggest that the prominence of characteristic

symptoms may change with age. Certain symptoms such as somatic complaints, irritability, and social withdrawal are particularly common in children, whereas psychomotor retardation, hypersomnia, and delusions are less common in prepuberty than in adolescence and adulthood. In prepubertal children, Major Depressive Episodes occur more frequently in conjunction with other mental disorders (especially Disruptive Behavior Disorders, Attention-Deficit Disorders, and Anxiety Disorders) than in isolation. In adolescents, Major Depressive Episodes are frequently associated with Disruptive Behavior Disorders, Attention-Deficit Disorders, Anxiety Disorders, Substance-Related Disorders, and Eating Disorders. In elderly adults, cognitive symptoms (e.g., disorientation, memory loss, and distractibility) may be particularly prominent.

Women are at significantly greater risk than men to develop Major Depressive Episodes at some point during their lives, with the greatest differences found in studies conducted in the United States and Europe. This increased differential risk emerges during adolescence and may coincide with the onset of puberty. Thereafter, a significant proportion of women report a worsening of the symptoms of a Major Depressive Episode several days before the onset of menses. Studies indicate that depressive episodes occur twice as frequently in women as in men. See the corresponding sections of the texts for Major Depressive Disorder (p. 372), Bipolar I Disorder (p. 385), and Bipolar II Disorder (p. 394) for specific information on gender.

Course

Symptoms of a Major Depressive Episode usually develop over days to weeks. A prodromal period that may include anxiety symptoms and mild depressive symptoms may last for weeks to months before the onset of a full Major Depressive Episode. The duration of a Major Depressive Episode is also variable. An untreated episode typically lasts 4 months or longer, regardless of age at onset. In a majority of cases, there is complete remission of symptoms, and functioning returns to the premorbid level. In a significant proportion of cases (perhaps 20%–30%), some depressive symptoms insufficient to meet full criteria for a Major Depressive Episode may persist for months to years and may be associated with some disability or distress (in which case the specifier In Partial Remission may be noted; p. 412). Partial remission following a Major Depressive Episode appears to be predictive of a similar pattern after subsequent episodes. In some individuals (5%–10%), the full criteria for a Major Depressive Episode continue to be met for 2 or more years (in which case the specifier Chronic may be noted; see p. 417).

Differential Diagnosis

A Major Depressive Episode must be distinguished from a **Mood Disorder Due to a General Medical Condition.** The appropriate diagnosis would be Mood Disorder Due to a General Medical Condition if the mood disturbance is judged to be the direct physiological consequence of a specific general medical condition (e.g., multiple sclerosis, stroke, hypothyroidism) (see p. 401). This determination is based on the history, laboratory findings, or physical examination. If both a Major Depressive Episode and a general medical condition are present but it is judged that the depressive symptoms

are not the direct physiological consequence of the general medical condition, then the primary Mood Disorder is recorded on Axis I (e.g., Major Depressive Disorder) and the general medical condition is recorded on Axis III (e.g., myocardial infarction). This would be the case, for example, if the Major Depressive Episode is considered to be the psychological consequence of having the general medical condition or if there is no etiological relationship between the Major Depressive Episode and the general medical condition.

A **Substance-Induced Mood Disorder** is distinguished from a Major Depressive Episode by the fact that a substance (e.g., a drug of abuse, a medication, or a toxin) is judged to be etiologically related to the mood disturbance (see p. 405). For example, depressed mood that occurs only in the context of withdrawal from cocaine would be diagnosed as Cocaine-Induced Mood Disorder, With Depressive Features, With Onset During Withdrawal.

In elderly persons, it is often difficult to determine whether cognitive symptoms (e.g., disorientation, apathy, difficulty concentrating, memory loss) are better accounted for by a **dementia** or by a Major Depressive Episode. A thorough medical evaluation and an evaluation of the onset of the disturbance, temporal sequencing of depressive and cognitive symptoms, course of illness, and treatment response are helpful in making this determination. The premorbid state of the individual may help to differentiate a Major Depressive Episode from a dementia. In a dementia, there is usually a premorbid history of declining cognitive function, whereas the individual with a Major Depressive Episode is much more likely to have a relatively normal premorbid state and abrupt cognitive decline associated with the depression.

Major Depressive Episodes with prominent irritable mood may be difficult to distinguish from **Manic Episodes with irritable mood** or from **Mixed Episodes.** This distinction requires a careful clinical evaluation of the presence of manic symptoms. If criteria are met for both a Manic Episode and a Major Depressive Episode (except for the 2-week duration) nearly every day for at least a 1-week period, this would constitute a Mixed Episode.

Distractibility and low frustration tolerance can occur in both **Attention-Deficit/Hyperactivity Disorder** and a Major Depressive Episode; if the criteria are met for both, Attention-Deficit/Hyperactivity Disorder may be diagnosed in addition to the Mood Disorder. However, the clinician must be cautious not to overdiagnose a Major Depressive Episode in children with Attention-Deficit/Hyperactivity Disorder whose disturbance in mood is characterized by irritability rather than by sadness or loss of interest.

A Major Depressive Episode that occurs in response to a psychosocial stressor is distinguished from **Adjustment Disorder With Depressed Mood** by the fact that the full criteria for a Major Depressive Episode are not met in Adjustment Disorder. After the loss of a loved one, even if depressive symptoms are of sufficient duration and number to meet criteria for a Major Depressive Episode, they should be attributed to **Bereavement** rather than to a Major Depressive Episode, unless they persist for more than 2 months or include marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Finally, **periods of sadness** are inherent aspects of the human experience. These periods should not be diagnosed as a Major Depressive Episode unless criteria are met for severity (i.e., five out of nine symptoms), duration (i.e., most of the day, nearly

every day for at least 2 weeks), and clinically significant distress or impairment. The diagnosis **Depressive Disorder Not Otherwise Specified** may be appropriate for presentations of depressed mood with clinically significant impairment that do not meet criteria for duration or severity.

Criteria for Major Depressive Episode

A. Five (or more) 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 (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) 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.
(2) 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)
(3) 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.
(4) insomnia or hypersomnia nearly every day
(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
(6) fatigue or loss of energy nearly every day
(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
(9) 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

B. The symptoms do not meet criteria for a Mixed Episode (see p. 365).

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.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Manic Episode

Episode Features

A Manic Episode is defined by a distinct period during which there is an abnormally and persistently elevated, expansive, or irritable mood. This period of abnormal mood must last at least 1 week (or less if hospitalization is required) (Criterion A). The mood disturbance must be accompanied by at least three additional symptoms from a list that includes inflated self-esteem or grandiosity, decreased need for sleep, pressure of speech, flight of ideas, distractibility, increased involvement in goal-directed activities or psychomotor agitation, and excessive involvement in pleasurable activities with a high potential for painful consequences. If the mood is irritable (rather than elevated or expansive), at least four of the above symptoms must be present (Criterion B). The symptoms do not meet criteria for a Mixed Episode, which is characterized by the symptoms of both a Manic Episode and a Major Depressive Episode occurring nearly every day for at least a 1-week period (Criterion C). The disturbance must be sufficiently severe to cause marked impairment in social or occupational functioning or to require hospitalization, or it is characterized by the presence of psychotic features (Criterion D). The episode must not be due to the direct physiological effects of a drug of abuse, a medication, other somatic treatments for depression (e.g., electroconvulsive therapy or light therapy), or toxin exposure. The episode must also not be due to the direct physiological effects of a general medical condition (e.g., multiple sclerosis, brain tumor) (Criterion E).

The elevated mood of a Manic Episode may be described as euphoric, unusually good, cheerful, or high. Although the person's mood may initially have an infectious quality for the uninvolved observer, it is recognized as excessive by those who know the person well. The expansive quality of the mood is characterized by unceasing and indiscriminate enthusiasm for interpersonal, sexual, or occupational interactions. For example, the person may spontaneously start extensive conversations with strangers in public places, or a salesperson may telephone strangers at home in the early morning hours to initiate sales. Although elevated mood is considered the prototypical symptom, the predominant mood disturbance may be irritability, particularly when the person's wishes are thwarted. Lability of mood (e.g., the alternation between euphoria and irritability) is frequently seen.

Inflated self-esteem is typically present, ranging from uncritical self-confidence to marked grandiosity, and may reach delusional proportions (Criterion B1). Individuals may give advice on matters about which they have no special knowledge (e.g., how to run the United Nations). Despite lack of any particular experience or talent, the individual may embark on writing a novel or composing a symphony or seek publicity for some impractical invention. Grandiose delusions are common (e.g., having a special relationship to God or to some public figure from the political, religious, or entertainment world).

Almost invariably, there is a decreased need for sleep (Criterion B2). The person usually awakens several hours earlier than usual, feeling full of energy. When the sleep disturbance is severe, the person may go for days without sleep and yet not feel tired.

Manic speech is typically pressured, loud, rapid, and difficult to interrupt (Criterion B3). Individuals may talk nonstop, sometimes for hours on end, and without regard for others' wishes to communicate. Speech is sometimes characterized by joking, punning, and amusing irrelevancies. The individual may become theatrical, with dramatic mannerisms and singing. Sounds rather than meaningful conceptual relationships may govern word choice (i.e., clanging). If the person's mood is more irritable than expansive, speech may be marked by complaints, hostile comments, or angry tirades.

The individual's thoughts may race, often at a rate faster than can be articulated (Criterion B4). Some individuals with Manic Episodes report that this experience resembles watching two or three television programs simultaneously. Frequently there is flight of ideas evidenced by a nearly continuous flow of accelerated speech, with abrupt changes from one topic to another. For example, while talking about a potential business deal to sell computers, a salesperson may shift to discussing in minute detail the history of the computer chip, the industrial revolution, or applied mathematics. When flight of ideas is severe, speech may become disorganized and incoherent.

Distractibility (Criterion B5) is evidenced by an inability to screen out irrelevant external stimuli (e.g., the interviewer's tie, background noises or conversations, or furnishings in the room). There may be a reduced ability to differentiate between thoughts that are germane to the topic and thoughts that are only slightly relevant or clearly irrelevant.

The increase in goal-directed activity often involves excessive planning of, and excessive participation in, multiple activities (e.g., sexual, occupational, political, religious) (Criterion B6). Increased sexual drive, fantasies, and behavior are often present. The person may simultaneously take on multiple new business ventures without regard for the apparent risks or the need to complete each venture satisfactorily. Almost invariably, there is increased sociability (e.g., renewing old acquaintances or calling friends or even strangers at all hours of the day or night), without regard to the intrusive, domineering, and demanding nature of these interactions. Individuals often display psychomotor agitation or restlessness by pacing or by holding multiple conversations simultaneously (e.g., by telephone and in person at the same time). Some individuals write a torrent of letters on many different topics to friends, public figures, or the media.

Expansiveness, unwarranted optimism, grandiosity, and poor judgment often lead to an imprudent involvement in pleasurable activities such as buying sprees, reckless driving, foolish business investments, and sexual behavior unusual for the person, even though these activities are likely to have painful consequences (Criterion B7). The individual may purchase many unneeded items (e.g., 20 pairs of shoes, expensive antiques) without the money to pay for them. Unusual sexual behavior may include infidelity or indiscriminate sexual encounters with strangers.

The impairment resulting from the disturbance must be severe enough to cause marked impairment in functioning or to require hospitalization to protect the individual from the negative consequences of actions that result from poor judgment (e.g., financial losses, illegal activities, loss of employment, assaultive behavior). By definition, the presence of psychotic features during a Manic Episode constitutes marked impairment in functioning (Criterion D).

Symptoms like those seen in a Manic Episode may be due to the direct effects of

antidepressant medication, electroconvulsive therapy, light therapy, or medication prescribed for other general medical conditions (e.g., corticosteroids). Such presentations are not considered Manic Episodes and do not count toward the diagnosis of Bipolar I Disorder. For example, if a person with recurrent Major Depressive Disorder develops manic symptoms following a course of antidepressant medication, the episode is diagnosed as a Substance-Induced Mood Disorder, With Manic Features, and there is no switch from a diagnosis of Major Depressive Disorder to Bipolar I Disorder. Some evidence suggests that there may be a bipolar "diathesis" in individuals who develop manic-like episodes following somatic treatment for depression. Such individuals may have an increased likelihood of future Manic, Mixed, or Hypomanic Episodes that are not related to substances or somatic treatments for depression. This may be an especially important consideration in children and adolescents.

Associated Features and Disorders

Associated descriptive features and mental disorders. Individuals with a Manic Episode frequently do not recognize that they are ill and resist efforts to be treated. They may travel impulsively to other cities, losing contact with relatives and caretakers. They may change their dress, makeup, or personal appearance to a more sexually suggestive or dramatically flamboyant style that is out of character for them. They may engage in activities that have a disorganized or bizarre quality (e.g., distributing candy, money, or advice to passing strangers). Gambling and antisocial behaviors may accompany the Manic Episode. Ethical concerns may be disregarded even by those who are typically very conscientious (e.g., a stockbroker inappropriately buys and sells stock without the clients' knowledge or permission; a scientist incorporates the findings of others). The person may be hostile and physically threatening to others. Some individuals, especially those with psychotic features, may become physically assaultive or suicidal. Adverse consequences of a Manic Episode (e.g., involuntary hospitalization, difficulties with the law, or serious financial difficulties) often result from poor judgment and hyperactivity. When no longer in the Manic Episode, most individuals are regretful for behaviors engaged in during the Manic Episode. Some individuals describe having a much sharper sense of smell, hearing, or vision (e.g., colors appear very bright). When catatonic symptoms (e.g., stupor, mutism, negativism, and posturing) are present, the specifier With Catatonic Features may be indicated (see p. 417).

Mood may shift rapidly to anger or depression. Depressive symptoms may last moments, hours, or, more rarely, days. Not uncommonly, the depressive symptoms and manic symptoms occur simultaneously. If the criteria for both a Major Depressive Episode and a Manic Episode are prominent every day for at least 1 week, the episode is considered to be a Mixed Episode (see p. 362). As the Manic Episode develops, there is often a substantial increase in the use of alcohol or stimulants, which may exacerbate or prolong the episode.

Associated laboratory findings. No laboratory findings that are diagnostic of a Manic Episode have been identified. However, a variety of laboratory findings have been noted to be abnormal in groups of individuals with Manic Episodes compared with control subjects. Laboratory findings in Manic Episodes include polysomnographic

abnormalities and increased cortisol secretion. There may be abnormalities involving the norepinephrine, serotonin, acetylcholine, dopamine, or gamma-aminobutyric acid neurotransmitter systems, as demonstrated by studies of neurotransmitter metabolites, receptor functioning, pharmacological provocation, and neuroendocrine function.

Specific Culture, Age, and Gender Features

Cultural considerations that were suggested for Major Depressive Episodes are also relevant to Manic Episodes (see p. 353). Manic Episodes in adolescents are more likely to include psychotic features and may be associated with school truancy, antisocial behavior, school failure, or substance use. A significant minority of adolescents appear to have a history of long-standing behavior problems that precede the onset of a frank Manic Episode. It is unclear whether these problems represent a prolonged prodrome to Bipolar Disorder or an independent disorder. See the corresponding sections of the texts for Bipolar I Disorder (p. 385) and Bipolar II Disorder (p. 394) for specific information on gender.

Course

The mean age at onset for a first Manic Episode is the early 20s, but some cases start in adolescence and others start after age 50 years. Manic Episodes typically begin suddenly, with a rapid escalation of symptoms over a few days. Frequently, Manic Episodes occur following psychosocial stressors. The episodes usually last from a few weeks to several months and are briefer and end more abruptly than Major Depressive Episodes. In many instances (50%–60%), a Major Depressive Episode immediately precedes or immediately follows a Manic Episode, with no intervening period of euthymia. If the Manic Episode occurs in the postpartum period, there may be an increased risk for recurrence in subsequent postpartum periods and the specifier With Postpartum Onset is applicable (see p. 422).

Differential Diagnosis

A Manic Episode must be distinguished from a **Mood Disorder Due to a General Medical Condition.** The appropriate diagnosis would be Mood Disorder Due to a General Medical Condition if the mood disturbance is judged to be the direct physiological consequence of a specific general medical condition (e.g., multiple sclerosis, brain tumor, Cushing's syndrome) (see p. 401). This determination is based on the history, laboratory findings, or physical examination. If it is judged that the manic symptoms are not the direct physiological consequence of the general medical condition, then the primary Mood Disorder is recorded on Axis I (e.g., Bipolar I Disorder) and the general medical condition is recorded on Axis III (e.g., myocardial infarction). A late onset of a first Manic Episode (e.g., after age 50 years) should alert the clinician to the possibility of an etiological general medical condition or substance.

A **Substance-Induced Mood Disorder** is distinguished from a Manic Episode by the fact that a substance (e.g., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the mood disturbance (see p. 405). Symptoms like

those seen in a Manic Episode may be precipitated by a drug of abuse (e.g., manic symptoms that occur only in the context of intoxication with cocaine would be diagnosed as Cocaine-Induced Mood Disorder, With Manic Features, With Onset During Intoxication). Symptoms like those seen in a Manic Episode may also be precipitated by antidepressant treatment such as medication, electroconvulsive therapy, or light therapy. Such episodes are also diagnosed as Substance-Induced Mood Disorders (e.g., Amitriptyline-Induced Mood Disorder, With Manic Features; Electroconvulsive Therapy–Induced Mood Disorder, With Manic Features). However, clinical judgment is essential to determine whether the treatment is truly causal or whether a primary Manic Episode happened to have its onset while the person was receiving the treatment (see p. 406).

Manic Episodes should be distinguished from **Hypomanic Episodes.** Although Manic Episodes and Hypomanic Episodes have an identical list of characteristic symptoms, the disturbance in Hypomanic Episodes is not sufficiently severe to cause marked impairment in social or occupational functioning or to require hospitalization. Some Hypomanic Episodes may evolve into full Manic Episodes.

Major Depressive Episodes with prominent irritable mood may be difficult to distinguish from Manic Episodes with irritable mood or from **Mixed Episodes.** This determination requires a careful clinical evaluation of the presence of manic symptoms. If criteria are met for both a Manic Episode and a Major Depressive Episode nearly every day for at least a 1-week period, this would constitute a Mixed Episode.

Attention-Deficit/Hyperactivity Disorder and a Manic Episode are both characterized by excessive activity, impulsive behavior, poor judgment, and denial of problems. Attention-Deficit/Hyperactivity Disorder is distinguished from a Manic Episode by its characteristic early onset (i.e., before age 7 years), chronic rather than episodic course, lack of relatively clear onsets and offsets, and the absence of abnormally expansive or elevated mood or psychotic features.

Criteria for Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

(1) inflated self-esteem or grandiosity
(2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
(3) more talkative than usual or pressure to keep talking
(4) flight of ideas or subjective experience that thoughts are racing
(5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
(7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The symptoms do not meet criteria for a Mixed Episode (see p. 365).

D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

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

Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.

Mixed Episode

Episode Features

A Mixed Episode is characterized by a period of time (lasting at least 1 week) in which the criteria are met both for a Manic Episode and for a Major Depressive Episode nearly every day (Criterion A). The individual experiences rapidly alternating moods (sadness, irritability, euphoria) accompanied by symptoms of a Manic Episode (see p. 357) and a Major Depressive Episode (see p. 349). The symptom presentation frequently includes agitation, insomnia, appetite dysregulation, psychotic features, and suicidal thinking. The disturbance must be sufficiently severe to cause marked impairment in social or occupational functioning or to require hospitalization, or it is

characterized by the presence of psychotic features (Criterion B). The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism) (Criterion C). Symptoms like those seen in a Mixed Episode may be due to the direct effects of antidepressant medication, electroconvulsive therapy, light therapy, or medication prescribed for other general medical conditions (e.g., corticosteroids). Such presentations are not considered Mixed Episodes and do not count toward a diagnosis of Bipolar I Disorder. For example, if a person with recurrent Major Depressive Disorder develops a mixed symptom picture during a course of antidepressant medication, the diagnosis of the episode is Substance-Induced Mood Disorder, With Mixed Features, and there is no switch from a diagnosis of Major Depressive Disorder to Bipolar I Disorder. Some evidence suggests that there may be a bipolar "diathesis" in individuals who develop mixed-like episodes following somatic treatment for depression. Such individuals may have an increased likelihood of future Manic, Mixed, or Hypomanic Episodes that are not related to substances or somatic treatments for depression. This may be an especially important consideration in children and adolescents.

Associated Features and Disorders

Associated descriptive features and mental disorders. Associated features of a Mixed Episode are similar to those for Manic Episodes and Major Depressive Episodes. Individuals may be disorganized in their thinking or behavior. Because individuals in Mixed Episodes experience more dysphoria than do those in Manic Episodes, they may be more likely to seek help.

Associated laboratory findings. Laboratory findings for Mixed Episode are not well studied, although evidence to date suggests physiological and endocrine findings that are similar to those found in severe Major Depressive Episodes.

Specific Culture, Age, and Gender Features

Cultural considerations suggested for Major Depressive Episodes are relevant to Mixed Episodes as well (see p. 353). Mixed episodes appear to be more common in younger individuals and in individuals over age 60 years with Bipolar Disorder and may be more common in males than in females.

Course

Mixed Episodes can evolve from a Manic Episode or from a Major Depressive Episode or may arise de novo. For example, the diagnosis would be changed from Bipolar I Disorder, Most Recent Episode Manic, to Bipolar I Disorder, Most Recent Episode Mixed, for an individual with 3 weeks of manic symptoms followed by 1 week of both manic symptoms and depressive symptoms. Mixed episodes may last weeks to several months and may remit to a period with few or no symptoms or evolve into a Major Depressive Episode. It is far less common for a Mixed Episode to evolve into a Manic Episode.

Differential Diagnosis

A Mixed Episode must be distinguished from a **Mood Disorder Due to a General Medical Condition.** The diagnosis is Mood Disorder Due to a General Medical Condition if the mood disturbance is judged to be the direct physiological consequence of a specific general medical condition (e.g., multiple sclerosis, brain tumor, Cushing's syndrome) (see p. 401). This determination is based on the history, laboratory findings, or physical examination. If it is judged that the mixed manic and depressive symptoms are not the direct physiological consequence of the general medical condition, then the primary Mood Disorder is recorded on Axis I (e.g., Bipolar I Disorder) and the general medical condition is recorded on Axis III (e.g., myocardial infarction).

A **Substance-Induced Mood Disorder** is distinguished from a Mixed Episode by the fact that a substance (e.g., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the mood disturbance (see p. 405). Symptoms like those seen in a Mixed Episode may be precipitated by use of a drug of abuse (e.g., mixed manic and depressive symptoms that occur only in the context of intoxication with cocaine would be diagnosed as Cocaine-Induced Mood Disorder, With Mixed Features, With Onset During Intoxication). Symptoms like those seen in a Mixed Episode may also be precipitated by antidepressant treatment such as medication, electroconvulsive therapy, or light therapy. Such episodes are also diagnosed as Substance-Induced Mood Disorders (e.g., Amitriptyline-Induced Mood Disorder, With Mixed Features; Electroconvulsive Therapy–Induced Mood Disorder, With Mixed Features). However, clinical judgment is essential to determine whether the treatment is truly causal or whether a primary Mixed Episode happened to have its onset while the person was receiving the treatment (see p. 406).

Major Depressive Episodes with prominent irritable mood and **Manic Episodes with prominent irritable mood** may be difficult to distinguish from Mixed Episodes. This determination requires a careful clinical evaluation of the simultaneous presence of symptoms that are characteristic of both a full Manic Episode and a full Major Depressive Episode (except for duration).

Attention-Deficit/Hyperactivity Disorder and a Mixed Episode are both characterized by excessive activity, impulsive behavior, poor judgment, and denial of problems. Attention-Deficit/Hyperactivity Disorder is distinguished from a Mixed Episode by its characteristic early onset (i.e., before age 7 years), chronic rather than episodic course, lack of relatively clear onsets and offsets, and the absence of abnormally expansive or elevated mood or psychotic features. Children with Attention-Deficit/Hyperactivity Disorder also sometimes show depressive symptoms such as low self-esteem and frustration tolerance. If criteria are met for both, Attention-Deficit/Hyperactivity Disorder may be diagnosed in addition to the Mood Disorder.

Criteria for Mixed Episode

A. The criteria are met both for a Manic Episode (see p. 362) and for a Major Depressive Episode (see p. 356) (except for duration) nearly every day during at least a 1-week period.

B. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

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

Note: Mixed-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.

Hypomanic Episode

Episode Features

A Hypomanic Episode is defined as a distinct period during which there is an abnormally and persistently elevated, expansive, or irritable mood that lasts at least 4 days (Criterion A). This period of abnormal mood must be accompanied by at least three additional symptoms from a list that includes inflated self-esteem or grandiosity (nondelusional), decreased need for sleep, pressure of speech, flight of ideas, distractibility, increased involvement in goal-directed activities or psychomotor agitation, and excessive involvement in pleasurable activities that have a high potential for painful consequences (Criterion B). If the mood is irritable rather than elevated or expansive, at least four of the above symptoms must be present. This list of additional symptoms is identical to those that define a Manic Episode (see p. 357) except that delusions or hallucinations cannot be present. The mood during a Hypomanic Episode must be clearly different from the individual's usual nondepressed mood, and there must be a clear change in functioning that is not characteristic of the individual's usual functioning (Criterion C). Because the changes in mood and functioning must be observable by others (Criterion D), the evaluation of this criterion will often require interviewing other informants (e.g., family members). History from other informants is particularly important in the evaluation of adolescents. In contrast to a Manic Episode, a Hypomanic Episode is not severe enough to cause marked impairment in social or occupational functioning or to require hospitalization, and there are no psychotic features (Criterion E). The change in functioning for some individuals may take the form of a marked increase in efficiency, accomplishments, or creativity. However, for others, hypomania can cause some social or occupational impairment.

The mood disturbance and other symptoms must not be due to the direct physiological effects of a drug of abuse, a medication, other treatment for depression (electroconvulsive therapy or light therapy), or toxin exposure. The episode must also not be due to the direct physiological effects of a general medical condition (e.g., multiple sclerosis, brain tumor) (Criterion F). Symptoms like those seen in a Hypomanic Episode may be due to the direct effects of antidepressant medication, electroconvulsive therapy, light therapy, or medication prescribed for other general medical conditions (e.g., corticosteroids). Such presentations are not considered Hypomanic Episodes and do not count toward the diagnosis of Bipolar II Disorder. For example, if a person with recurrent Major Depressive Disorder develops symptoms of a hypomanic-like episode during a course of antidepressant medication, the episode is diagnosed as a Substance-Induced Mood Disorder, With Manic Features, and there is no switch from a diagnosis of Major Depressive Disorder to Bipolar II Disorder. Some evidence suggests that there may be a bipolar "diathesis" in individuals who develop manic- or hypomanic-like episodes following somatic treatment for depression. Such individuals may have an increased likelihood of future Manic or Hypomanic Episodes that are not related to substances or somatic treatments for depression.

The elevated mood in a Hypomanic Episode is described as euphoric, unusually good, cheerful, or high. Although the person's mood may have an infectious quality for the uninvolved observer, it is recognized as a distinct change from the usual self by those who know the person well. The expansive quality of the mood disturbance is characterized by enthusiasm for social, interpersonal, or occupational interactions. Although elevated mood is considered prototypical, the mood disturbance may be irritable or may alternate between euphoria and irritability. Characteristically, inflated self-esteem, usually at the level of uncritical self-confidence rather than marked grandiosity, is present (Criterion B1). There is very often a decreased need for sleep (Criterion B2); the person awakens before the usual time with increased energy. The speech of a person with a Hypomanic Episode is often somewhat louder and more rapid than usual, but is not typically difficult to interrupt. It may be full of jokes, puns, plays on words, and irrelevancies (Criterion B3). Flight of ideas is uncommon and, if present, lasts for very brief periods (Criterion B4).

Distractibility is often present, as evidenced by rapid changes in speech or activity as a result of responding to various irrelevant external stimuli (Criterion B5). The increase in goal-directed activity may involve planning of, and participation in, multiple activities (Criterion B6). These activities are often creative and productive (e.g., writing a letter to the editor, clearing up paperwork). Sociability is usually increased, and there may be an increase in sexual activity. There may be impulsive activity such as buying sprees, reckless driving, or foolish business investments (Criterion B7). However, such activities are usually organized, are not bizarre, and do not result in the level of impairment that is characteristic of a Manic Episode.

Associated Features and Disorders

Associated features of a Hypomanic Episode are similar to those for a Manic Episode. Mood may also be characterized as dysphoric if irritable or depressive symptoms are more prominent than euphoria in the clinical presentation.

Specific Culture and Age Features

Cultural considerations that were suggested for Major Depressive Episodes are relevant to Hypomanic Episodes as well (see p. 353). In younger (e.g., adolescent) persons, Hypomanic Episodes may be associated with school truancy, antisocial behavior, school failure, or substance use.

Course

A Hypomanic Episode typically begins suddenly, with a rapid escalation of symptoms within a day or two. Episodes may last for several weeks to months and are usually more abrupt in onset and briefer than Major Depressive Episodes. In many cases, the Hypomanic Episode may be preceded or followed by a Major Depressive Episode. Studies suggest that 5%–15% of individuals with hypomania will ultimately develop a Manic Episode.

Differential Diagnosis

A Hypomanic Episode must be distinguished from a **Mood Disorder Due to a General Medical Condition.** The diagnosis is Mood Disorder Due to a General Medical Condition if the mood disturbance is judged to be the direct physiological consequence of a specific general medical condition (e.g., multiple sclerosis, brain tumor, Cushing's syndrome) (see p. 401). This determination is based on the history, laboratory findings, or physical examination. If it is judged that the hypomanic symptoms are not the direct physiological consequence of the general medical condition, then the primary Mood Disorder is recorded on Axis I (e.g., Bipolar II Disorder) and the general medical condition is recorded on Axis III (e.g., myocardial infarction).

A **Substance-Induced Mood Disorder** is distinguished from a Hypomanic Episode by the fact that a substance (e.g., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the mood disturbance (see p. 405). Symptoms like those seen in a Hypomanic Episode may be precipitated by a drug of abuse (e.g., hypomanic symptoms that occur only in the context of intoxication with cocaine would be diagnosed as Cocaine-Induced Mood Disorder, With Manic Features, With Onset During Intoxication). Symptoms like those seen in a Hypomanic Episode may also be precipitated by antidepressant treatment such as medication, electroconvulsive therapy, or light therapy. Such episodes are also diagnosed as Substance-Induced Mood Disorders (e.g., Amitriptyline-Induced Mood Disorder, With Manic Features; Electroconvulsive Therapy–Induced Mood Disorder, With Manic Features). However, clinical judgment is essential to determine whether the treatment is truly causal or whether a primary Hypomanic Episode happened to have its onset while the person was receiving the treatment (see p. 406).

Manic Episodes should be distinguished from Hypomanic Episodes. Although Manic Episodes and Hypomanic Episodes have identical lists of characteristic symptoms, the mood disturbance in Hypomanic Episodes is not sufficiently severe to cause marked impairment in social or occupational functioning or to require hospitalization. Some Hypomanic Episodes may evolve into full Manic Episodes.

Attention-Deficit/Hyperactivity Disorder and a Hypomanic Episode are both

characterized by excessive activity, impulsive behavior, poor judgment, and denial of problems. Attention-Deficit/Hyperactivity Disorder is distinguished from a Hypomanic Episode by its characteristic early onset (i.e., before age 7 years), chronic rather than episodic course, lack of relatively clear onsets and offsets, and the absence of abnormally expansive or elevated mood.

A Hypomanic Episode must be distinguished from **euthymia,** particularly in individuals who have been chronically depressed and are unaccustomed to the experience of a nondepressed mood state.

Criteria for Hypomanic Episode

A. A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days, that is clearly different from the usual nondepressed mood.

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

   (1) inflated self-esteem or grandiosity
   (2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
   (3) more talkative than usual or pressure to keep talking
   (4) flight of ideas or subjective experience that thoughts are racing
   (5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
   (6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
   (7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features.

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

Note: Hypomanic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar II Disorder.

Depressive Disorders

Major Depressive Disorder

Diagnostic Features

The essential feature of Major Depressive Disorder is a clinical course that is characterized by one or more Major Depressive Episodes (see p. 349) without a history of Manic, Mixed, or Hypomanic Episodes (Criteria A and C). Episodes of Substance-Induced Mood Disorder (due to the direct physiological effects of a drug of abuse, a medication, or toxin exposure) or of Mood Disorder Due to a General Medical Condition do not count toward a diagnosis of Major Depressive Disorder. In addition, the episodes must not be better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified (Criterion B).

The fourth digit in the diagnostic code for Major Depressive Disorder indicates whether it is a Single Episode (used only for first episodes) or Recurrent. It is sometimes difficult to distinguish between a single episode with waxing and waning symptoms and two separate episodes. For purposes of this manual, an episode is considered to have ended when the full criteria for the Major Depressive Episode have not been met for at least 2 consecutive months. During this 2-month period, there is either complete resolution of symptoms or the presence of depressive symptoms that no longer meet the full criteria for a Major Depressive Episode (In Partial Remission).

The fifth digit in the diagnostic code for Major Depressive Disorder indicates the current state of the disturbance. If the criteria for a Major Depressive Episode are met, the severity of the episode is noted as Mild, Moderate, Severe Without Psychotic Features, or Severe With Psychotic Features. If the criteria for a Major Depressive Episode are not currently met, the fifth digit is used to indicate whether the disorder is In Partial Remission or In Full Remission (see p. 412).

If Manic, Mixed, or Hypomanic Episodes develop in the course of Major Depressive Disorder, the diagnosis is changed to a Bipolar Disorder. However, if manic or hypomanic symptoms occur as a direct effect of antidepressant treatment, use of other medications, substance use, or toxin exposure, the diagnosis of Major Depressive Disorder remains appropriate and an additional diagnosis of Substance-Induced Mood Disorder, With Manic Features (or With Mixed Features), should be noted. Similarly, if manic or hypomanic symptoms occur as a direct effect of a general medical condition, the diagnosis of Major Depressive Disorder remains appropriate and an additional diagnosis of Mood Disorder Due to a General Medical Condition, With Manic Features (or With Mixed Features), should be noted.

Specifiers

If the full criteria are currently met for a Major Depressive Episode, the following specifiers may be used to describe the current clinical status of the episode and to describe features of the current episode:

Mild, Moderate, Severe Without Psychotic Features, Severe With Psychotic Features (see p. 411)
Chronic (see p. 417)
With Catatonic Features (see p. 417)
With Melancholic Features (see p. 419)
With Atypical Features (see p. 420)
With Postpartum Onset (see p. 422)

If the full criteria are not currently met for a Major Depressive Episode, the following specifiers may be used to describe the current clinical status of the Major Depressive Disorder and to describe features of the most recent episode:

In Partial Remission, In Full Remission (see p. 411)
Chronic (see p. 417)
With Catatonic Features (see p. 417)
With Melancholic Features (see p. 419)
With Atypical Features (see p. 420)
With Postpartum Onset (see p. 422)

The following specifiers may be used to indicate the pattern of the episodes and the presence of interepisode symptoms for Major Depressive Disorder, Recurrent:

Longitudinal Course Specifiers (With and Without Full Interepisode Recovery) (see p. 424)
With Seasonal Pattern (see p. 425)

Recording Procedures

The diagnostic codes for Major Depressive Disorder are selected as follows:

1. The first three digits are 296.
2. The fourth digit is either 2 (if there is only a single Major Depressive Episode) or 3 (if there are recurrent Major Depressive Episodes).
3. If the full criteria are currently met for a Major Depressive Episode, the fifth digit indicates the current severity as follows: 1 for Mild severity, 2 for Moderate severity, 3 for Severe Without Psychotic Features, 4 for Severe With Psychotic Features. If the full criteria are not currently met for a Major Depressive Episode, the fifth digit indicates the current clinical status of the Major Depressive Disorder as follows: 5 for In Partial Remission, 6 for In Full Remission. If the severity of the current episode or the current remission status of the disorder is unspecified, then the fifth digit is 0. Other specifiers for Major Depressive Disorder cannot be coded.

In recording the name of a diagnosis, terms should be listed in the following order: Major Depressive Disorder, specifiers coded in the fourth digit (e.g., Recurrent), specifiers coded in the fifth digit (e.g., Mild, Severe With Psychotic Features, In Partial Remission), as many specifiers (without codes) as apply to the current or most recent episode (e.g., With Melancholic Features, With Postpartum Onset), and as many

specifiers (without codes) as apply to the course of episodes (e.g., With Full Interepisode Recovery); for example, 296.32 Major Depressive Disorder, Recurrent, Moderate, With Atypical Features, With Seasonal Pattern, With Full Interepisode Recovery.

Associated Features and Disorders

Associated descriptive features and mental disorders. Major Depressive Disorder is associated with high mortality. Up to 15% of individuals with severe Major Depressive Disorder die by suicide. Epidemiological evidence also suggests that there is a fourfold increase in death rates in individuals with Major Depressive Disorder who are over age 55 years. Individuals with Major Depressive Disorder admitted to nursing homes may have a markedly increased likelihood of death in the first year. Among individuals seen in general medical settings, those with Major Depressive Disorder have more pain and physical illness and decreased physical, social, and role functioning.

Major Depressive Disorder may be preceded by Dysthymic Disorder (10% in epidemiological samples and 15%–25% in clinical samples). It is also estimated that each year approximately 10% of individuals with Dysthymic Disorder alone will go on to have a first Major Depressive Episode. Other mental disorders frequently co-occur with Major Depressive Disorder (e.g., Substance-Related Disorders, Panic Disorder, Obsessive-Compulsive Disorder, Anorexia Nervosa, Bulimia Nervosa, Borderline Personality Disorder).

Associated laboratory findings. The laboratory abnormalities that are associated with Major Depressive Disorder are those associated with Major Depressive Episode (see p. 352). None of these findings are diagnostic of Major Depressive Disorder, but they have been noted to be abnormal in groups of individuals with Major Depressive Disorder compared with control subjects. Neurobiological disturbances such as elevated glucocorticoid levels and EEG sleep alterations are more prevalent among individuals with Psychotic Features and those with more severe episodes or with Melancholic Features. Most laboratory abnormalities are state dependent (i.e., are present only when depressive symptoms are present). However, evidence suggests that some sleep EEG abnormalities persist into clinical remission or may precede the onset of the Major Depressive Episode.

Associated physical examination findings and general medical conditions. Individuals with chronic or severe general medical conditions are at increased risk to develop Major Depressive Disorder. Up to 20%–25% of individuals with certain general medical conditions (e.g., diabetes, myocardial infarction, carcinomas, stroke) will develop Major Depressive Disorder during the course of their general medical condition. The management of the general medical condition is more complex and the prognosis is less favorable if Major Depressive Disorder is present. In addition, the prognosis of Major Depressive Disorder is adversely affected (e.g., longer episodes or poorer responses to treatment) by concomitant chronic general medical conditions.

Specific Culture, Age, and Gender Features

Specific culture-related features are discussed in the text for Major Depressive Episode (see p. 353). Epidemiological studies suggest significant cohort effects in risk of depression. For example, individuals born between 1940 and 1950 appear to have an earlier age at onset and a greater lifetime risk of depression than those born prior to 1940. There is some evidence that Atypical Features are more common in younger people and that Melancholic Features are more common in older depressed people. Among those with an onset of depression in later life, there is evidence of subcortical white matter hyperintensities associated with cerebrovascular disease. These "vascular" depressions are associated with greater neuropsychological impairments and poorer responses to standard therapies. Major Depressive Disorder (Single or Recurrent) is twice as common in adolescent and adult females as in adolescent and adult males. In prepubertal children, boys and girls are equally affected.

Prevalence

Studies of Major Depressive Disorder have reported a wide range of values for the proportion of the adult population with the disorder. The lifetime risk for Major Depressive Disorder in community samples has varied from 10% to 25% for women and from 5% to 12% for men. The point prevalence of Major Depressive Disorder in adults in community samples has varied from 5% to 9% for women and from 2% to 3% for men. The prevalence rates for Major Depressive Disorder appear to be unrelated to ethnicity, education, income, or marital status.

Course

Major Depressive Disorder may begin at any age, with an average age at onset in the mid-20s. Epidemiological data suggest that the age at onset is decreasing for those born more recently. The course of Major Depressive Disorder, Recurrent, is variable. Some people have isolated episodes that are separated by many years without any depressive symptoms, whereas others have clusters of episodes, and still others have increasingly frequent episodes as they grow older. Some evidence suggests that the periods of remission generally last longer early in the course of the disorder. The number of prior episodes predicts the likelihood of developing a subsequent Major Depressive Episode. At least 60% of individuals with Major Depressive Disorder, Single Episode, can be expected to have a second episode. Individuals who have had two episodes have a 70% chance of having a third, and individuals who have had three episodes have a 90% chance of having a fourth. About 5%–10% of individuals with Major Depressive Disorder, Single Episode, subsequently develop a Manic Episode (i.e., develop Bipolar I Disorder).

Major Depressive Episodes may end completely (in about two-thirds of cases), or only partially or not at all (in about one-third of cases). For individuals who have only partial remission, there is a greater likelihood of developing additional episodes and of continuing the pattern of partial interepisode recovery. The longitudinal course specifiers With Full Interepisode Recovery and Without Full Interepisode Recovery (see p. 424) may therefore have prognostic value. A number of individuals have pre-

existing Dysthymic Disorder prior to the onset of Major Depressive Disorder, Single Episode. Some evidence suggests that these individuals are more likely to have additional Major Depressive Episodes, have poorer interepisode recovery, and may require additional acute-phase treatment and a longer period of continuing treatment to attain and maintain a more thorough and longer-lasting euthymic state.

Follow-up naturalistic studies suggested that 1 year after the diagnosis of a Major Depressive Episode, 40% of individuals still have symptoms that are sufficiently severe to meet criteria for a full Major Depressive Episode, roughly 20% continue to have some symptoms that no longer meet full criteria for a Major Depressive Episode (i.e., Major Depressive Disorder, In Partial Remission), and 40% have no Mood Disorder. The severity of the initial Major Depressive Episode appears to predict persistence. Chronic general medical conditions are also a risk factor for more persistent episodes.

Episodes of Major Depressive Disorder often follow a severe psychosocial stressor, such as the death of a loved one or divorce. Studies suggest that psychosocial events (stressors) may play a more significant role in the precipitation of the first or second episodes of Major Depressive Disorder and may play less of a role in the onset of subsequent episodes. Chronic general medical conditions and Substance Dependence (particularly Alcohol or Cocaine Dependence) may contribute to the onset or exacerbation of Major Depressive Disorder.

It is difficult to predict whether the first episode of a Major Depressive Disorder in a young person will ultimately evolve into a Bipolar Disorder. Some data suggest that the acute onset of severe depression, especially with psychotic features and psychomotor retardation, in a young person without prepubertal psychopathology is more likely to predict a bipolar course. A family history of Bipolar Disorder may also be suggestive of subsequent development of Bipolar Disorder.

Familial Pattern

Major Depressive Disorder is 1.5–3 times more common among first-degree biological relatives of persons with this disorder than among the general population. There is evidence for an increased risk of Alcohol Dependence in adult first-degree biological relatives, and there may be an increased incidence of an Anxiety Disorder (e.g., Panic Disorder, Social Phobia) or Attention-Deficit/Hyperactivity Disorder in the children of adults with Major Depressive Disorder.

Differential Diagnosis

See the "Differential Diagnosis" section for Major Depressive Episode (p. 354). A history of a **Manic, Mixed,** or **Hypomanic Episode** precludes the diagnosis of Major Depressive Disorder. The presence of Hypomanic Episodes (without any history of Manic Episodes) indicates a diagnosis of Bipolar II Disorder. The presence of Manic or Mixed Episodes (with or without Hypomanic Episodes) indicates a diagnosis of Bipolar I Disorder.

Major Depressive Episodes in Major Depressive Disorder must be distinguished from a **Mood Disorder Due to a General Medical Condition.** The diagnosis is Mood Disorder Due to a General Medical Condition if the mood disturbance is judged to be

the direct physiological consequence of a specific general medical condition (e.g., multiple sclerosis, stroke, hypothyroidism) (see p. 401). This determination is based on the history, laboratory findings, or physical examination. If it is judged that the depressive symptoms are not the direct physiological consequence of the general medical condition, then the primary Mood Disorder is recorded on Axis I (e.g., Major Depressive Disorder) and the general medical condition is recorded on Axis III (e.g., myocardial infarction). This would be the case, for example, if the Major Depressive Episode is considered to be the psychological consequence of having the general medical condition or if there is no etiological relationship between the Major Depressive Episode and the general medical condition.

A **Substance-Induced Mood Disorder** is distinguished from Major Depressive Episodes in Major Depressive Disorder by the fact that a substance (e.g., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the mood disturbance (see p. 405). For example, depressed mood that occurs only in the context of withdrawal from cocaine would be diagnosed as Cocaine-Induced Mood Disorder, With Depressive Features, With Onset During Withdrawal.

Dysthymic Disorder and Major Depressive Disorder are differentiated based on severity, chronicity, and persistence. In Major Depressive Disorder, the depressed mood must be present for most of the day, nearly every day, for a period of at least 2 weeks, whereas Dysthymic Disorder must be present for more days than not over a period of at least 2 years. The differential diagnosis between Dysthymic Disorder and Major Depressive Disorder is made particularly difficult by the fact that the two disorders share similar symptoms and that the differences between them in onset, duration, persistence, and severity are not easy to evaluate retrospectively. Usually Major Depressive Disorder consists of one or more discrete Major Depressive Episodes that can be distinguished from the person's usual functioning, whereas Dysthymic Disorder is characterized by chronic, less severe depressive symptoms that have been present for many years. If the initial onset of chronic depressive symptoms is of sufficient severity and number to meet criteria for a Major Depressive Episode, the diagnosis would be Major Depressive Disorder, Chronic (if the criteria are still met), or Major Depressive Disorder, In Partial Remission (if the criteria are no longer met). The diagnosis of Dysthymic Disorder is made following Major Depressive Disorder only if the Dysthymic Disorder was established prior to the first Major Depressive Episode (i.e., no Major Depressive Episodes during the first 2 years of dysthymic symptoms), or if there has been a full remission of the Major Depressive Episode (i.e., lasting at least 2 months) before the onset of the Dysthymic Disorder.

Schizoaffective Disorder differs from Major Depressive Disorder, With Psychotic Features, by the requirement that in Schizoaffective Disorder there must be at least 2 weeks of delusions or hallucinations occurring in the absence of prominent mood symptoms. Depressive symptoms may be present during **Schizophrenia, Delusional Disorder,** and **Psychotic Disorder Not Otherwise Specified.** Most commonly, such depressive symptoms can be considered associated features of these disorders and do not merit a separate diagnosis. However, when the depressive symptoms meet full criteria for a Major Depressive Episode (or are of particular clinical significance), a diagnosis of Depressive Disorder Not Otherwise Specified may be made in addition to the diagnosis of Schizophrenia, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified. Schizophrenia, Catatonic Type, may be difficult to distinguish from